Office Hour: Data Sharing at the Point of Care

February 16, 2024

Social Determinants of Health (SDOH): Social Needs Screening & Referral Measure Technical Assistance

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

Topic & Purpose

Today's featured topic: Using SDOH data at the point of care

Why is this important?

- Facilitates comprehension and utilization of SDOH screening and referral protocols
- Improves overall quality of care
- Works to mitigate health and social disparities by facilitating equitable access to vital social resources
- Supports the HRSN benefit roll-out

Today's Agenda

- Measure Requirements
- Discussion Kick Off: Liz Fero, OHSU
- Interactive Discussion
- Open Question & Answer Forum: **Priority questions related to all aspects of metric implementation**

Measure requirements related to data sharing at the point of care

15. Support a Data-Sharing Approach (Set up by MY 2024 & maintain in MY 2025)

Intent:
CCOs support networked providers to have access, at the point of care, to screening results and referral(s) made, even if the screening or referral occurs at the CCO level or at another clinic.

This element is met if the CCO provides access to a tool or tools that enable screening and referral data to be shared among networked providers who care for members or if the CCO otherwise ensures that networked providers use tools to share screening and referral data. Tools may include, for example, a Community Information Exchange (CIE), Health Information Exchange (HIE) or other screening and referral system for networked providers that enables screening and referral data to be shared.

Emerging Strategies around Data Sharing at the Point of Care

Liz Fero (she/her)
Primary Care Integration
Oregon Health & Science University

Screening for Social Determinants of Health Overview

Liz Fero MSN, RN, CPN and David Froelich
DATE: February 9th 2024

Background

Screening for social determinants of health (SDOH)

- *SDOH is a significant factor in health outcomes*
- *Increasingly screening is an expectation of health systems and a requirement of value-based programs (PCPCH, PCF, CCO metric for 2025)*
- *An Ambulatory Implementation Workgroup was asked to develop workflows & other elements including*
  - *Method of administration*
  - *Frequency of screening*
  - *Recommendations for Epic build*
  - *Trauma-informed care training*
  - *Support Connect Oregon / Unite Us launch*

There are eleven SDOH domains in the Wheel:

- Alcohol Use
- Depression
- Financial Resource Strain
- Food Insecurity
- Housing Stability
- Intimate Partner Violence
- Physical Activity
- Social Connections
- Stress
- Tobacco Use
- Transportation Needs

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Key Points for SDoH Screening

Domains – start small, focus on 4 key areas (with 9 related questions):

- Housing, Food Insecurity, Transportation, Financial Strain + "We cannot help with every need, but we can help look for resources. Would you like to talk with someone about this?"
- Other domains/questions will still be available in Epic (wheel, flowsheet), but will not appear on questionnaires

Workflow options:

- Paper-based Questionnaire (for patients with a visit – identifiable by column on the DAR)
- MyChart PreCheck Questionnaire (tied to visit type – annual preventive exam, WCCs)
- All patients, regardless of payor, will be screened for SDoH at least once a year

Recommended frequency of screening:

- Patients 3+yrs to be screened annually at minimum
- Pediatric patients under 2 to be screened twice a year

Epic Build:

- SDOH wheel added to the patient snapshot in Epic (in addition to being in the Longitudinal Plan of Care)
- Column in DAR indicating that a patient is due for SDOH screening

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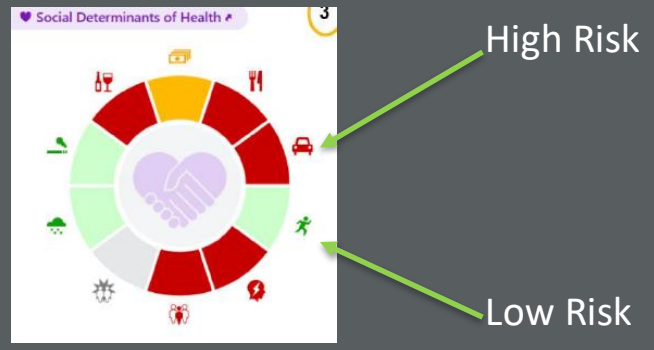
Additional Details

Clinic workflow:

- Patient answers through the MyChart pre-check in screening will populate the SDoH wheel for provider review



- Patients who request clinic support will have an automated email generated and sent to the clinic's preferred inbasket (most clinics have these go directly to the clinic social worker)
- Paper screenings will take place post check in and MA would enter patient responses via EPIC flowsheet
- EPIC wheel be populated once responses are entered & if a patient is high risk and requests to talk with a social worker the regular clinic workflow for social work hand off will take place
- Social workers have access to Connect Oregon and other resources to support the patient with the SDoH risks

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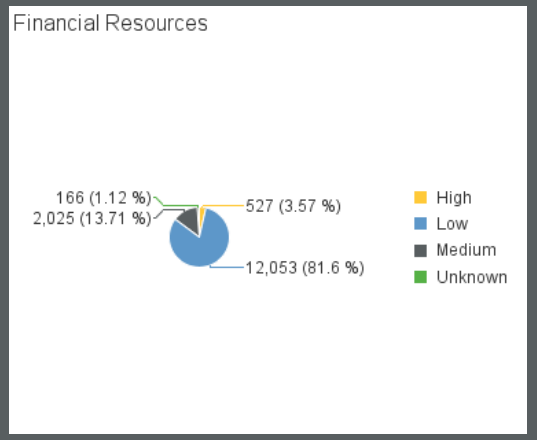
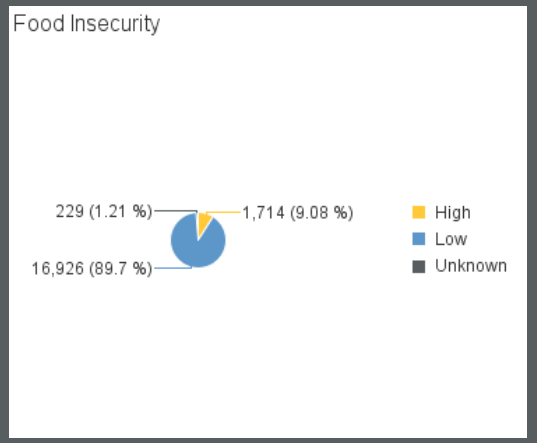
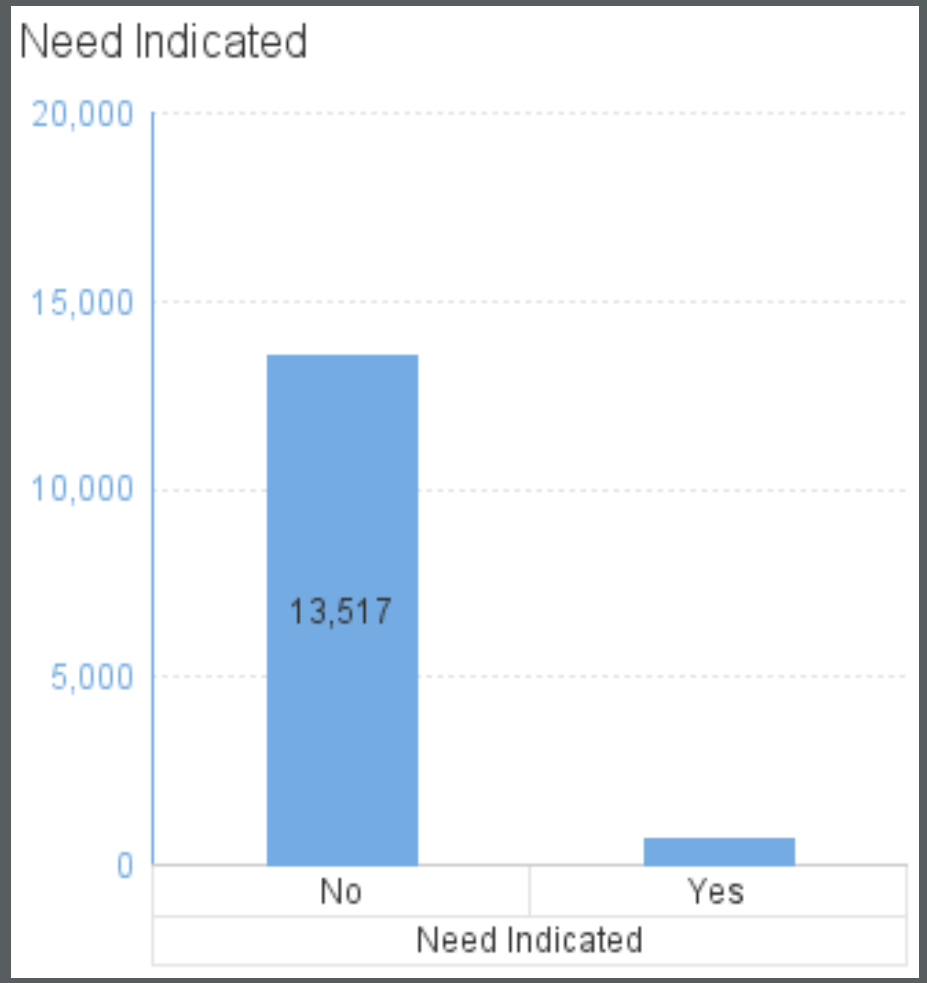
SDOH Data Dashboard







- SDoH Data collects percentages of patients & the SDoH to the 4 domains on the screening tool
- Data on patients who answer "yes" to speaking with a social worker at the clinic are recorded
- Data from social worker's referrals to community based organizations are collected in the Unite Us dashboard which is currently under development

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Discussion Questions

- What is one key takeaway you have from Liz's presentation?
- Is your CCO approaching this similarly or differently? How so?
- What has your CCO learned about how your clinical and community partners are using social needs screening data at the point of care?