TITLE: Incorporating social determinants of health and social needs in health care through research, quality improvement, and policy to advance health equity

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STUDENT SUBMISSION: No

TOPIC/TARGET AUDIENCE: Primary care clinics, CCOs, program evaluators, policy makers

ABSTRACT: It is broadly recognized that the social determinants of health and equity significantly impact length and quality of life. Downstream of these social determinants are an individual's social needs, which have been associated with poor health outcomes. Addressing social determinants of health and patients' social needs has the potential to improve health at both the population and individual levels as well as advance health equity. Therefore, there are increasing interests and efforts to incorporate social determinants of health and patients' social needs in health care. Through presentations about the Accountable Health Communities study, utilizing social needs data to address chronic diseases, and Medicaid flexibilities, this panel provides information about incorporating social determinants of health and social needs in health care. This panel highlights the importance of collaboration across health care, public health, and social service sectors. It provides an opportunity to discuss current work on understanding and addressing social determinants of health and social needs in Oregon.

OBJECTIVE(S): Describe current work happening in Oregon to incorporate social determinants of health in healthcare. Describe results from the Oregon Accountable Health Communities study. List strategies to utilize social needs data in a clinical setting from a quality improvement project. Identify strategies of CCOs in utilizing Medicaid flexibilities to address social needs.

PANEL MODERATOR: Anne King, MBA, CPM, Oregon Rural Practice-based Research Network, Oregon Health & Science University

PANEL ABSTRACT 1: The Study: The Oregon Accountable Health Communities (AHC) is one of 28 grantee sites nationally awarded by the Centers for Medicare and Medicaid Services (CMS) to screen Medicare and Medicaid beneficiaries for health-related social needs (HRSNs) in clinical settings, and connect (or navigate) beneficiaries to resources that can address their needs. Oregon's AHC model is unique due to its collaboration with Care Coordinated Organizations (CCO), public health departments, and health systems across the state to understand HRSN amongst Oregon's most vulnerable residents. Nearly 25,000 individual Oregonians were screened through the AHC model. The problem: Understanding the social needs of Oregon Medicare and Medicaid patients. Approach: Medicare and Medicaid beneficiaries connected to participating health systems across the state were offered the AHC screener. Based on eligibility criteria, beneficiaries were offered one of two interventions, depending on the prevalence of their social needs. Results: Social needs are prevalent in Oregon with 47% of survey respondents reporting at least 1 social need. Implications: Project partners, as well as people and organizations across the state, were informed of the most prevalent needs and resource gaps for these populations. This study has set the stage for further social needs work in Oregon.

PRESENTER 1: Zoe Major-McDowall

PANEL ABSTRACT 2: There is a growing body of evidence that addressing patients' social needs in a health care setting can improve patient health. While many primary care clinics in Oregon see the importance of understanding their patients' social needs, many need support to utilize that information. Oregon Rural Practice-based Research Network, in partnership with the Oregon Health Authority Public Health Division, Health Promotion and Chronic Disease Prevention Section, is providing education and technical assistance to clinics in Oregon around incorporating social needs in primary care. The program supports clinics in increasing social needs screening rates and using social needs data to inform clinical interventions to prevent and manage chronic diseases and advance health equity. This presentation provides examples of how social needs data can be used to inform clinical interventions as well as share strategies from clinics that are involved in this work. Primary care clinics across the state can use this information to inform social needs work within their own patient populations.

PRESENTER 2: Sara Wild, MPH

PANEL ABSTRACT 3: Medicaid flexibilities offered through Oregon's 1115 waiver provide integral funding structures to address the social determinants of health and equity (SDOH-E) in health care. Oregon Rural Practice-based Research Network provided technical assistance and educational programming to 16 Coordinated Care Organizations (CCOs) in implementing three flexibilities: Health-Related Services (HRS) and In Lieu of Services (ILOS) to address member and community needs beyond covered benefits in the Medicaid State Plan. Specific examples and strategies of CCOs using these flexibilities will be presented. Utilization of these structures, informed by member data and strong community partnerships, allow CCOs to understand and systemically address and fund the SDOH and social needs to advance health equity.

PRESENTER 3: Hannah Bryan