From Food Insecurity to Addressing Other Social Determinants of Health: Measurement Proposal

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Presentation Outline

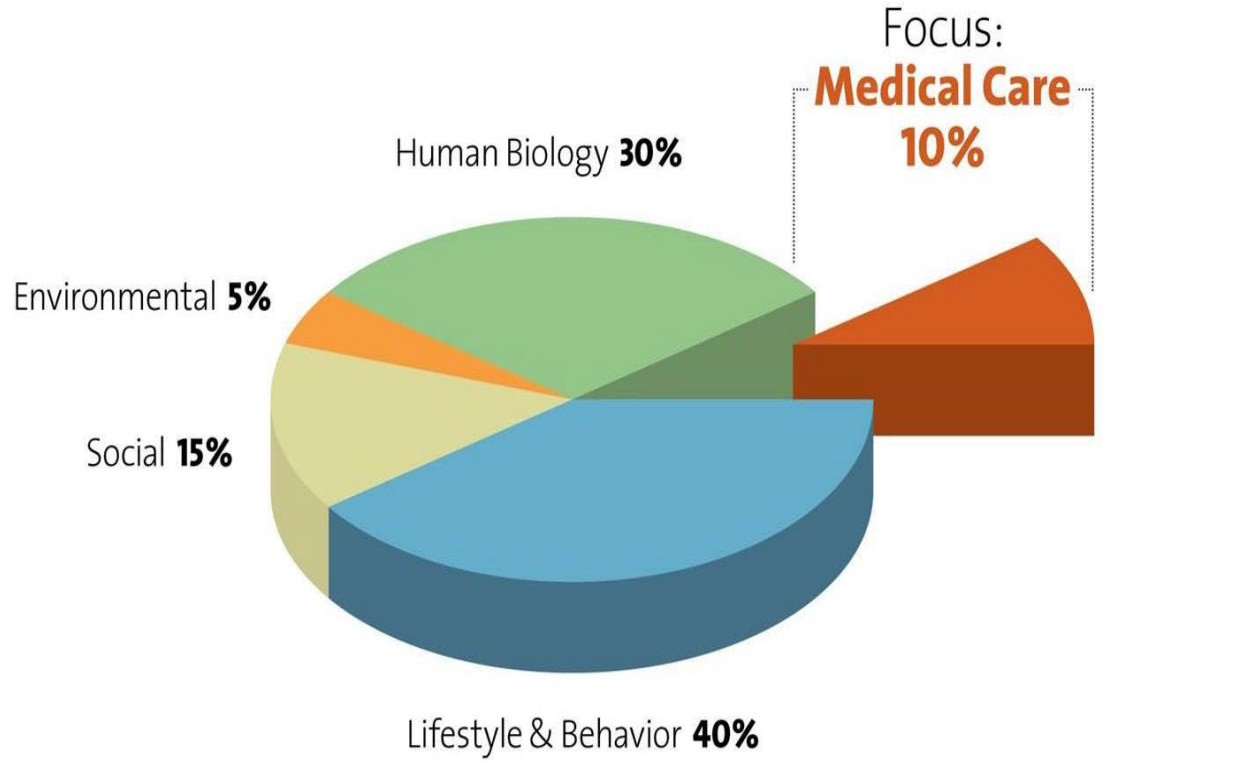
- History and current opportunity
- Summary of eastern state models for measuring social determinants of health at the plan level
- Next steps

History

- **July 2015 – July 2016:** TAG began discussions of a potential food insecurity screening measure following Metrics & Scoring Committee interest, ultimately developing a specification at the provider / clinic level
- **November 2017**: Metrics & Scoring Committee includes measure of food insecurity screening in list of 26 measures proposed to HPQMC
- **April 2018**: Based on Metrics & Scoring Committee recommendation, HPQMC includes food insecurity as one of its 16 developmental measures and subsequently highlights it as a high priority in terms of further development (crafting a reliable measure at the plan level)

Current State

- During this time, there has also been significant movement in the field around the social determinants of health (including, but not limited to, food insecurity).



SDH Domains in Commonly Used National Tools

PRAPARE

- Housing & stability
- Material Security (includes food security)
- Transportation
- Income
- Employment
- Education
- Race, Ethnicity, & language
- Migrant and/or seasonal farm work
- Veteran status
- Address/neighborhood
- Insurance
- Social integration and support
- Stress
- Optional measures on incarceration, refugee status, safety, and domestic violence

ACH Screening Tool

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs
- Interpersonal safety
- Financial strain
- Employment
- Family and community support
- Education
- Physical activity
- Substance use
- Mental health
- Disabilities

PRAPARE and AHC Cross walk

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Domain/topic	*PRAPARE*	*AHC*
Education	**10. What is the highest level of school that you have finished?** a. Less than a high school degree b. High school diploma or GED c. More than high school d. I choose not to answer this question	**(Optional) 33. What is the highest grade or year of school you completed?** □Never attended school or only attended kindergarten □Grades 1 through 8 (Elementary) □Grades 9 through 11 (Some high school) □Grade 12 or GED (High school graduate, diploma, or alternative credential) □College 1 year to 3 years (Some college, Associate's degree, trade, vocational, or technical school) □College 4 years or more (College graduate)
Housing	**7. What is your housing situation today?** e. I have housing f. I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a	**4. What is your living situation today?** □ I have a steady place to live □ I have a place to live today, but I am worried about losing it in the future □ I do not have a steady place to live

Education ✓
Housing ✓
Transportation ✓
Food ✓
Utilities ✓
Domestic violence ✓

Oregon Health Authority

Current State (cont)

- Focus on social determinants of health in Oregon's most recent Medicaid waiver, direction from the Governor to focus on this area, and in policy options to be included in CCO 2.0
- Very recent measurement development around social determinants of health in other states (more in later slides)

Opportunity

- Concern that a narrow focus on food insecurity would disrupt work that is already underway in terms of broader SDOH, and limit what we could achieve with a new incentive measure
- However, given the work around SDOH (which includes food security), there is an **opportunity** to expand the scope of the measure development work from a narrow focus on food insecurity to a broader focus social determinants of health.
- This would align with work currently happening the field, and broader efforts in our state, and nationally.
- This shift is supported by the Oregon Food Bank, the Oregon Primary Care Association, and the Oregon Health Authority.

Decision Needed:
After hearing our full presentation, does the Metrics & Scoring Committee support shifting this developmental work from food insecurity, specifically, to broader SDOH?

Eastern State Models for Measuring Social Determinants of Health at the Plan Level

So what are social determinants of health?

- Conditions in which people are born, grow, live work, and age
- Shaped by money, power, and resources: complex issues that need to be addressed at multiple levels and sectors
- These social determinants are largely responsible for health disparities and inequities.
- Examples are: ✓ affordable housing, ✓ economic security, ✓ safe neighborhoods, ✓ access to healthy and adequate foods, and ✓ exposure to environmental toxins or trauma.

O. Solar and A. Irwin, World Health Organization, "A Conceptual Framework for Action on the Social Determinants of Health," Social Determinants of Health Discussion Paper 2 (Policy and Practice), 2010, available at http://www.who.int/social_determinants/corner/SDHDP2.pdf.

NQF and CMS Recommendations for SDOH

Community and Healthcare System Linkages

- Acknowledge role of Medicaid in addressing SDOH
- Create a comprehensive, accessible and routinely updated list of community resources

Information Sharing and Measurement

- Harmonize tools that assess social determinants of health
- Create standards for input and extraction of social needs data from electronic health record
- Increase data sharing among different government agencies

National Quality Forum, "A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability," December 2017. Available at http://www.qualityforum.org/Publications/2017/12/Food_Insecurity_and_Housing_Instability_Final_Report.aspx.

Define-Describe Oregon Needs

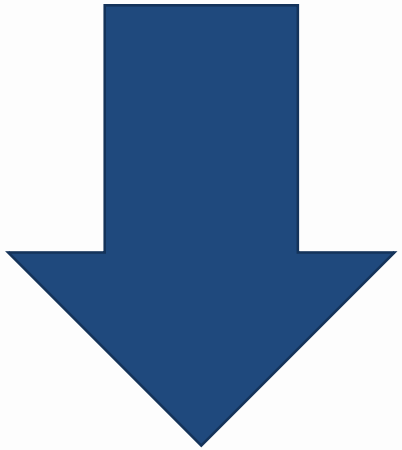
- Multi-sector focus to create better equity for members
- Approach must support OHA policy, health equity, demonstration waiver, governor report, quality framework/models in CCO 2.0
- Needs to fit in with existing programs and “resonate” with other activities such as:
  - ✓ Health equity work group
  - ✓ Social and Medical Complexity data releases
  - ✓ Health-related services and other payment structures
  - ✓ Transformation Center strategies-plans for technical assistance
  - ✓ Public Health strategies-plans for strategic health improvement
- Must not derail existing pilots and progress being made toward increased standardization of measures

RWJ National Funder for SDOH says states must accomplish a checklist of actions to make advances

- Identify and work with partners—OHA is doing this piece
  ✓ OPIP, ✓ DHS, ✓ Data warehouse, ✓ Transformation Center, ✓ OHSU, ✓ Food Banks
- Access existing sources of Data—OHA is doing this piece with OHSU health complexity work
- Use literature and qualitative data—doing this right now by researching other state approaches
- Analyze risk factors predictive or health and outcomes—Yet TO DO
- Get health care “used to working with” social determinants data in the medical sphere—OHA is doing with existing DHS-OHA Health Screenings for Foster Children metric

“Pointy” Metrics

The basis for incentive and quality measures so far

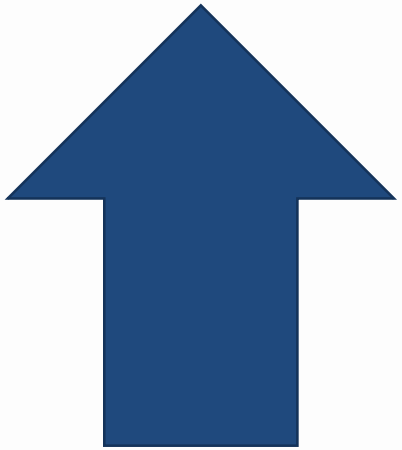


Tip of the point metrics examples:

- Developmental screening
- Access to services
- Colorectal cancer screening

Metrics that are “Pointy” are:

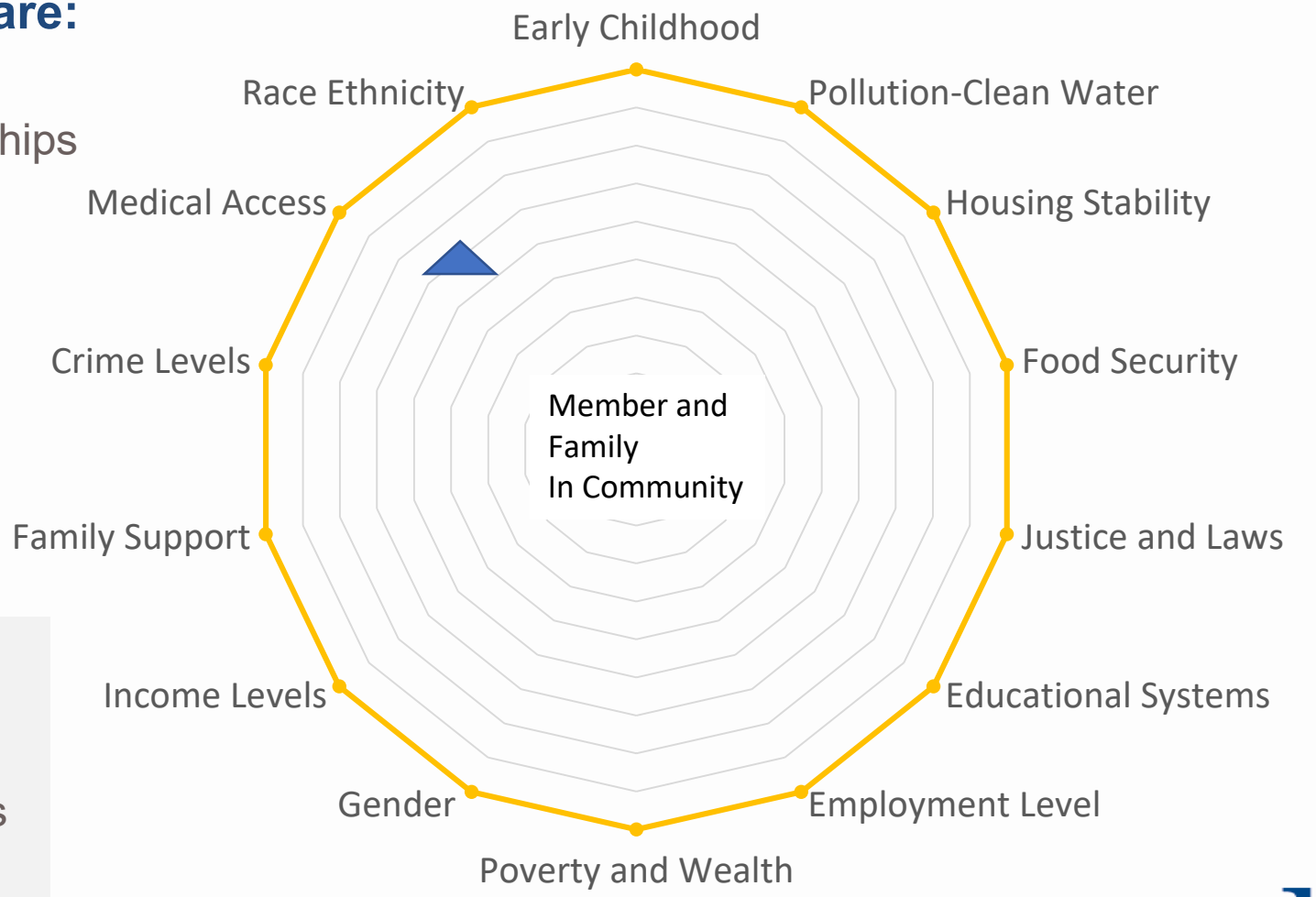
- Focused
- Evidence-based
- Single domain or specialty
- Often comparable to normative data
- Exact
- Equality based



Social determinants require "ROUND" metrics

Round measures are:

- Multiple domains
- Based on relationships
- Infrastructure
- Opportunities
- Community
- Qualitative
- Equity based
- Not normative



Close in to member and family are personal things like a job and permanent living space.

Distant are things like neighborhood or census tract rates of crime, graduation rates

Pointy metrics get dropped into this space, such as the blue triangle = Access to care from CAHPS

Adapted from:
https://www.researchgate.net/publication/254262096_Social_determinants_of_health_and_the_future_wellbeing_of_Aboriginal_children_in_Canada/figures?lo=1

Social Determinants of Health is about Communities

We need to ….

- Identify a “culture of health”
- Identify the network and leaders in the community -----
  a new infrastructure to bridge medical-social organizations
- Connect services in communities to improve health inequities as a result of lack of nutrition and food sources, housing, safety, education, employment, clean air and water, as well as other factors.
- Overall complex social factors cannot be solved by the medical profession alone but bridges can be built across sectors.
- Data are needed to help identify gaps in all of these needs
- Eastern states have created multiple domain and sector measures. Did a scan of four states: Minnesota, Massachusetts, Michigan, Rhode Island

https://www.rwjf.org/en/library/features/culture-of-health-prize/2016-winner-louisville-ky.html
Center for Health Care Strategies-Social determinants of health

Lessons from all States and Potential for Adaptation

- Social determinants is larger than a single measure
- Metrics are often reported out at both member and community levels
- Screeners are done at CCO or clinic levels. Requirements for measurement do not get in way of novel ideas for local work and partnerships-usually agnostic as to the screener but lists out domains that must be measured
- Community infrastructure is developed through identifying service support needs for that community using existing state and federal data by census tract or zip code (community level data) Member level is used for clinic/CCO work process planning
- Roles and responsibilities for social referrals are described in detail and connections to social services are updated and explicit
- Incentives and pay rates are at various levels of development

- http://www.jabfm.org/content/30/4/418.full.pdf+html – assessment of domains of screeners

Future of SDOH Measures for Oregon?

- Approval from HPQMC for expansion of focus toward broader domains
- Might require thinking of more rounded type measures that are qualitative in nature
- SDOH Model “structures” could be used either as an overall “score” in the incentive program or as a methodology to create other SDOH payments- not sure how this will work in Oregon
- Many other groups are working on social determinants issues in Oregon so taking a less prescriptive approach MIGHT be best as a first out of the gate approach as they are developing tools and strategies to help with more standardization as the area evolves—screener requirements are usually AGNOSTIC in these states
- Field not standardized but getting started seems important to momentum
- OHA has already started releasing child and family social information to CCOs and could expand this activity while remaining agnostic to exact choices for screeners or a single measure type.

Discussion and Decisions

- Does the Metrics & Scoring Committee support shifting this developmental work from food insecurity, specifically, to broader SDOH?
- If so, what are our next steps in terms of moving this proposal forward to the HPQMC?