Social Determinants of Health Metric: CCO Quality Incentive Program

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Equity Impact Assessment: Recommendations

INCLUDE

Equity in measure selection and retirement criteria

CONSIDER

Program structure changes

UTILIZE

Diverse knowledge and expertise

EDUCATE

Committee and staff about inequities and disparities

ENSURE

Equity principles followed in implementation & quality improvement activities

Oregon Health Authority

Comparison summary

Past Waiver

One metric set → CCOs earn bonus by meeting benchmark or target on percentage of all measures

HPQMC picks menu → M&SC picks metrics and benchmarks

New waiver

Upstream and downstream sets → greater focus on specific metrics; incentivize work on root causes of inequities *and* maintaining basic quality

Greater role for communities and members in setting priorities for metrics

1115 Waiver: Refocusing CCO metrics

Upstream and downstream metrics

Upstream

Root causes of health inequities. These metrics focus on things like socio-economic factors and discriminatory beliefs. For example: *Meaningful Language Access to Culturally Responsive Care*.

Downstream

Medical care. These metrics focus on things like screenings, treating chronic disease and immunizations. For example: *Controlling High Blood Pressure*.

Upstream and Downstream Sets

Upstream: Smaller set and likely home-grown measures

- Focused on strategic goal to eliminate health inequities by 2030
- For example, home-grown measures such as social determinants of health, meaningful language access, and health aspects of kindergarten readiness

Downstream: Selected from CMS Medicaid Core sets

- OHA will be required to report to CMS on about 35 Core measures
- Not all will be selected as incentive metrics
- For use in Oregon, OHA will stratify where possible using Race, Ethnicity, Language and Disability (REALD) data

Oregon Health Authority

What upstream metrics are already in place?

- Health assessments for children in ODHS custody
- Kindergarten readiness: CCO system-level social-emotional health
- Meaningful language access to culturally responsive health care services
- Social determinants of health: Social needs screening & referral

Measure Development – Guiding Principles

EQUITY

- Centers equity and trauma-informed practice
- Focused on improved health and well-being for all Oregonians
- Acknowledges limitations and potential harms (especially to patients/members)

FEASIBILITY

- Is feasible, especially for the health system to report or collect data on

ALIGNMENT

- Aligns with broader agency social determinants of health goals (and Medicaid 1115 demonstration waiver)
- Driven by a shared definition of and framework for addressing social determinants of health
- Lays the foundation to spur meaningful and sustainable collective action
- Considers alignment with Oregon Health Authority's and partners' other current social needs screening practices

Measure Overview

The **Social Determinants of Health: Social Needs Screening & Referral Measure** aims to acknowledge and address Oregon Health Plan members' social needs over the course of three years.

Social needs this measure addresses:

- Food insecurity
- Housing insecurity
- Transportation needs

Component 1 - Measurement Years 2023 – 2025: Assesses CCOs' plans for implementation of social needs screening and referral in an equitable, trauma-informed manner; ensures groundwork is laid for data sharing and reporting.

Component 2 - Measurement Years 2024 - 2026: Measures the percentage of CCOs' members screened and, as appropriate, referred to services.

*Oregon Medicaid Policy changes can be found here: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Changes.aspx

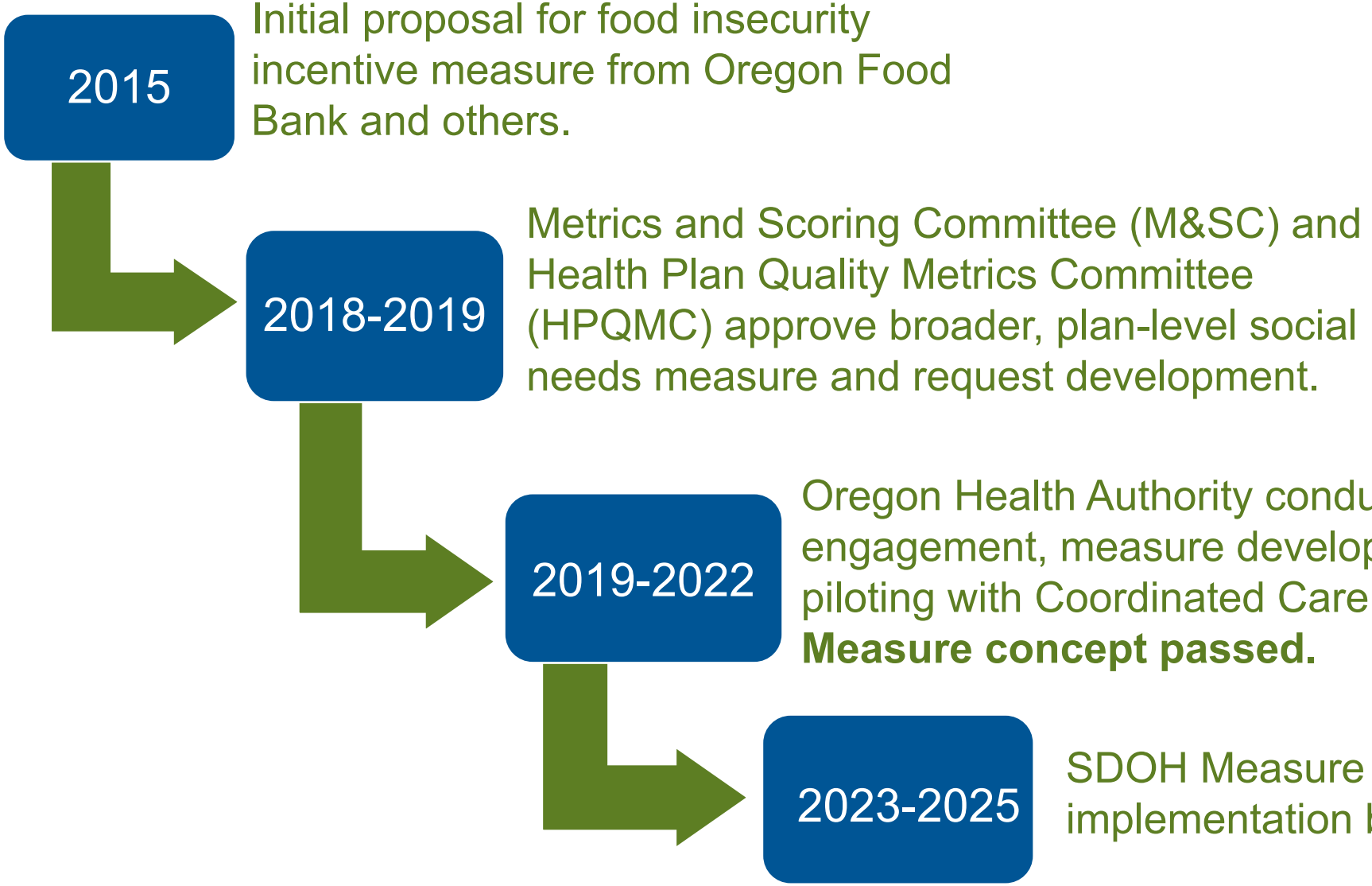
Must-Pass Elements by Measurement Year

Elements of work to be accomplished	2023	2024	2025
A. Screening practices			
Collaborate with members on processes and policies	Must pass	Must pass	Must pass
Establish written policies on training	Must pass	Must pass	Must pass
Assess whether/where members are screened	Must pass	Must pass	Must pass
Assess training of staff who conduct screening		Must pass	Must pass
Establish written policies to use Race, Ethnicity, Language and Disability (REALD) data to inform appropriate screening and referrals	Must pass	Must pass	Must pass
Identify screening tools or screening questions in use	Must pass	Must pass	Must pass
Assess whether Oregon Health Authority-approved screening tools are used		Must pass	Must pass
Establish written protocols to prevent over-screening	Must pass	Must pass	Must pass

Must-Pass Elements by Measurement Year

Elements of work to be accomplished	2023	2024	2025
B. Referral practices and resources			
Assess capacity of referral resources and gap areas	Must pass	Must pass	Must pass
Establish written procedures to refer members to services		Must pass	Must pass
Develop written plan to help increase community-based organization (CBO) capacity in Coordinated Care Organization service area		Must pass	Must pass
Enter into agreement with at least one community-based organization that provides services in each of the 3 domains	Must pass	Must pass	Must pass
C. Data collection and sharing			
Conduct environmental scan of data systems used in your service area	Must pass	Must pass	Must pass
Set up data systems to clean and use REALD data		Must pass	Must pass
Support a data-sharing approach within the Coordinated Care Organization service area		Must pass	Must pass

Measure Timeline



Planned support & TA for SDOH metric implementation

Screening, Referral, Data Webinars: 60-90 minute presentations for CCOs to learn more about the measure specifications

Statewide Webinars: 60-90 minute presentations for CCOs, Community-based Organizations and clinical providers to learn more about the measure specifications

Learning Collaboratives: 60-90 minute interactive sessions for CCOs , Community-Based Organizations and clinical providers to strategize and collaborate on measure implementation

January	February	March	April	May	June
- Screening Practices Webinar	- Screening Practices Learning Collaborative - Statewide Measure Webinar	- Referral Practices & Resources Webinar	- Referral Practices & Resources Learning Collaborative - Statewide Measure Webinar	- Data Collection & Sharing Webinar	- Data Collection & Sharing Learning Collaborative
One-on-One Technical Assistance					

Initial roll-out of implementation support

Two grounding webinars for CCOs, providers, community-based organizations

Goal: Provide an overview of the SDOH incentive metric (measure year 1) implementation goals, create space for best practice conversations, and assess needs to support implementation

- SDOH metric webinar for **CCOs/health care providers:** (11/8/22)
  - Slides
  - Recording

- SDOH metric webinar for **CCOs/community-based organizations** (11/14/22)
  - Monday, November 14, Noon – 1p.m.
  - Slides/recording forthcoming

Questions & discussion

- What *additional information* would be helpful for you/LPHAs to have about the incentive metric program and specifically the new SDOH/social needs screening incentive metric?
- How do you see LPHAs involved in this work with CCOs to implement their accountabilities related to the social needs screening metric?
- What would you like to ask of CCOs and OHA at the start of implementation for this SDOH/social needs screening incentive metric?