Advancing Health Equity & Data (AHEAD)

Social Determinants of Health (SDH) Metrics for Oregon Health Centers: An update from OPCA’s SDH Workgroup

Tuesday, August 27, 2019

Webinar Recording can be found here
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Webinar Functions

• Connect to audio via telephone or computer, NOT both (both will cause feedback)

• All participants are unmuted and will need to mute themselves

• Chat box
  » If you’re not available through audio, please use the chat box to participate in conversation.
Core AHEAD Team

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**Summer**, Administrative Coordinator
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sbrazell@orpca.org
Who’s on the call today?

Please submit the following in the chat box:

» Name(s)
» Preferred Pronouns
» Organization
» Role
<table>
<thead>
<tr>
<th>Topic</th>
<th>Time</th>
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<tbody>
<tr>
<td>AHEAD mid-year equity track evaluation</td>
<td>5 mins</td>
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<tr>
<td>Why an Equity Metric?? Connection to Strategic Plan</td>
<td>10 mins</td>
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<tr>
<td>PRAPARE dashboard (ready for use!)</td>
<td>5 mins</td>
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<tr>
<td>SDH Reporting Workgroup presentations</td>
<td>30 mins</td>
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<tr>
<td>• OHSU Richmond – Troy Carpenter</td>
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<td>• Winding Waters – Erik Carlstrom</td>
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<td>Discussion, Q &amp; A</td>
<td>20 mins</td>
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<td>Connecting the dots and next steps</td>
<td>10 mins</td>
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<tr>
<td>Evaluation/wrap up</td>
<td>10 mins</td>
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Health Equity Track: Mid-Year Evaluation
Who’s participating?
February Webinar Responses: Workflows, Team Communication, and Using the Electronic Health Record (EHR)

- Inform staff of the importance of SDH screening
- Geo mapping patients based on location and needs
- Consider data stratification
- Think about risk stratification
- Improve internal processes

Health Equity Track Attendance

- April: 61
- January: 44
- February: 63
- June: 42
April Webinar Responses: Using PRAPARE Data for Risk Stratification

- Review presenter's content with our Population Health Initiative
- Implementing risk score algorithm
- Compare SDH data to UDS data
- Adjusting population we're collecting data from
- Discuss with senior leadership
- Come up with a less stigmatized term than "risk score"

Health Equity Track Attendance:

- April: 61
- January: 46
- February: 43
- June: 42

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June Webinar Responses: Documenting Enabling Services and Responding to Social Needs

- Build partnerships with external organizations
- Educate additional initiatives we should focus energy on.
- Support the need for additional staffing
- Advocate for positions that are non-billable or have no direct reimbursement
- Tell the story of the needs we see and how to respond to it
- Use data to show what types of grants we can apply to

Health Equity Track Attendance

- April: 61
- January: 44
- February: 43
- June: 42
Why are we talking about a network metric?
Advancing Health Equity and Data (AHEAD) Collaborative
A year-long two track collaborative focused on supporting health centers in collecting and utilizing social determinants of health data to demonstrate value, highlighting promising practices in health centers. This collaborative consists of face-to-face, webinar, and peer-learning opportunities in 2019.

SDH Reporting Workgroup
A subgroup of AHEAD, this is a workgroup of clinics supported by OPCA that meets bi-monthly to explore collective reporting on SDH screening and domains of interest to better communicate value in an upstream payment environment.

2019 process
Provide status updates to OPCA Board, APCM leadership committee, and policy committee

CCO 2.0 & health policy environment moving upstream
Short and long-term vision

Now

2019

2022

Clinic SDH screening rates

SDH needs statewide

- Housing
- Food
- Employment
- Education
OPCA Strategic plan

% Patients Screened for Social Needs at CHCs in Oregon (*not real data*)

2019 – OPCA will have access to data from 50% of CHCs showing proportion of patients screened using PRAPARE

2021 – OPCA and 5 CHCs will have aggregated 5 domains from PRAPARE
SDHRWG Work to Date

February 2019

Built a charter
Established a definition

Today

Piloted data collection
Refined definition
PRAPARE Dashboard
### Monthly Dashboard Template

**Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences**

#### Reporting Month

May-19

**Patient Reach**

**Patients Served: All Sites**

<table>
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<th>Site (1-5 Adult)</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Total</th>
<th>Pop</th>
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**Total Patients Served:** 370

*Operational Screening: s= Patients Served: All patients who completed screen x and y

**Screening Target: 30%**

**Patients Served:**

<table>
<thead>
<tr>
<th>Adult</th>
<th>150</th>
<th>100</th>
<th>75</th>
<th>50</th>
<th>30</th>
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<th>2</th>
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<tr>
<td>Peds</td>
<td>100</td>
<td>70</td>
<td>50</td>
<td>30</td>
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<td>10</td>
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<td>3</td>
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<td>OB-GYN</td>
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<td>30</td>
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<td>10</td>
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<td>3</td>
<td>2</td>
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</table>

**Top SDOH Needs Identified**

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<tr>
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<th>Adult</th>
<th>OB-GYN</th>
<th>Peds</th>
<th>Total</th>
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<td>Food</td>
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<td>10</td>
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<td>35</td>
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<tr>
<td>Social Security</td>
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<td>5</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>Employment</td>
<td>20</td>
<td>10</td>
<td>5</td>
<td>35</td>
</tr>
<tr>
<td>Transportation</td>
<td>10</td>
<td>5</td>
<td>2</td>
<td>17</td>
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</table>

**Social Needs by Subtype**

<table>
<thead>
<tr>
<th>Need</th>
<th>Adult</th>
<th>Peds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
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<tr>
<td>Employment</td>
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<td>5</td>
</tr>
<tr>
<td>Social Security</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>
Presentations from….

Troy Carpenter
*Population Health Data Analyst*
*OHSU Family Medicine at Richmond Clinic*

Erik Carlstrom
*Data Analyst*
Winding Waters Clinic
OHSU Richmond

- Portland Metro Area
- 3 Sites: Main Clinic, SBHC, Walk-in Clinic
- ~15,500 UDS patients a year
- ~55,000 UDS visits a year
SDOH Screening Pilot

• Began piloting a screening process in November of 2018
  » Goal: Screen every patient, every medical visit, at main clinic. Scale over time.

• Health Center Staff
  » MAs facilitate screen during rooming process
  » CHWs follow up based on results and record data
Oregon’s healthcare environment is rapidly changing to better reflect the common understanding of the impact of the social determinants on health. Community health centers have been at the forefront of upstream interventions to address patient’s social needs since their inception. At a network level, the Oregon Primary Care Association has the unique opportunity to support a small group of health centers in standardizing this data collection for population health management, cost containment, and increased advocacy at the local, state and federal levels with the overall goal of expanding reporting beyond this small Social Determinant of Health Reporting Workgroup (SDHRWG).

Immediate Goals (within the first quarter of 2019):
SDHRWG meets and establishes charter.

Short Term Goals (within the first 9 months of 2019):
SDHRWG develops reporting definition for % patients screened and scopes out next steps, including reporting template for CHCs.
SDHRWG clinics begin to submit data to OPCA.

Intermediate Goals (by end of 2019):
- OPCA shares reporting template with more clinics and 50%+ are submitting data on % pts screened.
- OPCA begins aggregating % pts screened across network.

[Out of scope] Long term Goal (by end of year 2022):
- All CHCs are submitting aggregated data on patient SDH domains to OPCA
- OPCA is using network wide SDH data in stakeholder education

Deliverables (Short-term. Additional deliverables to be defined in the project plan)

1. Common charter for SDHWG for 2019
2. New template for reporting on percent of patients screened at CHC level
3. Process documented for submitting data to OPCA (tested and refined by SDHRWG)
4. Process documented for aggregating and communicating data back to CHCs (tested and refined with SDHRWG)
SDHRWG participants

CHCs participating:
- CHCs Benton & Linn
- Klamath Open Door
- La Pine
- Mosaic Medical
- Multnomah County
- Neighborhood Health Center
- OHSU Richmond
- Siskiyou
- Wallace Medical Concern
- Winding Waters

Deliverables for 2019
1. Common charter for SDHWG for 2019
2. New template for reporting on percent of patients screened at CHC level
3. Process documented for submitting data to OPCA (tested and refined by SDHRWG)
4. Process documented for aggregating and communicating data back to CHCs (tested and refined with SDHRWG)
Definitions to OPCA Network SDH Screening Metric

Measure: % of patients screened for SDH (non-UDS domains) in the last year

Numerator: distinct patients screened for any 1 or more non-UDS SDH question in PRAPARE in the last 12 months (rolling calendar)

Denominator: distinct active patients with a visit in the last 12 months (including children)

Link to specifications: Below is a complete list of UDS vs Non-UDS SDH domains:

<table>
<thead>
<tr>
<th>UDS SDH Domains</th>
<th>Non-UDS SDH Domains</th>
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<tbody>
<tr>
<td>Race</td>
<td>Education</td>
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<tr>
<td>Ethnicity</td>
<td>Employment</td>
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<tr>
<td>Veteran Status</td>
<td>Material Security (including: food insecurity, clothing, utilities, childcare, phone, and medical needs)</td>
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<tr>
<td>Farmworker Status</td>
<td>Social Isolation</td>
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<td>English Proficiency</td>
<td>Stress</td>
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<td>Income</td>
<td>Transportation</td>
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<td>Insurance</td>
<td>Housing Stability</td>
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<td>Neighborhood</td>
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<td>Housing Status</td>
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<tr>
<td>Optional Measures (these are non-UDS SDH domains)</td>
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<tr>
<td>Incarceration History</td>
<td>Domestic Violence</td>
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<tr>
<td>Safety</td>
<td>Refugee Status</td>
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Current SDH/Equity metric definition

• Numerator: Any non-UDS SDoH domain screened during a visit

• Two denominator definitions
  » Established Patients
    • At least 1 visit and have an assigned PCP
  » Active Patients
    • At least 1 visit
  » Patients who had a UDS visit (using the Depression Screening metric as a guideline)
## Storing Numerator Data

<table>
<thead>
<tr>
<th>MRN</th>
<th>Screening Date</th>
<th>WHO to BHRs?</th>
<th>CHW for f/u</th>
<th>CHW</th>
<th>Initial f/u date</th>
<th>Contact Method</th>
<th>Declined Support [don’t contact]</th>
<th>Prefer not to complete</th>
<th>RESULTS: All Negative</th>
<th>Utilities</th>
<th>Food</th>
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</table>
Obtaining Denominator Data

Established Patients

• Query OHSU data warehouse for patients with:
  » Appointment within time period
  » Appointment status = arrived and completed
  » Appointment with a medical provider (UDS)
  » Richmond PCP at time of Visit

Active Patients

• Same as Established definition but excluding the PCP constraint
SDOH Metric: Established vs. Active Patients

**Established**: Unique patients with a visit within a 12 month period and a Richmond PCP

**Active**: Unique patients with a visit within a 12 month period

<table>
<thead>
<tr>
<th>Site</th>
<th>Established Numerator</th>
<th>Active Numerator</th>
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</thead>
<tbody>
<tr>
<td>Main clinic</td>
<td>860</td>
<td>865</td>
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</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Established Denominator</th>
<th>Active Denominator</th>
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<tbody>
<tr>
<td>Main clinic</td>
<td>9,428</td>
<td>9,555</td>
</tr>
<tr>
<td>SBHC</td>
<td>83</td>
<td>219</td>
</tr>
<tr>
<td>Walk in</td>
<td>1790</td>
<td>6,070</td>
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<tr>
<td><strong>Total Count</strong></td>
<td><strong>11,301</strong></td>
<td><strong>15,844</strong></td>
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<tr>
<td>Screening %</td>
<td><strong>7.6%</strong></td>
<td><strong>5.4%</strong></td>
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</table>
Winding Waters Community Health Center

- Provides care for ~4400 patients in rural NE Oregon
  » 29,000 visits in 2018
- Integrated health care
  » Mental/Dental/Complementary
- Our payer mix is 30/30/30/10
- Became an FQHC in 2015
Collecting SDoH Data

Within OCHIN Epic

Clarity Reporting
## SDOH Metric: Established vs. Active Patients

### Established Patients

<table>
<thead>
<tr>
<th>Month</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Screening Rate</th>
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<tr>
<td>Nov-18</td>
<td>416</td>
<td>2726</td>
<td>15.26%</td>
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<tr>
<td>Dec-18</td>
<td>469</td>
<td>2738</td>
<td>17.13%</td>
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<tr>
<td>Jan-19</td>
<td>566</td>
<td>2787</td>
<td>20.31%</td>
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<tr>
<td>Feb-19</td>
<td>667</td>
<td>2803</td>
<td>23.80%</td>
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<tr>
<td>Mar-19</td>
<td>758</td>
<td>2825</td>
<td>26.83%</td>
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<tr>
<td>Apr-19</td>
<td>821</td>
<td>2804</td>
<td>29.28%</td>
</tr>
<tr>
<td>May-19</td>
<td>889</td>
<td>2823</td>
<td>31.49%</td>
</tr>
<tr>
<td>Jun-19</td>
<td>961</td>
<td>2818</td>
<td>34.10%</td>
</tr>
<tr>
<td>Jul-19</td>
<td>1019</td>
<td>2852</td>
<td>35.73%</td>
</tr>
</tbody>
</table>

*Visits as defined by Depression Screening UDS measure visit definition.*
SDOH Metric: Established vs. Active Patients

Active Patients

*Visits as defined by Depression Screening UDS measure visit definition.
SDHRWG – next steps

Today
Pilot test template
Pilot reporting to OPCA

Fall 2019
Refine as needed and share with network
50% CHCs share data point

End of 2019
OPCA to aggregate and share
We have network data on % screening!
Discussion
Wrap up
OPCA Strategic plan goals

2019 – OPCA will have access to data from 50% of CHCs showing proportion of patients screened using PRAPARE

2021 – OPCA and 5 CHCs will have aggregated 5 domains from PRAPARE

SDHRWG

Create a concrete metric definition and reporting template

Network scorecard

Set equity metric(s) for the network to review over time

APCM accountability

Establish accountability for PHE quadrant and reporting to OHA

Aligning efforts

• Showing value in moving upstream
• CCO 2.0
• CCO incentive metric
Quick Evaluation
What’s Ahead for AHEAD?

**Data Advancement**
Webinar: Advancing your Health Center’s In-House Analytics and Data Culture: Examples of Successful Practices
Wednesday, August 28 from 2-3:30pm PST

**Health Equity**
Webinar: Calculating Return on Investment (ROI) for SDH screening and intervention,
Tuesday, October 29 from 11-12:30 PST

**Save the Date:** AHEAD Face to Face Meeting
Dec. 10 Evening Networking & Dec. 11 Meeting
Eugene, OR
CHC Opportunities
Interested in showcasing your social needs care work with others?

• CCO Oregon Conference: Coordinated Care & the Road Ahead
  » Tuesday, September 24
  » Salem Convention Center
  » Contact Carly at chood@orpca.org

• NWRPCA Fall Conference (OPCA seeking co-presenter to present on AHEAD)
  » October 5-8 in Seattle, WA
  » Contact Stephanie at scastano@orpca.org
Thank you!