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2024 Forum on
Rural Population Health & Health Equity
OHSU

Asking Patients About Their Social Needs
Why It Matters, Getting Started, and Improving Patient Experiences

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2024 Forum on Rural Population Health & Health Equity

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- Audio has been muted for all participants upon entry
- Moderators will assist with Q+A at the end of the presentation
- Presentation slides will be posted at ohsu.edu/orhforum
- Sessions will be recorded and available to attendees
- Please take the session surveys!

Chat Waterfall

1) Name
2) Organization
3) Email
4) How does your job intersect with social needs activities?

In this session, we'll be…

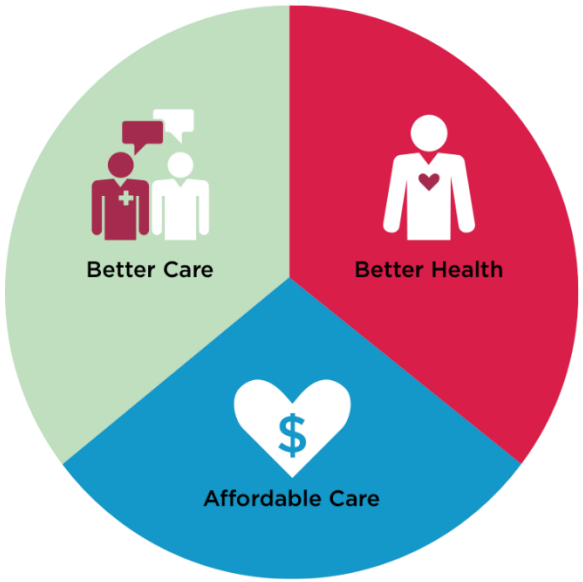
1. Reviewing why healthcare-based social needs activities may be important for patient health and well-being.
2. Discussing the Oregon context and offering practical resources.
3. Discussing first steps and how to ensure social needs activities are equitable and patient-centered.

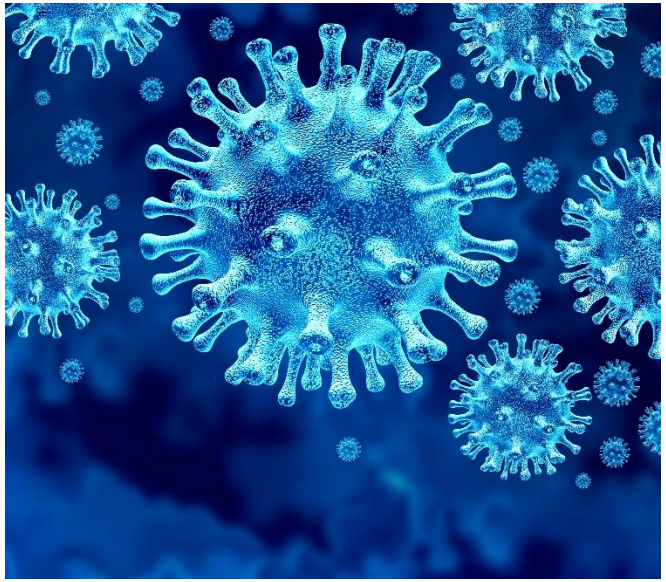
Why healthcare-based social needs activities may be important for patient health and well-being.

Anna Steeves-Reece

Health Is Largely Driven by Factors Beyond Healthcare

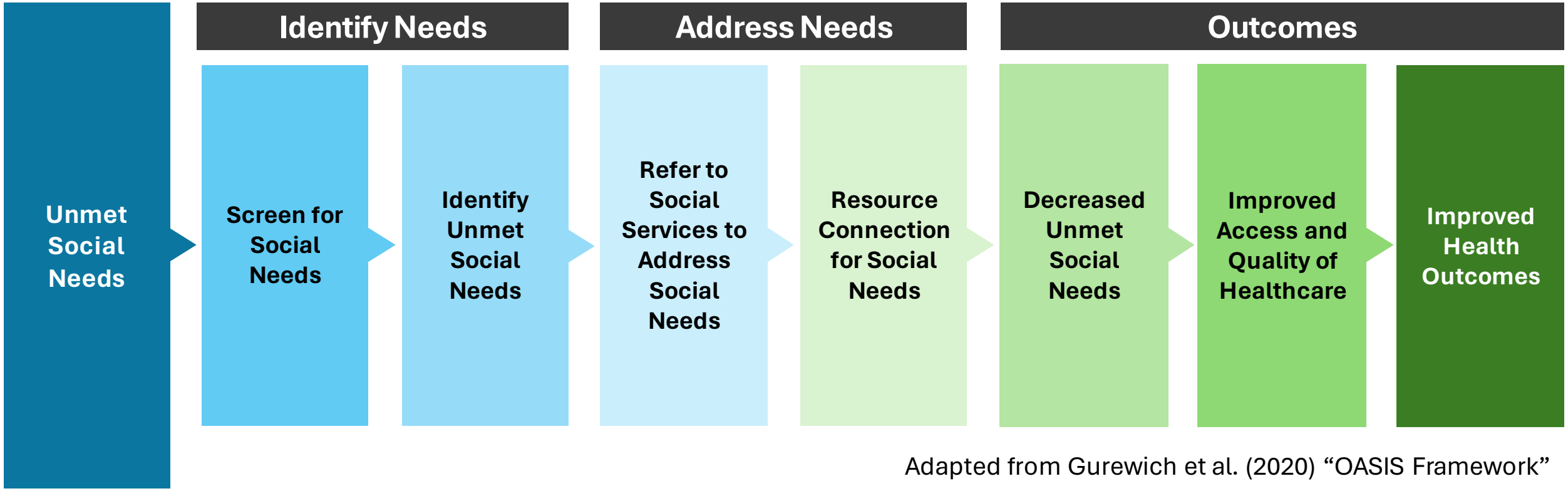
Escalation of Healthcare-Based Social Needs Interventions





“Social Services Connections Pathway”

Gottlieb et al. (2024)



Adapted from Gurewich et al. (2020) “OASIS Framework”

Limitations of the Social Services Connections Pathway

"Findings from interviews … identified challenges connecting beneficiaries to community services. When connections were made, resources often were insufficient to resolve beneficiaries' needs."

Renaud et al. (2023)

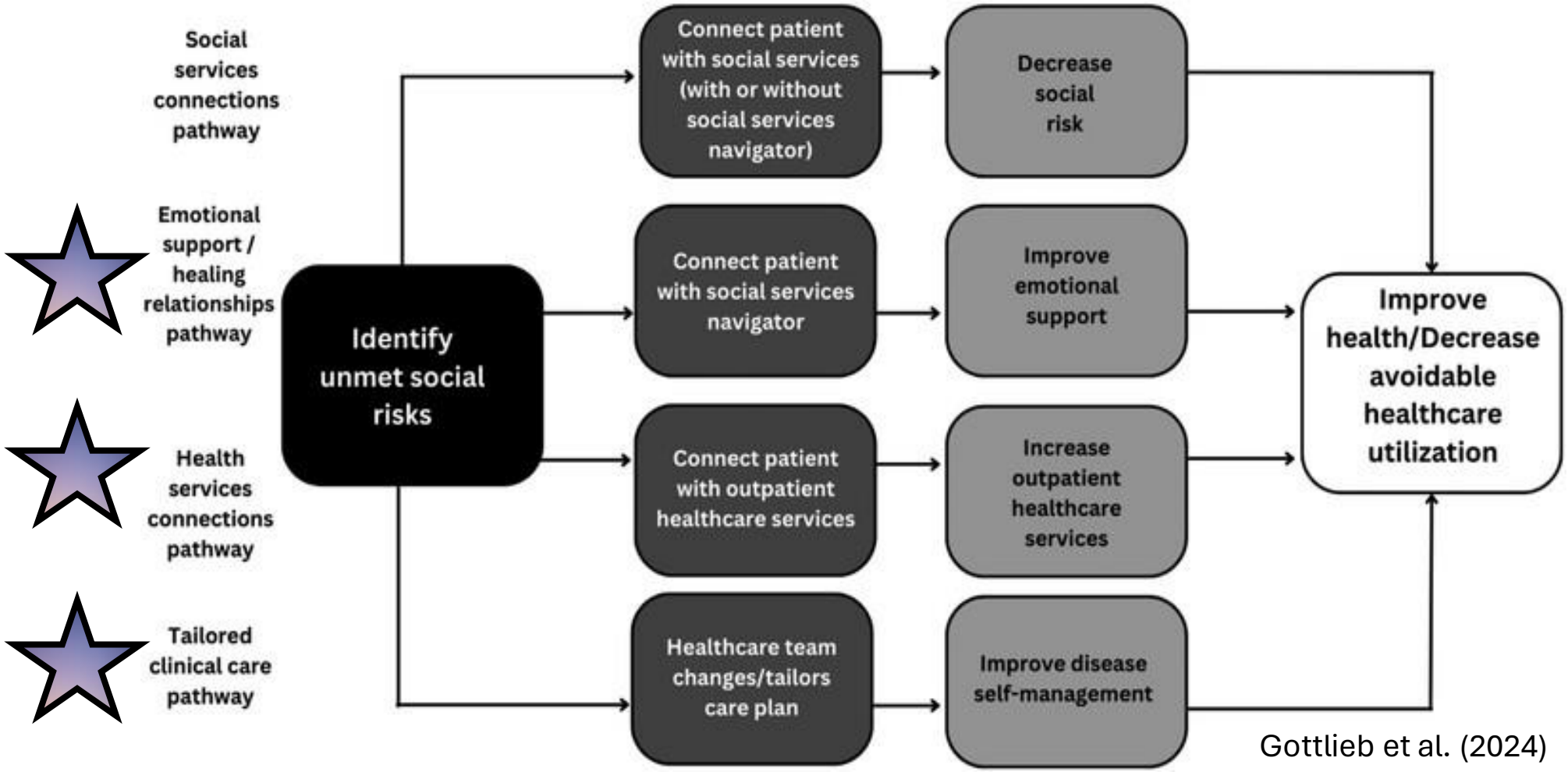
"When clinicians are not able to offer effective solutions to patients who disclose dire needs, they may set unrealistic expectations and frustrate patients."

Butler et al. (2020)

“An intriguing finding across a growing number of social care studies is that these programs influence health and health care utilization through multiple mechanisms—not solely through connections to social services.”

Gottlieb et al. (2024)

Social Interventions Research and Evaluation Network (SIREN)'s Social Care Logic Model



Gottlieb et al. (2024)

Patients Can Be Left Feeling Appreciative or Hopeful, Whether They Access Resources or Not.

"I was happy [to be asked the social needs screening questions] because it made me feel like things are starting to change in society … I really felt important and like things are starting to change."

25 to 34-year-old Hispanic female who did not access resources

"The way that my situation was handled … went above and beyond what I needed even … Honestly, I didn't' know that it was something that healthcare organizations took care of. I mean, it's more of a well-being business, you know, as opposed to just health. And that's something that I didn't realize you guys did."

<25-year-old White male who did not access resources

Steeves-Reece et al. (2022)

Patients Can Be Left Feeling Appreciative or Hopeful, Whether They Access Resources or Not.

"It's giving so much hope and kindness … Because of COVID … because of my heart condition and health condition … I have to stay away from people, I don't have the vaccine yet because of my heart and everything. So, I'm not as social as I used to be. And some people, their lights go dim. And you guys are like the lighthouse on the beach, saying, 'Here's the light, I'm trying to shine it to you.'"

45 to 54-year-old Multiracial female who did access resources

"I think the gesture showed me that there's more people out there that care about you than you originally thought. To be honest, I never thought that you guys would be the ones to call. It stood out to me in a big way, in a very nice way. It shows people that there is more hope out there than one would originally think.

55 to 64-year-old Black female who did access resources

Steeves-Reece et al. (2022)

First, Do No Harm.

“I don’t remember exactly, but when someone isn’t very nice to you, you would remember it … I think the person was nice. They were nice because of that, because I don’t really remember.”

65 to 74-year-old Hispanic male

Steeves-Reece et al. (2022)

Guiding Questions

- How can we **keep it simple**?
- What **will make sense** for our context?
- How can we design social needs activities that will further **strengthen our relationships with patients and the community**?

Oregon Context and Practical Resources

Anne King

Measures & Payment for Social Needs Screening

- Screening and referral for social needs in a clinical setting is time consuming and expensive
- Payment opportunities – some tied to quality measures and value-based payment arrangements, and others with fee-for-service reimbursement models
  - National quality measures for hospitals and clinics
  - State quality measures and value-based payment opportunities
  - Fee-for-service reimbursement mechanisms

Level Setting – Medical Coding & Value Sets

- **Procedure Codes** – Describe services or treatment a patient receives
  - Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS)
- **Diagnosis Codes** – Describe diagnosis or issue that the treatment aims to address.
  - International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), Z codes, Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT), Logical Observation Identifiers Names and Codes (LOINC)
- **Value Sets** – Are a subset of codes of one or more code systems that share a common concept and use

These code vocabularies all have codes associated with screening and referring a patient for food insecurity, housing insecurity, and transportation resources

National Quality Measures: NCQA HEDIS Measure- SNS-E

	HEDIS SNS-E	Data Requirements
Screening	% of membership screened for food, housing, and transportation and were positive	LOINC Codes
Intervention	% of positive screens receiving intervention* within 30 days of first positive screen	CPT, SNOMED, HCPCS codes*

* interventions defined in Gravity Project Value Sets includes assistance, assessment, coordination, counseling, education, evaluation, referral, provision

https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

Dual Eligible Special Needs Plans (D-SNP) Health Risk Assessment Screening

	D-SNP Measure	D-SNP Data Requirements
Screening	Initial and annual health risk assessments that include questions from approved instruments on housing, food, and transportation	Codes- screening instruments mapped to LOINC coding

https://www.cms.gov/files/document/r129mcm.pdf

CMS Screening for the Social Drivers of Health & Screen Positive Rate for the Social Drivers of Health

	MIPS SDOH 1 & 2	Data Requirements
Screening	SDOH-1: Percent of patients 18 years and older admitted to an inpatient hospital stay screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. SDOH-2: Rate 1 population screening positive	Numerator- Rate 1- Number of patients 18 and over screened using a standardized tool Rate 2- Number who screening positive Denominator- Number of admitted patients 18 years and over

https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

Certified Community Behavioral Health Clinic Screening Measure

	CCBHC	Data Requirements
Screening	Percentage of individuals with any insurance over 18 who have been screened within the measurement year for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety	Electronic health records (including billing records), paper health records, or a registry

https://www.cms.gov/files/document/r129mcm.pdf

NCQA Patient Centered Medical Homes (PCMH)

	PCMH KM 02 (Core) Comprehensive Health Assessment Requirements	PCMH data
Screening	• Screening for social determinants of health • Assessing population information • Identify and prioritize community resources needed by populations	• Documented process • Evidence of implementation
Referral	Referral to community organizations	• Documented process • Evidence of implementation

https://www.ncqa.org/wp-content/uploads/2020/07/20200727_NCQA_PCMH_Toolkit_for_Health_Centers.pdf

State of Oregon Quality Measures and Programs: Patient-centered Primary Care Home Program (PCPCH) (Oregon)

- PCPCH recognition criteria changing in January 2025 to more closely align with CCO requirements

	PCPCH	PCPCH Data Requirements
Screening	**3.D.2. (10 points):** Routinely screens or assesses entire patient population for at least 3 HRSN and refers patients with positive screens to community resources.	• Screening policy, procedure or workflow • Screening tool used
Referral	**3.D.3. (15 points):** Routinely screens and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly. • analyzes data to identify target populations or most prevalent HRSNs • engages in population-based interventions (direct services, community partnership, referral to HRSN organizations and tracking results)	• Screening policy, procedure or workflow • Screening tool used • Data on HRSN prevalence • Documentation of population-based intervention

State of Oregon Quality Measures: CCO Social Needs Screening & Referral Incentive Measure

Component 1- Structural Measure **2023-2025**

Screening Practices	Referral Practices and Resources	Data Collection and Sharing
• Develop social need screening policies and training protocols • Assess what social needs screening t • Assess where members are being screened for social needs tools are in use	• Assess capacity of local resources and gap areas • Develop plan to help increase CBO capacity in CCO service area • Form agreements with CBOS that provide housing, non-medical transportation, and food services	• Conduct environmental scan of data systems used in CCO service area • Develop data systems for collecting and using REALD data • Support data-sharing among organizations within CCO service area

Social Needs Screening & Referral Incentive Measure Specifications: SDOH-Metric-Expanded-Screening-Tools-3-23-23.pdf (oregon.gov)

SDOH Social Needs Screening & Referral Metric

Component 2

- Intended to measure the percentage of CCO members screened and referred to services.
- Beginning in 2025 CCOs will report on a sample of members who met continuous enrollment criteria.
- Hybrid model - multiple sources of data can be used including MIS/DSSURS, EHR, community information exchange (CIE), health information exchange (HIE), and other data sources

Rate 1: % who were screened

Numerator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Denominator: All members who meet continuous enrollment criteria except those who decline to be screened in all 3 domains

Rate 2: % who screened positive

Numerator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

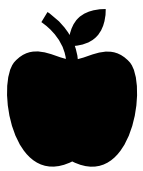
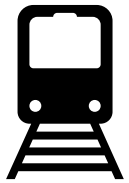
Denominator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Rate 3: % who screened positive and received a referral

Numerator: Members who received a referral within 15 calendar days for each domain in which they screened positive.

Denominator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

Measure Elements

Use of an OHA-approved Screening Tool

Approved Social Needs Screening Tools for Required Domains

Updated 3/23/23

	Food insecurity	Housing insecurity	Transportation
Accountable Health Communities (AHC)	✓	✓	✓
American Academy of Family Physicians (AAFP)	✓	✓	✓
Arlington	✓	✓	✓
Boston Medical Center Thrive (BMC Thrive)	✓	✓	✓
Comprehensive Universal Behavior Screen (CUBS)	*Question not recommended*	*Question not recommended*	✓
Health Begins	✓	✓	✓
Health Leads	✓	✓	✓
Housing Stability Vital Sign	*No question*	✓	*No question*
Hunger Vital Sign	✓	*No question*	*No question*
iHELP	✓	✓	*No question*
North Carolina Medicaid (NC Medicaid)	✓	✓	✓
Protocol for responding to and assessing patients' assets, risks and experiences (PRAPARE)	✓	✓	✓
PROMIS	*No question*	*No question*	✓
Safe Environment for Every Kid (SEEK)	✓	*No question*	*No question*
Survey of Well-being of Young Children (SWYC)	✓	*No question*	*No question*
U.S. Adult Food Security Survey	✓	*No question*	*No question*
U.S. Child Food Security Survey (Self-Administered Food Security Survey Module for Youth Ages 12 and older)	✓	*No question*	*No question*
U.S. Household Food Security Survey	✓	*No question*	*No question*
U.S. Household Food Security Survey: Six-Item Short Form	✓	*No question*	*No question*
WeCare	✓	✓	*No question*
WellRx Questionnaire	✓	✓	✓
Your Current Life Situation (YCLS)	✓	*Question not recommended*	✓

Are there other social needs quality measures you are tracking?

If yes, please list them in the chat.

Quality Measures and Payment

- National social needs screening measures are generally tied to some sort of value-based payment arrangement

- Not all state social needs screening and intervention quality measures or programs are currently tied to payment, but this is a quickly moving landscape so check with your payer-partners about any programs that they are offering

Fee-for-service Payment- CMS 2024 Physician Fee Schedule new HCPCS codes for SDOH risk assessment

SDOH Assessment Code:

- **G0136: Administration of standardized, evidence-based SDOH assessment** 5-15 minutes, up to 1x every 6 months
  - Housing, food, transportation, utilities screening
  - Provided by a licensed providers such as physician, NP, PA, certified nurse specialist
  - In person or telehealth
  - Can be stand-alone or provided with an evaluation and management visit, behavioral health office visit, or annual wellness visit

This code could be coupled with a Z code to indicate a positive screen

This code is currently open for encounter data submission to OHA

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

CMS 2024 Physician Fee Schedule- New HCPCS codes for SDOH risk assessment

Community Health Integration Codes:

- **G0019- Community health integration services** up to 60 minutes per calendar month
  - Includes person-centered assessment, understanding personal and cultural needs, facilitating patient-driven goal-setting, and providing tailored support
  - Includes coordinating receipt of services including social services
  - Provided by auxiliary personnel, **including licensed CHWs** under the direction of a physician or other practitioner

- **G0022- Community health integration services** additional 30 minutes (no limit)

This code could be coupled with a Z code to indicate navigation occurred

This code is currently open for encounter data submission to OHA

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

CMS 2024 Physician Fee Schedule- New HCPCS codes for SDOH risk assessment

Principal Illness Navigation Codes:

For patients with high-risk physical and/or behavioral health condition

- **G0023: Principal illness navigation services** up to 60 minutes per calendar month
  - Includes person-centered assessment, including understanding SDOH needs
  - Includes coordinating access to and receipt of social services
  - Facilitating and providing social and emotional support to help patient cope with the condition, SDOH needs, and adjust daily routines to better meet diagnosis and treatment goals
  - Provided by auxiliary personnel, **including licensed patient navigators**, under the direction of a physician or other practitioner
- **G0024: Principal illness navigation services** additional 30 minutes per calendar month

This code could be coupled with a Z code to indicate navigation occurred

This code is currently open for encounter data submission to OHA

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

CMS 2024 Physician Fee Schedule- New HCPCS codes for SDOH risk assessment

Principal Illness Navigation Codes:

For patients with high-risk physical and/or behavioral health condition

- **G0140: Principal illness navigation services** up to 60 minutes per calendar month
  - Includes person-centered assessment, including understanding SDOH needs
  - Includes coordinating access to and receipt of social services
  - Facilitating and providing social and emotional support to help patient cope with the condition, SDOH needs, and adjust daily routines to better meet diagnosis and treatment goals
  - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
  - Provided by auxiliary personnel, **including licensed peers**, under the direction of a physician or other practitioner
- **G0146: Principal illness navigation services** additional 30 minutes per calendar month

This code is currently open for encounter data submission to OHA

This code could be coupled with a Z code to indicate navigation occurred

https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0

First steps and ensuring that social needs activities are equitable and patient-centered.

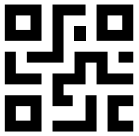
Kellee Rosales

OHA Approved Screener

- If your clinic has already picked a screener, add it in the chat!
- Choosing an approved screening tool by OHA.
- OHA approved list:
  - https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Needs-Screening-Tools.aspx
- Many EHRs already have SDOH screener built in!

SDOH Screening Ideas

- QR code for patient to self-administer screening



- Paper form to complete at check-in

- Developing a call-back list if patients would like to be called, texted, or emailed later to answer SDOH screening questions and be connected with community resources

Workflow Ideas

Reflect on workflows already in place for existing screeners	**Screened at annual check-in, each visit, during problem visit, suspected social needs, history of substance abuse**
What is working in this already existing workflow?	**What would need to change?**
If your clinic currently screens patients…	**Assess if questions already ask patients about housing, food insecurity, and transportation needs**
Would this workflow work for social needs screening?	**Build on processes you already have in place**

Workflow Mapping Example

MA - **Scrubs Charts, gives paper screener to front desk**
Front Desk - **Gives patient paper screener at check in**

Did patient complete screener?

Yes

- MA asks if they want to talk about any questions
- Enters screener responses into EHR
- Notifies CHW or social worker for follow up with patient

No

MA asks if they would like to go over questions together

If patient responds no

STOP

No

MA asks if they would like to go over questions together

If patient responds yes

- MA verbally ask questions
- Enters screener responses into EHR
- Notifies CHW or social worker for follow up with patient

SDOH Screening Project

Background:

- Started in October 2022
- We have called over 8,300 patients in Eastern Oregon
- 3 on our team: 2 for English patients & 1 for Spanish patients
- We call about 150-200 patients per week
- We call EOCCO members with 2+ ED visits in the pat six months (pulled from Collective Medical)
- We use the AHC Screener and REALD questionnaire

SDOH Survey

Accepts SDOH survey –

- Can we ask some questions to better connect you to resources?
- Proceed with SDOH screening & REALD questions
- Unite Us to connect patients to CBOs, be able to track who has received help, and who still needs resources

Declined SDOH survey, but wants resources –

- We still connect them to resources

No need for resources

- We always provide our phone number and EOCCO

Either way, patients are VERY grateful with either outcome

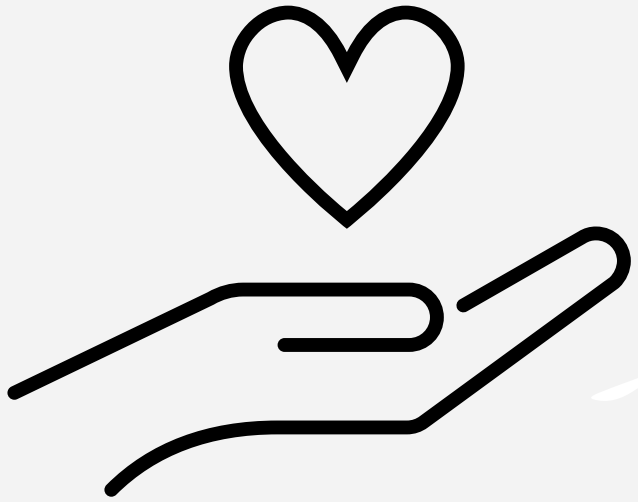
Social Needs Data in Eastern Oregon

Top Client Needs:

- 35% Food Assistance
- 26% Housing & Shelter
- 15% Transportation

Client Demographics:

- 21% White
- 51% Female
- 37% Adult (18-44)



Referring Patients

Create a list of community resources to share with patients:

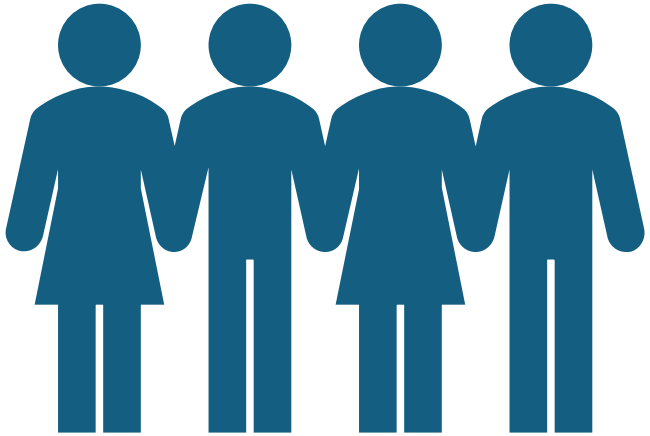
- EOCCO provides free transportation to medical appointments
- 211info.org
- Oregon Food Bank Food Finder
- EOCCO SDOH Community Resource Guide
- Refer & connect patients on Unite Us

Community Health Workers (CHWs)

- Make connections & develop trust with patients based on lived experience
- Help encourage & guide patients towards healthy habits, self management and increased independence
- CHWs also work with a patient's care manager, primary care team, and other agencies to address the patients needs

Social Needs Training Topics

- Motivational Interviewing
- Empathic Inquiry
- Cultural Responsiveness
- Trauma-Informed Care
- Patient's Right to Refuse a Social Needs Screening
- Equitable Screening

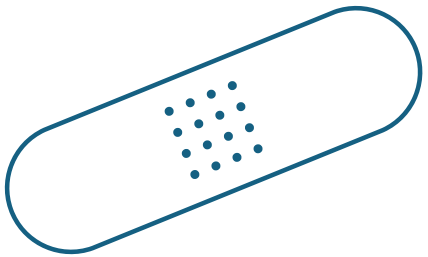


Motivational Interviewing

Use motivational interviewing to…

- Explore the gaps between their current situation and their desired outcomes
- Foster collaborative decision-making by involving the patient in determining next steps
- Use patient’s priorities to determine subsequent care planning and delivery

Empathic Inquiry



Use empathic inquiry principles to…

- Relate to patients from a place of nonjudgment, understanding, and curiosity
- Create an atmosphere where patients feel both heard and valued
- Actively listen to understand the individual's perspective
- Evoke, affirm, and center patient goals and priorities
- Express genuine empathy for their challenges

Trauma-Informed Care

Use trauma-informed practices to…

- Create an environment that promotes **safety, trust**, and **empowerment**
- Realize how trauma affects the experiences and behaviors of families, communities, and individuals
- Recognize the signs of trauma. These signs may be specific to gender, age, or setting
- Respond with language, behaviors, and policies that respect those who have experienced traumatic events
- Resist re-traumatization

Cultural Responsiveness

Use cultural responsiveness principles to…

- Acknowledge that patients' cultural background can impact how they communicate their symptoms, pain, and physical or emotional concerns
- Consider the impact of culture on patients' time and space orientation, eye contact, and food choices
- Create a culturally safe environment such as having a certified medical translator available during medical appointments, communicate using plain language, and providing information in their native language
- Fully see, value, and respect patients' differences of identity, background, experiences, and health needs

Equitable Screening

Use equitable screening practices:

- Everyone has the right and opportunity to attain the highest level of healthcare to achieve the best possible physical, emotional, and social well-being
- Providing care that does not vary in quality because of the patients' characteristics, ethnicity, gender and socioeconomic status
- Not making assumptions based on an individual's actual or perceived abilities, disabilities or traits
- Recognizing that some populations require additional resources and opportunities to reach their full health potential

Patient Rights

Patient Right to Refuse a Social Needs Screening

- Patient autonomy involves making independent decisions that align with personal values and goals
- Patients have the right to decline to be screened or decline referrals/further intervention
- Even when a patient screens positive for a social need, they may not want or need help at that time

When people are socially connected & have relationships where they feel valued, cared for and supported, they are…

- more likely to make healthy choices
- more likely to have improved health
- better able to cope with stress, trauma, adversity, anxiety, and depression

Success Stories from EOCCO Members

- Member lost their health insurance after the pandemic ended. He was going to wait to reapply for health insurance until after his 62nd birthday…
- Helped member with travel expenses
- Connected patients to baby formula, school supplies & sports for children
- Member needing feminine hygiene products
- Member out of work for 3 months due to ice storm
- Connecting with members who declined a social needs screening

Questions?

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