Bree Collaborative	Social Determinants and Health Disparities Workgroup
March 18, 2021	8:00 – 9:30 a.m.
Virtual

MEMBERS PRESENT

Phyllis Cavens, MD, Medical Director, Child and Adolescent Clinic, Vancouver

Alison Bradywood, DNP, MPH, RN, NEA-BC, Senior Director, Clinical Quality & Practice, Virginia Mason

Yogini Kulkarni-Sharma, AVP, Health Plan Quality Improvement at Molina Healthcare

Ashley Lile, Director of Training & Technical Assistance, Washington Association for Community Health

Kevin Conefrey, Vice Present, HR & Corporate Services, First Choice Health

Janice Tufte, Patient Partner, PCORI,

AcademyHealth

Cindee Dewitt, Program Manager, Community Resource Specialist Program, Kaiser Permanente

Laurel Lee, VP Network Management, Molina Healthcare

Karie Nicholas, GC, MA, Epidemiologist, Washington Association for Community Health

Michael Garrett, Principal, Mercer

Carol Moser, executive director, Greater Columbia ACH

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative

Amy Etzel, Bree Collaborative

Nick Locke, MPH, Bree Collaborative

John Liu, MD, Network Medical Director, Optum Care Network

Rachel Madding, School Mental Health Program Manager, Highline Public Schools

Meg Jones, Director, Government Relations, Pacific Source

Kate McLean, Director, Clinical Programs, Quilted Health

Brianna Ramos, Department of Health

Brissa Perez, Tribal Engagement Specialist, Greater Columbia ACH

Frances Gough, Chief Medical Officer, Molina

Jennie Harvell, Clinical Quality and Care Transformation, Health Care Authority

Karen Hougen, Project Manager in Operations, Molina

Kathie Olson, VP Health Services, Molina

INTRODUCTIONS AND APPROVAL OF MINUTES

Nick Locke, MPH, Bree Collaborative, opened the meeting and those present introduced themselves.

> *Motion:* Approval of December minutes
>
> *Outcome:* No detractors. Mr. Locke left room for members to email changes post-meeting.

Mr. Locke went over the outline for the day's discussion and specific thoughts about the draft recommendation framework.

DISCUSSION ON PLANS AND PAYMENT MODELS

Member Spotlight: Molina

- Laurel Lee, VP of Network Management, and Kathie Olson, VP of Health Services, at Molina Healthcare presented on Molina's work to address SDOH from a Medicaid Managed Care perspective.
- Molina identifies social risk through health screening at enrollment for Medicaid patients, predictive modelling, and referrals from their case managers or providers in their network. "No wrong door"
- Molina supports their providers' SDOH capacity through information sharing, Value-Based Payments, and investments in Collective Medical for behavioral health integration.

- Current SDOH investments include investments in social services for members, investments in case management and education for providers, and their Community Innovation Fund to provide grants to community organizations.
- Discussion included:
  - There is a lack of inclusion of dental services in MCO plans and SDOH work in general.
  - Future communication technology (such as CIEs like UniteUs or 2-1-1) must be interoperable in order to keep the entire care team and social service providers up-to-date about intervention efforts.

Broad Discussion on SDOH Interventions:
- Mr. Locke asked the group what other incentives would encourage providers to address SDOH
  - Carol Moser, with Greater Columbia ACH, mentioned that the ACH ties VBPs to a percentage of patients being screened for SDOH. It would also be useful to have direct reimbursements to providers for each screening completed.
  - Janice Tufte, patient partner, mentioned that VBP will hopefully improve outcomes by targeting care toward effective interventions.
- Mr. Locke asked the group about the possibilities for direct investments in social services
  - ACHs are working to create community linkage programs that would provide investments and incentives for community organizations.
  - Molina is working to identify the social need and gaps, and then there might be future opportunities to invest in social services.
  - Keving Confrey, with First Choice Health, mentioned that there are several ways to think about these investments from a benefits perspective. First – there could be a per-member charge similar to EAP benefit programs. Second – there could be a case-by-case charge or a benefit investment in a large social service convener (like UniteUs), but probably not direct investments from benefits into single social service organizations.
- Closing thoughts included a discussion on data sharing and communication in the broad public-private sectors. Dr. Cavens talked about the McKinney Vento Act, which mandates public schools to survey their populations for housing insecurity, but this information is not shared with providers.

RECOMMEDATION FRAMEWORK COMMENTS
- Mr. Locke asked the group about the appropriateness of the four framework categories: Identification, Tracking and Measurement, Follow-Up, and Incentives and Investments
  - Important to include a discussion of patients in the incentives/investments section. What kinds of communication will encourage patients to accept screening? What would make patients feel safe enough to ask for assistance?
  - Patient-centered care could be an over-arching, or umbrella theme that has relevance to every section in the framework. Include equity and communication tools.
  - Alison Bradywood mentioned that the first bucket "Identification," could be split into two sections – "Planning" and "Identification Workflows." The planning section might include equity and communication, as well as delineate between pre-screening and screening.
- The "Identification" section included some changes to screening location, frequency of follow-up, universal workflow recommendations, and the distinction between "screening" and "assessment"
  - The group agreed that setting a target metric of "% patient population screened" would be unwise, as different clinics have different capacities.
  - Kevin Confrey reminded the group that in order to get reimbursed for screening, the screening must occur at either primary or specialty care settings (not out in community).
  - The group agreed that follow-up was essential. Patients should be screened at every visit to the clinic, with a minimum of yearly follow-up for screening, as social needs can change quickly.

- o The recommendations should distinguish between "screening," which can be quick and occur frequently, and "assessment" which are more in-depth follow-ups about patients social need and supports.
  - o Although workflows should be adopted to clinical needs, some standards include: the provider should not conduct screening themselves, providers should be kept in the loop about results.
  - o Alison (VM) has seen research that patient self-report is the gold standard for screening, followed-up by an in-person assessment. Ashley (WACHC), mentioned that some of their clinics have seen in-person screening improve the patient-care team relationships.
- The "Tracking and Measurement" section needs to be expanded to include better guidance on a registry, and be clear about using standard HIT vocabulary codes.
  - o SDOH registries can be a good first step, but it is also important to apply SDOH as filters to other registries, to see how SDOH are mediating factors for other health outcomes.
  - o While registries can be a good way to understand the extent of SDOH, SDOH data collection brings unique challenges like privacy, stigma, and concerns about CPS. Important to create a TPO relationship with an individual for data in the registry.
  - o Jennie Harvell (HCA) mentioned the importance of supporting interoperable exchange, using framing like "SDOH data that is captured should be linked to HIT vocabulary codes," and "Systems that are used to capture SDOH contnetn should support interoperable exchange of this content." HIT vocabulary could include content codes (Z-codes) and exchange codes (FHIR, CCDA)
  - o Several workgroup members mentioned including funding for training or communication to work with providers and change the culture around coding for social risk. Currently z-codes are rarely used and providers do not see why they should take on the administrative burden of coding for non-billable items.

CLOSING COMMENTS

The group ended the discussion after "Tracking and Measurement" to continue the conversation about "Follow-Up" and "Incentives and Investments" at the next meeting. Mr. Locke asked the group how further recommendations for specific stakeholders could support workgroup members.
- o The workgroup agreed that the goal is to find a path that connects patients to needed services, whether community based or commercial based. What are the means to do this, and how is it effective?

Mr. Locke thanked attendees for the conversation and the meeting was adjourned.