



Addressing Social Determinants of Health & Equity through Health-Related Services

Background

In 2012, under a renewal to its 1115 Medicaid demonstration waiver, Oregon began the process of transforming its Medicaid delivery system by establishing coordinated care organizations (CCOs), charging them with integrating and coordinating care and requiring them to meet key quality metrics tied to financial incentives for achieving performance benchmarks. CCOs receive an integrated global payment for each member, which provides CCOs with the flexibility to offer health-related services (HRS) to improve the health of Oregon's Medicaid population. These HRS were known as flexible services, but through the 1115 Medicaid demonstration waiver for 2017–2022, OHA expanded HRS to include flexible services and community benefit initiatives.

HRS are defined as non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being. One

of the purposes of HRS is to give CCOs a specific funding mechanism within their global budgets to address the social determinants of health (SDOH) including the health-related social needs of their members.

For coordinated care organizations (CCOs) to use federal Medicaid funds to pay for HRS, they must comply with state and federal criteria. For a full definition of HRS, CCOs should rely primarily on the [OHA HRS Brief](#)ⁱ and Oregon Administrative Rules (OARs) [410-141-3500](#)ⁱⁱ and [410-141-3845](#).ⁱⁱⁱ The Code of Federal Regulations ([45 CFR 158.150](#)^{iv} and [45 CFR 158.151](#)^v) should be used for supplemental CCO guidance only.

The purpose of this guidance document is to define HRS and SDOH-E, and provide guidance on how CCOs can use HRS to improve member and community SDOH-E and report this spending accurately via Exhibit L. Additional guidance and technical assistance on other HRS topics can be found on [OHA's HRS website](#).^{vi}

Definitions

Health-related services (HRS): Non-covered services under Oregon's Medicaid State Plan that are not otherwise administrative requirements and are intended to improve care delivery and overall member and community health and well-being.

Flexible services (FS): Cost-effective services delivered to an individual OHP member to supplement covered benefits and improve their health and well-being.

Community benefit initiatives (CBI): Community-level interventions that include — but are not limited to — OHP members and are focused on improving population health and health care quality.

SDOH-E in Oregon

In 2017, Governor Brown outlined expectations for CCOs' next five-year contracts (2020–2024), which included SDOH-E as one of four key areas for CCOs to improve member health. To support this, the Oregon Health Authority has identified HRS as the primary strategy by which CCOs can help address their members' SDOH-E.

Definition of SDOH-E

In 2019, OHA modified the Oregon Medicaid Advisory Committee definition of social determinants of health^{vii} to create a definition of SDOH-E in Oregon Administrative Rule (OAR 410-141-3735^{viii}). This SDOH-E definition encompasses three different and interrelated terms as defined below: the social determinants of health (SDOH), the social determinants of equity (SDOE), and health-related social needs (social needs).

- ✓ **Social determinants of health:** The social, economic and environmental conditions in which people are born, grow, work, live and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.
- ✓ **Social determinants of equity:** Systemic or structural factors that shape the distribution of the social determinants of health in communities. Examples include the distribution of money, power and resources at local, national and global levels, institutional bias, discrimination, racism and other factors.
- ✓ **Health-related social needs:** An individual's social and economic barriers to health, such as housing instability or food insecurity.

Each of these SDOH-E concepts plays a unique role in impacting individual and community health, and each requires different strategies to improve health. Individual-level efforts that address social needs, such as referrals to community health workers or social services, can address barriers to housing stability or social isolation and improve health. Community-level efforts can improve community health by addressing SDOH and SDOE directly through policy and systems change.

Examples of HRS that address SDOH-E

The list below provides categories and general examples (neither the categories nor examples are comprehensive) of potential CCO HRS investments to address SDOH-E. For any categories with known CCO investments, those examples have also been included and will be added to over time. It is important to note that while “health and health care” (for example, improving access to health care services) is sometimes included under SDOH, it is not listed here because this is already part of the core functions of CCOs and Oregon's health care system. These efforts could still meet HRS criteria, but they would not be considered SDOH-E efforts.

Access to banking/credit

- ✓ Community education programs to improve banking and credit literacy

Access to healthy food

- ✓ Provider prescriptions for vegetables (for example, Veggie Rx program)
- ✓ Healthy food boxes for pick-up or delivery

- ✓ Farmers market support

Access to outdoors, parks

- ✓ Walking trails improvement
- ✓ Parks and playground installations or improvements

Example CCO Expenditures

- ✓ Installed fully accessible playground equipment in a neighborhood park where many CCO members live. (CBI)
- ✓ Funded a 1.5-mile fit trail with 20 fit stations along the trail for the entire community to enjoy. Also added a 1.5-mile gravel trail for additional outdoor access. (CBI)

Access to transportation (non-medical)

- ✓ Bicycles for active transportation
- ✓ Car repairs
- ✓ Car seats
- ✓ Vouchers for gasoline
- ✓ Active transportation improvements (for example, safe bicycle lanes and sidewalks)
- ✓ Safe Routes to School program

Example CCO Expenditures

- ✓ Provided CCO member transportation services for Women, Infants and Children appointments, Department of Human Services appointments, Alcoholics/Narcotics Anonymous meetings, court appearances, and grocery shopping. (FS)
- ✓ Supported new bicycle share programs in neighborhoods with limited public transit access. (CBI)

Citizenship/immigration status

- ✓ Legal assistance to address citizenship issues

Corrections

- ✓ Employment service program for people with a criminal history

Crime and violence (including interpersonal violence)

- ✓ Funding support for community organizations that serve people affected by domestic violence
- ✓ Violence intervention services

Diaper security

- ✓ Vouchers for members to access diapers

Discrimination (for example, race, ethnicity, culture, sexual orientation, gender, disability)

- ✓ Culturally specific traditional health worker program

Early childhood education and development

- ✓ Abuse prevention
- ✓ Cribs for Kids education program
- ✓ Parenting programs

Example CCO Expenditures

- ✓ Provided parent coaching and education for CCO members within the Transitional Treatment Recovery Services homes. Focused on helping residents retain custody of children, close their DHS case, and remain clean and sober. (FS)
- ✓ Provided “Family Check Up,” an evidence-based parenting education and skills-building program for CCO members. (FS)
- ✓ Provided cribs and safe sleeping education to CCO members with newborns to prevent infant sleep-related deaths. (FS)

Employment

- ✓ GED program
- ✓ Job training program
- ✓ Job application assistance
- ✓ Employment service program for people with a substance use disorder

Environmental conditions (for example, air and water quality, resiliency from wildfires and natural disasters)

- ✓ Community education about lead in drinking water and lead water testing

Food security

- ✓ Food assistance

High school graduation and higher education enrollment

- ✓ School-based restorative justice program

Income

- ✓ Short-term utility bill assistance
- ✓ Essential utility set-up

Housing stability (including homelessness)

- ✓ Legal assistance to maintain housing
- ✓ Hotel rooms for recovery or as a bridge for hospital discharge
- ✓ Short-term rental assistance
- ✓ Temporary housing
- ✓ Supportive services within homeless shelters
- ✓ Parenting programs

Example CCO Expenditure

- ✓ Provided legal assistance for CCO members facing housing eviction and other related legal issues. (FS)

Housing quality, availability and affordability

- ✓ Housing safety and quality inspections
- ✓ Home environment remediation services
- ✓ Legal assistance for home environment remediation (for example, mold remediation by landlord)
- ✓ Roof repair
- ✓ Plumbing
- ✓ Small house construction projects, including accessibility and safety modifications (for example, steps up to a home)

Language and literacy

- ✓ Start Making a Reader Today program
- ✓ Reach Out and Read program
- ✓ Adult literacy program
- ✓ Farmers market support

Social integration (for example, unity, inclusion and participation at all levels of society)

- ✓ Drop-in center for peer support
- ✓ Community youth programs

Trauma (for example, adverse childhood experiences)

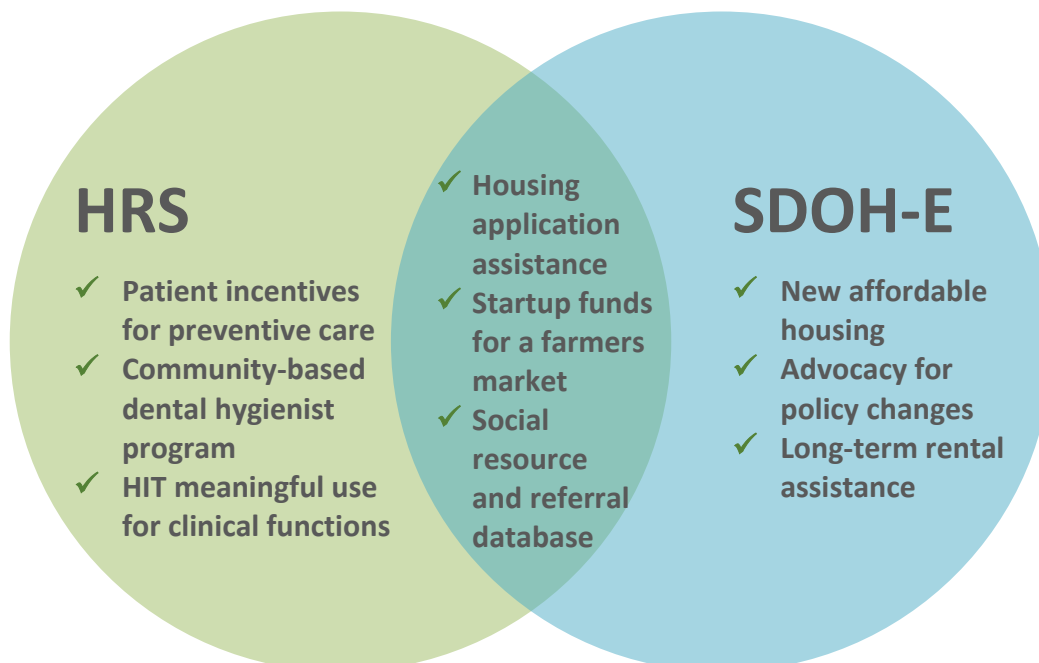
- ✓ Cross-sector adverse childhood experiences and trauma-informed care training

SDOH-E and HRS reporting

CCOs should use this guidance document to help determine which HRS expenditures qualify as addressing SDOH-E and how to report them. CCO HRS is reported through the Exhibit L financial reporting template that is submitted to OHA twice per year. In these reports, CCOs note which HRS expenditures are intended to address SDOH-E. However, checking yes or no for addressing SDOH-E does not affect whether the expenditure counts as HRS.

As stated above, HRS is the primary strategy by which CCOs can address the SDOH-E of their members and community. However, many potential HRS efforts do not address SDOH-E, and thus would not warrant being counted as SDOH-E spending in Exhibit L. That is, not all HRS are meant to address SDOH-E and not all SDOH-E efforts will meet HRS criteria. For example, a more clinically focused intervention, such as expanding access to community-based oral health care, could be HRS, but is not an SDOH-E effort. Diagram 1 below provides a framework for how HRS expenditures may also be considered as efforts to address SDOH-E.

Diagram 1. Relationship between HRS and SDOH-E efforts



Flexible services and community benefit initiatives

Efforts that both address SDOH-E and meet HRS criteria could be flexible services (FS) or community benefit initiatives (CBI). It is important to consider that all HRS intended to address SDOH-E may involve collaboration with public health agencies, social service agencies and community-based organizations (CBOs) that are already addressing the community's SDOH-E. The two CBI requirements to 1) have a role for CCO community advisory councils, and 2) promote alignment with the CCO's community health improvement plan further support CCO collaboration with other agencies and CBOs.

Flexible services may be used to address members' social needs, like housing, food, legal and employment supports. More specifically, HRS provided to members that involve social needs assessment, referral and intervention, such as housing application assistance or legal assistance for members in need, are good examples of FS that would be reported as addressing SDOH-E in Exhibit L.

CBI may be used to directly address SDOH, such as funding a farmers market in a food desert, or SDOE, such as a culturally specific traditional health worker program. More specifically, community level HRS that improve population health by addressing social and environmental conditions, such as supporting the development of bike lanes and farmers markets, also count as addressing SDOH-E in the Exhibit L report. CBIs may also be used to address social needs for large groups of members, such as HIT integration with social resource and referral systems for both members and non-members in the primary care setting.

Additional resources

In addition to other resources a CCO may identify, OHA has identified the following resources as acceptable sources for published studies or evidence to support a health-related service:

- ✓ Centers for Disease Control and Prevention (CDC):
 - [CDC Community Health Improvement Navigator](#): Expert-vetted tools and resources for health system, hospital, public health agency and other community organization staff leading community health improvement efforts.
 - [CDC Health Impact in 5 Years \(HI-5\)](#): Highlights non-clinical, community-wide approaches that have evidence reporting 1) positive health impacts, 2) results within five years, and 3) cost effectiveness or cost savings over population lifetime.
 - [CDC Social Determinants of Health](#): Resources for social determinants of health data, tools for action, programs and policy.
- ✓ [Community Preventive Services Task Force Findings](#): What works to promote healthy communities.
- ✓ [Healthy People 2020](#): Resources, organized by domain, to help learn how communities across the country are addressing the social determinants of health.
- ✓ [Leveraging the Social Determinants of Health](#): The Massachusetts Foundation's report on what works for interventions addressing social determinants of health.
- ✓ [Social Interventions Research & Evaluation Network](#) (SIREN): University of California, San Francisco's SIREN works to improve health and health equity by advancing high quality research on health care sector strategies to improve social conditions.

- [SIREN Evidence & Resource Library](#): Includes both peer-reviewed and other types of resources, such as webinars and screening tools/toolkits on medical and social care integration.
- ✓ [OHA Health Evidence Review Commission](#): Multisector intervention reports on population-based health interventions or other types of interventions that happen outside of clinical settings.

References

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- i OHA HRS Brief: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-Health-Related-Services-Brief.pdf>
 - ii OAR 410-141-3500: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265499>
 - iii OAR 410-141-3845: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265554>
 - iv 45 CFR 158.150: https://www.ecfr.gov/cgi-bin/text-idx?SID=656e988fc35ee492f4fcfce234067cd1&mc=true&node=se45.1.158_1150&rgn=div8
 - v 45 CFR 158.151: https://www.ecfr.gov/cgi-bin/text-idx?SID=656e988fc35ee492f4fcfce234067cd1&mc=true&node=se45.1.158_1151&rgn=div8
 - vi OHA HRS website: www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx
 - vii Oregon Medicaid Advisory Committee. (May 2018). Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon’s CCO Model. Available at: www.oregon.gov/oha/HPA/HP-MAC/Documents/MAC_AddressingSDOH_CCOmodel_Recommendations_FINAL.pdf
 - viii OAR 410-141-3735: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=265591>