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*Lane Community Health Council is the governing board of PacificSource Community Solutions - Lane.

Lane County Coordinated Care Organization (COO) Community Advisory Council (CAC)

Remote Meeting via Zoom

March 27, 2023, 2023

12 pm – 2 pm

CAC Members: Co-Chair Char Reavis (PacificSource OHP representative), Co-Chair Tara DaVee (Trillium OHP representative), Brian Johnson (Lane County Public Health), Drake Ewbank (PacificSource OHP representative), Josephine Williams (PacificSource OHP representative), Kristin Gustafson (PacificSource OHP representative), Lana Gee-Gott, MD (PacificSource Clinical Advisory Panel Liaison), Michelle Thurston (Trillium OHP representative), Sheila Wegener (OR Dept of Human Services), Silver Mogart (Trillium OHP representative), Tannya Devorak (PacificSource OHP representative), Isis Barone (PacificSource OHP representative)

Attendees: Debi Farr (Trillium Community Health Plan), Katharine Ryan (PacificSource Community Solutions), Kayla Watford (Lane County Public Health), Lee Bliven II (Trillium OHP representative), Leilani Brewer (PacificSource Community Solutions), Lucy Zammarelli (LaneCare), Sadie Baretta (Lane County Public Health), Senna Towner (Oregon Health Authority), Suzy Kropf (Lane Community Health Council), Teresa Coppola (Lane County Public Health), Lauriene Madrigal (Lane Community Health Council), Grace Jelks (Lane Council of Governments, Transcriptionist), Steve Allan (Lane Community Health Council Board), Rhonda Busek (Lane Community Health Council), Samantha Duncan (Be Your Best), Ailed Diaz (Trillium Community Health Plan), Amy Davidson (Trillium Community Health Plan), Charlotte Carver (South Coast Regional Early Learning), Elisabeth Maxwell (Lane County Public Health), Bob Colabianchi (Orchid Clinic), Mark Buchholz (PacificSource Community Solutions), Andrea Ketelhut (PacificSource Community Solutions), Kaassi Brownlee (Trillium Community Health Plan), Nena Hayes (Lane County Public Health

Facilitator: Tara DaVee, CAC Co-Chair **Point Person:** Nena Hayes

I. Welcome and Introductions

a. Co-Chair Tara DaVee opened the meeting and reviewed the agenda.
b. CAC members shared their names, pronouns, and affiliations.
c. The committee reminded attendees of shared meeting agreements included in the agenda packet.
d. There was no public comment.

II. Routine Approvals

a. **February Minutes:** Silver Mogart moved to approve the February CAC minutes as presented, Michelle Thurston seconded, and the motion passed.

III. CCO Presentation: Social Determinants of Health Social Needs Screening

a. **PacificSource Community Solutions:** Andrea Ketelhut presented on the Social Determinants of Health Social Needs Screening and Referral Practices. Social Determinants of Health (SDOH) are the social, economic, and environmental factors which affect a person's health and quality of life. Examples include: safe housing, income, education, and access to food. SDOH factors can disproportionately affect minority and other vulnerable populations. To achieve whole-person wellness, SDOH factors must also be addressed. Trillium and PacificSource are working to create policies regarding social needs screening practices related to food, housing, and transportation needs. Feedback is requested and final versions of policies will be brought back to the Board for further feedback.
b. **Trillium Community Health Plan**: Kassandra Brownlee talked about the CCO Quality Measures: i.e., statewide metrics monitored by OHA for all CCOs that measure a variety of health topics. There are 15 metrics that CCOs are using to create strategies to improve performance. Examples include adolescent immunizations, depression screenings, diabetes control, and pediatric dental visits. New and innovative metrics are created by OHA, which initially focus on "system building" for the first few years. New in 2023, OHA created the Social Determinants of Health (SDOH) Needs Screening and Referral Metric, which is focused on food, housing, and transportation needs. CCOs will be tasked with creating policies to support community members, work with community-based organizations to build capacity for referrals and to meet needs, and support data sharing.

IV. Break

V. CAC Discussion: Social Determinants of Health Social Needs Screening

a. Questions for the CAC include:

1) *What is important for a screener to be aware of prior to performing an SDOH screening for food, housing, and transportation needs? Example: trauma informed and culturally sensitive.*
CAC members' comments included the importance of having a shared life experience for a deeper understanding, whether there is a baseline question to determine needs, spotlighting screeners that have these shared experiences (peer support specialists), making sure resources are updated and accurate, being sensitive to communication and other challenges, making sure the questions are not overwhelming or making people feel judged, consider reading comprehension for persons with lower reading levels, being prepared to provide resources in response to the questions asked, using effective visual aids, reducing paperwork, being mindful of survey/question fatigue, providing a mechanism for hand-offs between case managers and community providers, making sure a variety of screening tools are available, and recognition of the difficulty for people to provide records due to long-term record keeping issues.
2) *How would you prefer to be screened for food, housing, and transportation needs? Example: paper, telephonic, in person, digital (tablet sign in, phone app, email).*
3) CAC members thought all of the above should be made available. Kristin Gustafson shared her intake experience at the physician's office. The intake form asked a variety of questions and at the end of the visit, her family was provided with resources based upon her answers.
4) *How often should a person be screened for food, housing, and transportation needs? Example: monthly or annually.*
CAC members commented that increased frequency of screenings might discourage participants. There is a need of finding an appropriate mechanism for screenings in emergency situations. Suggestion was made to ask participants for input on how often they would feel comfortable being screened.
5) *Does screening frequency depend on how the person was last screened?*
CAC members suggested there be some sort of mechanism to trigger screenings for people who either need follow-up or experience an

emergency situation. Depending on the need, 3-6 month follow-ups might be fine.

VI. Updates and Announcements

a. **Trillium Community Health Plan Board:** Kayla Watford gave an update on the March 13th Trillium Board meeting. Dr. Hanson provided an overview of the Clinical Advisory Panel's 2023 focus areas (to be shared next month). The Board also watched the Quit Tobacco in Pregnancy (QTiP) program web training featuring co-presenters, Tara DaVee and Jacqueline Moreno. This web training features states' best practices in tobacco prevention and is available as a resource through the Centers for Medicare and Medicaid Services (CMS). Link to video. Trillium announced in March about the Request for Proposals (RFP) for Community Benefit Initiatives. There will be approximately $18 million awarded to local organizations with a focus on improving healthy outcomes, alleviating health disparities, and advancing health equity. The project timeline reflects the end of the RFP process in April, at which time the review process will begin. Two CAC members representing Trillium Community Health Plan will be invited to serve on the scoring committee. Awarding and contracting will happen between May and July. Trillium CEO Sarah Brewer presented an overview of Centene at the Trillium Board meeting.

b. **Lane Community Health Council Board:** Tannya Devorak gave an update on the March 14th LCHC Board meeting. Jacqueline Moreno presented on the Tobacco, Use Prevention and Cessation Program. The Board discussed ways the Clinical Advisory Panel (CAP) and community partners could support these tobacco prevention efforts.. Discussions also included 2023 Board priorities, rural recruitment, and engagement strategies. The LCHC is also seeking a representative from the CAC who is a PacificSource Community Solutions member to join the LCHC Board of Directors. Members who have questions or want to learn more about the Board position can contact Suzy Kropf by Wednesday, April 5. Tannya Devorak also offered to answer questions about the Board position.

c. **Oregon Health Authority**: Senna Towner, OHA Innovator Agent, gave an update about OHP eligibility determinations. Redeterminations are a big focus this month, as they are required for current OHP recipients beginning on April 1st. Members have 90 days to respond to the eligibility

redetermination notice. CCOs are not allowed to directly assist participants with paperwork. The ineligible date is closer to 150 days and the basic health plan is more of a Bridge program modeled after Medicaid.

CAC members suggested there is a need for more bilingual assisted resources. Questions included whether OHP participants will be ineligible in May, clarification of the basic health plan, reinstating the Work Program for SNAP participants, and planning on giving more time to this issue at next month's meeting.

Follow-up from Senna after the CAC meeting includes the following notes:

- An important point of clarification about redetermination notices: OHA is using a "passive renewal" (i.e., auto verification) process, and only those who do not have eligibility information verified through the process will be required to submit new information, and those who are auto-verified will get a notice stating no action is required. So, all current OHP members will get a notice, but only some will be required to submit documentation in response to that notice.
- Work requirements are going back into place for able bodied adults without dependents (ABAWD) for SNAP benefits starting July 1st. Not for OHP. Work requirements were terminated for SNAP during the pandemic; they weren't in place for OHP pre-pandemic.

VII. Annual CAC Demographic Survey

a. Kayla Watford discussed the CAC Demographic Survey Request and why it is important to our CAC.
b. Kayla Watford discussed providing support for completing the survey (Due April 10, 2023).

VIII. Breathing Exercise (optional)

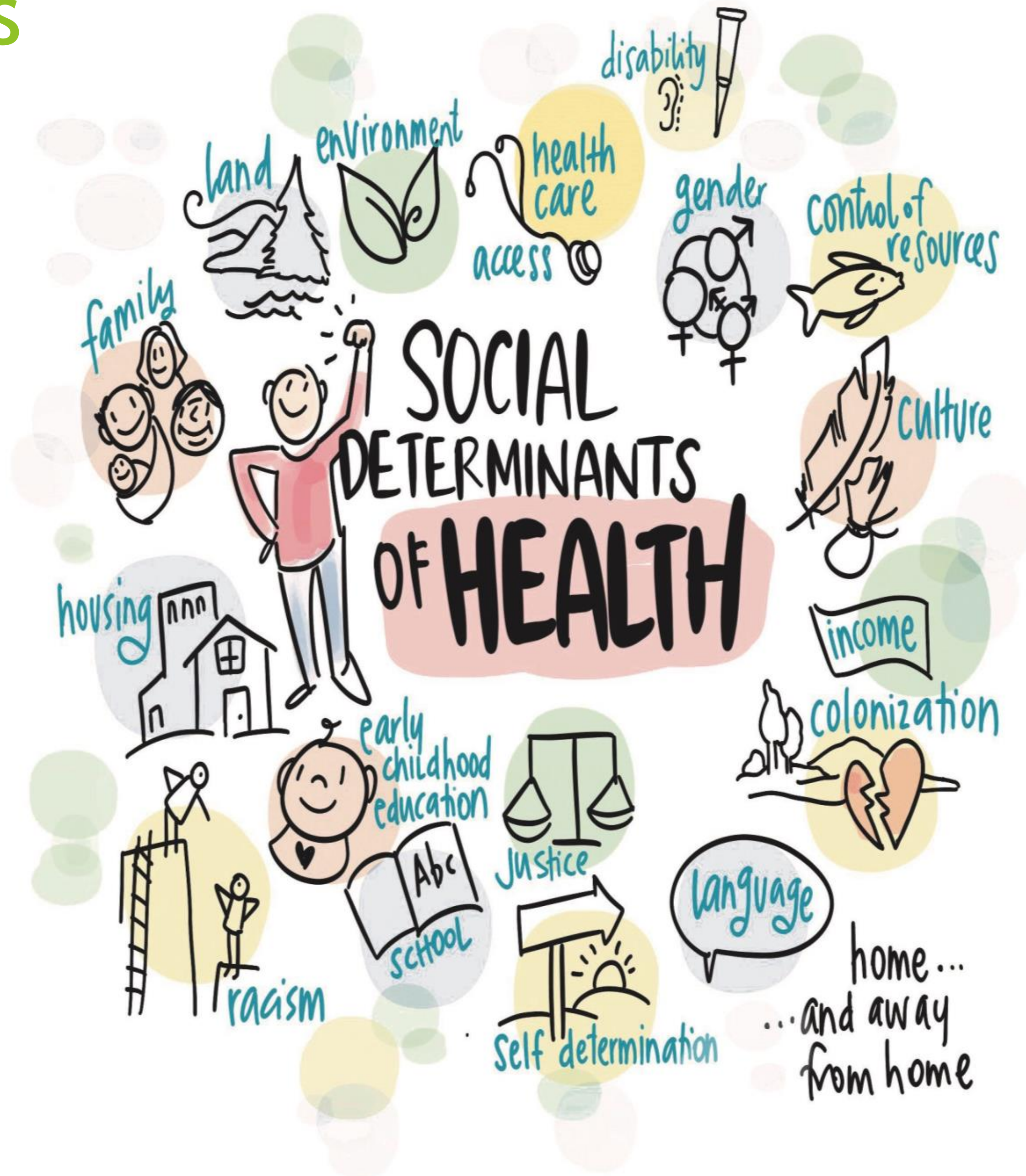
Social Determinants of Health: Social Needs Screening & Referral Practices

PacificSource Community Solutions & Trillium Community Health Plan

What are Social Determinants of Health (SDOH)?

- The social, economic and environmental factors which affect a person's health and quality of life.
  - Examples include safe housing, income, education, employment, access to nutritious food, etc.
- The distribution of SDOH factors can (and do) disproportionately affect minority and other vulnerable populations. This is referred to as the social determinants of health and equity.

- <u>To help achieve whole-person wellness, SDOH factors must also be addressed.</u>



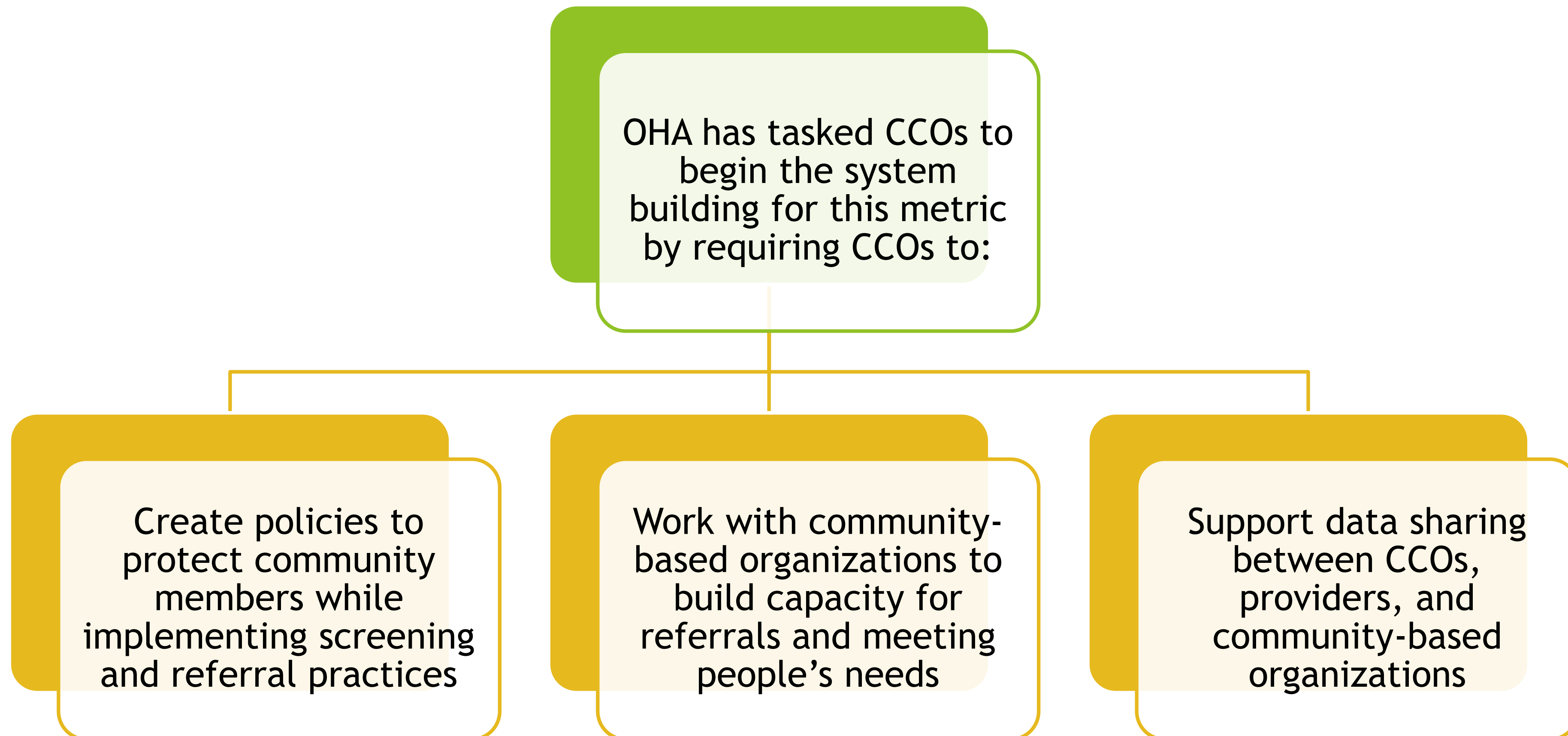
What are CCO Quality Measures?

- Statewide metrics monitored by OHA for all CCOs that measure a variety of health topics
  - Requirements/benchmarks also determined by OHA
- In 2023, there are 15 metrics which CCOs are creating strategies to improve performance on.
  - Topics such as: adolescent immunizations, depression screenings and follow-up, diabetes control, pediatric dental visits, etc.

- OHA also creates new, innovative metrics for this program
  - When this happens, the first couple years of the metric focus on ‘system building’ so that CCO’s and the community can prepare for the improvements to come

SDOH Social Needs Screening & Referral Metric

New in 2023, OHA created a metric focused on social needs screening and referrals, specifically focused on food, housing and transportation needs



SDOH Metric System Building – Where are we now?

- Trillium & Pacific Source are working to create policies & procedures regarding social needs screening practices related to food, housing and transportation needs.
- We are here today to get your feedback on things to consider and/or include in these policies as we are working to develop them.
  - We will bring back final versions of our policies later in the year for further feedback.

Questions for the CAC

Seeking input to help inform the policies related to screening for food, housing and transportation needs

Question 1

- What is important for a screener to be aware of prior to performing an SDOH screening for food, housing and transportation needs?
  - Considerations already identified:
  - Trauma informed – Acknowledges the prevalence and impact of trauma in a person's life and recognizes that healthcare teams need to have a complete picture of a person's life situation in order to provide effective care. Being trauma informed allows a screener to understand the how and why behind a situation.
  - Culturally sensitive – Acknowledges that cultural differences and similarities between people exist based on many factors and influence each person's values, behavior, and approach to health/wellness. Being culturally sensitive allows a screener to understand cultural differences exist without assigning value (good or bad) and to provide patient-centered care within the context of the person's culture/beliefs.

Question 2

- How would you prefer to be screened for food, housing and transportation needs?
  - Paper (independently)
  - Telephonic
  - In person
  - Digitally (tablet, phone app, e-mail)

Question 3

- Keeping in mind that SDOH factors can changes over time, how often should a person be screened for food, housing and transportation needs?
  - Monthly
  - Yearly

- Does this differ based on how a person was last screened?
  - For example, if a person screened positive for food insecurity, should they be screened again more/less frequently than if they had screened negative?

Question 4

- Everyone has the right to decline a SDOH screening, do you want to be asked each time if you would like to be screened?
  - Yes
  - No

Question 5

- Who should perform the screening for food, housing and transportation needs?
  - CCO (Trillium or Pacific Source)
  - CBO (Community based organization)
  - PCP (Primary care provider)
  - BH (Behavioral health provider)
  - Dentist
  - Specialists (Cardiologist, Neurologist, Orthopedist, etc.)
  - Hospital (Emergency Room or Inpatient facility)

Question 6

- Who should we share the outcome of the screening with?
  - Varies – ask us first
  - PCP
  - Community based organization

Thank you!

- Any questions for the CCOs?
- Next steps:
- CCO’s will incorporate feedback into the policies we develop regarding social needs screening and referrals.
- We will return to you with final versions of our policies for any additional feedback.
  - We will share the policies, procedures and resources we develop with community and provider organizations, to create alignment of practices in Lane County and to increase effectiveness through collaboration.
  - Note that CCO policies may differ due to internal workflows/processes, but CCOs will work to align policies as much as possible.