Healthy Opportunities Pilots: Standard Plan Roundtable on the Evidence Base

April 12, 2022
Meeting #2

Context & Objectives

Context

- This is the second meeting in the Healthy Opportunities Evidence Based Roundtable Series.
- The roundtable series offers a **forum for PHPs, the Department and local and national experts** to discuss the latest findings and share key resources and insights.
- This meeting will cover an introduction to a handful of resources and tools to review the evidence base, while the next meetings will offer domain-specific discussions (e.g., food, housing, interpersonal violence/toxic stress, transportation).
- As a reminder, PHPs must **develop a plan for their investments, due to the Department on May 17, 2022**, that reflects strategic consideration of high priority populations and current evidence regarding which services offer the greatest benefit to specific populations.

Objectives for Today's Meeting

- Provide an introduction to Social Interventions Research & Evaluation Network (SIREN)
- Discuss ways to engage with SIREN and other resources and tools:
  - Evidence and Resource Library
  - Monthly newsletters, podcast, research meetings
  - Commonwealth Fund ROI Calculator
  - PCORI Evidence Map

Roundtable Meeting Series Schedule

Working Session #	Tentative Timing	Topic	Objective
1	4/6	Introduction to Meeting Series	Provide context for PHPs' role in maximizing the value of the Pilots; review the "Enrolling High-Priority Pilot Populations Plan" report requirements
2	Today	Introduction to SIREN	General orientation to SIREN to describe the database and search option
3	4/21	Evidence Overview 1 (*tentatively: Pilot evaluation overview; food)*	Forums to discuss the state of the art and key issues surrounding the evidence base for Pilot service domains with NC and national subject matter experts
4	4/29	Evidence Overview 2 (*tentatively: housing, IPV/toxic stress and transportation)*	
5	May	Network Leads Presentation	Provide an overview of Pilot region demographics and key considerations for delivering Pilot services

Each SP is asked to share at least one evidence base resource, relevant initiative or key question during an "Evidence Overview" meeting. SPs should let DHHS know in advance which Healthy Opportunity domain their contribution will address.

Introduction to SIREN

https://sirenetwork.ucsf.edu

UCSF
University of California
San Francisco
advancing health worldwide

Social Interventions Research & Evaluation Network

SIREN's mission is to improve health and health equity by advancing high quality research on health care sector strategies to improve social conditions.

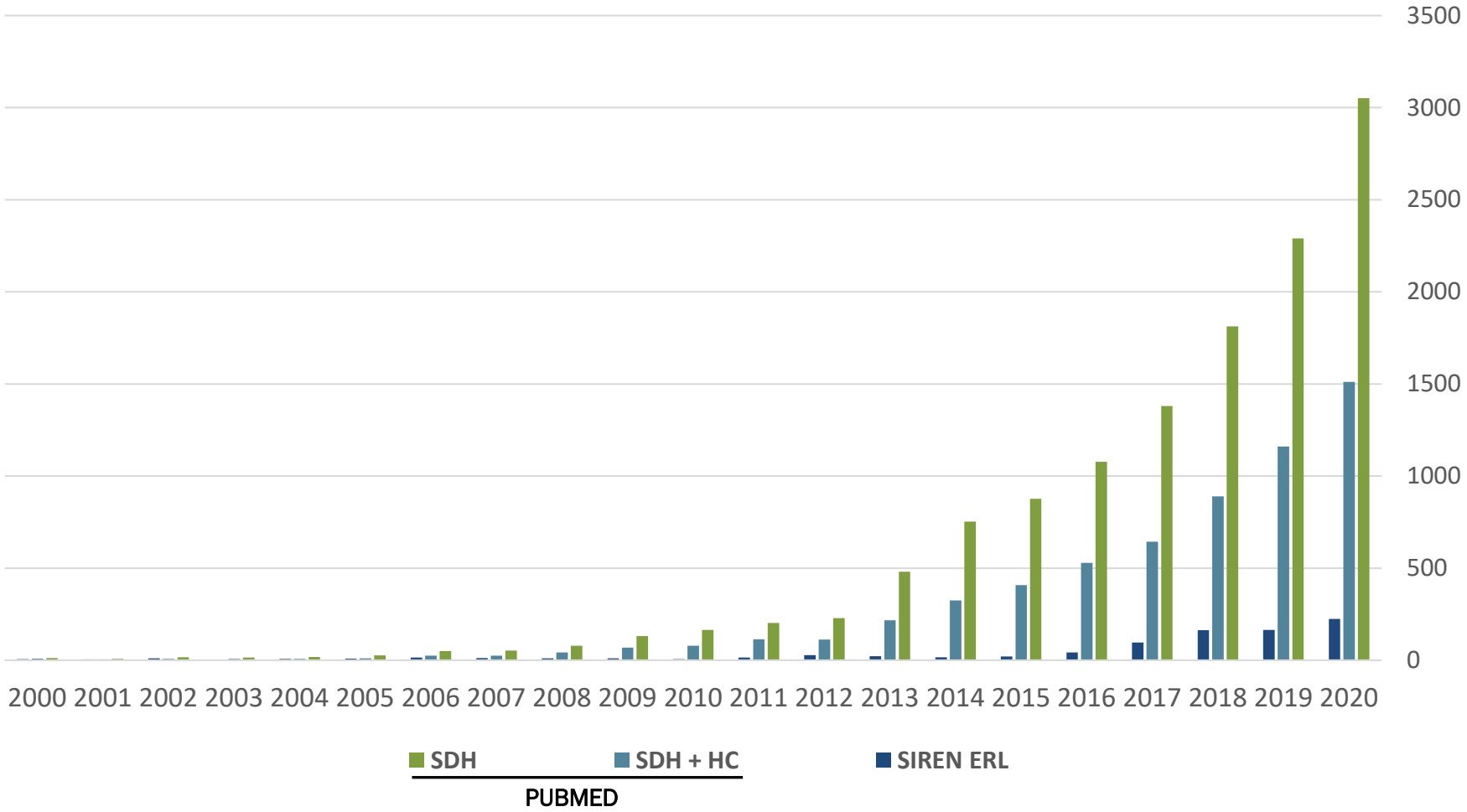
Activities include:

Catalyzing high quality research

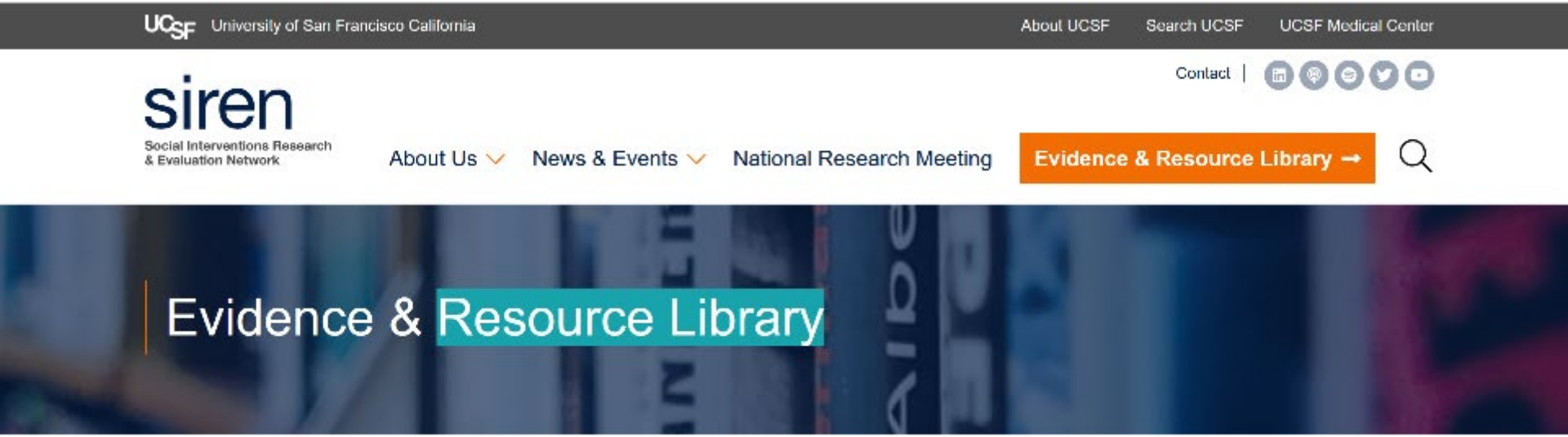
Collecting & disseminating research findings

Providing research consultation services

SDH-related Publications Have Grown Tremendously



SIREN Evidence and Resource Library



- Searchable database of research and implementation tools about healthcare-based SDOH interventions.
- Includes 1900+ resources; updated monthly.
- Available at https://sirenetwork.ucsf.edu/tools/evidence-library

SIREN Evidence and Resource Library

Search Resource

Type Keyword

Filters Expand all

- **Resource Type** +
- **Study Design** +
- **Population** +
- **Outcome** +
- **Social Determinant of Health** +
- **Screening Research** +
- **SIREN Resources** +

Submit Search

Download Search Results

Download Now

Displaying 1 - 9 of 1910

1 2 3 4 5 6 7 8 9 ... →

Screening for health-related social needs in pediatric value-based care: Moving from why to how

T.V. Nguyen, R.J. Chung, C. Wong
JAMA Pediatr

Publication year
2022
Resource type
Commentaries & Blogs

Health-related social needs (HRSN) are critical factors in children's health that can be assessed through informal questioning or use of formal screening instruments such as WE CARE, IHELP, or iScreen.

A mixed methods evaluation of interventions to meet the requirements of California Senate Bill 1152 in the emergency departments of a public hospital system

B.R. Taira, H. Kim, K.T. Prodigue, L. Gutierrez-Palominos, A. Aleman, L. Steinberg, G. Tchakalian, K. Yadav, R. Tucker-Seeley R.
Milbank Q

Publication year
2022
Resource type
Peer Reviewed Research

Policy Points Clarifications to Senate Bill (SB) 1152 are necessary to address the differences between inpatient and emergency department (ED) discharge processes, determine how frequently an ED must deliver the SB 1152 bundle of services to a single patient, and establish exp

Keywords: *Emergency department*

SIREN Monthly Newsletter

siren

Social Interventions Research & Evaluation Network

March 2022 Newsletter

Highlights | Research Round-Up | Application Opportunities | Policy Opportunity
Postdoctoral Opportunity | Upcoming Events | In Case You Missed It

Highlights

SIREN 2022 National Research Meeting and Call for Proposals

We are excited to announce that SIREN will hold a free, virtual National Research Meeting in September and October 2022 applying a racial equity lens to social care research. The objectives of this meeting are to:

March Research Round-Up

As always, articles in the round-up (and more!) can be found in the SIREN Evidence and Resource Library.

Peer-Reviewed Articles

Awareness/Screening

Implementing Health-Related Social Needs Screening in Western Colorado Primary Care Practices: Qualitative Research to Inform Improved Communication with Patients
E.T. Broaddus-Shea, K. Fife Duarte, K. Jantz, J. Reno, L. Connelly, & A. Nederveld
Health and Social Care in the Community
This research was supported by a 2019 SIREN Grant. Information about SIREN funded projects is available here.

Addressing Adverse Childhood Experiences in Primary Care: Challenges and Considerations
H. Dubowitz, D. Finkelhor, A. Zolotor, J. Kleven, & N. Davis
Pediatrics

Assistance

Multi-need interventions

Implementation and Evaluation of Social Determinants of Health Practice Models Within Community Pharmacy
A.A. Foster, C.J. Daly, T. Logan, et al.
Journal of the American Pharmacists Association

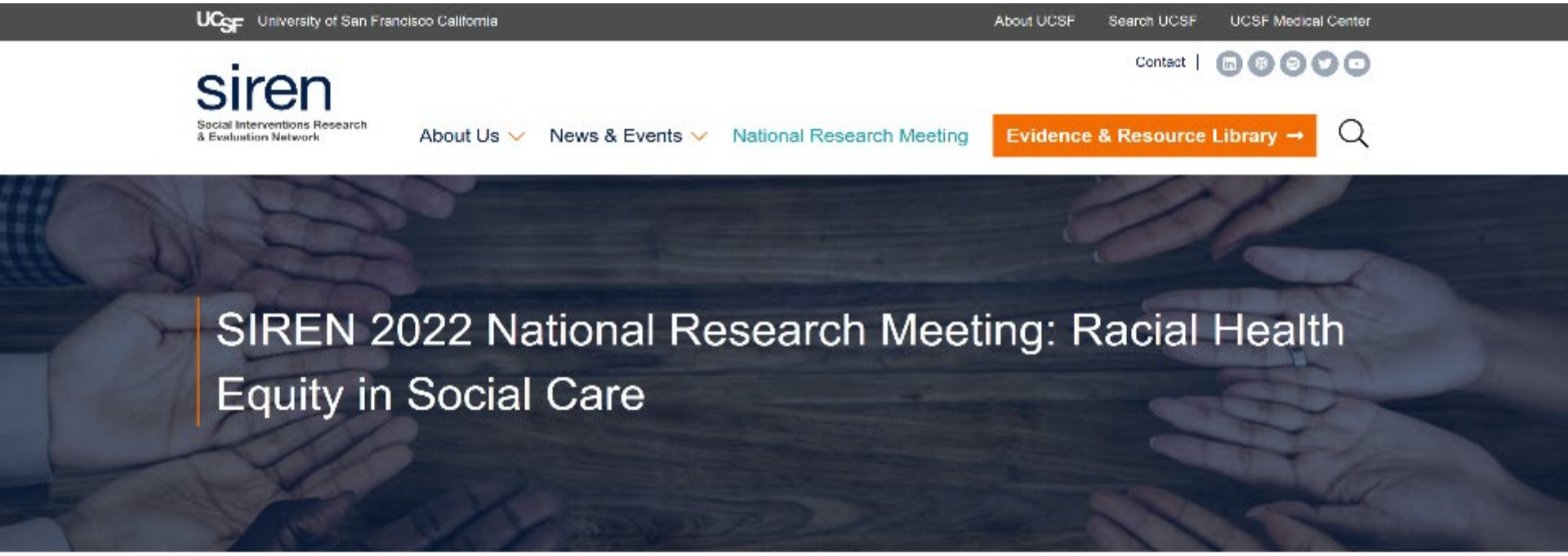
A Missed Opportunity? How Health Care Organizations Engage Primary Care Clinicians in Formal Social Care Efforts
T.K. Fraze, L.B. Beidler, & L.M. Gottlieb
Population Health Management

SIREN Podcast

30 min episodes on complex issues related to integration of medical and social services.

Available on all podcast apps.

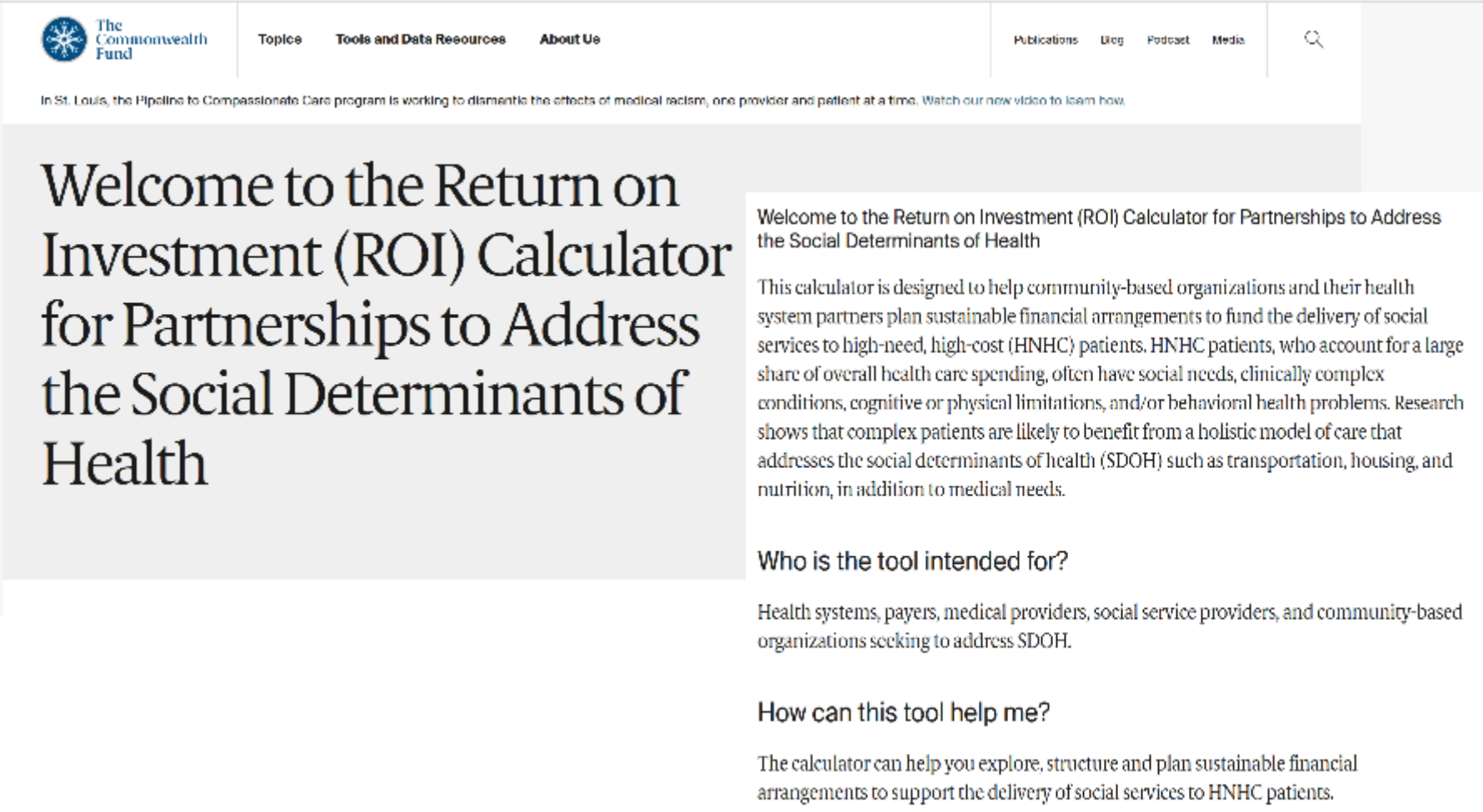
Research Meetings



Thurs Sept 15, Tues Sept 27, and Wed Oct 12, 2022, from 9am-12pm PT / 12-3pm ET.

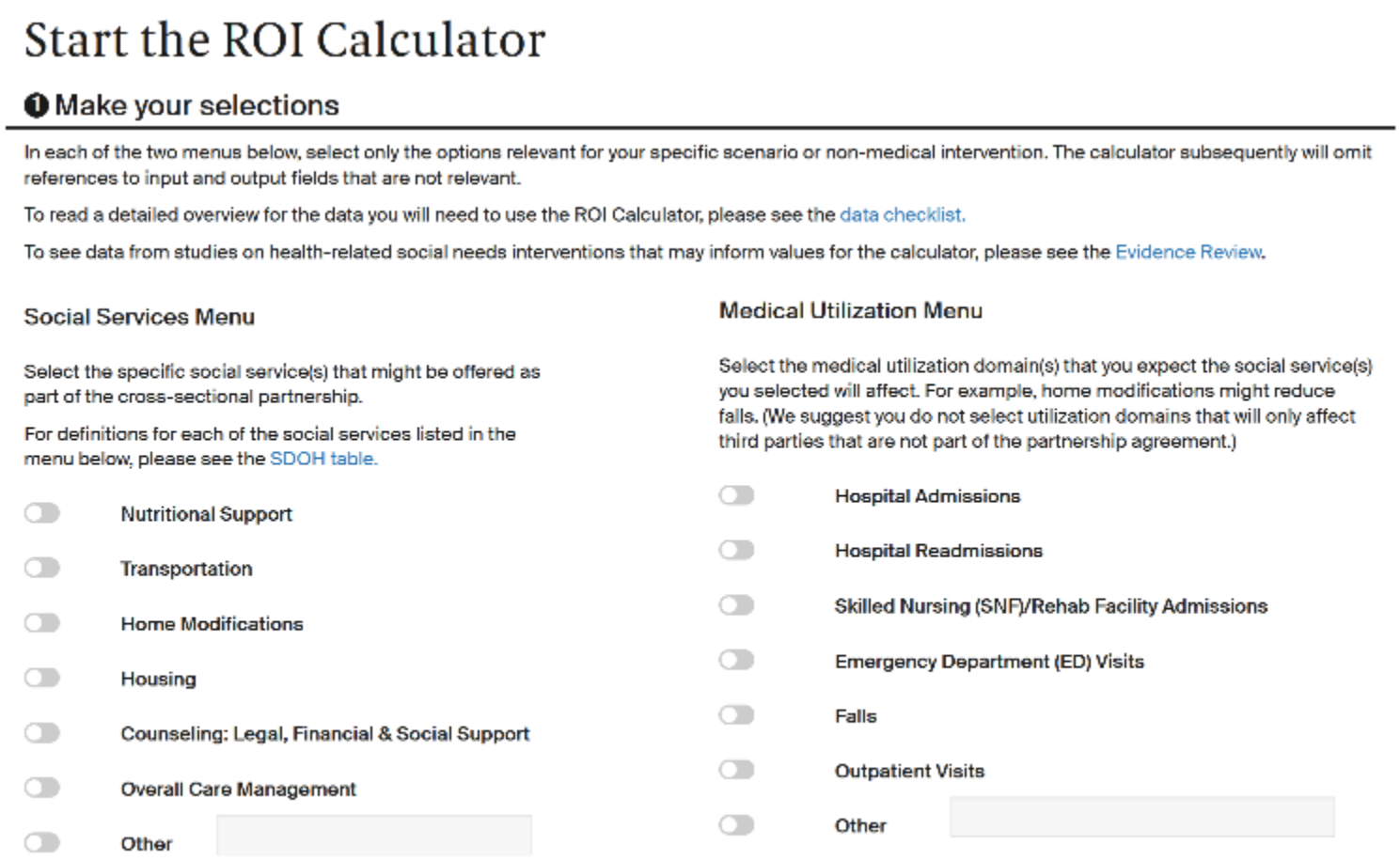
Call for proposals open through April 22, 2022: https://sirenetwork.ucsf.edu/national-research-meeting

Commonwealth Fund ROI Calculator Tool



Available at: https://www.commonwealthfund.org/roi-calculator-app

Commonwealth Fund ROI Calculator Tool



Available at: https://www.commonwealthfund.org/roi-calculator-app

Commonwealth Fund ROI Calculator Tool

ROI Calculator Help Documents & Guides

SDOH Table: Describes the non-medical services this tool supports. There is also an option to plan a particular service not listed in the table by selecting "other" in the calculator.

Data Checklist: An overview of the inputs you and your partner organization will need to use this tool.

Average Cost & Utilization Table: A table of national average health care utilization rates and costs of services for patients with complex needs and all adults living in the community. If you do not have baseline rates and costs to enter, use this table to find values to input into the calculator.

Evidence Review: A collection of relevant evidence on the impact of health-related social needs interventions from peer-reviewed and gray literature. Use this review to find estimates that you can enter in the calculator to generate ROI scenarios or a break-even analysis in case you do not have program data easily available.

Step-by-Step Guide: This hypothetical case example demonstrates how you can use the Average Cost and Utilization Tables and the Evidence Guide to derive relevant inputs and impacts needed by the calculator.

Calculation Guide: Provides explanations of formulas the tool uses to calculate its results.

Available at: https://www.commonwealthfund.org/roi-calculator-app

Commonwealth Fund ROI Calculator Tool

Use Cases: Learn how community-based and health care organizations have used the ROI Calculator to determine the value of health-related social services and develop contractual partnerships to pay for them.

- Learning Report: Using the ROI Calculator to Measure Return on Investment in Addressing Health-Related Social Needs
- Case Study of Homage Senior Services: Calculating the ROI of a Partnership to Meet the Health-Related Social Needs of Medicare Advantage Plan Members
- Case Study of Health Care Access Now: Calculating the ROI of a Care Coordination Program to Address Social Determinants of Health

Commonwealth Fund ROI Calculator Evidence Review

ROI Calculator for Partnerships to Address the Social Determinants of Health

The Commonwealth Fund
Affordable, quality health care. For everyone.

Review of Evidence for Health-Related Social Needs Interventions

July 2019

Mekdes Tsega, Corinne Lewis, Douglas McCarthy, Tanya Shah, and Kayla Coutts

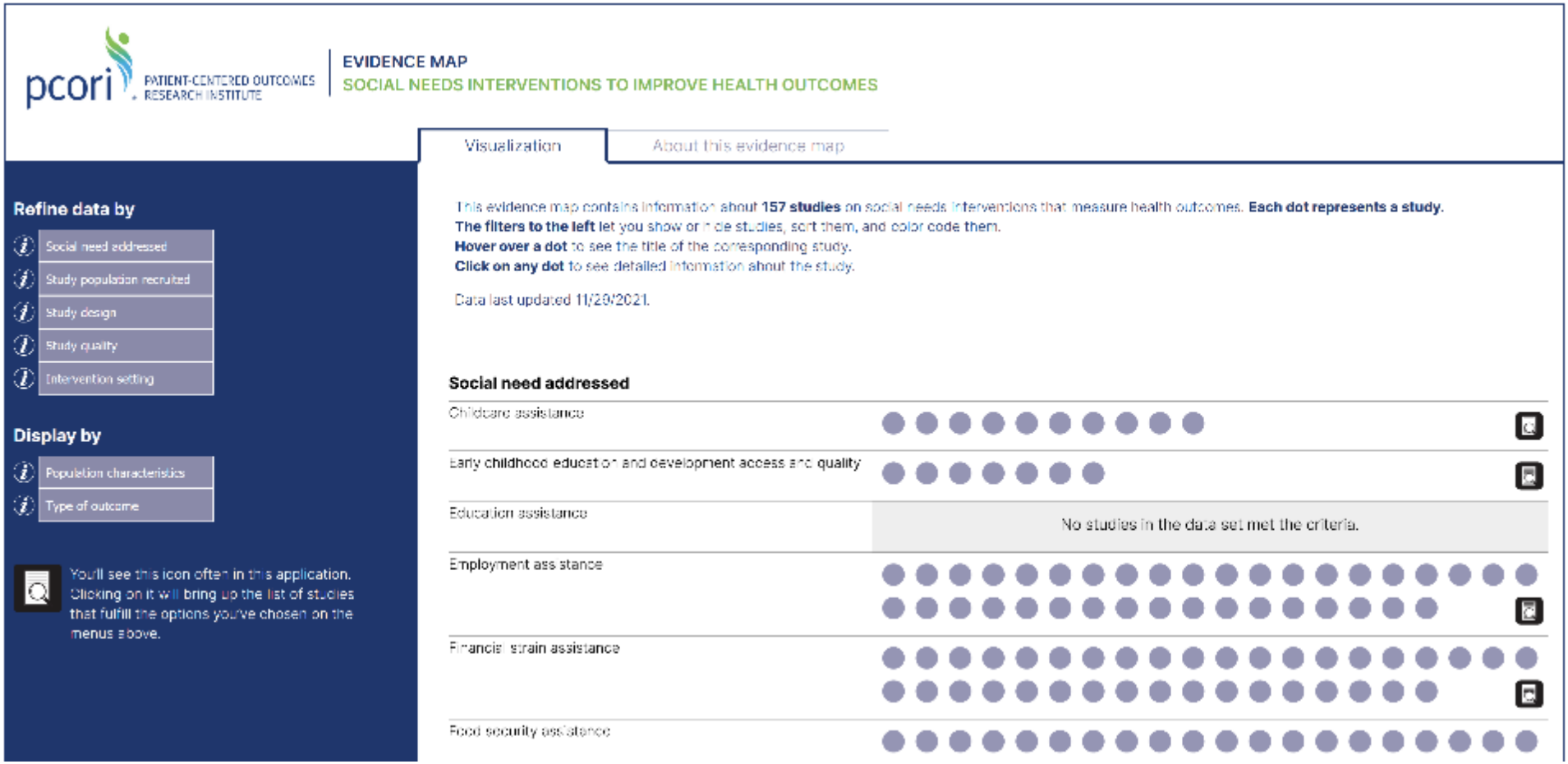
What's Included in the Review

The review includes relevant evidence from peer-reviewed and gray literature that reported on the costs of social service interventions and/or health care utilization outcomes for adult patients or clients. The evidence is presented in six tables by type of social service need including:

- Housing
- Nutrition
- Transportation
- Home Modification
- Care Management
- Counseling: legal, financial, and social supports

Available at: https://www.commonwealthfund.org/sites/default/files/2019-07/ROI-EVIDENCE-REVIEW-FINAL-VERSION.pdf

PCORI Evidence Map

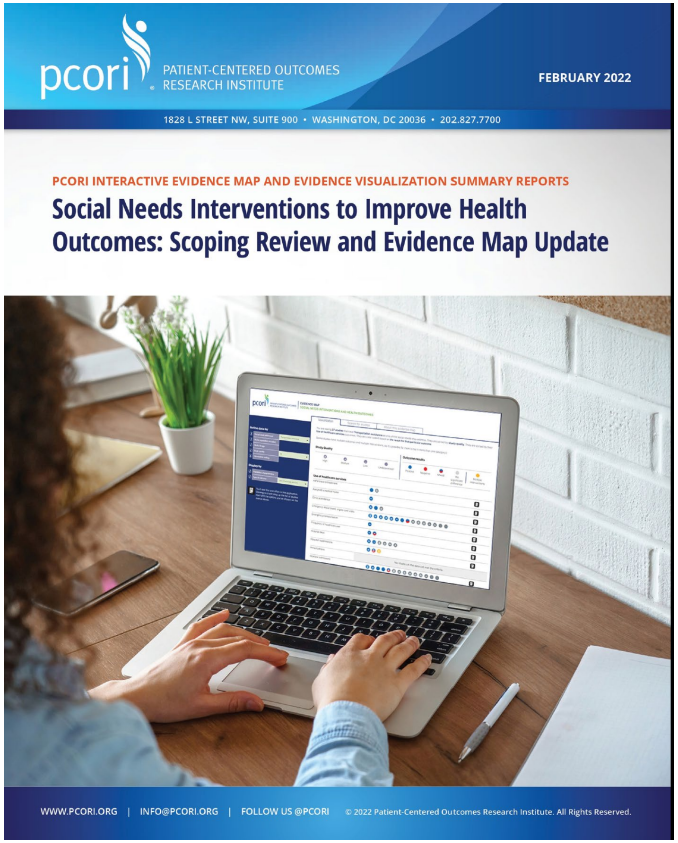


Available at: https://www.pcori.org/sites/default/files/social-needs-interventions/index.html#

PCORI Evidence Map

Available at: https://www.pcori.org/sites/default/files/social-needs-interventions/index.html#

PCORI Evidence Map Summary Report (Feb 2022)



Summary and Overview

We previously reported on interventions addressing social determinants of health and health outcomes in August 2021 and published an evidence map allowing interactive visualization of intervention characteristics for this evidence base. This report summarizes the results of an updated search, last conducted on November 29, 2021 (November 2021 data update).

The search yielded 19 additional studies (in 23 publications), for a cumulative total of 157 studies (in 178 publications). In reviewing patterns and trends in the evidence, we noted that nearly half (47%) of eligible studies (N = 157) were published in the past 6 years (2016-2021). As research accumulates, the total number of randomized controlled trials (RCTs) has increased over time, but observational single-arm studies have become a larger proportion of the evidence base. RCTs and single-arm studies each comprise 31% of all 157 studies, while 29% are cohort studies with comparison groups, and 10% are comparative effectiveness studies. Included studies most commonly cited health care services access and quality (n = 113 studies) as well as housing stability and quality (n = 95 studies) as social needs addressed. Forty-nine studies included majority black populations, and 20 included majority Hispanic or Latino populations. No single group was a majority in 38 studies. More than three-quarters of studies (n = 124) focused on adults (aged ≥18 years). Health care utilization outcomes were most commonly reported and included resource-intensive events such as emergency department visits and inpatient admissions. Most studies reported positive (ie, results consistent with the study's intended direction of effect), mixed (ie, inconsistent results across multiple but similar outcomes), or no effects; a minority reported negative outcomes (ie, results favoring the comparison arm). More commonly reported outcomes were more likely to present a mixed picture or no effects, whereas less commonly reported outcomes generally favored the intervention

US Preventive Services Task Force Review

US Preventive Services Task Force

FREE

September 1, 2021

Screening and Interventions for Social Risk Factors

Technical Brief to Support the US Preventive Services Task Force

Results Many multidomain social risk screening tools have been developed, but they vary widely in their assessment of social risk and few have been validated. This technical brief identified 106 social risk intervention studies (N = 5 978 596). Of the interventions studied, 73 (69%; n = 127 598) addressed multiple social risk domains. The most frequently addressed domains were food insecurity (67/106 studies [63%], n = 141 797), financial strain (52/106 studies [49%], n = 111 962), and housing instability (63/106 studies [59%], n = 5 881 222). Food insecurity, housing instability, and transportation difficulties were identified by key informants as the most important social risk factors to identify in health care. Thirty-eight studies (36%, n = 5 850 669) used an observational design with no comparator, and 19 studies (18%, n = 15 205) were randomized clinical trials. Health care utilization measures were the most commonly reported outcomes in the 68 studies with a comparator (38 studies [56%], n = 111 102). The literature and key informants described many perceived or potential challenges to implementation of social risk screening and interventions in health care.

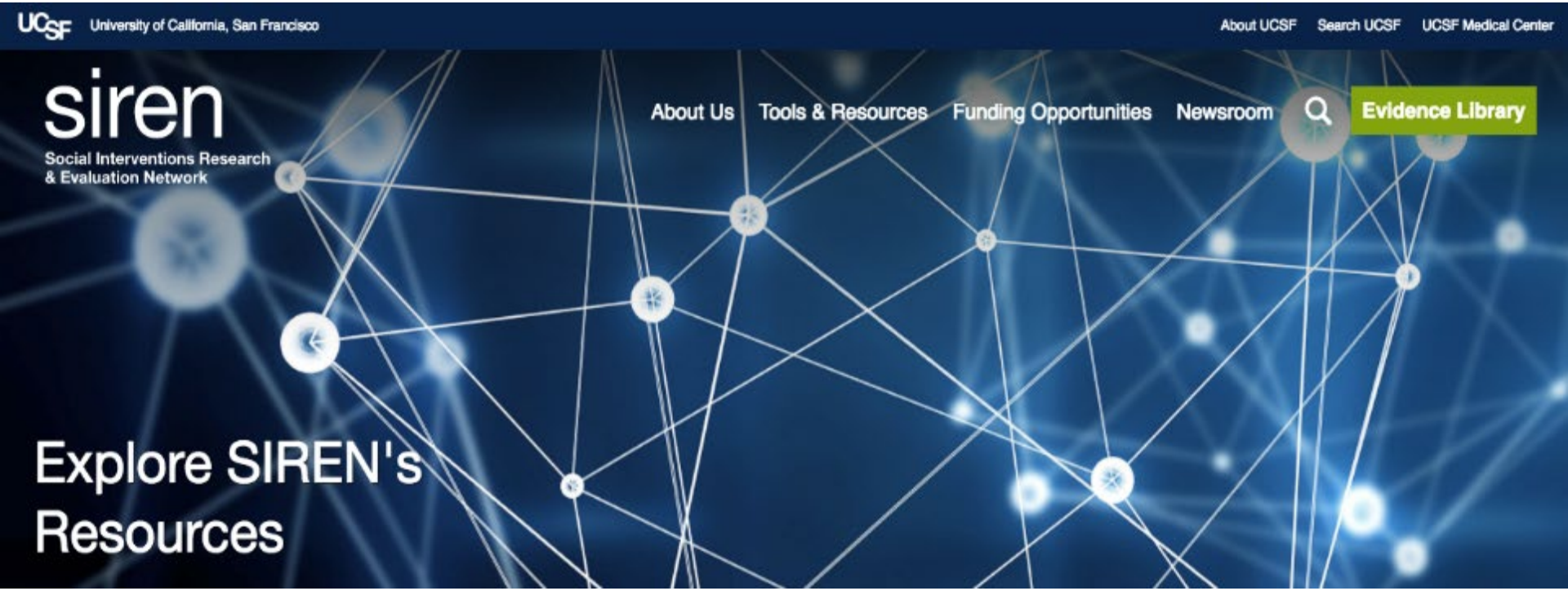
Conclusions and Relevance Many interventions to address food insecurity, financial strain, and housing instability have been studied, but more randomized clinical trials that report health outcomes from social risk screening and intervention are needed to guide widespread implementation in health care.

Available at: https://jamanetwork.com/journals/jama/fullarticle/2783975

Resources Recap

- SIREN Evidence and Resource Library: Search the literature by social need, population, and outcome. Includes intervention studies and reviews (and opinion articles and reports).
- PCORI Evidence Map: Search the literature by social need, population, and outcome. Only includes intervention studies (no reviews).
- Commonwealth Fund ROI Calculator Tool: Calculate the ROI for a given intervention (need to know its likely impact)
- Key recent reviews:
  - PCORI Evidence Map Updated Report, February 2022
  - USPSTF systematic review, Sept 2021
  - Commonwealth Fund Evidence Review, July 2019 (currently being updated)

Contact Information



Caroline.Fichtenberg@ucsf.edu
siren@ucsf.edu
sirenetwork.ucsf.edu

Q&A

Reminders & Next Steps

- The next meeting in the Roundtable series is scheduled for **April 21st from 2:30 – 3:30 PM ET** and will cover 1) an overview of the Healthy Opportunities Pilots evaluation, and 2) the evidence base for food-related Pilot services.
- Scheduling for subsequent meetings is underway.
- The Enrolling High Priority Pilot Populations Report is due to the Department on **May 17, 2022**.

Appendix

Who Qualifies for Pilot Services?

To qualify for pilot services, Medicaid managed care enrollees must live in a Pilot Region and have:

At least one Physical/Behavioral Health Criteria:
(varies by population)

- **Adults** (e.g., having two or more qualifying chronic conditions)
- **Pregnant Women** (e.g., history of poor birth outcomes such as low birth weight)
- **Children, ages 0-3** (e.g., neonatal intensive care unit graduate)
- **Children 0-20** (e.g., experiencing three or more categories of adverse childhood experiences)

At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

Meet service specific eligibility criteria, as needed.

Healthy Opportunities Pilots: Qualifying Physical/ Behavioral Health Criteria

Population	Age	Physical/Behavioral Health-Based Criteria
Adults	22+	• 2 or more chronic conditions. Chronic conditions that qualify an individual for Pilot program enrollment include: BMI over 25, blindness, chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, substance use disorder, chronic endocrine and cognitive conditions, chronic musculoskeletal conditions, chronic mental illness, chronic neurological disease and chronic renal failure, in accordance with Social Security Act section 1945(h)(2). • Repeated incidents of emergency department use (defined as more than four visits per year) or hospital admissions.
Pregnant Women	N/A	• Multifetal gestation • Chronic condition likely to complicate pregnancy, including hypertension and mental illness • Current or recent (month prior to learning of pregnancy) use of drugs or heavy alcohol • Adolescent ≤ 15 years of age • Advanced maternal age, ≥ 40 years of age • Less than one year since last delivery • History of poor birth outcome including: preterm birth, low birth weight, fetal death, neonatal death
Children	0-3	• Neonatal intensive care unit graduate • Neonatal Abstinence Syndrome • Prematurity, defined by births that occur at or before 36 completed weeks gestation • Low birth weight, defined as weighing less than 2500 grams or 5 pounds 8 ounces upon birth • Positive maternal depression screen at an infant well-visit
	0-21	• One or more significant uncontrolled chronic conditions or one or more controlled chronic conditions that have a high risk of becoming uncontrolled due to unmet social need, including: asthma, diabetes, underweight or overweight/obesity as defined by having a BMI of <5th or >85th percentile for age and gender, developmental delay, cognitive impairment, substance use disorder, behavioral/mental health diagnosis (including a diagnosis under DC: 0-5), attention deficit/hyperactivity disorder, and learning disorders • Experiencing three or more categories of adverse childhood experiences (e.g. Psychological, Physical, or Sexual Abuse, or Household dysfunction related to substance abuse, mental illness, parental violence, criminal behavioral in household) • Enrolled in North Carolina's foster care or kinship placement system

Healthy Opportunities Pilots: Social Risk Factors

Risk Factor	Definition
Homelessness and Housing Insecurity	• Individuals who are **homeless**: defined as an individual who lacks housing, including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing. • Individuals who are **housing insecure:** including individuals who, within the past 12 months, have ever stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch surfing); are worried about losing their housing; or within the past 12 months have been unable to get utilities (heat, electricity) when it was really needed.
Food Insecurity	Patients who are experiencing food insecurity—defined as the disruption of food intake or eating patterns because of lack of money and other resources--including those who: • Report reduced quality, variety, or desirability of diet. There may be little or no indication of reduced food intake. This is considered low food security. • Report multiple indications of disrupted eating patterns and reduced food intake. This is considered very low food security. • Report that within the past 12 months they worried that their food would run out before they got money to buy more. • Report that within the past 12 months the food they bought did just not last and they didn't have money to get more.
Transportation Insecurity	Patients for whom, within the past 12 months, a lack of transportation has kept them from medical appointments or from doing things needed for daily living.
At risk of, witnessing, or experiencing interpersonal violence	Patients who report that they feel physically or emotionally unsafe where they currently live; within the past 12 months have been hit, slapped, kicked or otherwise physically hurt by anyone; or within the past 12 months have been humiliated or emotionally abused by anyone.

NC DHHS Healthy Opportunities Standardized Screening Questions. Available: https://www.ncdhhs.gov/screening-tool-english-providers-final/download

PHPs' "Enrolling High Priority Pilot Populations" Report (1/2)

PHPs are required to submit the Healthy Opportunities Pilot Enrolling High-Priority Population Plan by May 17, 2022 (45 days prior to Pilot Service Delivery Year 2).

In the Plan, PHPs must:

1. Identify priority populations; and
2. Describe strategies and operational approaches for ensuring equitable distribution of Pilot investments

1. Identifying Priority Populations

PHPs must report on the anticipated proportion of enrollees for the second Pilot service delivery year (July 1, 2022 – June 30, 2023) who will:

- Be pregnant
- Be children ages 0-21
- Have high health care expenditures as determined by the PHP
    - The PHP must define "high-cost populations", describe the methods the PHP will use to identify high-cost Pilot enrollees and any available evidence-base regarding the impact of Pilot-like services on this population.
- Meet any additional priority population designations the PHP intends to focus on for Pilot enrollment (at the PHP's discretion)
    - The PHP must describe how it will identify and define this population and the evidence-based rationale for focusing on the additional priority populations.

PHPs' "Enrolling High Priority Pilot Populations" Report (2/2)

2. Ensuring Equitable Distribution of Pilot Investments

For the second Pilot service delivery year, the PHP must submit a description of its strategies and operational approaches for:

- Identifying and enrolling members residing in Pilot regions to ensure **inclusive representation of priority populations**.
- Ensuring the **racial and ethnic composition of Pilot enrollees and expenditures** are at least proportional to **Medicaid demographics** in the Pilot region.
- Ensuring that **historically marginalized populations and communities in the Pilot region are proportionally represented** among Pilot enrollees and service expenditures, including at minimum to meet the following goals:
  - Starting in Pilot Service Delivery Period II, the PHP shall direct Pilot services to be distributed to the following groups during each Service Pilot Delivery Period:
    - At least thirty-three percent (33%) of Pilot enrollees are pregnant enrollees or children ages 0-21.
    - At least thirty-three percent (33%) of Pilot enrollees are high-cost populations.
  - The PHP shall ensure that historically marginalized populations and communities in the Pilot region are at least proportionately represented in the delivery of Pilot services and service expenditures.