Task Force Feedback on Social Determinants of Health Outstanding Design Element Draft

NOVEMBER 2021

The comments below were collected from Task Force members in response to the SDOH ODE Draft recommendation presented at the October 28th 2021 Task Force meeting.

TF Member	Comments
Dr. John Santa	In the recommendations I believe that the report should direct the Board to make SDOH a top priority when savings from administration or health care has occurred. Resources for SDOH should be given directly to regional entities to make community investments with both short and long term SDOH impact. 1) Patients and communities should be confident that the priority for savings is reinvestment in them and the communities they live in. Oregon and other states with the encouragement of CMS have begun the process of providing “SDOH benefits” (my term) by identifying ways in which the “insurance model” (like CCOs) can help subpopulations with those issues (housing, food, non emergency transport etc). This also can involve services of community health care workers. The CCOs have started to try to do that under the current waiver but overall they have spent about .7% of their budgets in doing so. As always there is a very significant degree of variation with some CCOs reporting much more of these expenses than other CCOs. The proposed waiver seeks to improve that process via more flexible funding, getting CMS match for it etc. This basically relies on a pretty traditional medical model approach---ie the health care systems/providers screen for these folks and respond with SDOH services. There is a metric being developed to better measure this. And that means there is discussion about how to get the EMR vendors to make this possible and of course discussion about how much are we going to spend on administering this and measuring it and whether there are any clinical outcomes that can be measured and realistically thought to improve. We should all be a bit skeptical of this process since as always there will be many barriers to implementing this and likely huge variation. We may get this done well in 10-15 years… 2) My hope is that SDOH is considered as a priority higher up in the organization. My hope is that the single payer commits to equity and SDOH improvement at the highest level and does so in a way that truly transfers money and power, not so much to individuals but to communities. My sense is the way to do this is to transfer money and power to the regional entity described in our governance process with expectations that the regional entity uses the money and power to invest in much more significant ways in the community to truly change the wealth and power equation in the community. In the proposed waiver, “Regional Community Investment Collaboratives” are proposed to be created that will do this. The hope is that these collaboratives will get $$ from Federal, state and CCO sources and then be able to invest them in the community.

	3) I think the single payer will need to have financial reserves to weather delivery system ups and downs that the actuaries will have to advise on the extent of. I think the single payer will need to have public health reserves. If public health is actually in the single payer these reserves may need to be more substantial than if they are not. Even if they are not, there should still be a public health reserve of some sort to be better prepared to avoid the chaos we faced in early 2020. We really have not talked about where public health will sit in our scheme but that is another topic. 4) I think the single payer will need to have reserves for capital investments for the delivery system. Recall this was a topic that Chad especially emphasized. We decided that the regional entity would hold these reserves and distribute them as needed based on community input. This will be a huge issue when it comes to allocation of hospital $$ especially. It means significant dollars will be held at the regional level rather than being paid out in the delivery system budget. Hopefully this will reduce the need for the huge reserves some of the hospitals appear to have. I was stunned at the size of the reserve fund that was reported early in COVID at Salem Health and Providence. I suspect many of our health systems are holding huge amounts of money in reserve---meanwhile communities are falling apart. And of course many of the hospitals have foundations with hundreds of millions of dollars. 5. My hope is that a state like Oregon via a single payer could convince the delivery systems that it is time to be serious about waste, overuse, medical harm and prioritize savings in all of those areas. A substantial part of that savings would go to improve the community---not to build a new lobby, not to increase the salaries of folks already in the top 5% of wage earners, not to shareholders of for profits. Over my lifetime enormous advances have occurred that saved hundreds of billions of dollars---but these savings were quickly eaten up by the folks with power. Laparoscopic surgery for example should have saved us billions but instead quickly became a profit center and actually increased costs. Many other examples. 6. In many respects Oregon is already headed in this direction in the proposed waiver. I think by 2026 when that waiver is ending that there might be agreement that we need to get even more serious about it and move to a single payer if we want to reach equity and SDOH goals 7. As we all know, near 20% of our GDP goes through the health industry. And I am pretty sure that the health industry has been as good or better than any other industry in terms of creating income inequality and moving resources in communities from housing, food and other needs to health. We have watched this happen for 40 years.
Dr. Sam Metz	Addressing the SDOH should be a second phase project after the first phase: successful implementation of a single payer plan. Once the single payer plan generates resources from its various efficiencies, much of these subsequent saving can be diverted to communities for SDOH.
Chuck Sheketoff	I think some SDOH efforts need to be implemented from the outset because they are so integral to the health care being provided...housing for those needing treatment for addictions and mental health issues comes to mind.

	I think our enabling legislation can direct State agencies that spend funds on social determinants of health to identify those funds and be responsive in their priorities to the new universal healthcare agency's (and their regional groups) priorities in spending those funds.
Glendora Claybrooks	**Task Force Findings and Proposed Draft Recommendation** Regarding the passage framework of SDOH, the proposal must reflect that SB 770 **Section 3** identifies the objectives and goals required to address SDOH in **Section 6 (a)** that describes the scope of the design. Section 6(a) directs the TF to follow the directions outlined in **Sections 4, 5**, which include the frameworks the TF must consider based on its findings and recommendations toward identifying the barriers and meeting the socio-cultural and economic needs of the population. Based upon the findings, I recommend the following be incorporated into our proposal. **<u>The Task Force on Universal Health Care finds that addressing SDOH-E is foundational for:</u>** 1. Addressing the unmet socio-economic and environmental health and healthcare needs toward improving and or eliminating nutritional (food desserts) deficits, homelessness, inadequate mental health treatments, and minimal access to community healthcare facilities, home health, and long and short-term care services. 2. Addressing health risks in the built environment, such as lead exposures, poor air, and water quality, and non-emergency medical transportation, etc. that impact health conditions and poor health outcomes known to result in disproportionate health disparities, inequities, and inequalities among the disenfranchised and marginalized minority and rural populations and their communities. 3. Ensuring that Oregon's HCAO Plan benefit coverage and services provide for diverse cultural healthcare providers, linguistics, DME needs, and health literacy education. It is important to ensure a systematic and equilibrium health care system that is representing a just and fair society whereby all Oregonians will benefit from a healthcare plan with equal opportunities. The TF must recommend to the Legislative Assembly that the HCAO Board examines the most crucial elements creating an unequal healthcare system and poor health outcomes. These variables are most affiliated with the current barriers impeding high-value quality, access, and affordable

	health care services. Therefore, based on research findings and feedback from its community advisory committee and technical advisory groups. The TF's recommendations should indicate that the qualitative health-related factors influencing the existing organizational and institutional structures are the policies, processes, programs, and decision-making models. Because of these findings, it is justified that these aspects below be thoroughly investigated and transformed. My humble thoughts... · Finances · Organizational aspects · Practices · Distribution · Delivery · Management