Gap Analysis: Social Determinants of Health

Quality Department

2025

Contents

Background

The Social Determinants of Health (SDoH) incentive measure requires Umpqua Health Alliance (UHA) to attest to screening and referring members for food, housing, and transportation needs to the Oregon Health Authority (OHA) by completing four buckets of work: policies and procedures, gap analysis, CBO contracting, and systematic assessment of screening and referral data sources; all of which incorporate member feedback.

The following information is a detailed gap analysis of the Douglas County service area related to food, housing, and transportation needs. The gap analysis used data from the Oregon Hunger Task Force, Oregon Housing Alliance, and Rural Health. U.S. Food and Drug Administration to understand where Douglas County stands compared to Oregon statewide. Additionally, the gap analysis reviews a 2022 study of Medicaid population compared to UHA health risk assessment (HRA), claims data, and Community Information Exchange (Unite Us) data to estimate potential gaps in screenings and referrals. Lastly, UHA developed Tableau Dashboards to provide a deeper understanding of the unique member diagnosis and CBO distribution by the social need domain, as well as stratifying this data by REALD identifiers.

The purpose of this gap analysis is to assist UHA with establishing goals and identifying gaps in care, which is expanded upon within the 2026 SDoH Action Plan Roadmap.

Douglas County Overview

In Douglas County, the prevalence of food-insecure individuals and children surpasses the average for the state of Oregon. Specifically, 23% of people in Douglas County report experiencing food insecurity despite not qualifying for federal nutrition assistance. Additionally, 20% of children in food-insecure households do not meet the criteria for federal nutrition assistance[1].

Douglas County faces significant levels of unmet housing needs, accompanied by a scarcity of affordable housing options. One out of four renters expend over 50% of their income solely on rent while three out of four renters with extremely low incomes are expending over 50% of their income on rent. Additionally, one in 21 students in Douglas County experienced homelessness in the year 2019 – 2020, accounting for 670 children. Furthermore, the poverty rate in Douglas County surpasses that of Oregon's statewide[2].

Rural communities encounter challenges in accessing healthcare services, leading to a higher risk of disease compared to individuals residing in urban areas[3]. Transportation, both for medical and non-medical needs, presents a barrier within rural areas. This difficulty could impact the ability of rural residents to maintain employment or complete essential tasks. Only an estimated 5% of Oregon's rural population lives in a census block group with a density considered necessary by sources to provide regular fixed route bus services. The limited transportation resources available in rural regions put many residents at a significant economic and social disadvantage[4].

See below table(s) for a comparison of Douglas County to Oregon statewide.

Table 1

Hunger Statistics 2021	Douglas County, OR	Oregon Statewide
Food Insecure Individuals	14.0%	11.5%
Food Insecure Children	20.8%	14.6%

Table 2

WIC Utilization 2022	Douglas County, OR	Oregon Statewide
Individuals Served	4,307	110,967
Families Served	2,466	65,179
% of Pregnant Women Served	45%	28%
% Served under 5 years of age	75%	75%

Table 3

SNAP Utilization 2017	Douglas County, OR	Oregon Statewide
Households receiving benefits	17.8%	14.7%
Households receiving benefits with children > 18 years old	34.8%	40.5%

Table 4

Poverty & Income Statistics 2021	Douglas County, OR	Oregon Statewide
Median household income	$52,479	$70,084
Persons in Poverty	16.5%	12.2%
Unemployment Rate	6.4%	4.9%

Table 5

Housing 2017	Douglas County, OR	Oregon Statewide
Median Renter Wage	$11.99	$14.84
Wage needed to afford a 2-bedroom apartment at HUD's fair market rent.	$14.10	$19.86

Community Themes and Strengths Assessment (CTSA)

In 2023, UHA conducted a Community Themes and Strengths Assessment (CTSA) to identify health priorities in Douglas County, revealing several key social determinants of health (SDoH). Food access and security emerged as a significant concern. In 2021, the county's food insecurity rate was 12%, with 17% of those affected ineligible for SNAP benefits. The rate was even higher among children, at 16.8%. Additionally, 65.5% of Douglas County students were eligible for free or reduced-price meals in 2022, well above the state average of 55%. Limited access to food remains an issue, with 42.5% of residents reporting limited food availability and 6.7% living in designated food deserts. These concerns were echoed in survey responses and community discussions.

Access to health and social services was also identified as a barrier. Approximately 66.7% of CTSA survey respondents reported challenges in accessing health care, citing limited appointment availability and a lack of services in their area. However, more than half of respondents agreed or strongly agreed that their communities offered sufficient social services to meet residents' needs.

Safe and affordable housing was another major theme. About 30% of respondents said they were unable to afford rent or mortgage payments at least several times per year. Housing cost burden varied across the county, with the highest in Canyonville (46.7%) and the lowest in Melrose (9.5%). Other towns with significantly higher housing burdens than the county average included Tri-City (35.2%), Roseburg (34%), Glendale (33.5%), Sutherlin (32.9%), and Yoncalla (32.7%).

Economic stability remains a pressing issue. In 2021, 17.5% of Douglas County residents lived in poverty, compared to 12.2% statewide. The county's poverty rate rose substantially from 10.3% in 2019 to 17.5% in 2021. The unemployment rate, however, improved from 7.8% in 2020 to 5.3% in 2022. Respondents identified key community priorities such as access to good jobs, a healthy economy, and affordable housing. Notably, 50% of respondents indicated they lacked sufficient funds to pay for at least one essential item in the past month or year.

Social Needs Screenings & Referrals: Gaps Identified Through Secondary Data

Overview

The following estimates draw from the 2022 study "Prevalence of Social Risk Factors and Social Needs in a Medicaid Accountable Care Organization (ACO)". These projections are designed to illustrate potential gaps in Douglas County's social needs screening and referral processes. All figures should be interpreted as such.

Study Benchmarks

According to the 2022 ACO study:

- 25.3% of Medicaid ACO patients were screened for social needs.

- 30.4% of completed screenings were positive for at least one social risk factor (housing, food, transportation).
- 13.9% of screened patients received a referral for a social need.

Projected UHA Screening & Referral Volumes Based on Study Rates

If UHA screened 25.3% of members (≈9,833 individuals), projections based on the study would be:

- Positive Screenings (30.4% of those screened): 2,989
  - Food insecurity (16.7%): 1,642
  - Housing instability (7.7%): 757
  - Transportation needs (6.0%): 590
- Referrals (13.9% of those screened): 1,367
  - Food referrals (4.5%): 442
  - Housing referrals (6.2%): 610
  - Transportation referrals (3.2%): 315

These projections illustrate the approximate volume of social needs UHA might expect to identify if screening and referral patterns aligned with the study's findings.

Actual UHA Screening & Identification Rates

UHA screening activity exceeds the projected benchmark:

- Total UHA screenings: 14,881 (~38% of membership), significantly higher than the projected 9,833.
  - Food insecurity: 4,631
  - Housing instability: 6,252
  - Transportation insecurity: 3,998

However, despite higher screening volume, positive screening rates are substantially lower than expected.

- UHA Positive Screenings (9.9% of screenings): 1,471
  - Food insecurity (1.9%): 287
  - Housing instability (5.5%): 832
  - Transportation insecurity (2.3%): 352

Actual UHA Referral Rates

Referral rates also fall below study benchmarks:

- UHA Referrals (5.3% of screenings): 789
  - Food referrals (1.8%): 275
  - Housing referrals (3.1%): 466
  - Transportation referrals (0.3%): 48

Key Takeaways

Overall, UHA is screening members for social needs at a much higher rate than projected based on ACO study benchmarks; however, the rate at which UHA identifies positive social needs is considerably lower than expected. While UHA screens more members, it is detecting fewer instances of food insecurity, housing instability, and transportation challenges compared to study norms. Referral rates show a similar pattern—UHA is under-referring across all three domains when compared to the study's 13.9% referral benchmark. Despite these lower-than-expected identification and referral rates, UHA's referral volumes have continued to steadily increase year over year, indicating ongoing progress as screening and referral infrastructure matures.

Member SDoH Diagnosis Compared to CBO Distribution Identified Through Primary Data

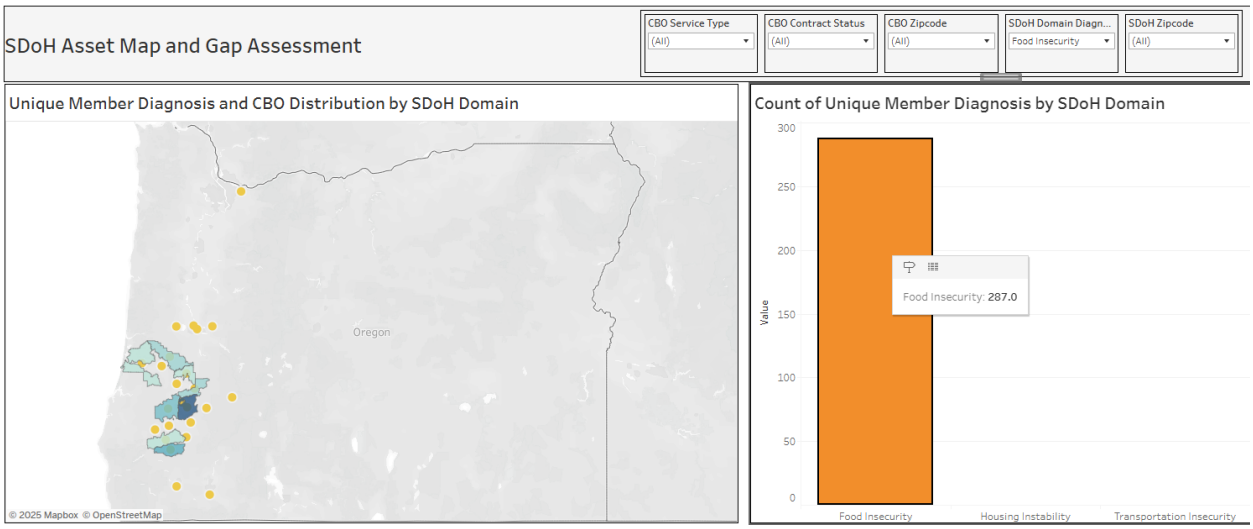
UHA developed a Tableau dashboard to identify unique member diagnoses and Community-Based Organization (CBO) distribution by Social Determinants of Health (SDoH) domain. In 2023 and 2024, UHA collected CBO data based on where members received flex services. In 2025, the Community Engagement Department refined this approach by creating a Douglas County CBO list that includes only organizations actively partnering with the CCO and serving Oregon Health Plan (OHP) members. The previous list included entities such as auto repair shops, RV parks, and apartments, which do not meet the definition of a CBO capable of sending and receiving referrals. As a result of this change, the number of CBOs reflected in the 2025 gap analysis differs from those reported in 2024.

SDoH member diagnosis data was collected from a combination of claims and clinical data. The data from UHA's HRA was identified by mapping the PRAPARE screening responses to ICD-10-CM Z Codes using the crosswalk provided by the National PRAPARE® team. The data from the claims extract was identified using the NIH value sets outlined in Appendix two of the Social Needs Screening and Referral Measure specifications.

UHA completed an asset map of available CBOs who can provide social need services to UHA members. The asset map identified 46 CBOs addressing food, housing, and transportation needs. Of these, there are 41 identified CBOs in Douglas County, with 9 under contract with UHA. UHA has identified 1,471 unique members who have screened positive for either a food, housing, or transportation need. Among these 1,471 individuals, 78 diagnoses exist outside of Douglas County, signifying that 5.3% of members who have a diagnosis reside outside of Douglas County, while the remaining 94.6% reside in Douglas County. Additionally, 10.8% of identified CBOs operate outside of Douglas County, none of which have contracts with UHA.

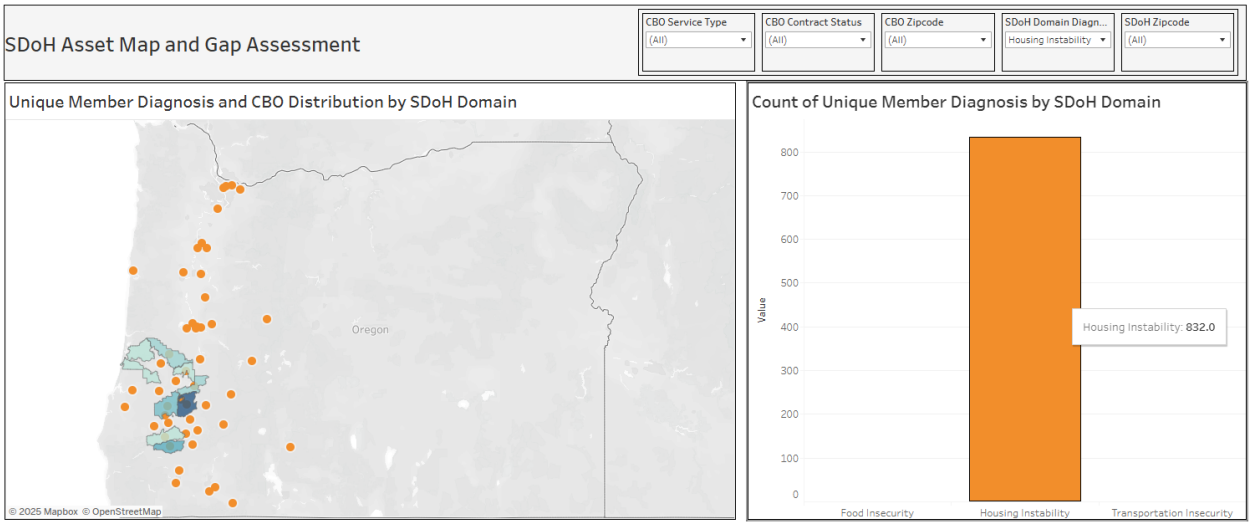
Asset Map & Gap Assessment: Food

Specifically, 0.7% of UHA members have screened positive for food insecurity. Within the realm of food services, there are a total of 32 CBOs. Among these, 4 have contracts with UHA, 15 are not contracted with UHA, and the contract status of 13 remains unknown.



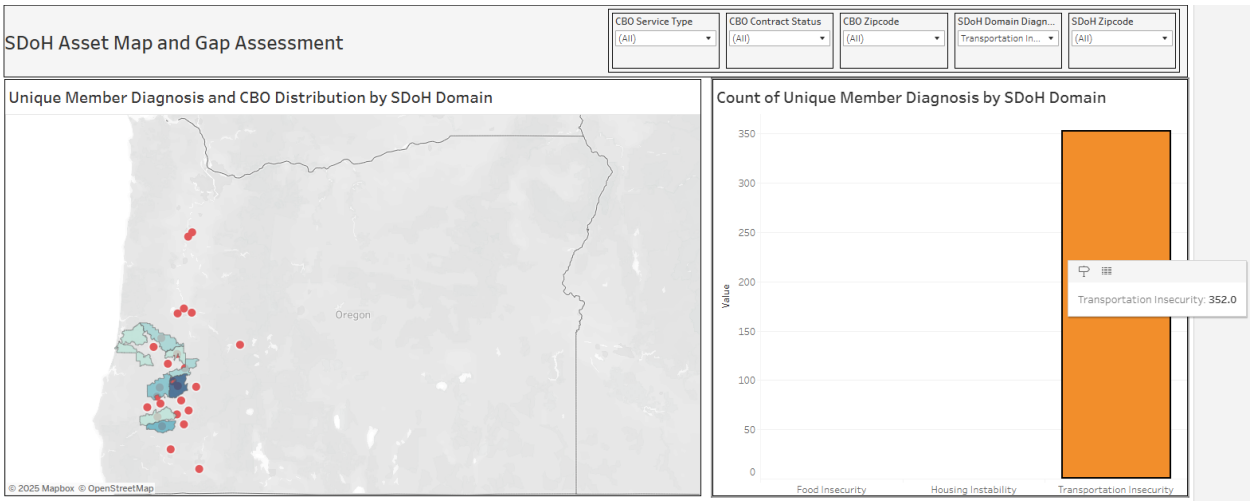
Asset Map & Gap Assessment: Housing

Regarding housing, 2.07% of UHA members have screened positive for housing instability. There are a total of 16 CBOs who provide housing services. Of these, 5 are contracted with UHA, 8 are not contracted with UHA, and the contract status of 3 are unknown.



Asset Map & Gap Assessment: Transportation

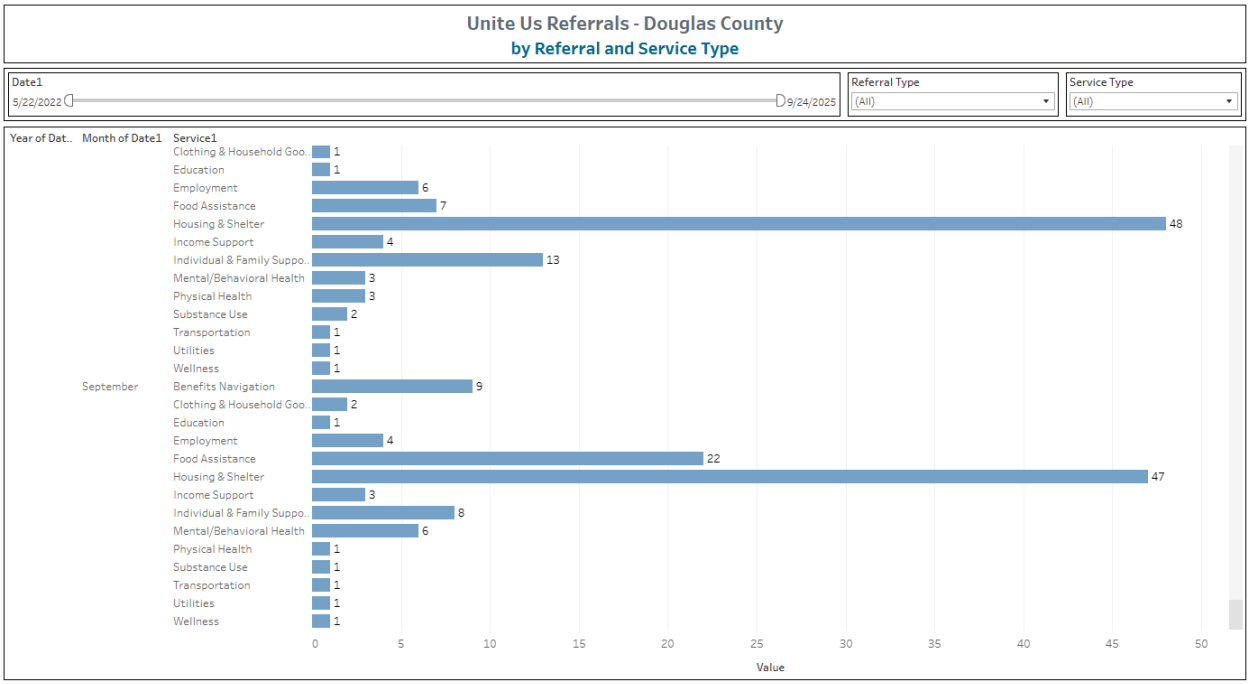
Concerning transportation, 0.88% of UHA members have screened positively for transportation insecurity. There is a total of 0 CBOs that provide transportation services, however UHA is contracted with Bay Cities to offer transportation services.



The SDoH Asset Map and Gap Assessment Tableau Dashboard can be found here.

Unite Us Referrals Tableau Dashboard

UHA has additionally created a dashboard to track referrals made through the Unite Us platform. This dashboard is updated quarterly. The most frequently rejected domains are Housing & Shelter, Food Assistance, and Benefits Navigation.



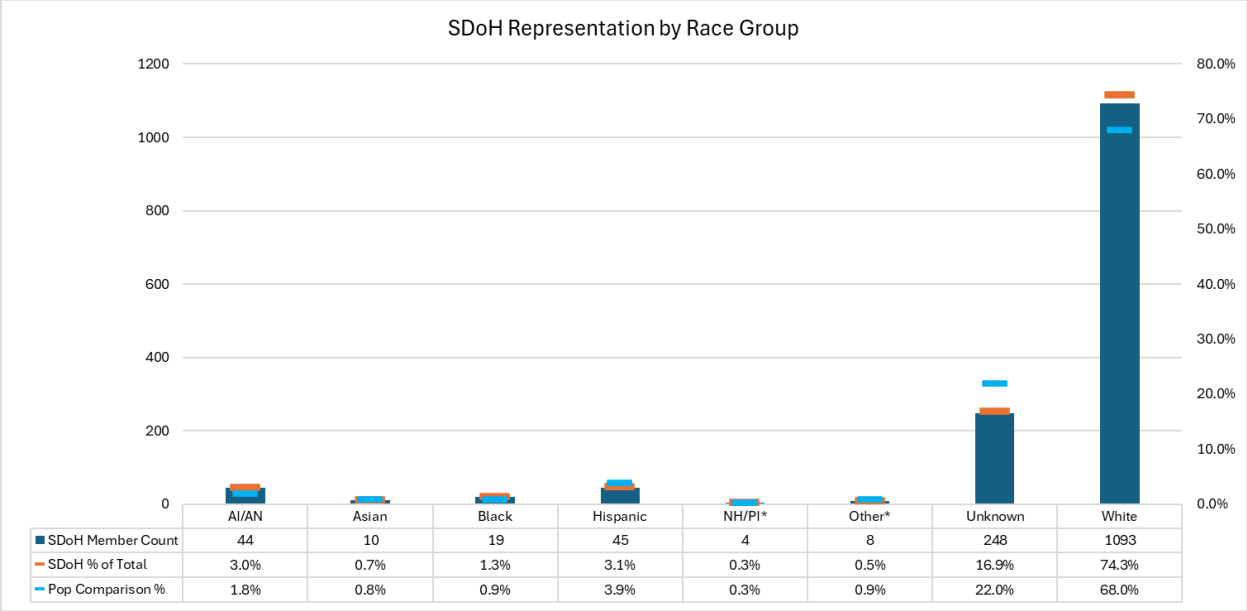
READLD Analysis Using Primary Data

UHA has a Tableau dashboard that stratifies SDoH domains by members' READLD identifiers based on the results outlined in the prior section. This data gives a greater understanding of which member groups are disproportionately under-screened or under-referred for food, housing, and transportation needs.

The unknown race group showed the highest incidence of SDoH diagnoses, constituting 23.45% of the total member group. In contrast, they make up 14.52% of UHA's member population, indicating a higher prevalence of SDoH diagnoses within this racial group.

American Indian/Alaska Native members have an SDoH diagnosis rate of 3.0%, which exceeds their 1.8% representation in UHA's member population. Similarly, both Black and White members show higher proportions of SDoH diagnoses relative to their representation: 1.3% of SDoH diagnoses are among Black members compared to 0.9% of the overall population, and 74.3% of SDoH diagnoses are among White members compared to 68.0% of the UHA population.

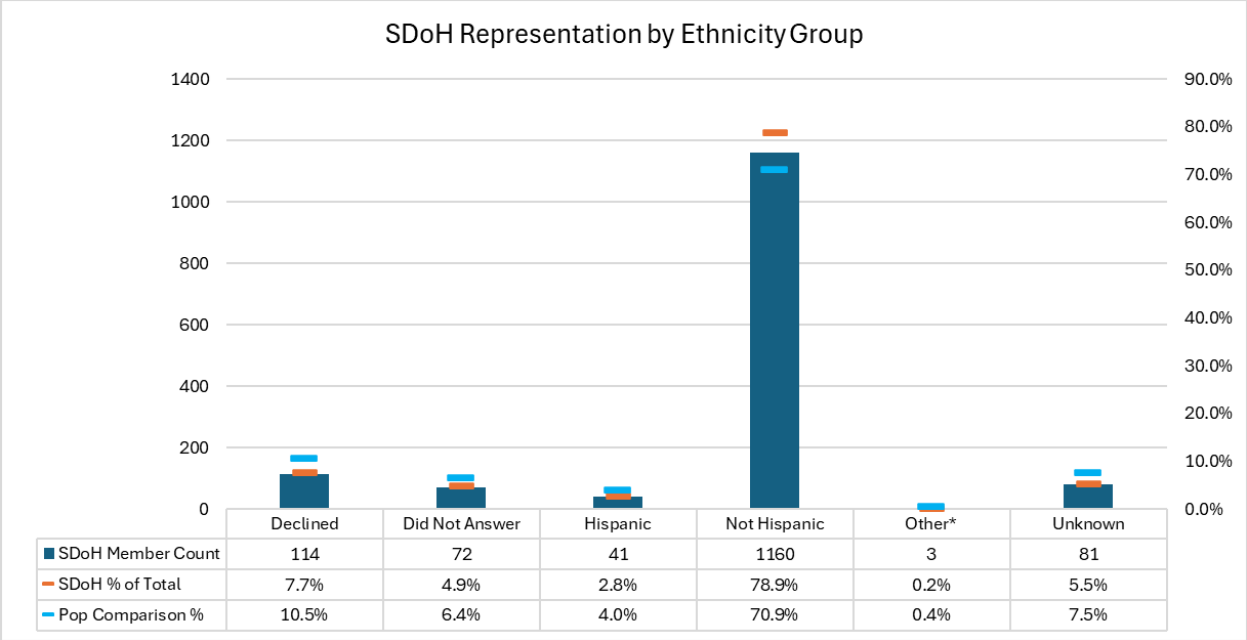
Race Group



	AI/AN	Asian	Black	Hispanic	NH/PI*	Other*	Unknown	White
SDoH Member Count	44	10	19	45	4	8	248	1093
SDoH % of Total	3.0%	0.7%	1.3%	3.1%	0.3%	0.5%	16.9%	74.3%
Pop Comparison %	1.8%	0.8%	0.9%	3.9%	0.3%	0.9%	22.0%	68.0%

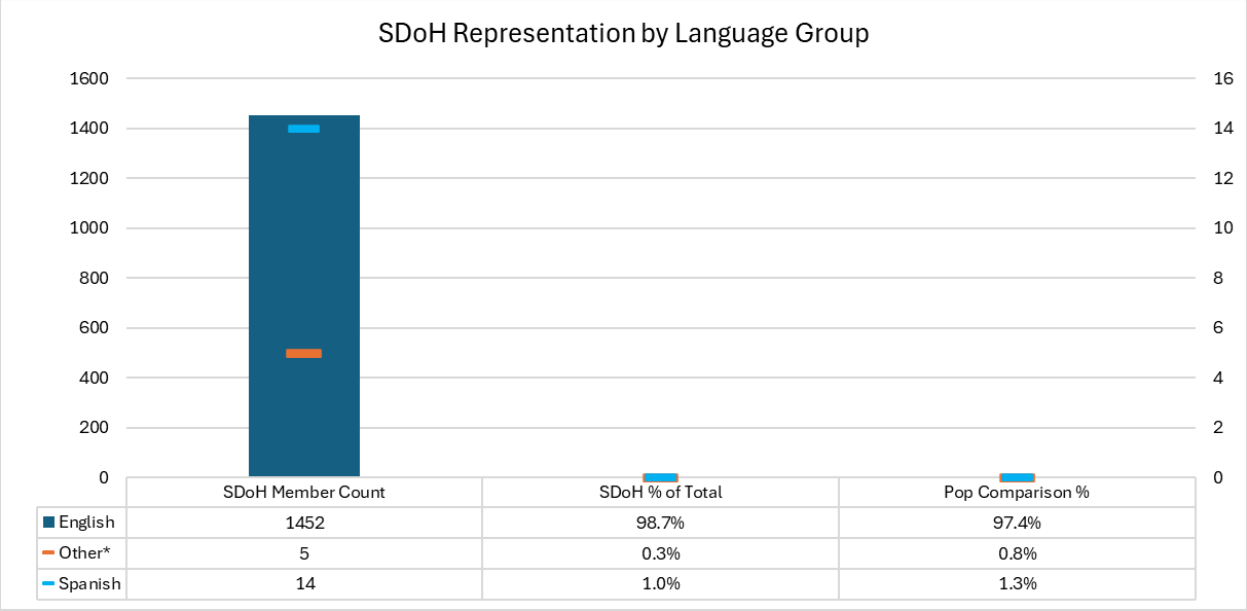
Ethnicity Group

Non-Hispanic individuals exhibit the most significant disparity among ethnic groups, with a prevalence of SDoH diagnoses at 78.9%, compared to their relative population comparison of 70.9%.



Spoken Language

The most notable disparity within the spoken language categories is observed in English-speaking individuals. English speaking individuals account for 98.7% of the total SDoH member diagnoses group, which is slightly higher than their representation of 97.4% in UHA's member population. To note, language groups with fewer than 10 members have been blinded for confidentiality and statistical reliability.



The Tableau Dashboard can be found here.

SDoH Representation Graph Definitions

SDoH Member Count: This figure represents the exact number of individuals within each specific category of the population subset.

SDoH % of Total: This calculation illustrates the proportion of each category relative to the entire population within the SDoH member group. This adjusted rate considers differences in category sizes, enabling the identification of disparities. It highlights the percentage of each race, ethnicity, and language category in relation to the total SDoH member count.

Population Comparison %: This calculation serves as a benchmark against UHA's overall member population. It provides insights into how the demographic composition of each category compares to the demographic distribution of UHA's member population.

Summary

The gap analysis highlights significant social needs across Douglas County, particularly in food access, housing stability, and transportation. Countywide indicators show higher rates of food insecurity, poverty, and housing cost burden compared to Oregon overall, with rural transportation challenges compounding barriers to essential services and economic mobility. Community Themes and Strengths Assessment (CTSA) findings reinforce these concerns, as residents consistently identified food access, safe and affordable housing, healthcare access, and economic stability as key priorities and unmet needs. These structural challenges create a landscape where many residents face overlapping barriers that directly influence health outcomes and overall well-being.

Screening and referral data reveal that UHA is conducting far more social needs screenings than predicted based on national Medicaid ACO study benchmarks, with 14,881 screenings completed compared to the estimated 9,833; however, housing, food, and transportation needs appear under-identified, and referrals across all domains remain lower than expected. Despite these gaps, referral volume is increasing year over year, indicating growth in system capacity and improved integration of the Unite Us platform. Additionally, Tableau dashboards developed by UHA show that the vast majority of members with SDoH-related diagnoses reside within Douglas County and that available community-based organization (CBO) resources are unevenly distributed, particularly in transportation, where no CBOs currently provide services aside from UHA's contracted provider.

Equity-focused analyses further reveal disproportionate impacts among certain demographic groups. Members with unknown race, American Indian/Alaska Native members, and Black members all show higher rates of SDoH diagnoses relative to their representation in the overall UHA population. Non-Hispanic members are also slightly overrepresented in social needs diagnoses. Combined, these findings underscore the need for targeted strategies to improve screening accuracy, expand culturally responsive referral pathways, strengthen CBO partnerships—particularly in high-need domains—and ensure ongoing REALD-informed monitoring as UHA advances its 2026 SDoH Action Plan.

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