Social Determinants of Health: Social Needs Screening and Referral Measure – MY 2023

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a Social Determinants of Health Measurement Workgroup Screening for Social Needs.

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐PQI ☐Survey ■Other Specify: Workgroup and OHA-developed

Measure Utility:

■CCO Incentive ☐State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Member Type:

■CCO A ■CCO B

Data Source:

- Component 1 – structural measure: CCO attestation (beginning first year of use and continuing through year 3)
- Component 2 – hybrid measure: sample reporting using MMIS/DSSURS, EHR, community information exchange (CIE), health information exchange (HIE), and other qualifying data sources (beginning 2024 and continuing through 2026)

Measurement Period: January 1, 2023 – December 31, 2023

2023 Benchmark:

- Component 1 – structural measure: Must-pass elements for Measurement Year 2023, as set out in Table 1 below. To support planning for future years, recommended must-pass elements for later years are included; however, only 2023 must-pass elements have been finalized.
- Component 2 – hybrid measure: Measurement Year 2023 – not reporting. No benchmark.
    - Reporting on Component 2 begins in Measurement Year 2024. Benchmarks for Component 2 are anticipated no earlier than Measurement Year 2025.

Note on telehealth: This measure is telehealth-eligible. The Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Measure Details – Component 1, Structural Measure

Measure Components and Scoring – Component 1

Social Needs Screening and Referral CCO Self-Assessment

In recent years, recognition has grown of the profound impact social factors like income, environmental conditions and racism have on a person's health. The goal of the Social Needs Screening and Referral measure is that CCO members have their social needs acknowledged and addressed.

Component 1 of the measure assesses CCOs' action plans to ensure social needs screening and referral is implemented in an equitable and trauma-informed manner. It also ensures CCOs lay the groundwork for data sharing and reporting as required in Component 2. CCOs will complete a self-assessment that includes questions about social needs screening tools and methods, data collection mechanisms, trauma-informed practices, and protocols for referring CCO members to community resources.

For each measurement year, the CCO must: (1) answer all self-assessment questions and (2) attest to having accomplished all "must-pass" elements required for that year. These elements assess how well CCOs identify and coordinate services for members with social needs in the domains of

1. Food insecurity,
2. Housing insecurity and
3. Transportation needs.

For the self-assessment, **CCOs will answer questions based on services in place on December 31 of the measurement year**. Data collection will occur through a survey tool that OHA will distribute to CCOs.

The CCO must accomplish all required must-pass items for the measurement year. No partial credit will be given. The work to be accomplished increases from year to year. Table 1 reflects the measurement year when each element is a must-pass requirement to satisfy the structural measure.

Descriptions of the elements of work to be accomplished during each measurement year are briefly summarized in this table. **Complete descriptions of each element are provided below Table 1**.

Table 1: Must-Pass Elements for Component 1, by Measurement Year (MY)

	Elements of work to be accomplished	MY 2023	MY 2024	MY 2025
A. Screening practices				
1.	Collaborate with CCO members on processes and policies	Must pass	Must pass	Must pass
2.	Establish written policies on training	Must pass	Must pass	Must pass
3.	Assess whether/where members are screened	Must pass	Must pass	Must pass
4.	Assess training of staff who conduct screening		Must pass	Must pass
5.	Establish written policies to use REALD data to inform appropriate screening and referrals	Must pass	Must pass	Must pass
6.	Identify screening tools or screening questions in use	Must pass	Must pass	Must pass
7.	Assess whether OHA-approved screening tools are used		Must pass	Must pass
8.	Establish written protocols to prevent over-screening	Must pass	Must pass	Must pass
B. Referral practices and resources				
9.	Assess capacity of referral resources and gap areas	Must pass	Must pass	Must pass
10.	Establish written procedures to refer members to services		Must pass	Must pass
11.	Develop written plan to help increase community-based organization (CBO) capacity in CCO service area		Must pass	Must pass

	Elements of work to be accomplished	MY 2023	MY 2024	MY 2025
12.	Enter into agreement with at least one CBO that provides services in each of the 3 domains	Must pass	Must pass	Must pass
C. Data collection and sharing				
13.	Conduct environmental scan of data systems used in your service area	Must pass	Must pass	Must pass
14.	Set up data systems to clean and use REALD data		Must pass	Must pass
15.	Support a data-sharing approach within the CCO service area		Must pass	Must pass

Elements are grouped together by topic areas A-C from Table 1. Definitions are in Appendix 3.

A. Screening practices

1. **Collaborate with CCO members on processes and policies (MY 2023-2025)**
    - **Intent:** CCO member voices are reflected in the policies and processes established by CCOs regarding screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.
    - **This element is met if** the CCO collects and incorporates input from members on written policies for screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.
    - **Examples of activities meeting this element**:
        - The CCO collects and documents member input on social needs screening and referral processes through its Community Advisory Council or member focus groups at least annually.
        - The CCO conducts a member survey with open-ended questions on screening, referral, and data-sharing practices that are analyzed, synthesized, and incorporated into final written policies.
    - **Examples of activities *not* meeting this element:**
        - The CCO engages with its members but does not retain documentation of member input on social needs screening, referral, and data sharing practices.
        - The CCO engages with community members generally but is not able to confirm input from CCO members specifically.
2. **Establish written policies on training (establish in MY 2023 and review in MY 2024 & 2025)**
    - **Intent**: Training is well planned, and CCO staff and partners – including contractors, in-network providers, and CBO partners – have access to written protocols and best practices for assessing members' unmet social needs.
    - **This element is met if** the CCO establishes and maintains a written policy on the training for CCO staff members and shares the policy with partners conducting social needs

screening. Training may be provided through electronic/ online training modules, presentations, classroom formats, and structured coaching and mentoring. Topics addressed must include patient engagement, empathic inquiry and motivational interviewing, trauma-informed practices, and cultural responsiveness and equitable practices. The training policy also should be clear that members may decline to be screened or to accept referrals.

- **Examples of activities meeting this element**:
  - A CCO policy manual shared with staff and partners includes a dedicated section on assessing members' unmet social needs.
  - An online website or application displays CCO policies for staff and partners, including a dedicated section on assessing members' unmet social needs.

- **Examples of activities *not* meeting this element:**
  - Trainings on assessing members' unmet social needs do not include clear written policies for staff and partners.
  - An online training program does not have links to or otherwise share written CCO policies on assessing members' unmet social needs.
  - Written CCO policies do not address critical considerations for assessing members' unmet social needs, including: (1) trauma-informed practices, (2) empathic inquiry or motivational interviewing, (3) culturally responsive and equitable practices, and (4) clear protocols for referring members to available community resources.

3. **Assess whether and where screenings are occurring (MY 2023-2025)**
   - **Intent**: CCOs understand where screenings occur, so they can coordinate screening and referral activities, identify gaps, and share policies and resources.

   - **This element is met if** the CCO conducts a systematic assessment of screenings that are done by (1) CCO staff, (2) all provider organizations listed in the CCO's Delivery System Network (DSN) report and (3) any CBOs, social service agencies, or other social determinants of health and equity partners with which the CCO has contracts, memoranda of understanding (MOUs), grants, or other agreements for addressing social needs. This assessment should identify where members are predominantly being screened for unmet social needs (e.g., at primary care clinics, upon enrollment with the CCO, at a local housing resources organization). The CCO must be able to determine, at a minimum, whether organizations are screening members for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

   - **Examples of activities meeting this element**: In addition to assessing screenings done within the CCO, the CCO does any of the following:

- Annually surveys provider organizations listed in the CCO's DSN report, CBOs, social service agencies, and other organizations on social needs assessments,
- Collects regular reporting from provider organizations listed in the CCO's DSN table, CBOs, and social service agencies specifically on the prevalence of social needs assessments, or
- Maintains a real-time or near real-time list of services offered by all provider organizations in the DSN table, CBOs, and social service organizations in their service area, with a specific indication for social needs assessments.

- **Examples of activities *not* meeting this element:**
  - A survey of network providers asks about social needs screenings in general, but not about screening specifically for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
  - Information reported (through a survey or regular reporting) prior to the measurement year.
  - An assessment of screenings occurring in the service area by network providers does not include an assessment of CBOs and social service agencies.

4. **Assess training of staff members who conduct screening (MY 2024 and review in MY 2025)**
   - **Intent**: CCOs ensure that partners – including contractors, in-network providers, and CBO partners – provide training to staff who conduct screenings.
   - **This element is met if** the CCO reviews the training policies of its partners and, if needed, provides training resources to partners.
   - **Examples of activities meeting this element**:
     - The CCO surveys its partners about training policies and practices. If a partner has a gap in policies or practices, the CCO suggests resources, such as the CCO's training policy as a model or training opportunities such as webinars on trauma-informed screening practices.
   - **Examples of activities *not* meeting this element**:
     - The CCO inquires about training policies or practices, but offers no recommendations to partners who lack policies or training resources.
5. **Establish written policies for using disaggregated race, ethnicity, language and disability (REALD) data to inform work on social needs screening and referrals (establish in MY 2023 and review in MY 2024 and 2025)**
   - **Intent:** CCOs use disaggregated REALD data to help understand and respond to members' needs in a culturally responsive way.
   - **This element is met if** the CCO has developed and distributed written policies for analyzing and using disaggregated race and ethnicity, disaggregated language, and

disaggregated disability data to understand the populations served. The policies should describe how disaggregated REALD data is used to inform training, screening, and referral practices and to develop relationships with culturally specific CBOs and other resources to meet members' needs.

- **Examples of activities meeting this element**:
  - The CCO has established and distributed written policies, as outlined in Element 2 above, including protocols for analyzing and using disaggregated REALD data.

- **Examples of activities *not* meeting this element:**
  - Generic written CCO policies on use of REALD do not specifically address use of REALD data in social needs screening and referral practices.
  - Policies address only aggregated REALD data use.

6. **Identify screening tools or screening questions in use, including available languages (MY 2023-2025)**
   - **Intent:** CCOs understand how screening is occurring so they can coordinate screening, trainings and other resources.

   - **This element is met if** the CCO has reviewed the screening tools or questions used by CCO staff *and* systematically contacted (1) the provider organizations listed in the CCO's DSN report and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs to inquire about screening tools or questions used at these organizations. The CCO should also track the language(s) used for each screening tool or set of questions.

   - **Examples of activities meeting this element**:
     - The CCO conducts a survey of these organizations (may be part of the same survey as Element 3, assess whether/ where members are screened) during the measurement year and inquires about screening tools or questions used at these organizations.
     - The CCO combines survey data with relevant, current (within the measurement year) data pulled from a community information exchange system (CIE), health information exchange (HIE), or other system that includes CCO and/or partner information on social needs screening.
     - The CCO maintains real-time or near real-time electronic systems for tracking screening tools and questions in use in the service area.

   - **Examples of activities *not* meeting this element:**
     - CCO does not collect information about whether screening tools and questions are able to assess all three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

- CCO does not collect information about languages in which the screening tools or questions are available.

7. **Assess whether OHA-approved screening tools are being used (MY 2024-2025)**
    - **Intent:** CCOs understand whether approved screening tools are being used.

      Note: Component 2 of this measure requires the use of an OHA-approved screening tool for data reported about screening and referrals. During an annual specifications update process, interested parties will have an opportunity to propose changes to the approved list.

    - **This element is met if** the CCO compares the information collected in Element 6 with the list of OHA-approved screening tools in Appendix 1.

8. **Establish written protocols for preventing over-screening (establish in MY 2023 and review in MY 2024 & 2025)**
    - **Intent:** CCOs establish, implement and maintain processes to prevent over-screening. Over-screening, which could be retraumatizing, may occur if a member is asked to complete screening processes multiple times and in multiple settings in a relatively short period, such as several months.

      Note: Conversational follow-up questions are not considered over-screening. For example, if a member screened positive for food insecurity and was given assistance in applying for SNAP benefits, then it would be appropriate follow-up to ask the member if the assistance helped resolve the need.

      Beginning in the second year this measure is incentivized, Component 2 requires CCOs to report annual screening for each of the three domains. Members may decline to be screened or decline to accept a referral, and members' choices will not count against the CCO's performance.

    - **This element is met if** the CCO analyzes factors that might lead to over-screening, develops strategies to mitigate risk of harm, writes protocols, and distributes them to staff who engage in screening. These protocols may be incorporated into the CCO's training policy (see Element 2, establish written policies on training).

    - **Examples of activities meeting this element**:
        - The CCO uses its data about where members are screened, works with partners to identify situations when members are most likely to be over-screened, and develops strategies to avoid potential harm. The strategies are reflected in protocols that are distributed to the CCO's partners. Strategies might include
            - technology, such as use of data sharing to check CCO members' social needs screening history prior to conducting a new screening;

- processes, such as screening at the household level if, for example, a parent or guardian answering the screening questions indicates that the answers are applicable to multiple children in the household; and
- training resources, such as empathic inquiry or other motivational interviewing techniques to determine members' comfort level and history with being screened for unmet social needs.

- **Examples of activities *not* meeting this element:**
  - The CCO skips analysis of potential risk areas, for example, by failing to assess current screening practices before writing its policy.
  - The CCO writes a policy but doesn't distribute it or doesn't include strategies to be used in the screening process to avoid the risk of harm.

B. Referral practices and resources

9. Assess the capacity of available resources and gap areas (MY 2023-2025)

- **Intent:** CCOs understand capacity and gaps in available resources so they can connect members to culturally responsive community resources and they can prioritize investments in building capacity.

- **This element is met if** the CCO conducts an inventory of CBO and other resources in the CCO service area that provide services to reduce or eliminate food insecurity, housing insecurity, and transportation needs and then compares the available resources with estimated unmet needs among CCO members.

- **Examples of activities meeting this element**:
  - The CCO creates an inventory of available resources by drawing on information sources such as
    - The CCO's shared Community Health Assessments (CHAs),
    - Data from a CIE, HIE or other resource or referral system or
    - Consultation with organizations that support connections with community resources.

    The CCO compares that inventory with other data on needs. In the first year, this may be county-level or statewide data and subsequently, CCOs might use baseline data from the prior year. These data are compared with available resources to estimate the rate of unmet social needs among CCO members.
  - The CCO has data sharing arrangements that enable a real-time or near real-time dashboard showing available community resources at the time of referrals, with capabilities for exporting reports on available community resources. The CCO compares that dashboard with other data to estimate the rate of unmet social needs among CCO members.

- **Examples of activities *not* meeting this element:**
    - The CCO maintains contracts and/or MOUs with CBOs for housing, food, and transportation needs but has not assessed the timeliness and availability of resources for referred members with unmet social needs.
    - The CCO refers all members to generic community resources without ensuring the resource has capabilities to provide culturally responsive services.

10. **Establish written procedures to refer members to services (establish in MY 2024 and review in MY 2025)**
    - **Intent:** The CCO has a clear process so that when a member screens positive for one or more unmet needs, the member is referred to culturally responsive services to address their needs.

    - **This element is met if** the CCO has written procedures for referring members in a timely manner to services that are culturally responsive and can address their needs. Referrals should occur when a CCO member screens positive for one or more unmet needs in the domains of food insecurity, housing insecurity or transportation needs *and* the member is interested in receiving a referral (that is, the member is offered and does not decline a referral).

    - **Examples of activities meeting this element**:
        - The CCO uses the data from its inventory (Element 9, Assess capacity of referral resources and gap areas) to understand available resources and maintains policies or contractual agreements with partners that detail specific responsibilities and protocols for referring members to available, culturally responsive resources.

    - **Examples of activities *not* meeting this element:**
        - The CCO refers all members to generic community resources without ensuring the resource has capabilities to provide culturally responsive services.

11. **Develop a written plan to help increase the capacity of CBOs in CCO service area (establish in MY 2024 and review in MY 2025)**
    - **Intent:** CCOs make and implement plans to close gaps in available, culturally responsive resources to meet members' housing, food, and transportation needs.

    - **This element is met if** the CCO develops a written plan to meet members' unmet needs in the domains of food insecurity, housing insecurity, and transportation needs. The plan builds off the CCO's assessment of capacity and includes information about how the CCO will provide resources such as financial or staffing resources to increase CBO capacity. The plan aligns with related work such as the use of Health-Related Services funds and the Supporting Health for All through REinvestment (SHARE) Initiative.

- **Examples of activities meeting this element**:
    - The CCO publishes a detailed plan, incorporating the assessment of capacity among CBOs in the service delivery area, that outlines specific financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members' housing, food, and transportation needs.
    - The CCO updates or expands an existing plan or assessment to include annually updated financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members' housing, food, and transportation needs.

- **Examples of activities *not* meeting this element:**
    - Written plans that do not incorporate specific findings from the assessment of capacity relative to housing, food, and transportation needs.
    - Written plans that do not outline specific financial, infrastructure, and staffing investments planned for increasing CBO capacity.

12. **Enter into an agreement with at least one CBO that provides services in each of the three domains (food, housing, transportation) (MY 2023-2025)**
    - **Intent:** CCOs build partnerships with community organizations to expand capacity and better meet members' needs.

    - **This element is met if** the CCO has a fully executed contract, MOU, LOA, grant or other agreement in place with (1) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing food insecurity; (2) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing housing insecurity; and (3) at least one CBO, social service agency, or other social determinants of health and equity partner for transportation needs. Such agreements may include contracts for case management services or navigation to assist members in applying for SNAP or other benefits to address identified needs.

    - **Examples of activities meeting this element**:
        - The CCO has only one or two agreements in place, but the CBO, social service agency, or other social determinants of health and equity partner is able to address more than one type of need. In this case, the same agreement may be counted toward each need addressed.
        - The CCO has received a grant award for one of the SDOH domains with a specific CBO identified as the SDOH service provider.

    - **Examples of activities *not* meeting this element:**
        - Only verbal or informal agreements with CBOs exist between the CCO and CBOs.
        - Agreements with CBOs, taken together, do not address all three domains.

C. Data collection and sharing

13. **Conduct an environmental scan of data systems used in the CCO service area** to collect information about members' social needs, refer members to community resources and exchange social needs data. **(scan in MY 2023 and update in MY 2024 & 2025)**
    - **Intent:** CCOs understand how social needs screening and referral data is collected and exchanged so they can promote effective data-sharing practices.
    - **This element is met if** the CCO systematically reviews how any social needs screening and referral data is captured and/or exchanged at (1) the provider organizations listed in the CCO's DSN table and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs. The review identifies any standardized codes being used to capture data about screening and referrals (e.g., LOINC, SNOMED, ICD10, CIE data dictionary). Questions in the template for CCO Health Information Technology (HIT) Roadmaps are a good starting point for the environmental scan.
    - **Examples of activities meeting this element**:
        - The CCO conducts a survey (may be part of the same survey as Element 3, assess whether and where screenings are occurring) of provider organizations and CBOs during the measurement year and asks about data systems used for social needs screening and referral.
        - The CCO collects annual reporting from provider organizations and CBOs with specific requirements for reporting social needs screening and referral data.
    - **Examples of activities *not* meeting this element:**
        - The CCO collects information on what data systems are used by providers and CBOs without identifying data collection and data exchange processes.
        - The CCO conducted their latest environmental scan of data systems before the start of the measurement year.

14. **Set up data systems to clean and use REALD data (set up by MY 2024 and maintain in MY 2025)**
    - **Intent:** CCOs set up data systems so they can effectively use REALD data received from OHA and other sources to inform processes for screening and referrals for social needs.
    - **This element is met if** the CCO uses disaggregated REALD data to understand the populations served by your CCO and identify resources to meet members' needs.
    - **Examples of activities meeting this element**:
        - The CCO uses disaggregated REALD data to tailor training on how to provide culturally responsive screening and referrals and to work with community

partners to address any gaps in culturally responsive services to meet members' social needs.

- **Examples of activities *not* meeting this element:**
  - The CCO collects and stores disaggregated REALD data, but has not used the data to modify or add new community engagement and/or social needs screening and referral practices.

15. Support a data-sharing approach (set up by MY 2024 and maintain in MY 2025)

- **Intent:** CCOs support networked providers to have access, at the point of care, to screening results and referral(s) made, even if the screening or referral occurs at the CCO level or at another clinic.

- **This element is met if** the CCO provides access to a tool or tools that enable screening and referral data to be shared among networked providers who care for members or if the CCO otherwise ensures that networked providers use tools to share screening and referral data. Tools may include, for example, a CIE, HIE, or other screening and referral system for networked providers that enables screening and referral data to be shared.

  Note: CCOs will be asked to briefly identify the approach used and its availability to networked providers (e.g., our CCO pays for a subscription to ABC CIE, which has onboarded X# of clinics and Y# of CBOs in our service area).

- **Examples of activities meeting this element**:
  - The CCO pays, incentivizes, or subsidizes network providers' subscription to a community information exchange (e.g., Unite Us, findhelp, etc.).
  - The CCO establishes agreements with network providers that require them to connect to a tool that enables sharing and receiving screening and referral data.

- **Examples of activities *not* meeting this element:**
  - The CCO participates in a HIE or CIE collaborative, but the CCO has not entered into agreements with network providers to enable sharing social needs data or invested in infrastructure for network providers.
  - The CCO is connected to a tool that enables sharing of social needs data, but the CCO has neither made agreements with network providers for their use of the tool nor instituted incentives, subsidies, or other investments in network providers' use of the tool.

Measure Components and Scoring – Component 2

Component 2 will first be reported in Measurement Year (MY) 2024. It is included in the 2023 specifications to support planning for future years.

In accordance with OHA's commitment to work toward an equitable, transformative healthcare delivery system that addresses social factors impacting members' health status, Component 2 is intended to measure the percentage of CCO members screened and, as appropriate, referred for services for three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

In MY 2024 through 2026, CCOs will report on an OHA-identified sample of members who met continuous enrollment criteria. The sample will be designed to ensure that children and adults are included in roughly the same proportions as in overall CCO membership; for example, if the sample of CCO members is 411 people and children compose 40% of that CCO's membership, then the sample would include 165 children. Guidance on the process for hybrid measure review will be posted to the CCO metrics webpage.

Rates 1 and 2 will be calculated in MY 2024, and Rate 3 will be added in MY 2025.

Rate 1: The percentage of CCO members from the OHA-identified sample who were screened for each of the three required domains at least once during the measurement year; and

Rate 2: Of the sample population screened, the percentage of CCO members with a positive screen for any of the three required domains.

Note: Performance on Rate 2 is not intended to be benchmarked; rather, it is calculated to understand the prevalence of identified needs in the CCO. In addition, Rate 2 is a necessary step in the process to calculate Rate 3.

Rate 3: Of the sample population with an identified need, those who received at least one referral.

Note: Rate 3 measures referrals made, not closed loop referrals.

Data elements required denominator – Rate 1: Count of unique members who meet continuous enrollment criteria. OHA will provide CCOs with the sampling frame for data collection.

Required exclusions for denominator – Rate 1: None.

Denominator Exceptions – Rate 1: Member declines to be screened. If a member does not meet numerator criteria because they decline to be screened, then they also are removed from the denominator.

Data elements required denominator – Rate 2: Members from Rate 1 denominator who were screened at least once in the measurement year for all three required domains using OHA-approved screening tool (s). (Note: This is the same as the Rate 1 numerator.)

Required exclusions for denominator – Rate 2: None.

Data elements required denominator – Rate 3: Members from Rate 2 denominator who screened positive for one or more needs in the required domains. (Note: This is the same as Rate 2 numerator.)

Required exclusions for denominator – Rate 3: None.

Denominator Exceptions – Rate 3: Member declines to receive a referral. If a member does not meet numerator criteria because they declined to receive a referral, then they also are removed from the denominator.

Continuous enrollment criteria: Continuously enrolled with the CCO for at least 180 days in the measurement year[1].

Allowable gaps in enrollment: None.

Anchor Date (if applicable): Not applicable.

Data elements required numerator – Rate 1: Members who were screened at least once in the measurement year for all three required domains using OHA-approved screening tool(s).

Data elements required numerator – Rate 2: Members who screened positive for one or more needs in the required domains during screenings for the three domains.

> **Note**: This measure does not require screening to occur more frequently than once per measurement year, and CCOs should avoid over-screening. If a CCO has results from more than one screening during the measurement year, any positive result from any complete screening during the measurement should be entered.

Data elements required numerator – Rate 3: Members who received a referral for each unmet social need.

Based on the sample list of CCO members provided by OHA, CCOs will input data separately for each of the SDOH screening domains using an OHA-supplied data collection sheet. CCOs must enter the following data elements for each member in the sample:

1. For each domain, was the member screened during the measurement year? (yes, no, member declined screening)
2. If screened, result for each domain of the most recent screening (positive, negative)
3. Approved screening tool used
4. Screening location (CCO, clinic, hospital, CBO, other)
    - If other screening location, specify
5. Coding approach (ICD-10 diagnosis Z codes, LOINC, SNOMED, other)
    - If other coding approach, specify
6. Codes used to identify each domain (food insecurity, housing insecurity, and transportation needs)
7. If screening result was positive, was member referred to a resource (yes, no, member declined referral).
   Note: This question is optional in measurement year 2, but will become a required question in measurement years 3-4.
8. Data source used (claims, charts, EHR, CIE, HIE, case management system, other)
    - If other data source, specify

[1] The 180 days requirement is a minimum within a measurement year. If a member is enrolled with the same CCO for 360+ days of the year, they contribute to only one denominator hit for the CCO. If a member switched from one CCO to another within the measurement year and had continuous 180 days with both CCOs, this member will qualify for denominator for both CCOs in the same year.

Appendix 1: Approved Social Needs Screening Tools for Required Domains

Adult screening tools for selected domains

	Food insecurity	Housing Insecurity	Transportation
American Academy of Family Physicians (AAFP)	✓	✓	✓
Accountable Health Communities (AHC)	✓	✓	✓
Arlington	✓	✓	✓
Boston Medical Center Thrive (BMC Thrive)	✓	✓	✓
Health Begins	✓	✓	✓
Health Leads	✓	✓	✓
Housing Stability Vital Sign	*No question*	✓	*No question*
Hunger Vital Sign	✓	*No question*	*No question*
North Carolina Medicaid (NC Medicaid)	✓	✓	✓
Protocol for responding to and assessing patients' assets, risks and experiences (PRAPARE)	✓	✓	✓
Your Current Life Situation (YCLS)	✓	*Question not recommended*	✓

Pediatric screening tools for selected domains

	Food insecurity	Housing Insecurity	Transportation
Housing Stability Vital Sign	*No question*	✓	*No question*
Hunger Vital Sign	✓	*No question*	*No question*
iHELP	✓	✓	*No question*
Survey of Well-being of Young Children (SWYC)	✓	*No question*	*No question*
WeCare	✓	✓	*No question*

Appendix 2: Codes and Value Sets

These codes and value sets may be used to identify the occurrence of screening, unmet needs and referrals for reporting Component 2. Given the evolving availability of SDOH coding, Component 2 will not be limited to these codes; CCOs will be allowed to identify other approaches.

Codes reflecting the occurrence of screening

LOINC Coding		
Food Insecurity	88121-9	Hunger Vital Sign (HVS) question panel
	88122-7 and 88123-5	LOINC Question Codes Within the past 12 months we worried whether our food would run out before we got money to buy more [U.S. FSS] Within the past 12 months the food we bought just didn't last and we didn't have money to get more [U.S. FSS]
	93025-5	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE] question panel
	93031-3	LOINC Question Code Have you or any family members you live with been unable to get any of the following when it was really needed in past 1 year [PRAPARE]
Housing Insecurity	93025-5	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE] question panel
	71802-3 and 93033-9	LOINC Question Codes What is your housing situation today? Are you worried about losing your housing?
Transportation	93025-5	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE] question panel

Value sets for identified needs and referrals

These value sets are maintained by The Gravity Project and can be accessed through the Value Set Authority Center (select The Gravity Project from the drop-down for Steward). For additional background, see The Gravity Project's terminology workstreams.

Name	Code System(s)	OID	Code Count	Use
Food Insecurity Diagnoses	ICD10CM SNOMEDCT	2.16.840.1.113762.1.4.1247.17	12	Identified need
Food Insecurity Service Requests	CPT HCPCS	2.16.840.1.113762.1.4.1247.11	128	Referral

Name	Code System(s)	OID	Code Count	Use
	SNOMEDCT			
Food Insecurity Procedures	CPT HCPCS SNOMEDCT	2.16.840.1.113762.1.4.1247.7	128	Referral
Homelessness Diagnoses	ICD10CM SNOMEDCT	2.16.840.1.113762.1.4.1247.18	4	Identified need
Housing Instability Diagnoses	ICD10CM SNOMEDCT	2.16.840.1.113762.1.4.1247.24	9	Identified need
Inadequate Housing Diagnoses	ICD10CM SNOMEDCT	2.16.840.1.113762.1.4.1247.48	6	Identified need
Homelessness Procedures	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.20	85	Referral
Homelessness Service Requests	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.21	85	Referral
Housing Instability Procedures	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.44	54	Referral
Housing Instability Service Requests	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.45	54	Referral
Inadequate Housing Procedures	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.52	44	Referral
Inadequate Housing Service Requests	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.53	44	Referral
Transportation Insecurity Diagnoses	SNOMEDCT	2.16.840.1.113762.1.4.1247.26	4	Identified need
Transportation Insecurity Procedures	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.27	27	Referral
Transportation Insecurity Service Requests	CPT SNOMEDCT	2.16.840.1.113762.1.4.1247.28	27	Referral

Appendix 3: Definitions

Culturally Responsive: providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Providers must demonstrate awareness of, and sensitivity to, cultural differences and similarities, and the effect on the member's care.

Community Information Exchange: a network of healthcare and human/social service partners using a technology platform with functions such as a shared resource directory, "closed loop" referrals, reporting, social needs screening, and other features to electronically connect people to social services and supports.

Data Sharing: allows doctors, nurses, pharmacists, case managers, other health and social care providers and members to appropriately access and securely share a person's health and service information electronically—improving the speed, quality, safety, and cost of services provided.

Environmental Scan: a process of engaging with relevant stakeholders to gain a thorough and comprehensive understanding of experiences, opportunities, barriers, risk, challenges, and successes to inform future planning.

Empathic Inquiry: relating to patients, from a place of non-judgmental curiosity and understanding. Empathic Inquiry is intended to facilitate collaboration and emotional support for both patients and screeners through the social needs screening process, as well as evoke patient priorities relating to social determinants of health needs for integration into subsequent care planning and delivery processes.

Health Equity: Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.
Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Over-screening: includes processes and practices that purposely or inadvertently lead to members repeated or duplicate completion of social needs screenings in a short time period, commonly due to a lack of data sharing across the member's care providers.

Screening Tools: assessment questionnaires, either in electronic or paper formats, for identifying individuals' unmet social needs.

Screening Questions: individual questions related to assessing individuals' unmet social needs.

Social needs include things like housing instability, food insecurity, and transportation. *Health*-related social needs makes clear that these social needs impact a person's health.

Timely Referral: refers to the reasonable connection of members to available community resources capable of meeting their social needs in a timeframe consistent with the member's expectations and a timeframe that optimizes their overall health and well-being.

Trauma-informed Practices: (1) Realize how trauma affects the experiences and behaviors of the family, groups, organizations, communities, and individuals. (2) Recognize the signs of trauma. These signs may be specific to gender, age, or setting. (3) Respond using language, behaviors, and policies that respect children, adults, and staff members who have experienced traumatic events. (4) Resist re-traumatization. Stressful environments or specific practices can trigger painful memories, interfering with recovery and well-being. Organizations must review and change practices as needed to avoid re-traumatization.

REALD Data: a type of demographic information that stands for race, ethnicity, language, and disability. Additional information and implementation resources are available: https://www.oregon.gov/oha/OEI/Pages/REALD.aspx

Re-traumatization: a person who is still suffering from the impact of a previous trauma has heightened vulnerability to stressful events that follow and experiences an adverse reaction to services provided that do not recognize and modify practices to account for the past trauma.