Oregon Health Authority

Social Determinants of Health: Social Needs Screening and Referral Measure – MY 2025

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 data sources (beginning 2025 and continuing through 2026)

Measurement Period: Component 1 - January 1, 2025 to December 31, 2025

Component 2 – December 15, 2024 to December 14, 2025

Note the cut-off date is on December 14 so referral can occur by the end of 2025.

Past Benchmark for OHA measurement year	2023	2024	2025
Component 1 – minimum points from must pass questions	CCO must attest to completion of all recommended MY2023 must-pass elements in Table 1	CCO must attest to completion of all recommended MY2024 must-pass elements in Table 1	CCO must attest to completion of all recommended MY2024 must-pass elements in Table 1
Component 2 – reporting method and data collection requirement	Not required	Not required	Sample with 90% completeness threshold
Component 2 – % of members screened and % of members who received a referral	Not required	Not required	Not required
Source:	Committee consensus	Committee consensus	Committee consensus

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

Changes in specification from MY2024 to MY2025:

Component 1:No changes

Component 2:

- OHA is proposing a stratified random sample with a 95% confidence level and a three percent margin of error. The sample size will be 1,067 members.
- Added a completeness threshold of 90% for the sample.
- For Rate 1 Percent Screened, time period clarified for the screening period and continuous enrollment.
- Clarified the footnote for continuous enrollment period and its relationship to the Rate 1 Percent Screened denominator.
- Allow unknown values count towards Component 2 completeness threshold.
- Appendix 1 Template for Component 2 Reporting changes are in blue text. Added Screened for Social Needs field and made clarifications based on December public comment. Removed requirement that recorded annual screening be most recent one in the measurement year. Clarified that unknown screening outcome meant that the record would not be a numerator hit for rate 1.
- Appendix 2 Social Needs Screening Tools Process changes are in blue text.
- Appendix 3 Good Faith Effort added.
- Appendix 4 referral definition added to the glossary and made clarifications based on December public comment.

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 or exempted 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
12.	Enter into agreement with at least one CBO that provides services in each of the three 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 4.

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. 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:**
  - Policies on assessing members' unmet social needs not distributed to staff and partners.

- An online training program described in the policies 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) made available to members 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 or exempted screening tools are being used (MY 2024-2025)**
    - **Intent:** CCOs understand whether OHA-approved or exempted screening tools are being used.

        Note: Component 2 of this measure requires the use of a screening tool for data reported about screening and referrals from the OHA approved list or exempted by OHA at the organizational level. OHA strongly encourages the use of screening tools from the OHA-approved list. CCOs will have an opportunity to submit tools for exemption at the organizational and/or approval at the statewide level annually (see Appendix 2).

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

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 third 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)**

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- **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.

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- **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 an agreement with one or more CBO, social service agency, or other social determinants of health and equity partner that can provide case management services for housing, food, and transportation and/or can directly supply members with housing, food, and transportation.
    - **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 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).

- **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) 2025.

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 2025 through 2026, CCOs will report on an OHA-identified sample of members who met continuous enrollment criteria. The sample size will be 1,067 members for each CCO.[1] The sample will be designed to ensure that children and adults are included in roughly the same proportions as in the overall CCO membership; for example, if children compose 40% of that CCO's membership and the sample is 1067, then the sample would include 427 children.

Appendix 1 Template for Component 2 reporting provides additional information on how and what to report. For MY 2025, the CCO must complete data collection for at least 90% of the sample (the completeness threshold). The CCO must gather and provide screening and referral information in the sample reporting template provided by OHA (see Appendix 1). All required fields must be completed in each of the domains to receive credit towards the completeness threshold. This includes confirming if no screening and referrals were made. Unknown will also count towards the completeness threshold if a good faith effort is made (see Appendix 3). Records, where required fields are blank, will not count.

Rate 1: The percentage of CCO members from the OHA-identified sample who were screened for each of the three required domains using an OHA-approved or exempted screening tool 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 for each identified need.

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

Screening (intake) period: December 15 of the year prior measurement year, to December 14 of the measurement year.[2]

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[1] OHA used a stratified random sample with a 95% confidence level and a three percent margin of error with an assumed a screening rate (rate 1) of 50%. The sample size will allow for preliminary race, ethnicity, language, and disability (REALD) results to be examined.

[2] Note the cutoff date is December 14th so the 15 calendar day referral period can occur by the end of the measurement year. This change ensures that all measurement activities for component 2 will be completed by the end of the measurement year.

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Continuous enrollment criteria: Continuously enrolled with the CCO for at least 180 days[3] during the screening period.

Allowable gaps in enrollment: None.

Anchor Date (if applicable): Not applicable.

Denominator – Rate 1: All CCO members who meet continuous enrollment criteria. OHA will provide CCOs with the sampling frame for data collection.

Denominator Exclusions – Rate 1: None.

Denominator Exceptions – Rate 1: Member declines to be screened in all three domains with an OHA - approved or exempted screening tool. If a member declines one or two of the three domains, they will not qualify for a denominator exception. The member will remain in the denominator and must be screened in the domains not declined to meet the numerator criteria.

Numerator – Rate 1: Members who were screened at least once during the screening period for all three required domains using an OHA-approved or exempted screening tool(s).

Denominator – Rate 2: Rate 1 numerator

Denominator Exclusions and Exceptions– Rate 2: None.

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

Denominator – Rate 3: Rate 2 numerator

Denominator Exclusions – Rate 3: None.

Denominator Exceptions – Rate 3: Member declines all referrals. If a member does not decline all referrals, they will not qualify for a denominator exception and must receive referrals for all remaining positive social need(s).

Numerator – Rate 3: Members who received a referral within 15 calendar days for each domain in which they screened positive.

See Appendix 1: Template for Component 2 Reporting for data collection specifications and guidance.

[3] The 180 days requirement is a minimum. If a member switched from one CCO to another and had 180 continuous days with both CCOs, this member will qualify for denominator for both CCOs in the same year. If the member is only continuously enrolled with one CCO for 180 days or more, the member only counts once towards the denominator. OHA anticipates that for the vast majority of CCO members, each member will only count once.

Appendix 1: Template for Component 2 Reporting

Based on the sample list of CCO members provided by OHA, CCOs will input data separately for each of members identified. The fields required for each member are outlined in the table below.

The screening can occur at any point during the screening period and the subsequent referral for all positive domains has to be made within 15 calendar days of the screening. This measure does not require screening to occur more frequently than once per measurement year, and CCOs should work to avoid re-traumatization through over-screening. Screening for each domain can occur at separate times, but members must be screened in all three domains during the measurement year to meet the Rate 1 criteria. OHA encourages screening for all three domains at the same time.

The name of the screening tool must be documented in the record; however, OHA does not require that information in the data collection template, just that an OHA-approved or exempted screening tool was used. For the screening to count as complete, the measure does not require a specific score to be documented in the record, only that the result is positive or negative for each screened domain. Positive or negative results should be calculated based on the instructions in the approved or exempted screening tool. If the result is unknown, the screening is considered incomplete and will not count towards the numerator for Rate 1.

This measure is member-based and is required once per year, not at all encounters with the member. OHA encourages CCOs to report the most recent screening for the measurement year. However, CCOs can choose which screening and referral episode to record for each domain. A member will only be counted once during the measurement year for the metric. Domains will be assessed discretely for each domain's screening episode since screening for all three domains is not required to occur at the same time. However, screening and referral episodes within a domain cannot be mixed. This means referrals must be within 15 days of the screening for each domain.

A referral must be made for each positive domain to qualify for Rate 3 numerator. Whether the referral was accepted or declined for each positive domain must be documented. A member can choose to decline any or all referrals.

OHA strongly encourages CCOs and participating providers to document the screening and referral in alignment of measure specifications within two business days of when each occurs. At this time, OHA does not have documentation timeframe requirements for this measure. CCOs and providers should follow all applicable state and federal requirements for documentation.

Field	Valid Input Value	Definition	Sample Reporting[4]
Coordinated Care Organization name		Corresponds to Health Analytics reporting CCO Name	OHA
Date loaded	YYYYMMDD	Date OHA pulled the sample data	OHA, Sample Only

[4] For full population reporting, CCOs would be required to report OHA assigned fields for coordinated care organization and member id. All other OHA assigned fields will be removed from the full population template.

Member ID	Member's Medicaid ID		OHA
Member name	Last Name, First Name MI		OHA
Member date of birth	YYYYMMDD		OHA
Match flag	Yes, No	This field is to be reported by the CCO and only for hybrid reporting. CCOs must report 'Match Flag' (Yes/No) field for all visits sampled by OHA. 'Yes' – was a member of the CCO for 180 consecutive days or more. 'No' – was not a member of the CCO for 180 or more consecutive days.	CCO, Required, Sample Only (If match flag = no, CCOs do not have to complete Screened for Social Needs question and the Housing, Food, and Transportation domains.)
Screened for Social Needs	Yes, No, Unknown	Yes – a social needs screening occurred during the measurement year for food, housing, or transportation. Indicate even if member declined the screening in full or part of the screening. No – a social needs screening did not occur during the measurement year. This can be indicated if a member had a known interaction and no record can be found for a screening for food, housing, or transportation. Unknown – member did not interact with a screening or referral partner CCOs should leave blank when member was not reviewed by CCO staff to determine if screening and referral occurred or when a good faith effort was not made to screen and collect data for sample.	CCO, Required, Sample Only
Housing Domain			
Screened for housing insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed housing screening with member No – CCO or partner did not complete screening for housing need with member and member did not decline	CCO, Required

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		Declined – Member declined the housing screening or declined to finish the housing screening. Unknown – Not known whether member completed or declined housing screening	
Approved or exempted housing screener offered	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted housing screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the housing domain. No - Age appropriate and OHA-approved or exempted housing screening tool was not offered to member. The tool was not on OHA-approved screening tool list and the organization did not have an exemption from OHA for use of a different housing screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA approved screening tool list in the housing domain.	CCO, Required if screened for housing insecurity 'Yes' or 'Declined'
Date of housing screen	YYYYMMDD	Date of housing screening completed or declined	CCO, Required if screened for housing insecurity 'Yes' or 'Declined'
Result of housing screening	Positive, Negative, Unknown	Positive – Housing screening completed and indicated housing need. Negative – Housing screening completed and did not indicate housing need. Unknown – Result of housing screening is not known.	CCO, Required if screened for housing insecurity 'Yes'
If positive, received housing referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with housing resources. No – Member did not receive a referral to an organization and/or provider that can assist with housing resources.	CCO, Required if result of housing screening 'Positive'

		Declined – Member indicated that they did not want and/or need a referral for housing resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received housing referral.	
Date housing referral made	YYYYMMDD	Date housing referral made or declined	CCO, Required if received housing referral 'Yes' or 'Declined'
Food Domain			
Screened for food insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed food screening with member No – CCO or partner did not complete screening for food insecurity with member and member did not decline Declined – Member declined the food screening or declined to finish the food screening Unknown – Not known whether member completed or declined food screening	CCO, Required
Approved or exempted food screener offered	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted food screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the food domain. No - Age appropriate and OHA-approved or exempted food screening tool was not offered to member. The tool was not on OHA approved screening tool list and the organization did not have an exemption from OHA for use of a different food screening tool.	CCO, Required if screened for food insecurity 'Yes' or 'Declined'

		Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA approved screening tool list in the food domain.	
Date of food screen	YYYYMMDD	Date of food screening completed or declined	CCO, Required if screened for food insecurity 'Yes' or 'Declined'
Result of food screening	Positive, Negative, Unknown	Positive – Food screening completed and indicated food need. Negative – Food screening completed and did not indicate food need. Unknown – Result of food screening is not known.	CCO, Required if screened for food insecurity 'Yes'
If positive, received food referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with food resources. No – Member did not receive a referral to an organization and/or provider that can assist with food resources. Declined – Member indicated that they did not want and/or need a referral for food resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received food referral.	CCO, Required
Date food referral made	YYYYMMDD	Date food referral made or declined	CCO, Required if received food referral 'Yes' or 'Declined'
Transportation Domain			
Screened for transportation needs	Yes, No, Declined, Unknown	Yes – CCO or partner completed transportation screening with member No – CCO or partner did not complete screening for transportation need with member and member did not decline	CCO, Required

		Declined – Member declined the transportation screening or declined to finish the transportation screening Unknown – Not known whether member completed or declined transportation screening	
Approved or exempted transportation screener used	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted transportation screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the transportation domain. No - Age appropriate and OHA-approved or exempted transportation screening tool was not offered to member. The tool was not on OHA approved screening tool list and the organization did not have an exemption from OHA for use of a different transportation screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA-approved screening tool list in the transportation domain.	CCO, Required if screened for transportation need 'Yes' or 'Declined'
Date of transportation screen	YYYYMMDD	Date of transportation screening completed or declined	CCO, Required if screened for transportation need 'Yes' or 'Declined'
Result of transportation screening	Positive, Negative, Unknown	Positive – Transportation screening completed and indicated transportation need. Negative – Transportation screening completed and did not indicate transportation need. Unknown – Result of transportation screening is not known.	CCO, Required if screened for transportation need 'Yes'
If positive, received transportation referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with transportation resources.	CCO, Required if result of transportation need 'Positive'

		No – Member did not receive a referral to an organization and/or provider that can assist with transportation resources. Declined – Member indicated that they did not want and/or need a referral for transportation resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received transportation referral.	
Date transportation referral made	YYYYMMDD	Date transportation referral made or declined	CCO, Required if received transportation need 'Yes' or 'Declined'

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Appendix 2: Social Needs Screening Tools Process

Background

To systematically review and evaluate new screening tools, selection criteria are necessary. In 2021, a subcommittee of the Social Determinants of Health Measurement Workgroup first met to review and recommend screening domains, tools, and questions to be used to receive credit for the Component 2 Rate 1 percent of members screened. This Subcommittee initially developed five criteria to be used by OHA to approve new screening tools.[1]

In Spring 2023, a new Screening Tool Committee was convened to 1) review and provide recommendations to improve the current evaluation criteria and 2) discuss the approval process for CCO submitted tools. Committee members included academic subject matter experts, clinical practice based subject matter experts, community based organization representatives, and one Oregon Health Plan (Medicaid) member. Two members of the 2023 Screening Tool Committee were also members of the original 2021 SDOH Workgroup Subcommittee. The 2023 committee met twice to create recommendations that helped to create this SDOH Screening Tool Form and exemption/approval process.

OHA Approved Screening Tool List

OHA strongly encourages CCOs and organizations that are conducting SDOH screenings to use tools from the OHA approved SDOH screening tools list. Having a common screening tool across the CCO population can streamline the process administratively and lead to better coordination of care. The approved SDOH screening tool list contains tools that have housing, food, and/or transportation questions that automatically qualify as acceptable for use for the identified SDOH metric domains. These tools do **not** need to be submitted to OHA for exemption to be used by a CCO, practice, CBO, or other SDOH screening partner.

As new tools are added, OHA will post the tools on the Social Needs Screening Tools website and notify CCOs through the CCO TAG (Technical Advisory Group) Listserv and the technical assistance contractor. To be added to the CCO TAG Listserv, please send an email to Metrics.Questions@odhsoha.oregon.gov.

Approved screening tools are no longer separated by adult and pediatric to prevent potential confusion and over screening within the same household. The screening tools should be used for the population the tool was developed. For example, the Accountable Health Communities (AHC) tool can be given to a child's caretaker on behalf of the child.

Screening Tool Review Process

OHA will review new social needs screening tools annually. Two types of reviews may be conducted through this process: 1) exemption to use the tool for a limited group of providers and community partners and 2) addition to the statewide approved SDOH screening tool list. During the tool review, OHA will only examine the domains relevant to the metric, and only those questions identified for the

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metric domain require exemption or approval to meet Component 2 Rate 1 percent of members screened requirements.

The deadline for submitting additional tools for a given measurement year is June 30th of the previous year. For example, the tool submission deadline for MY2025 is June 30th, 2024. If providers and community partners wish to submit a tool - including "home grown" tools, they can do so by submitting the tool to their CCO. The CCO will collect the tools and submit them to OHA through an online form. It is recommended that providers and community partners consult their CCO for guidance on evidence-based and approved tools within the CCO system.[2] OHA strongly encourages CCOs and organizations that are conducting SDOH screenings to use tools from the OHA approved SDOH screening tools list.

When submitting new tools, the CCO will need to complete the SDOH Screening Tool Form on behalf of the organization. The form will be available online for submission to OHA. CCOs must include the screening tool in the format that the CCO member receives the tool. If the screening is conducted verbally, OHA requires CCOs to submit any instructions read to the member, the questions asked, and each response option. The information requested in the form is vital to aligning with the measure intent and incomplete submissions will be denied.

Organizational Level Exemption:

Requirements for screening tool exemption at the organizational level:

1. Tool applies to at least one of the following domains:
    a. Both housing insecurity and houselessness
    b. Food insecurity
    c. Transportation needs
2. Cultural competency and understandability by population
    a. At a minimum, a 6th grade reading level or less
3. Trauma-informed language and screening methodology (e.g., timing)
4. Tool provides option for member to decline all relevant domains
5. Tool provides clear indication of positive result for all relevant domains

OHA Approved List Additions:

Below is a list of desired qualifications list for all screening tools. To be added to the OHA approved screening tool list, the tool must meet all organizational level exemption requirements as well at least three of the four items listed below.

1. Useable in medical and non-medical settings
2. Tested for validity and reliability
3. Available in multiple languages
4. Input from community and/or OHP members in the development and use of the screening tool

Appendix 3: Good Faith Effort

Good faith effort is required when using unknown values to count towards the Component 2 completeness threshold for each CCO's sample. Measurement Year (MY) 2025 is the first year that CCOs are required to systematically screening and referring members for housing, food, and transportation in alignment with these measure specifications. The following information should be used to complete the template in Appendix 1.

Unknown, No, and Blank Values

Completing data collection is vital to inform SDOH metric quality improvement strategies and, in future years, goal setting by the Metrics and Scoring Committee. Below is clarification on when unknown, no, and blank should be used in the Appendix 1 template.

- An **"unknown"** response should only be used when the data collection method failed to find the information needed. Unknowns will count towards the completion threshold as long as a good faith effort (as defined below) is made.
- A **"no"** response should be used when it is reasonable to assume the activity did not occur or there is documentation that activity did not occur. For example, it would be reasonable to assume that no screening occurred if a visit occurs and no screening was documented. If a screening occurred and no record of a referral can be found, it is reasonable to assume a referral did not occur. However, if a screening and/or referral did occur and an aspect related to a specific field was not documented, unknown should be used.
- Data fields should be left **blank** when a good faith effort has not been made to collect the data. Any required field that is left blank will invalidate the record from counting towards the competition threshold.

Defining Good Faith Effort

To meet the requirements of a good faith effort for data collection, each of these four characteristics must be present:

1. ***CCO must have an established screening and referral process for housing, food, and transportation*.** The sample data collection for screening and referral begins in MY 2025, the third year of the measure. CCOs should have established screening and referral processes by the beginning of MY 2025. Screening only in primary care clinics will not be enough to meet the measure as it progresses and goals set for performance. CCOs should continue to build screening and referral processes that will achieve universal screening of all members once a year.
2. ***CCO must have data collection and workflow protocols to gather screening and referral information aligned with the component 2 template*** *(Appendix 1).* The first two years, MY 2023 and MY 2024, required CCOs to establish policies, workflows, and data collection through component 1 must pass requirements. CCOs will continue to refine component 1 requirements in MY 2025, the last year of the structural component. This is why new requirements were not

added in MY 2025. Instead, all component 1 requirements should be refined as the component 2 screening, referral, and data collection is implemented.

3. ***CCO must provide and/or support access to a tool or tools that enable screening and referral data to be shared in their network*** *per component 1 item 15 requirements.* CCOs should have established protocols and platforms to track and share data needed for the sample per component 1 MY 2024 and MY 2025 requirements.
4. ***CCO must gather data from partners with whom they have an established relationship to complete SDOH measure screening and referrals, and from sources internal to the CCO.*** For example, if a CCO has established plans to complete screenings and referrals with a community-based organization and a health care clinic, CCOs will need to make a systematic effort to collect data from those groups. CCOs should be working with screening and referral partners throughout the year to ensure data will be received in the correct format. Establishing automated processes and protocols that streamline data collection can reduce administrative burden on CCOs and their partners.

CCOs are **not** required to collect data from those with whom the CCO does **not** have an established relationship to complete SDOH metric screening and referrals.

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Appendix 4: 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. Changes in life circumstances, loss of employment, and other factors may indicate the need for additional screening. Frequent screening done in a non-traumatizing, patient centered way that supports autonomy to decline is not over-screening in these circumstances.

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

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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 make 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

Referral: a documented exchange of information, with the member's permission, to social services that could reasonably address the social need of food, housing and/or transportation identified from the screening. Ideally, member should be given information on the social service as well. The member may opt to receive contact information to the social services only.

A referral should contain information about the member's contact information and their housing, food, and/or transportation needs. If approved by the member, the referral should also include language and cultural preferences. If a member opts to receive contract information for the social service agency, the referral should have the agency's contact information and what services the agency can provide in relation to the member's social need.

A member may decline to receive a referral for one or all identified social needs. To receive numerator credit for rate 3 percent of members referred, the referral must be made for all identified social needs that the member wants referrals for within 15 days of the screening.

Re-traumatization: a person who has experienced previous trauma has heightened vulnerability to further traumatization. They may experience an adverse reaction to services provided that do not recognize and modify practices to account for the past trauma.