Social Determinants of Health (SDOH) Screening and Referral Metric: Learning Collaborative Playbook

Learning Together for Better Health, Better Care and Equity

Measure Year: 2024

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

How to use this playbook

Thank you for your participation in the Social Determinants of Health (SDOH) Screening and Referral Metric Learning Collaborative. **The 2024 SDOH Metric technical specifications outline the requirements for the measure.** This playbook is an optional tool that your CCO may choose to use as a complement to each Learning Collaborative and the technical specifications. The playbook provides suggestions, and can help your CCO think through practical steps to take related to the 2024 measure goals in the following areas:

After each Learning Collaborative session, we invite you to work through the sections relevant to the topic area with your internal teams. **Office hours** are scheduled for CCOs who would like to bring their learnings, pain points, "ah-has!" and other findings to discuss with the Technical Assistance (TA) team and their Learning Collaborative colleagues.

Managing the Change Within Your Network

This measure represents an opportunity for CCOs and their partners to have a meaningful impact on member needs and advance health equity. Implementing this measure requires significant systems change for CCOs and their community and clinical partners. Some steps, or "plays," to engage and sustain the needed systems change with your external partners and within your network may include:

- ✓ Organize an advisory group of community, provider and member partners including people with lived experience
- ✓ Engage partners at every level
- ✓ Develop a communication and outreach plan to engage CCO staff and external clinical and CBO partners – identify the "why" behind the change
- ✓ Conduct listening sessions to gauge community and provider partner readiness
- ✓ Develop and share a roadmap for the metric implementation

For more guidance on change management, see the SDOH Metric 2023 Playbook.

Centering Equity in SDOH Screening and Referral Practices

Your CCO has done the hard work to lay the foundation for SDOH screening and referral practices. By working to meet MY2023 "must-pass" elements, you have made meaningful progress in bringing together health care and social care to address Oregon Health Plan (OHP) members' complete health needs. As your CCO plans the work for MY2024, consider how you can continue to deepen your methods to advance equity. For example, how can your CCO expand on efforts in your **Health Equity Plan** to center equity in SDOH screening and referral practices? Retrieve up-to-date Health Equity Plan information from the CCO contract forms website. Building on your efforts to advance equity will help ensure that everyone can access culturally-responsive social resources and services without bias and that these services respect different communities and cultures.

OHA Health Equity Definition

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 or resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices

The plays in this section represent best practices for your CCO to prioritize equity as you develop your SDOH initiatives. Consider structuring these key plays around the Engagement, Continuous Improvement, and Accountability standards of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

Resources to support a health equity approach to metric implementation:

- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A set of action steps developed by the U.S. Department of Health and Human Services intended to advance health equity by providing guidance for organizations to implement culturally and linguistically appropriate services.
- ODHS and OHA Writing Style Guide 2023: Practical guidance to create accessible and inclusive communications.
- OHA REALD Implementation Webpage: Find examples of using Race Ethnicity and Language Disability data to inform health strategies, guidance on asking REALD questions of patients, and Oregon Administrative Rules and policies.

- OHA Using REALD and SOGI to Identify and Address Health Inequities: Understand the intent of REALD and Sexual Orientation and Gender Identity data collection, rules, regulations, and data justice.
- Transformational Community Engagement to Advance Health Equity: Download this report from Health Equity Solutions and the Robert Wood Johnson Foundation to learn about approaches to community engagement to advance health equity.
- DeBeaumont Foundation Build health workbook: This workbook is for cross-sector partners engaged in early stages of collaboration to strengthen community-wide health equity.
- City of Philadelphia Equitable Community Engagement Toolkit: A collection of best practices for equitable community engagement. Each section of the toolkit is organized around a common challenge.

Play One: Understand Your Members and How to Serve Them Equitably

In this foundational play, the emphasis is on gaining a deep understanding of the diverse makeup of your membership and integrating practices that support a diverse membership. By analyzing demographic factors such as age, race, ethnicity, disability, language preferences, socioeconomic status, and other relevant characteristics, your CCO can gain valuable insights into the unique needs of the community you serve. This approach also helps identify any gaps in culturally-responsive resources. This play sets the stage for developing culturally-responsive strategies that promote inclusivity, ultimately enhancing the effectiveness of your CCO's SDOH and Equity (SDOH-E) strategy, including contract deliverables such as the Health Equity Plan and Transformation and Quality Strategy.

Key Steps:

- ✓ **Demographic Analysis:** Begin by collecting and analyzing demographic data related to your membership. Include data sources such as Race, Ethnicity, Language and Disability (REALD) data. You may already be working on this step as part of your Health Equity Plan.
    - What sources of REALD data can you leverage to understand member demographics better and guide your assessment of member needs?

- ✓ **Training:** Provide training for staff to enhance cultural competence and understanding of diverse backgrounds. Ensure your partners also conduct staff training in cultural competency and responsiveness.
    - SDOH Metric Social Needs Screening Training Resources

- ✓ **Community Engagement:** Establish communication channels with community members from diverse backgrounds to gather insights on their experiences, preferences, and needs related to navigating social systems.
    - Consider engaging your community advisory council (CAC), your Regional Health Equity Coalition (RHEC), and culturally-specific community-based organizations to better understand the lived experiences and unique cultural needs of your members

- ✓ **Language Access:** Support access to language assistance services and ensure that they are available not only during screening but also when members are accessing social resources. This helps individuals with limited English proficiency feel more comfortable and ensures they can fully access and benefit from the services provided.
    - How can you support clinical and social resource providers in providing language assistance services for members?

Play Two: Cultivate Strong Partnerships

In this strategic play, the focus is on building strong partnerships to collectively advance equity within the community your CCO serves. By fostering collaborations with local organizations, community groups and, importantly, organizations that serve specific cultural and linguistic populations, you create a network that collectively works to dismantle systemic and structural racism, promotes inclusivity, and enhances the overall well-being of the community.

Key Steps:

- ✓ **Identify Potential Partners:** Begin by exploring your community to find local organizations, community groups, and culturally-specific organizations that share the goal of improving social health.

- ✓ **Set Clear and Shared Goals:** Clearly outline what you want to achieve together, making sure your objectives align with the broader mission of dismantling systemic racism and advancing social equity.

- ✓ **Start with Transparency**: What level of participation and power-sharing are you asking of and offering to potential partners as you develop the relationship?
    - **Recommended reading:** Understanding Community Engagement pages 2-4 of the Transformational Community Engagement to Advance Health Equity Report from Health Equity Solutions and the Robert Wood Johnson Foundation

- ✓ **Start the Conversation:** Initiate open and constructive conversations with potential partners to understand their perspectives, priorities, and unique strengths. Actively create opportunities and pathways within these collaborations, for partners to exercise their inherent power and knowledge about what they need.

- ✓ **Create Inclusive Collaborations:** Develop collaborative initiatives that involve a mix of organizations, community groups, and culturally-specific entities, ensuring diversity in your approach.

- ✓ **Ensure Mutual Benefits:** Create projects and initiatives that benefit both your CCO and your partners, forming a partnership that is mutually beneficial and fosters a commitment to long-term collaboration.

- ✓ **Continuous Engagement:** Keep the lines of communication open, maintaining regular and transparent communication with your partners to share progress, discuss challenges, and identify opportunities for collective problem-solving.

- ✓ **Value Partners' Time and Labor:** When working with community groups and OHP members, compensate community partners for their time and work involved in engaging with your CCO to inform your SDOH and equity efforts.
    - Utilize CCO community investment programs, like SHARE and HRS CBI to support partners' work with your CCO.

Establish Alignment Across SDOH Initiatives and Programs

Your CCO is likely exploring how to align social needs screening and referral metric efforts and various OHA SDOH initiatives and programs, including the Health-Related Social Needs benefits (HRSN), Community Capacity Building Funds (CCBF), Health-Related Services (HRS), In Lieu of Services (ILOS) and the Supporting Health for all through REinvestment (SHARE) Initiative. By fostering synergy between these initiatives, the aim is to maximize impact, streamline resources, and create a holistic, seamless experience for members navigating health and social care systems.

More information about each SDOH Initiative referenced in this section:

- 1115 OHP Waiver Health Related Social Needs (HRSN) benefits
- Community Capacity Building Funds (CCBF)
- Health Related Services (HRS)
- In Lieu of Services (ILOS)
- Supporting Health for all through Reinvestment (SHARE) initiative
- Comparing CCO Spending Initiatives SHARE, HRS, and ILOS
- HRS SHARE ILOS 101 for Community Partners (includes CCBF comparison)

Play One: Align the SDOH Screening and Referral Metric with Other SDOH Initiatives

To effectively align screening and referral practices with the HRSN benefit, HRS, ILOS, SHARE and CCBF initiatives, consider the following key components:

Key Steps:

- ✓ **Screening Process:** Develop a standardized screening process that incorporates the eligibility determination requirements for HRSN benefits and the essential SDOH Screening and Referral Metric Elements. Use OHA approved screening tools, and ensure the proper training (e.g. cultural responsiveness, trauma-informed care, empathic inquiry) for those administering the screening.

- ✓ **Front Door for Determining Eligibility:** Support the member experience by establishing a single point of entry for members who are screened and have social needs. Determine eligibility for HRSN-covered services and access to HRS flexible services seamlessly for member. Incorporate the diverse needs and perspectives of members in front door design.

- ✓ **Referral Process:** Establish clear protocols for making referrals based on the results of the screening and eligibility process. This workflow may require decision trees identifying eligibility and appropriate funding streams, and will require a step identifying whether a member is part of a transitions population defined in the 1115 OHP Waiver and eligible for the HRSN benefits. Establish a structured method to link individuals with social needs services and resources.

- ✓ **Community Investments:** The various funding streams for community investments, including HRS Community Benefit Initiative (CBI) and SHARE, complement the implementation of the SDOH screening and referral metric. Your CCO can identify opportunities to align community investment funding streams with the goals and objectives of the metric so that these investments align with the specific needs identified through initial screening data, especially where resources for common needs are sparse.

  For example, if social needs screening or referral data from your community information exchange (CIE) or chart review shows that many of your members have social needs after screening for food insecurity, and if your assessment of available resources and gaps (Element 9) shows that there are insufficient food access resources in your service area, this data could inform the community's priorities in the Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) process and allocation of HRS CBI or SHARE funds for community level programs.

  Further, comparing disaggregated REALD data and information from the gap assessment to identify if there are gaps in culturally-specific resources (Element 14) may reveal a need and opportunity to prioritize a culturally or linguistically specific food access program when allocating HRS CBI funds or SHARE funds.

  When developing a written plan to help increase CBO capacity in the service area (Element 11), your CCO may choose to invest in expanding the capacity of an existing CBO program by covering administrative capacity costs with CCBF grant funds, investing in novel program development and service delivery with HRS CBI funds, or by constructing a community kitchen and walk-in cooler space to enable a Veggie Rx produce drop off point with SHARE dollars.

Play Two: Map Program Intersections

Mapping intersections between SDOH programs is crucial for creating an ecosystem that addresses individuals' multifaceted health and social needs. This play aims to enhance collaboration, reduce redundancies, and optimize resources, ultimately leading to a more holistic and impactful approach to improving the health and well-being of the communities served by your CCO.

Key Steps:

- ✓ **Inventory SDOH Programs:** Begin by creating a detailed inventory of all existing SDOH programs within your organization and in the community, ensuring a comprehensive understanding of goals, objectives, and target populations.

- ✓ **Align Data:** Promote the use of standardized codes and value sets in screening and referral systems to facilitate interoperability and accurate data exchange.

- ✓ **Solicit Community Input:** Engage a diverse group of community partners, including program managers, community representatives, and frontline staff, in discussions to gain insights into the practical aspects of each program and potential areas of intersection.

- ✓ **Align Goals and Measures of Success:** Align the goals and measures of different SDOH programs, as well as Community Health Improvement Plans (CHP) to create a unified framework for measuring success. Monitor disparities across programs by including in this framework a measure of member-level social needs services by REALD-SOGI categories. This alignment enhances accountability and ensures a collective focus on desired outcomes. Gather input from communities affected by social resource inequities to help shape goals and desired outcomes.

- ✓ **Coordinate across programs:** Facilitate regular coordination meetings between your CCO teams responsible for different SDOH programs and CCO staff responsible for financial management. This ensures ongoing communication and alignment of upstream investment efforts.

- ✓ **Ask for Clarification:** Engage with OHA and contracted technical assistance providers when questions arise about using these programs synchronously.

- ✓ **Identify Populations:** Identify specific populations or individuals who may benefit from the intersection of multiple programs. This could include individuals with complex health and social needs requiring a more comprehensive approach, such as members with special health care needs as defined in the CCO and Intensive Care Coordination Contract.

- ✓ **Written Agreements for Provision of Services:** Where possible, work with CBO partners that provide services in the three metric domains to align with HRSN Service Provider requirements and support them if they choose to also be an HRSN provider. Technical support may include: provider enrollment; information about how to be a Medicaid provider; support for data sharing and reporting; and more. Include provision of services for non-transition populations in written agreements with HRSN service providers so that referral workflows can align for both the incentive metric universal screening and referral and the HRSN benefit for transition populations.

Play Three: Optimize Available Resources

This play provides suggestions on how to establish resource allocation across different programs and populations; and how to identify optimization opportunities. This includes ensuring that resources are strategically deployed to address common challenges, shared goals and address inequities for populations that have been historically underserved. Optimizing and coordinating resources can lead to improved collaboration with partners, streamlined operations, equity, and enhanced overall effectiveness in addressing the diverse needs of the communities served by your CCO.

Key Steps:

- ✓ **Inventory Resources:** Conduct a comprehensive inventory of resources across different programs, including available funding streams (e.g. member benefits, community and capacity investment dollars, personnel, technology, and existing infrastructure). Be sure to identify partners with the potential to support the diverse populations served by your CCO.

- ✓ **Analyze Common Challenges:** Identify common challenges faced by various programs and populations. This could include barriers in service delivery such as language access, lack of culturally acceptable services, accessibility for persons with disabilities, resource constraints, or overlapping needs within the community.

- ✓ **Identify Shared Goals:** Clearly define shared goals and objectives that span multiple programs. This could involve improving access to SDOH services for specific populations or enhancing overall community well-being.

- ✓ **Utilize Resources Strategically:** Develop a strategy for utilizing resources thoughtfully to address shared goals and challenges. Consider allocating resources to programs where they can have the most significant impact on underserved populations and enhance community capacity.

- ✓ **Continuous Monitoring and Adaptation:** Establish a system for continuous monitoring of resource allocation and program performance. Be prepared to adapt the approaches based on ongoing assessments and evolving priorities you are hearing from your community and clinical partners.

Play Four: Braiding Funding

Braided funding combines two or more funding streams to support a single purpose, while tracking and reporting on those streams individually. In the context of the SDOH Screening and Referral Metric, it is possible to braid numerous SDOH initiatives to provide social resources to members.

Braiding Funding Scenario 1: Mike, food and utility resources

Current context

An **OHP Member, Mike**, completes a social needs screening with a licensed community health worker (CHW) at a community-based organization (CBO) that is a registered HRSN service provider. The CHW uses an **OHA approved or exempted screening tool** and identifies that mike experiences food insecurity, has stable housing, and has sufficient non-medical transportation.

The CHW uses empathic inquiry to identify Mike's specific needs and uses his priorities to jointly develop a care plan. The CHW uses HRSN covered services eligibility criteria and determines that that Mike is not a part of a HRSN covered population defined in the 1115 OHP Waiver, thus is not eligible for HRSN food benefits. The CHW learns that Mike does not have access to fresh produce due to a cost barrier, has trouble preparing whole unprocessed foods due to a dysfunctional stove, and has difficulty paying utility bills. The CCO that manages Mike's care uses a blend of payment to meet Mike's needs.

Connecting Mike with resources

Mike's CCO uses a **value-based payment arrangement** to pay the CBO to screen for social needs using an OHA Approved or Exempted Screening tool[1]. and aligning with 1115 OHP Waiver HRSN screening protocol.

→ It is determined that Mike is not part of a HRSN covered population defined in the 1115 OHP Waiver demonstration.

Mike screens positive for food insecurity.

→ There is a **community food pantry** where Mike can pick up weekly shelf-stable dry goods, but no produce.

→ Based on Mike's needs and priorities, **HRS flexible services** can be used to: Enroll Mike in a Veggie Rx program, help pay a utility bill that keeps cooking equipment on, and purchase cooking equipment such as a stove.

→ Mike has the social resources he needs to stay healthy!

Community investments

- **HRS CBI funds** could be used to develop a community garden, excess produce can be donated to the local food pantry.
- **SHARE funds** could be used to build cold storage, such as a walk-in cooler, for a local food pantry to store perishable foods.
- **CCBF Funds** could be used to invest in training staff on use of new community information exchange (CIE) systems for a CBO that is also a HRSN Service Provider under the 1115 Waiver.

→ Stronger community resources to refer Mike to, and better food access infrastructure for all!

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1. To meet SDOH Screening and Referral Incentive Metric requirements, an approved or exempted screening tool must be used. See a list of the approved tools and annual review process here (https://www.oregon.gov/oha/hpa/dsi-tc/pages/social-needs-screening-tools.aspx

Braiding Funding Scenario 2: Lucia, food and transportation resources

Current context

OHP Member, Lucia, completes a social needs screening with a licensed community health worker (CHW) at a community- based organization (CBO) that is a registered HRSN service provider. The CHW uses an **OHA approved or exempted screening tool**. Lucia does not have stable housing, experiences food insecurity, and does not have sufficient non-medical transportation. Lucia also has a clinical condition, which in combination with being at risk of homelessness as defined by HUD[2], makes her a part of the transition population defined under the 1115 OHP Waiver and eligible for health-related social needs (HRSN) benefits.

The CHW uses empathic inquiry to identify Lucia's specific needs and uses her priorities to jointly develop a care plan. The CHW learns that Lucia has trouble affording a balanced diet, getting to the grocery store, and preparing whole unprocessed foods due to a dysfunctional stove and difficulty paying a utility bill. The CHW addresses her food insecurity by leveraging multiple state SDOH initiatives.

Connecting Lucia with resources

Lucia's CCO uses a **value-based payment arrangement** to pay the CBO to screen for social needs using an OHA Approved or Exempted Screening tool[1]. **HRSN outreach and engagement services** can be used to determine eligibility for HRS benefits through the 1115 OHP Waiver.

Lucia is a part of a HRSN covered population as defined in the 1115 OHP Waiver demonstration.

Lucia screens positive for food insecurity and insufficient transportation.

Use **HRSN benefit** to pay for the CHW to provide application support for Supplemental Nutrition Assistance Program (SNAP) benefits.

Lucia is eligible for **SNAP,** but it is not enough to overcome the cost barrier she faces to maintain a balanced diet *AND* she cannot get to the store to use her SNAP benefits.

Use **HRSN benefit** to increase access to a balanced diet by enrolling Lucia in a Veggie Rx program. (HRS cannot be used for an otherwise covered service)

Lucia's CCO can use **HRS flexible services** to pay a utility bill that keeps cooking equipment going, and to purchase cooking equipment such as a stove.

Lucia's CCO uses **HRS flexible services** to provide transportation through an expanded agreement with their non-emergent medical transportation (NEMT) vendor. With this resource, Lucia can get a ride to and from the grocery store to use her SNAP benefits.

HRSN benefit ends after six months. Lucia still faces economic barriers to accessing food. Her CCO can use **HRS flexible services** to keep Lucia enrolled in the Veggie Rx program.

Lucia has the social resources she needs to stay healthy!

Community investments

- **HRS CBI funds** could be used to fund a CBO to hire a CHW to provide noncovered services, such as connection to social resources.
- **SHARE funds** could be used to buy a bus to shuttle low-income families to social resources like a grocery store or DHS office.
- **CCBF Funds** could be used for administrative costs to sustain or expand food access and distribution services for a CBO that is a HRSN Service Provider under the 1115 Waiver.

Stronger community resources to refer Lucia to, and better food access infrastructure for all!

2. For the federal definition of "at risk of homelessness" applicable to the HRSN benefit, see 91.5 Code of Federal Regulations from the National Archives and Records Administration (https://www.ecfr.gov/current/title-24/subtitle-A/part-91#p-91.5(At%20risk%20of%20homelessness)

Section 1: Screening Practices

All activities for elements introduced in Measure Year (MY) 2023 should be completed or updated annually, and are also must-pass in MY 2024 and future measure years. For worksheets on screening practices must-pass elements introduced in MY 2023 see the MY2023 LC Playbook on the OHA Transformation Center webpage.

New MY 2024 Must-Pass Elements

A. Assess training of staff who conduct screening
B. Assess whether OHA-approved screening questions are in use

Worksheet A: Assess Training of Staff Who Conduct Screening (Element 4)

Overview (from specifications[1])

To meet this element, CCOs must review the training policies of its partners, and if needed provide training resources to partners.

Key Play	Steps our CCO could take:
This element should ensure that staff and partners who are conducting training are doing so in line with policy created for Element 2. Survey clinical and CBO partners that conduct screening about training policies and practices to understand if a partner has gaps in policies or practices. Review must-pass Element 2 for important training topics. Share training resource suggestions, such as the CCO's training policy as a model or training opportunities such as webinars on trauma-informed screening practices. Please refer to the SDOH Screening & Referral Metric: Social Needs Training Resources guidance document for a compilation of free social needs training resources.	☐ Create a survey that includes questions around training policies and practices. ☐ Disseminate the survey to partners. ☐ Analyze responses and identify gaps in policies and practices. ☐ Share CCO's training policy as a model, and training resources with partner. ☐ Develop (or expand existing) list of training resources based on partners' needs for training. ☐ Use survey results to update the training policies developed in Element 2. Add training practices discovered at partner organizations, or remove training policies that aren't meaningful.

Questions to Consider:

- What are our partners' current training policies for addressing social determinants of health (SDOH)?
- How frequently do our partners conduct training sessions for their staff on SDOH screening and referral practices, and what topics are covered?
- Do our partners have a feedback mechanism in place to assess the effectiveness of their training programs?

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[1] For more detail on requirements, see technical specifications. This worksheet is an optional tool and complements each Learning Collaborative.

- Are there specific areas within SDOH screening and referral practices where our partners may require additional training or support?
- Are there opportunities for joint training sessions or knowledge-sharing forums (with other CCOs or partners) to enhance the overall competency of our network?
- How can we effectively share our own training policies as a model for our partners?
- How can we support our partners to access and participate in relevant training opportunities?
- How can we encourage our partners to utilize the Social Needs Training Resources guidance document to access free social needs training resources?

Worksheet B: Assess Whether OHA-Approved Screening Tools Are Used (Element 7)

Overview (from specifications[1])

To meet this element, CCOs will need to compare the information collected in Element 6 with the list of OHA-Approved Screening Tools.

Key Play	Steps our CCO could take:
Analyze survey results from clinical and CBO partners that are collected in Element 6, Identify screening tools or screening questions in use, including available languages. Compare information with the list of OHA-approved screening tools.	☐ Review Element 6 worksheet and initiate annual activities to assess screening tools in use across CCO staff, clinical partners, and CBO partners. ☐ Analyze survey results. ☐ Identify if partners are using OHA-approved screening tools. ☐ Create a tracking sheet that includes information about the partners screening tools currently in use.

Questions to Consider:

- How will we track partners screening tools in use on an ongoing basis?
- How will we approach communicating with partners about updates to OHA-approved screening tools in our outreach efforts?
- Have partners highlighted any barriers or challenges in implementing OHA approved screening tools in the survey?

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[1] For more detail on requirements, see technical specifications. This worksheet is an optional tool and complements each Learning Collaborative.

- How can these barriers be addressed collaboratively with clinical and CBO partners, considering OHA-approved tools as a benchmark?
- Review the SDOH Screening and Referral Metric FAQ answers about screening tools, submit a tool for exemption, and use tools embedded in EHR systems for additional support.
- How can the analysis of survey results inform strategies for continuous improvement in SDOH screening practices across the network?
- Are there specific actions or interventions to implement based on the survey findings?

Section 2: Referral Practices and Resources

All activities for elements introduced in Measure Year (MY) 2023 should be completed or updated annually, and are also must-pass in MY 2024 and future measure years. For worksheets on referral practices and resources must-pass elements introduced in MY 2023 see the MY2023 LC Playbook on the OHA Transformation Center webpage.

New MY 2024 Must-Pass Elements

A. Establish written procedures to refer members to services
B. Develop written plan to help increase community-based organization (CBO) capacity in CCO service area

Worksheet A: Establish Written Procedures to Refer Members to Services (Element 10)

Overview (from specifications[1])

To meet this element, CCOs will need to analyze factors that might lead to over-screening, develop strategies to mitigate risk of harm, write protocols, and distribute 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).

Key Play	Steps our CCO could take:
Use data about where members are screened, work with partners conducting screening to identify situations when members are most likely to be over-screened*, and develop strategies to avoid potential harm. Include strategies in protocols that are distributed to clinical and CBO partners.	☐ Analyze data gathered when completing Element 3 to understand where members are screened. ☐ Review element 1 worksheet for key steps to engage CCO members in the policy and procedure development process. ☐ Gather input from your Community Advisory Council (CAC) and/or the Regional Health Equity Coalition (RHEC) in your area around member screening preferences. ☐ Consider gathering feedback about social needs screening and referral practices from members in ongoing member surveys annually.

Questions to Consider:

Data utilization:

- How effectively are we using data to understand where our members are being screened for social determinants of health (SDOH)? What data sources or types of data are we using? Are there populations of members we are missing with our current approaches?

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[1] For more detail on requirements, see technical specifications. This worksheet is an optional tool and complements each Learning Collaborative and the technical specifications.

- What insights does the data provide regarding trends, patterns, and preferences in screening locations?

- How will our CCO incorporate the interpreted data into your protocols?

Clinical partners:

- What is the greatest need or barrier regarding social needs screening and referral workflows for clinical partners in our Delivery System Network (DSN)?

- What screening and referral processes do clinics use for other health needs, such as depression screening? Could these workflows be replicated for social needs screening and referral?

- What tools will be used to ensure that providers can see past screening and referral activity for a member at the point of care, be it from a clinical or community setting?

Community partners:

- How might our CCO collaborate with CBO partners to identify situations or contexts where members might be over-screened for SDOH?

- What are specific scenarios, environments or areas that might lead to over-screening?

- Are there certain member demographics, health or other characteristics that may cause over-screening or under-screening for certain people or groups? Be sure to engage with partners that serve members with multiple social needs and/or chronic conditions who may frequently engage with the CBO and health care system.

- How will we use clinical-community data sharing systems to monitor screening frequency and identify when it happens?

Members:

- How are data privacy and consent considerations factored into the strategies to avoid potential harm?

- How are members informed and engaged to provide consent for screening in various situations, using trauma informed practices?

- What mechanisms are in place to gather feedback from members about screening practices?

- How can a feedback loop be established to ensure that strategies are effective and responsive to evolving needs?

*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.

Worksheet B: Develop Written Plan to Help Increase CBO Capacity in CCO Service Area (Element 11)

Overview (from specifications[1])

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 Service** funds and the **Supporting Health for All through REinvestment (SHARE) Initiative**.

Key Play	Steps our CCO could take:
Publish a detailed plan, incorporating findings from your capacity assessment of CBOs in the service area. Outline specific financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members housing, food, and transportation needs. Develop plan to ensure assessment is updated annually. Consider leveraging 1115 OHP Waiver Community Capacity Building Funds (CCBF) to support CBOs who will provide both HRSN benefits and food or housing resources to members under the metric. This element builds on Element 9. Review the Element 9 worksheet in the 2023 SDOH Metric LC Playbook to find regional and local datasets related to the three metric domains.	☐ Identify and examine existing assessments and/or data sources to assess capacity – review Element 9 worksheet. ☐ Identify capacity barriers to volume and quality of service provision for CBO partners. ☐ Evaluate your assessment methods and processes for continuous improvement. ☐ Analyze assessment findings. ☐ Detail infrastructure/capacity strategies and goals in the published plan.

Questions to Consider:

Assessment Methods and Process:

- What criteria and metrics are used to evaluate the capacity of each CBO?
- How do the community-based organizations in your service area prefer to connect, for example. email, phone, in-person meetings?
- Is our CCO prepared to do culturally-responsive outreach? Utilize existing resources aligned with state and federal law to support outreach in languages representative of CCO populations.
- Are there opportunities for community input to shape the strategies and priorities to address members' needs?
- What will our process look like to ensure the assessment is updated annually?

(Continued…)

[1] For more detail on requirements, see technical specifications. This worksheet is an optional tool and complements each Learning Collaborative and the technical specifications.

- How is feedback from CBOs incorporated into the annual assessment and planning process?
- Are there regular forums or channels for communication to engage CBO partners and ensure ongoing collaboration and adjustments to the plan?

Assessment Findings:

- In our service area, which SDOH domain has adequate or abundant capacity?
- Which domain has the fewest resources in our service area? Where are the gaps in resources compared to member need in our service area?
- Based on the results of disaggregated REALD data (Element 14) what culturally-specific resources are needed in our service area?
- Which community-based organizations in our service area are most equipped to serve culturally and linguistically specific member populations?

Capacity & Infrastructure Planning:

- In what ways can infrastructure support be provided to CBOs to boost their capacity in addressing members' needs? How will funds be allocated to enhance CBO capacity, and what sources of funding are considered (e.g. SHARE, HRS Community Benefit Initiatives, 1115 OHP Waiver Community Capacity Building Funds, value-based payment arrangements)?
- Are there specific infrastructure improvements or technology enhancements identified in the plan?
- Are there plans for training and development to enhance the skills of CBO staff to support housing, food, and transportation needs?
- How can staffing strategies be integrated into the plan to address potential gaps in personnel within CBOs?
- Consider the sustainability of available funding sources for CBO service providers. How can you support capacity of CBOs so that they can employ staff to reliably deliver food, housing, and transportation services?

Section 3: Data Collection and Sharing

All activities for elements introduced in Measure Year (MY) 2023 should be completed or updated annually, and are also must-pass in MY 2024 and future measure years. For worksheets on data collection and sharing must-pass elements introduced in MY 2023 see the MY2023 LC Playbook on the OHA Transformation Center webpage.

New MY 2024 Must-Pass Elements

A. Set up data systems to clean and use REALD data
B. Support a data-sharing approach within the CCO service area

Worksheet A: Set Up Data Systems to Clean and Use REALD Data (Element 14)

Overview (from specifications[1])

To meet this element, CCOs must use disaggregated REALD data to understand the populations served by your CCO and identify resources to meet members' needs.

Key Play	Steps our CCO could take:
Analyze disaggregated REALD data to identify gaps in screening and referrals. Work with community partners to understand and address inequitable access to culturally responsive services.	☐ Clean and analyze the disaggregated REALD data to gain insights into inequitable access to culturally-responsive services and disparities in screening and referral outcomes. ☐ Use findings from Element 9 to identify culturally-responsive resources in the community. ☐ Collaborate with community partners. Community Advisory Council and/or Regional Health Equity Coalition (RHEC) to share findings from the REALD data analysis and seek input to understand their perspectives on gaps in culturally-responsive services. ☐ Develop actionable strategies, in collaboration with community partners, and members, to address identified service gaps.

Questions to Consider:

- What sources of REALD can we leverage to better understand member demographics?
- What culturally-specific organizations, services, or resources already exist in our service area and are they representative of the populations that the CCO serves?
- What strategies can be implemented in collaboration with community partners to address the identified gaps in culturally-responsive services?
- How can we incorporate the interpreted data from REALD sources into current screening and referral protocols?

(Continued…)

- How can training programs be customized based on members social needs (identified using the disaggregated REALD data) to ensure they are culturally-responsive?
- Are there specific social needs that emerge as priorities within certain communities that require tailored solutions?
- How can we use this disaggregated data to inform capacity building investment strategy (Element 11)?

Worksheet B: Support a Data-Sharing Approach (Element 15)

Overview (from specifications[1])

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.

Key Play	Steps our CCO could take:
Pay, incentivize or subsidize network providers' subscription to CIE (e.g., Unite Us, findhelp) and establish strategies (e.g. contract agreements) agreements with clinical and CBO providers that promote connection to a CIE tool and enable the sharing of screening and referral data.	☐ Design a data-sharing approach with community members that provides an opportunity for them to make meaning of the data that represents their needs. ☐ Connect with clinical and CBO partners to identify what data sharing tools are already in use or preferred. ☐ Clearly articulate the benefits, responsibilities, and any incentives tied to participation. ☐ Identify barriers to using data sharing tool of choice (e.g., CIE), and use incentives to help providers and CBOs overcome these barriers. ☐ Communicate the benefits of subscribing to the CIE tool to network providers.

Questions to Consider:

Addressing barriers:

- What barriers do our clinical and CBO partners face in using data sharing tools to share social needs screening and referral data? What steps can we take to address these barriers?
- How will any proposed financial incentives for documenting in data sharing tools or supports for onboarding or continued use impact network providers' willingness to participate in data sharing tools?

(Continued…)

- How can concerns or questions from providers and CBOs be addressed proactively?
- If member questions or concerns arise, how will those be addressed?
- How effective is the training and onboarding process for CBOs and network providers regarding the use of the data sharing tool we're using?

Integration:

- What challenges, if any, are network clinical and CBO providers facing in integrating the data sharing tool with their existing systems (e.g., electronic health record (EHR), case management platforms)?
- How can integration processes be streamlined to minimize disruptions?

Engagement:

- What metrics are in place to monitor provider and CBO engagement with the data sharing tool over time?
- How can engagement data inform strategies to encourage sustained participation?
- How clear and comprehensive are the agreements we have with CBOs and network providers regarding their subscription to the data sharing tool and their use of it?
- What communication strategies will be employed to effectively convey the benefits of subscribing and using the data sharing tool to network providers and CBOs?
- How can our CCO help to adequately equip partners to navigate and utilize the data sharing tool for screening and referrals?
- Is there a structured mechanism for collecting feedback from CBOs and network providers regarding their experiences with the data sharing tool?
- How is feedback being used to address any challenges or improve the user experience?

Reporting and evaluation:

- How frequently are reports generated on the impact of the data sharing tool on care coordination, screening, and referrals?
- How are these reports communicated to internal and external invested partners?
- What lessons have been learned from the implementation, and how can these insights inform ongoing adaptations?

Spotlight: Payment Arrangements for Providers

Strategies to Encourage Providers to Screen and Refer

Although screening and referral data reporting doesn't begin this measurement year, it's not too early to begin defining strategies for engaging clinical and CBO partners. CCOs can consider adding this metric to their existing value-based payment programs, or designing new ones, particularly in the case of CBO partners. Since there is synergy with this metric and other quality programs that clinical partners already pursue, such as the Patient-Centered Primary Care Home program, CCOs could develop communications and technical assistance outreach to providers to help them align their workstreams to meet the requirements of multiple programs.

Worksheet: Payment Arrangements for Providers

Overview

There are no metric requirements around payment arrangements. However, the experience of other CCO metrics and SDOH efforts of this kind (e.g. North Carolina's Healthy Opportunity pilots) is that busy clinics and CBO partners are more likely to prioritize work that is tied to compensation.

Key Play	Steps our CCO could take:
Design and implement a payment strategy for clinical and CBO partners that rewards equitable, trauma informed, and complete data collection.	☐ Consider what aspects of the metric to include in value-based payment arrangements with your clinical providers to incentivize screening and referral, and trauma-informed and equitable screening. ☐ Develop a value-based payment arrangement for metric participation by community agencies, such as pay-for-performance on the metric. ☐ Implement a pay-for-performance payment based on completing telephone outreach to members who have not been seen in clinics in the prior year.

Questions to Consider:

- Are there ways we could structure your value-based payment arrangements to reduce over-screening, such as rewarding documentation in the CIE so others working with the member have access?
- Could our CCO add a health equity component, such as rewards for screening priority populations, to value-based payment arrangements with providers and community agencies?
- How can we align payment for SDOH metric activities with CCBF capacity building grants and HRSN benefit payment arrangements, or your Community Benefit Initiative investments?

Spotlight: Helping Your Partners Find Success Using Community Information Exchange (CIE)

Strategies for engaging partners in CIE

Community Information Exchange (CIE) is network of collaborative partners using a multidirectional technology platform to connect people to the services and supports they need. Partners may include human and social services, health care, and other organizations. CIE enables partners to coordinate efficiently to address social needs and health equity at various levels in Oregon. This section focusing on CIE is designed to guide the development of effective strategies for engaging partners in CIE to support metric implementation.
For additional spotlight on CIE, see SDOH Metric 2023 LC Playbook.

Worksheet:

Overview

There are no metric requirements around engaging partners to use CIE in measure year 2024. However, CCOs need to support a data-sharing approach by ensuring network providers have access to screening results and referrals made at the point of care. Refer to Element 15 and worksheet above. Appropriate and timely use of CIE platforms throughout the screening and referral process makes these information exchange platforms successful. Without CBOs that provide food, housing, and transportation resources engaged in CIE, and without CBOs and clinical care teams making referrals through the platform, the system does not effectively function. Connecting with clinical and CBO partners and supporting them to address barriers to using CIE is a valuable approach for building successful clinical and social needs providers' referral and data sharing systems.

Key Play	Steps our CCO could take:
If your CCO will leverage CIE to support measure requirements (screening and referrals), develop a plan for how to engage and support partners in use of CIE.	☐ Connect with partners (survey or informal inquiry) and inquire about their use of CIE, current workflows, and barriers to using CIE. ☐ Identify successful clinical or CBO partners who have integrated CIE into their screening and referral workflow ☐ Use these examples as recommendations and to help. troubleshoot with providers who struggle with consistent CIE use.

Questions to Consider:

- What barriers do we already know our partners' experience when using CIE?
- What questions will we include in our inquiry to partners?

(Continued…)

- How can we incentivize regular CIE use with our clinical partners? What about our CBO and social service partners?
- Based on what we know about barriers to using and frequently updating CIE, how can we help increase capacity in our CBO partners?
- Are there opportunities to leverage other programs, such as the Community Capacity Building Funds (CCBF) to help partners access additional resources to overcome these barriers?
- How can we reduce the burden that CIE data entry and platform use poses to clinical and social service providers?
- How can we support partners in adapting CIE into their workflow?
- How will you message the "why", or value of using CIE with partners?
- How can we support partners in participating in CIE governance and decision-making?

Appendix D. Definitions

Dismantling systemic racism: is a movement to tear down the systems that perpetuate racial group inequities toward the goal of all people having equitable access to resources throughout our social and structural systems. Dismantling systemic racism requires systems thinking, and may include actions such as reforming policy that may have discriminatory effects, using disaggregated REALD to better understand , and facilitating meaningful participation (see power-sharing) of people from diverse racial and ethnic groups in policy and institutional decision making processes[2].

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.

Power-sharing: is an approach to shared decision-making, and is an important part of creating health interventions and initiatives that are responsive to and inclusive of the needs of all invested parties. There are several different models of power-sharing, which can range from asking the community to inform the decision to sharing decision making power with invested parties. It is highly recommended that those engaging with invested parties, including Community Advisory Councils, other Medicaid member groups, and Community-Based Organizations, and medical providers read the Transformational Community Engagement to Advance Health Equity Report from Health Equity Solutions and the Robert Wood Johnson Foundation.

Structural racism: A system in which public policies, institutional practices, cultural representations and other norms work in various, often reinforcing ways to perpetuate racial group inequities. It is a feature of the society in which we all exist[1].

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 or resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices

Health Related Services (HRS): are non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being. Health-related services include:

- Flexible services, which are cost-effective services offered to an individual member to supplement covered benefits, and
- Community benefit initiatives, which are community-level interventions focused on improving population health and health care quality. These initiatives include members, but are not necessarily limited to members.

Supporting Health for All through REinvestment (SHARE): The SHARE Initiative comes from a legislative requirement for coordinated care organizations (CCOs) to invest some of their profits back into their communities. After meeting minimum financial standards, CCOs must spend a portion of their net income or reserves on services to address health inequities and the social determinants of health and equity (SDOH-E).

In Lieu of Services (ILOS): In lieu of services (ILOS) are services determined by the state to be medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan.

Value-based Payment (VBP): Payment to a provider that explicitly rewards the value that can be produced through the provision of health care services to CCO members.

MY2023 Playbook Resources

Past tools to support metric implementation for MY2023 elements can be found on the in the MY2023 LC Playbook on the OHA Transformation Center webpage. All tools are *optional* and are not required for metric requirements.

- **Appendix A** includes an **Action Planning Tool,** that may be a useful project management tool for CCOs to utilize to support implementation of the metric.
- **Appendix B** includes a **Sample Project Charter Template**, that may be useful when working through creating agreements for the metric.
- **Appendix C** includes **Sample Survey Questions for Social Needs Screening Partners** to help CCOs meet must-pass elements 3,6, and 13.