SOCIAL DETERMINANTS OF HEALTH: SOCIAL NEEDS SCREENING & REFERRAL MEASURE

METRIC OVERVIEW

METRIC GOAL

The goal of the Social Needs Screening and Referral measure is for CCO members to have their social needs acknowledged and addressed.

COMPONENTS

Component 1

- **Structural Measure**: CCO attestation (beginning 2023 and continuing though 2025)

Component 2

- **Hybrid measure**: Sample reporting using MMIS/SDDURS, EHR, community information exchange (CIE), health information exchange (HIE), and other data sources (beginning 2025).

COMPONENT I

COMPONENT 1 OVERVIEW

Polices & Procedures

- Social Needs Screening & Referral
- Collaborative Social Needs Screening and Referrals
- REALD and SOGI Data

Survey

- Whether/where members are screened
- Training of staff who conduct screenings
- Screening tools used (including available languages)
- Assess whether OHA-approved screening tools are utilized
- Data systems used (Unite Us, EHRs, etc.)

Contracting

- Enter into agreements with CBOs
- Support a data sharing approach (Unite Us)

Assessment

- Assess capacity of available resources and gap areas
- Create a written plan to increase capacity of CBOs
- Set up data systems to utilize REALD data

Reporting begins in 2025

COMPONENT 2

COMPONENT 2 OVERVIEW

Purpose

- Component 2 is intended to measure the percentage of CCO members screened with an OHA approved SDoH tool and, as appropriate, referred for services for three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

Screening (intake) period

- December 15 of the year prior measurement year, to December 14 of the measurement year.

Continuous enrollment criteria

- Continuously enrolled with the CCO for at least 180 days during the screening period.

Allowable gaps in enrollment

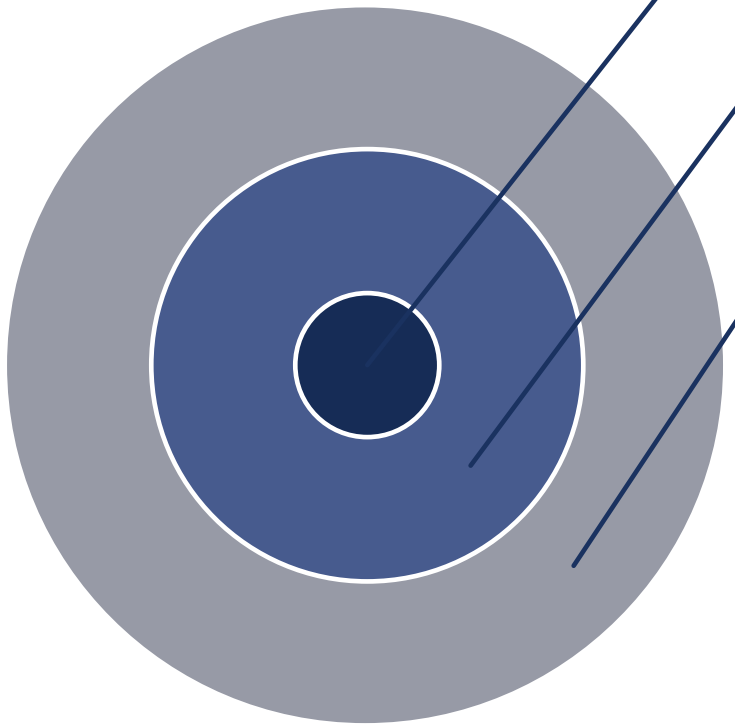
- None.

Reporting begins in 2025

COMPONENT 2 OVERVIEW CONT.

Notes:

- Members must receive referrals within 15 calendar days for each domain they screened positive.
- There are no exclusions. There are exceptions; members who decline all three domains and members who decline all referrals will be removed from the denominator.
- Rate 3 measures all referrals made, not just closed loop referrals.
- Performance on Rate 2 is not intended to be benchmarked; rather, it is calculated to understand the prevalence of identified needs in the CCO.



Rate 3

- Of the sample population with an identified need, those who received at least one referral for each identified need

Rate 2

- Of the sample population screened, the percentage of CCO members with a positive screen for any of the three required domains

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

Reporting begins in 2025

SCREENING RECOMMENDATIONS

Screen Oregon Health Plan (OHP) members for social needs annually using an Oregon Health Authority (OHA) approved SDoH screening tool.

- The list of OHA approved screening tools can be found at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Needs-Screening-Tools.aspx.
- UHA recommends using the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) screening tool.

Overscreening protocols should be implemented to limit the (re)traumatization or harm of members.

- Review QI11 for additional recommendations on how to avoid oversreening.

NOTABLE SCREENING GUIDANCE

No longer being asked to report every answer to every question (new collection parameters for direct data connections will be communicated out soon).

American Academy of Family Physicians (AAFP) Social Needs Screening no longer recommended for Domain 3 (Transportation).

Different tools and different dates of service are permitted throughout measure period, so mix and match tools as needed to suit your needs without modifying the approved tools.

DATA CAPTURING

UHA will request social needs screening and referral data from provider practices and partner organizations annually.

- UHA highly encourages the use of Unite Us to track social needs and referral data.
  - If you have questions or are interested in onboarding to the Unite Us platform, contact UHreports@umpquahealth.com.
- Partners who do not wish to use Unite Us will be required to share data with UHA annually via chart review, claims, or EHR data.

The pathways for capturing social needs screening and referral information include:

- Community Information Exchange (CIE) – Unite Us
- Billing/Claims
  - ICD-10 Diagnosis Z Codes
  - LOINC Codes
- Electronic Health Record (EHR)
  - Discrete Data Field (i.e., Smartform)
  - EHR – SNOMED CT
  - Free Text in Patient Chart*
  - Screening Form Uploaded into Patient Chart*

* These methods are less preferred andwill require manual chart review by the practice at the end of each measurement year

RESOURCES

- 2025 SDoH Technical Specifications
- OHA Approved Screening Tools
- QI10 – Social Needs Screening & Referral
- QI11 – Collaborative Social Needs Screening and Referral Training
- QI12 – REALD and SOGI Data
- Recommended SDoH Training
- SDoH Incentive Metric Webpage (OHA)

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OPEN DISCUSSION

WHAT DOES YOUR TEAM NEED TO BE SUCCESSFUL WITH THE SDOH METRIC?