Social Determinants of Health Measurement Work Group
Final Report

February 2021

Oregon **Health** Authority

Acknowledgements

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Executive Summary

Background & context

In recent years, a growing number of health care providers have started to acknowledge the profound impact social factors like income, environmental conditions and racism have on a person's health. While community organizations and social service agencies have long been screening for social needs in order to provide social services, social needs screening in health care settings is a relatively newer and growing practice.

In 2015 Oregon metrics stakeholders started exploring the possibility of an incentive measure focused on social determinants of health (SDOH) by developing a clinic-level food insecurity screening measure, which was considered but not adopted by the Metrics & Scoring Committee (MSC). In 2018 the Oregon Health Policy Board identified recommendations for the next coordinated care organization (CCO) contract, or CCO 2.0. Per direction from the Governor these recommendations included a specific focus on addressing SDOH and health equity. This same year, with support from community-based organizations, the measurement governing bodies — the MSC and the Health Plan Quality Metrics Committee (HPQMC) — revisited the idea of a broader, plan-level SDOH measure that would include, but not be limited to, food insecurity. The MSC requested that the Oregon Health Authority (OHA) develop a measure concept that includes social needs screening completion and reporting of data, and possibly referral data.

In response to these requests and priorities, OHA started the process of developing a broader social needs screening measure concept in 2019 and convened a public work group in 2020. This report provides a summary of the measure development process and final measure concept that was selected. As described in more detail below, the work group recommended a measure concept that allows use of data from any source to report on screening CCO members. In putting forward this measure for consideration, OHA and partners recognize that social needs screening in itself is not the end goal, but this measure builds toward a broader vision of tracking CCO member referrals, ensuring the provision of services, and making improvements to underlying conditions across communities.

Measure concept selected for recommendation to Metrics & Scoring Committee

After thorough consideration of the benefits and drawbacks of several measure concepts, the work group selected *Measure Concept 1: Rate of social needs screening in the total member population using any qualifying data source* for recommendation to the MSC, with nine of 13 present work group members voting for this option. The work group found this option best aligned with the work group's guiding principles of centering equity; ensuring alignment with the broader vision of OHA and the existing efforts of partners; and feasibility of implementation. The work group felt that this measure concept also has the most potential to be transformative and move the Medicaid system toward its desired future state: screening that leads to receipt of services, and partnerships across organizations and sectors to share information and support members. The work group noted that, while there is no perfect measure, the benefits of moving forward on building a statewide system of screening for social needs would be more beneficial to health and equity than not moving a

measure concept forward. In fact, members expressed concern that further delaying inclusion of a social needs screening measure could have detrimental impacts to CCO members, especially given the deleterious impact of the COVID-19 on health, well-being and equity.

To fully implement the measure, the work group proposes a multi-year glide path, which in the first year requires CCOs to submit a plan identifying their approach, including the codes they will use and how they will collect the data. The proposed concept also requires CCOs to report screening data on an OHA-identified sample starting in the second year of implementation. The sampling period lasts three years, and reporting on the full population starts in the fifth year of implementation. The glide path allows time to identify workable solutions for any implementation challenges and leverages emerging health information technology approaches.

Measure concept development process

To create a measure concept for the MSC, OHA invited sixteen of over 50 applicants to participate in a public work group that met between October and December 2020. These sixteen work group members represent a broad range of organizations, experiences and perspectives, including community-based organizations, healthcare providers and health systems, and CCOs. The work group was also supported by non-voting national partners including the National Committee for Quality Assurance (NCQA) and Bailit Health, and local partners from the Oregon Department of Human Services and HIT Commons. The work group reviewed multiple potential measure concepts using its agreed guiding principles: equity, alignment, and feasibility.

The COVID-19 pandemic disrupted the original time frame for convening the work group. To ensure the work progressed OHA oversaw an advisory committee, or "expanded planning team," comprised of OHA staff and national and state experts to review ongoing partner efforts, state and national trends, evidence, and promising practices in social needs screening, and to develop four measure concepts for work group consideration. OHA also partnered with consultants from the Oregon Rural Practice-based Research Network (ORPRN) and Nancy Goff & Associates (NGA) to develop a compendium of relevant peer-reviewed research and an environmental scan of social needs screening efforts in Oregon to assist the work group in the measure development process. Finally, OHA staff shared measure concepts with OHA leadership, several OHA advisory committees, and CCO community advisory council coordinators for high-level feedback and guidance on the concepts under consideration.

Measure concept strengths, limitations and recommendations

The work group's full analysis and recommendations regarding the recommended measure concept are presented here. First, strengths are shared, then limitations are listed with accompanying recommendations for mitigation. Greater detail about the strengths and recommendations can be found in the full report.

Strengths of proposed measure concept

The work group members felt a significant strength of the proposed measure concept (over others the work group considered) is that it would incentivize screening of all CCO members, which

promotes equity and ensures no members with social needs are missed. Further, CCOs could report whether members have been screened in multiple settings and via multiple data collection strategies, allowing for flexibility and alignment with current systems and practices at the local level (including current screening at community organizations). In addition, the work group identified the following additional strengths the final proposed measure concept over others it considered:

- The measure is the most inclusive as it casts the widest net.
- This measure is inclusive of the most settings for screening which enables screening at meaningful points of opportunity, including at member enrollment.
- The measure is inclusive of the other measure concept options.
- The measure has the potential to transform the system.
- The measure provides the opportunity to collect both patient-level and population-level data that can inform the health system about broad population needs for services and solutions.
- The measure is flexible enough to change and grow as new efforts emerge.

Limitations about proposed measure concept, with mitigation recommendations

The work group provided the following suggestions for implementing the measure in alignment with the guiding principles (equity, alignment and feasibility). Many of these suggestions can be addressed in later phases of the measure development process or through training and best practices, so despite these limitations, the work group recommends moving forward with the measure concept at this time.

Providing screening without referrals to services

The biggest concern about the proposed measure concept (and all the draft measure concepts) is that members would be screened for data collection purposes, and those who screened positive for a social need would not be offered a referral to services.

⇒ Recommendation 1
Identify a process up front for offering referrals to services to keep the long-term vision of tracking referrals and provision of services central to this work.

Increasing the demand for services without increasing the supply

Community organizations are already overburdened, and not all members are currently being screened.

⇒ Recommendation 2
Invest time up front to align systems and resources in communities (which may require additional resources). The work group views this measure as a catalyst for aligning the systems, practices and resources across organizations and sectors in communities in advance of the screening implementation.

⇒ Recommendation 3
Data should be standardized so statewide information about social needs is available.

Rescreening and possibly retraumatization if screening is not coordinated

Since the proposed measure concept allows for screening in any setting and data to be collected from any source, it is important to set up a system for sharing data among organizations to avoid rescreening and retraumatization, and ensure data is available at the point of care.

⇒ Recommendation 4
Screening data should be made available at the point of care for all members.

⇒ Recommendation 5
Leverage this measure to accelerate progress toward addressing social needs through emerging technology solutions, like community information exchanges (CIEs).

Increased administrative burden for OHA, CCOs and possibly other partners

Collecting data from multiple sources will place a higher reporting burden on CCOs, a higher administrative burden on OHA, and may place a higher burden on all screening entities.

⇒ Recommendation 6
At first limit the number of screening domains to the highest statewide priorities, including food and housing to allow partners to get systems in place to standardize and aggregate data, and prepare for increased demand for services.

⇒ Recommendation 7
Consider the magnitude of this measure within the context of the whole measure set. While this measure has the potential to be transformative and positively impact other health measures, the implementation will be a heavy lift and should not be considered equal in effort to implementing nationally standardized measures.

⇒ Recommendation 8
Create a menu of screening tools that is inclusive of tools currently in use.

⇒ Recommendation 9
Crosswalk the measure requirements with other related CCO requirements. Align with statewide efforts to collect race, ethnicity, language and disability data (REALD) so social needs information can be stratified at the state and local level.

⇒ Recommendation 10
Further define measure components in the technical specifications and structural measures, where possible.

Background & Context

In recent years, a growing number of health care providers have started to acknowledge the profound impact social factors like income, environmental conditions and racism have on a person's health. Addressing these social determinants of health (SDOH) will be necessary to make improvements in population health, which can also potentially lead to lower costs. Medicaid members, who live with lower incomes, are more likely to experience the "downstream" effects of SDOH at the individual level, called health-related social needs, such as food insecurity or lack of stable or safe housing. One study found that nearly half of the Medicaid population in Oregon has one or more social needs, and communities of color are disproportionately affected (Oregon Accountable Health Communities, May 2020).

Oregon's 1115 demonstration waiver allows for flexible use of Medicaid funds to implement programs to address SDOH and improve health beyond traditional medical care. Ensuring coordinated care organizations (CCOs) focus on addressing their members' SDOH is one of four priority areas set by Oregon's governor for the current CCO contract, or CCO 2.0. Through this effort, Oregon's 15 CCOs are expected to move beyond the medical setting to build partnerships, increase community investments and align community-wide strategies. CCO 2.0 creates a pathway for addressing the social needs of members in the immediate term, and ultimately addressing SDOH at the community and state levels.

The first step in addressing social needs is to identify them. Screening is a common approach used to identify social needs. Community organizations and social service agencies have long been screening for social needs in order to provide social services. Social needs screening in health care settings is a relatively newer and growing practice. In Oregon, a variety of health care settings, including behavioral health, primary care, hospitals and local health agencies, screen patients and families for social needs. Most of these settings use their own screening tools, as the development of multi-domain social needs screening tools for health care is a relatively new phenomenon and widely used standardized tools do not yet exist. Many tools used in health care settings have been created in the last five years.

A handful of states, including Massachusetts, Rhode Island and North Carolina, have started working toward providing financial incentives to "accountable-care-like" organizations (entities playing roles similar to CCOs in those states) for screening Medicaid members for social needs. These states have engaged in public processes to determine whether to require specific screening tools, domains, questions and screening data collection modalities.

Oregon has explored financial incentives for screening for several years. Oregon's CCO quality incentive program enables CCOs to earn funds from a quality pool by improving health and care on a set of quality metrics. In 2015 Oregon metrics

Definitions
(OAR 410-141-3735)

Social determinants of health
The social, economic and environmental conditions in which people are born, grow, work, live and age, and are shaped by the social determinants of equity. These conditions significantly impact length and quality of life and contribute to health inequities.

Social determinants of equity
Systemic or structural factors that shape the distribution of the social determinants of health in communities. Examples include the distribution of money, power and resources at local, national and global levels, institutional bias, discrimination, racism and other factors.

Health-related social needs
An individual's social and economic barriers to health, such as housing instability or food insecurity.

stakeholders started exploring the possibility of an SDOH-focused incentive measure by developing a clinic-level food insecurity screening measure, which was considered but not adopted by the MSC. This measure was available for use in CCOs' performance improvement projects (PIPs). The MSC chose not to include this measure in the CCO quality incentive program because of difficulties in reliably aggregating the clinic-level data to the CCO level. However, MSC remained interested in further developing the measure and using the incentive program to address social needs and SDOH.

In 2018 the Oregon Health Policy Board identified recommendations for CCO 2.0, which per direction from the Governor included a specific focus on addressing SDOH and health equity. In this same year, with support from community-based organizations including the Oregon Food Bank and the Oregon Primary Care Association (OPCA), the measurement governing bodies — MSC and the Health Plan Quality Metrics Committee (HPQMC) — revisited the idea of a broader, plan-level SDOH measure that should include, but not be limited to, food insecurity. The MSC requested that OHA develop a measure concept that includes social needs screening completion and reporting of data, and possibly referral data as well. It also requested that the measure align with other states exploring SDOH related measurement, and existing local efforts. This direction was reinforced by a [2019 letter from Governor Brown,](#) which called for the CCO quality incentive program to include transformational measures aligned with CCO 2.0 goals.

Oregon's efforts to develop a social needs screening incentive measure

In response to these requests and priorities, OHA started the process of developing a broader social needs screening measure concept in 2019 and convened a public work group in 2020. This report provides a summary of the measure development process and final measure concept that was recommended. As described below, OHA staff and consultants engaged stakeholders in intensive information gathering to prepare for the public work group, which met from October to December 2020. The measure concept put forward by the work group for MSC consideration (described in detail below) would require all CCO members to be screened for a select group of social needs. CCOs would be responsible for ensuring that screening is done, yet the screening could be conducted by any partners in any setting, including clinics and community organizations.

As shown in the timeline below, the measure concept development described in this report is just the beginning of a multi-year process. If this measure concept is approved by the MSC, ample time will be needed for the next stage of developing technical specifications and pilot testing, which will begin in 2021. The earliest date this measure could be included in the CCO quality incentive program would be 2023 (see Figure 1 below).

Figure 1. Measure development timeline
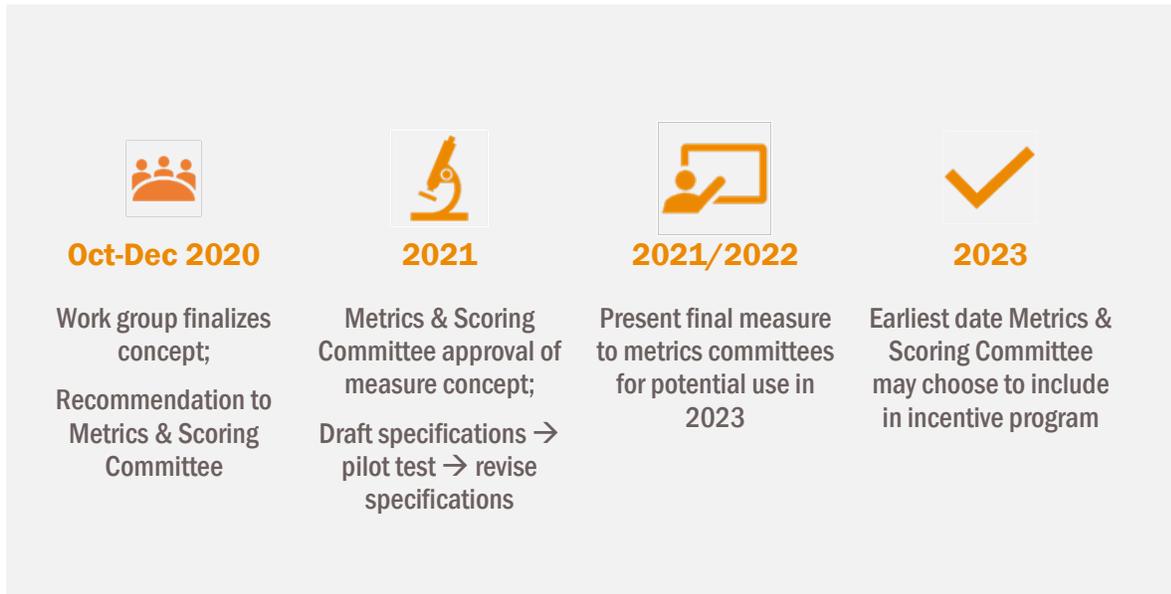
Oct-Dec 2020	2021	2021/2022	2023
Work group finalizes concept; Recommendation to Metrics & Scoring Committee	Metrics & Scoring Committee approval of measure concept; Draft specifications → pilot test → revise specifications	Present final measure to metrics committees for potential use in 2023	Earliest date Metrics & Scoring Committee may choose to include in incentive program

In putting forward this measure for consideration, OHA and partners recognize that social needs screening in itself is not the end goal. However, this measure provides the opportunity to build toward a broader vision of tracking CCO member referrals, ensuring the provision of services, and making improvements to underlying conditions across communities (see Figure 2 below). In the process of developing this measure concept, OHA has engaged dozens of stakeholders to learn about the current state of social needs screening, the barriers and challenges to implementing universal screening, and the shared vision of partners across the state. The lessons learned through this process are valuable regardless of whether the social needs screening measure concept is adopted as a part of the CCO quality incentive program, as they can inform social needs screening efforts across Oregon.

In addition to high-level alignment with OHA's CCO 2.0 goals, the work done to develop this measure aligns with other work occurring within OHA and beyond. Oregon's new State Health Improvement Plan, Healthier Together Oregon, includes several strategies to address SDOH such as housing, food, transportation and wages. Additionally, OHA recently adopted a 10-year goal to eliminate health inequities. If implemented in an equitable and trauma-informed way, screening for social needs can be one step to improve health equity.

Figure 2. Vision of where a measure could take us

Scope of current measure

Screening and/or referral process measures: screen & report, referral provided

Screening/ referral outcome measures: track closed loop referrals, services received

Social needs outcome measures: track needs met, health outcomes

SDOH process and outcome measures: track activities to improve SDOH, improvements to SDOH (e.g. housing stability) on a community scale
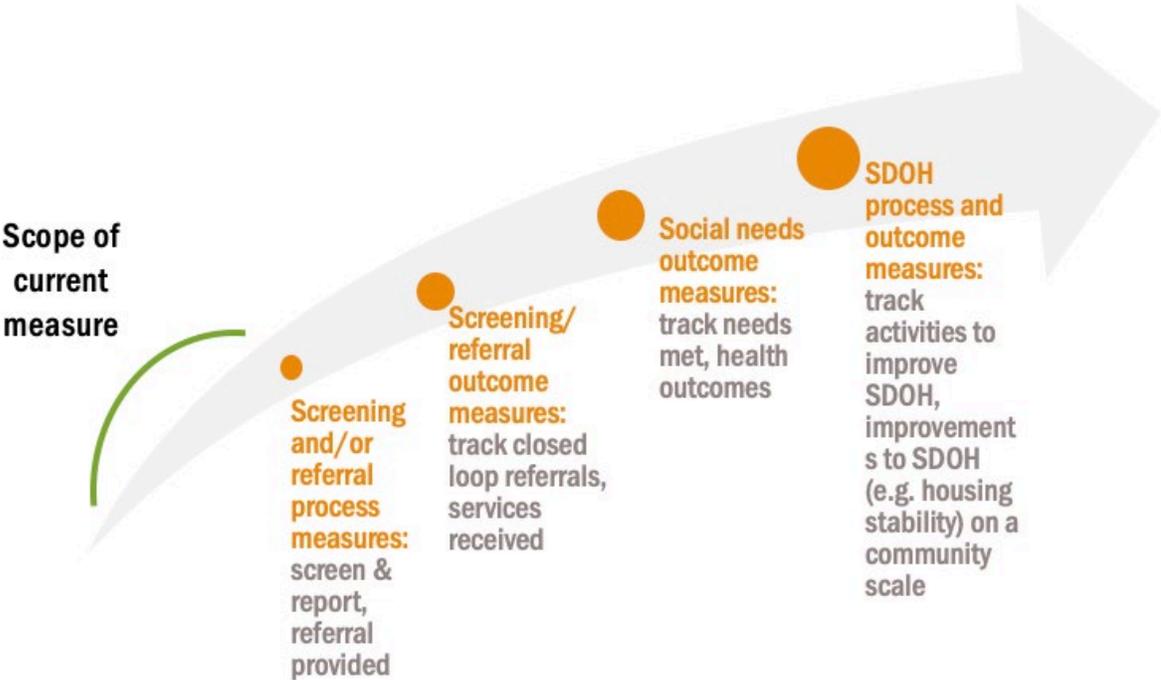
Measure concept development process

Measure development timeline

Figure 3 below provides a high-level view of the robust measure concept development process.

Figure 3. Measure development timeline
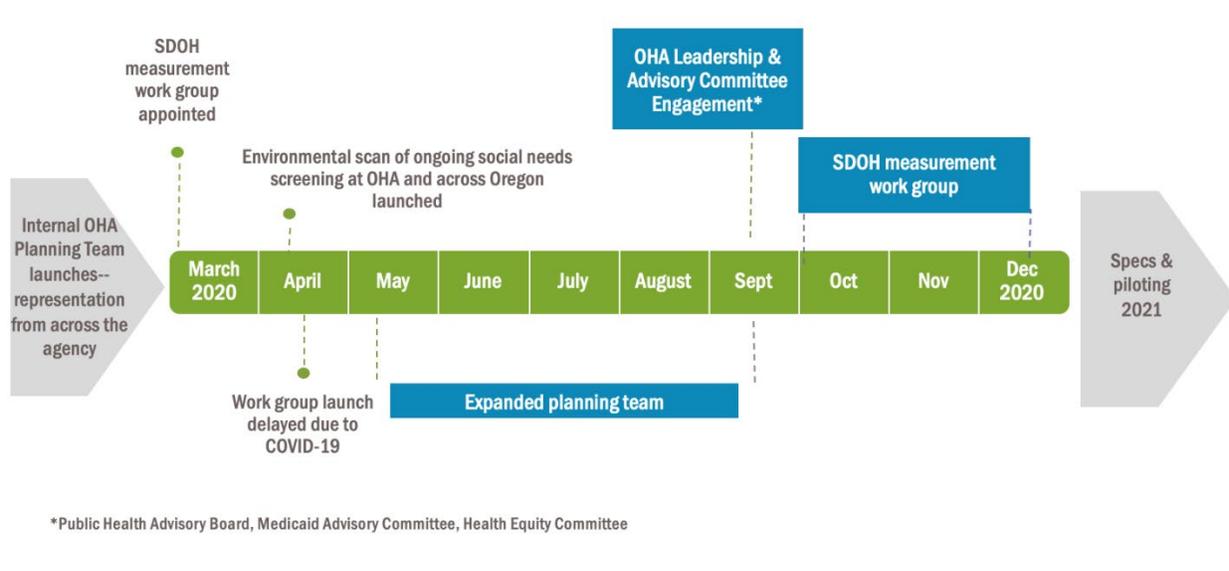
Social needs screening is currently underway in communities across Oregon, and in many cases systems and practices have been well established for years. To support the public work group process described below, OHA used several strategies to consult dozens of experienced stakeholders, including interviews, surveys, presentations and stakeholder meetings. A summary of the various efforts to support the work group process is presented in Table 1, and explained in further detail below.

Table 1. Stakeholder engagement for the social needs screening measure

Effort	Purpose	Participants	Timeline
SDOH Measurement work group	Identify and recommend social needs screening measure concept to MSC and HPQMC	Invited stakeholder applicants with expertise from health and social service sectors	Appointed in March 2020; convened October–December 2020
Environmental scan	Collect information about ongoing social needs screening efforts in Oregon	Consultants Nancy Goff and ORPRN; key stakeholder interviewees; CCOs; Health Share of Oregon CCO health system partners	March–April 2020
OHA social needs screening coordination meetings	Advise social needs screening measure development and share social needs screening practices and approaches	Relevant OHA program staff	May–June 2020
Expanded planning team	Develop 3-5 social needs screening measure concepts for the work group's consideration	OHA; Oregon Department of Human Services; National Committee for Quality Assurance; Bailit Health; HIT Commons; OCHIN; other technical experts	May–September 2020
OHA leadership, advisory committees, and CCO community advisory councils	Advise on high-level measure concepts	Several groups were engaged for feedback, including the Medicaid Advisory Committee, Public Health Advisory Board and the Health Equity Committee	September–October 2020

Project launch and work group appointed

OHA started the social needs screening measure development process in early 2020 (see full timeline above in Figure 3), with the goal of convening a public work group to identify a measure concept that incentivizes social needs screening to recommend to the MSC by December 2020. OHA partnered with consultants NGA to manage the project and facilitate work group meetings, and ORPRN to provide technical expertise related to social needs screening. ORPRN was able to draw from experience it has garnered from its Centers for Medicare and Medicaid Services grant to lead the implementation of the Accountable Health Communities project, a national social needs screening model.

OHA invited sixteen work group members from a pool of applicants that applied through an open recruitment process. Members represented a broad range of organizations, experiences and perspectives, including lived and/or professional experience related to SDOH and social needs screening, measurement or data, racial/ethnic diversity and geographic diversity. Members represented social service and community-based organizations, CCOs, large health systems, clinical providers (including traditional health workers), measurement and data experts, public health, tribes and long-term services and supports. See Appendix A for the full list of work group members.

Project delay and expanded planning team

Shortly after OHA appointed the work group members in March 2020, COVID-19 began spreading in Oregon. Because many of the work group members and OHA were leading statewide and regional pandemic response efforts, OHA leadership decided to delay the work group process for six months. To maintain momentum and progress on measure development, OHA convened an advisory committee composed of staff and national and state experts (expanded planning team) to review ongoing partner efforts, state and national trends, evidence, and promising practices in social needs screening, and to develop 3–5 measure concepts for work group consideration. The team met five times between May and September 2020, and the outcomes of their process are shared later in the report. See Appendix B for the full list of expanded planning team members.

Environmental scan and background research

ORPRN and NGA prepared two key resources to assist the work group in their measure development process: 1) a compendium of relevant peer-reviewed research on social needs screening topics, and 2) an environmental scan of social needs screening efforts in Oregon. The environmental scan included interviews with 14 representatives from OHA, other governmental agencies and community partners; and a survey of 13 of 15 CCOs and four major Health Share of Oregon CCO health system partners. Through the interviews and surveys, ORPRN collected information about current social needs screening practices, referrals, service provision and equity and trauma-informed practices.

The environmental scan found that many social needs screening efforts are planned and underway at CCOs, health systems, state programs, individual clinics and community organizations. It also found that multiple screening questions and tools are used, and despite some alignment in the screening domains (for example, food and housing), the questions asked vary across different efforts. Further, while there is growing interest in a more standardized, coordinated statewide system for screening and data collection, there is uncertainty about the rapidly evolving landscape and how the activities of various partners will align. Many are optimistic about the potential of health information technology to facilitate increased social needs screening and data sharing in electronic health records (EHRs) and community information exchanges (CIEs). The full findings of the environmental scan and background research are included in Appendix C of this report.

OHA social needs screening coordination and committee input

In addition to the external committees and consultant efforts described above, relevant OHA program staff, leadership and committees were invited to provide input into measure concept development. In May and June 2020, OHA convened two social needs screening coordination meetings with OHA program staff from a variety of programs across the agency (including behavioral health, public health, equity and inclusion) to provide their perspectives and experiences of social needs screening.

OHA staff also shared measure concept principles and progress with several OHA leadership and advisory committees (Medicaid Advisory Committee, Public Health Advisory Board, Health Equity Committee) and CCO community advisory council coordinators for high-level feedback and

guidance on the concepts under consideration. The committees' feedback is summarized in Appendix D, but all committees generally agreed on the following approach to social needs screening:

- Center racial equity in the measure and approach
- Ensure a patient-centered approach
- Address concerns about screening without follow-up
- Ensure data sharing across organizations, which will be crucial to success
- Avoid overburdening providers and members
- Ensure some structure *and* some flexibility in the measurement approach

Social Needs Screening Measures

Guiding principles for measure concept development

Early in the measure development process, a set of guiding principles for the social needs screening measure was created to ensure various committee members were aligned around the vision for the measure. The guiding principles aimed to first and foremost center *equity* in the measure concept. They also ensure the measure *aligns* with the broader vision of OHA and the existing efforts of partners and is *feasible* to implement. The full list of guiding principles is included in Box 1 below. In developing the principles, the work group and expanded planning team considered the metrics committees' (MSC and HPQMC) criteria for developing metrics to ensure this group was in alignment.

Box 1. Guiding principles for measure concepts

EQUITY
- ✓ Centers equity and trauma-informed practice
- ✓ Remains focused on the ultimate outcome of improved health and well-being for all Oregonians
- ✓ Acknowledges limitations and potential harms (especially to patients/members) that could result from our work

ALIGNMENT
- ✓ Aligns with broader agency SDOH goals (and Medicaid 1115 demonstration waiver)
- ✓ Is driven by a shared definition of and framework for addressing SDOH
- ✓ Lays the foundation to spur meaningful and sustainable action to address social needs into the future
- ✓ Builds collective action toward shared goals and standardization in priority/approach
- ✓ Considers alignment with OHA's (and partners') other current social needs screening practices

FEASIBILITY
- ✓ Is feasible, especially for the health system to report or collect data on

To center *equity* in the measure development process, ORPRN and the OPCA compiled and shared with the work group background research on equitable and trauma-informed best practices. The OHA health equity definition (see Box 2 below) was shared and referenced at several points in the process, and an "equity checklist" that integrated the various best practices was developed for the expanded planning team and the work group to quickly reference during meetings (see Appendix E

for full equity checklist). The stakeholder engagement described above, including the environmental scan, was conducted to gather information about the practices of partners and ensure *alignment* of efforts. Finally, to examine the *feasibility* of measure concepts, OHA metrics staff and technical experts were included in the process.

Box 2. 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, 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 redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

– Oregon Health Policy Board & Oregon Health Authority

Design decisions

The development of a social needs screening measure involves a number of design decisions, including who will be screened and where the screening will take place. These decisions are complex and interrelated and cannot be made in a linear way. Through a technical assistance opportunity from the Robert Wood Johnson Foundation and Princeton's State Health and Value Strategies program, OHA and the expanded planning team received support from Bailit Health, a national firm that has provided consultation to other states on social needs screening incentive measures. Bailit Health provided technical assistance related to the key design decisions that other states considered, and made recommendations about the best options for Oregon's measure. The work group made design decisions by weighing extensive background information (peer reviewed research, equity and trauma-informed practices, information from other states) against the work group's guiding principles of equity, alignment and feasibility. A summary of the key design decisions and the recommendations of the expanded planning team is presented in Table 2 below.

Table 2. Summary of measure concept design recommendations from the expanded planning team

Design decision	Recommendation
Domains – Which social needs will members be asked about? Should these domains be standardized across the state?	Standardize screening for the greatest social needs statewide (food and housing), and allow flexibility for CCOs to screen for additional domains that align with local priorities.
Screening tools – Should OHA specify a standard screening tool to be used statewide, allow flexibility in tools, or only track screening completion (and not social needs)?	To acknowledge and accommodate variability and strive for future alignment, OHA should approve a menu of screening tools. This would allow partners to continue screening with current tools in use and allow for some tracking of social needs statewide.*
Individual versus household screening – Should individuals or households be screened?	From an equity and feasibility perspective, screening should occur at the individual level.
Responsibility – Who should be responsible for conducting the screening?	Since the goal is to create a CCO incentive measure, the CCO will be responsible for ensuring screening is completed; however, CCOs can delegate screening to partners.
Screening setting – Should the screen be conducted in a clinical setting, a non-clinical setting, or both?	The option for screening to be conducted in non-clinical settings (possibly in addition to clinical settings) should be included so that screening conducted at community organizations can be counted.
Population eligible for screening – Should all CCO members be screened, or just a subgroup of high-risk members?	All CCO members should be screened, since this promotes equity.
Documentation and data collection – Where should data be collected and stored: in EHRs (for example, LOINC and SNOMED codes), in claims-based systems (for example, z-codes), in CIEs, or another method?	Allow for flexibility in data collection and documentation requirements, which will be in large part determined by who is accountable for the screening, the screening setting, and how the information will be shared across entities.

Due to limited time with the work group, OHA convened a subcommittee of work group members to approve a menu of screening tools and questions. The subcommittee recommendations are presented in Appendix I.

Measure concepts considered

After the in-depth consideration of the design decisions above, the expanded planning team proposed at least ten measure concepts and weighed each of those concepts against the guiding principles — equity, alignment and feasibility — to narrow the list to four concepts to propose to the work group (see Appendix F for excluded measure concepts and rationale). The final list of four measure concepts differed in the population screened (full population, children only, or primary care patients) and the data source (all sources, z-codes, or EHR). Table 3 below provides a summary of the final four measure concepts presented to the work group, and full descriptions are included in Appendix G.

Table 3. Measure concepts considered by the work group

Measure concepts	1. *Rate of social needs screening in the total member population – any data source * this is the measure being proposed	2. Rate of social needs screening in children 0–21 – any data source	3. Rate of social needs screening in the total member population – z-codes	4. Rate of social needs screening for members with a primary care visit – EHR
Denominator	Total CCO membership	CCO members ages 0–21	Total CCO membership	CCO members with a primary care visit
Numerator	CCO members screened	CCO members ages 0–21 screened	CCO members screened	CCO members screened

Work group measure concept selection process

The work group held four meetings via videoconference between October and December 2020, with the goal of identifying a measure concept to recommend to the MSC by February 2021. With MSC's approval, the measure concept can be turned into detailed measure specifications that are pilot tested, so that HPQMC and MSC can consider the measure for inclusion in the CCO quality incentive program. During the four meetings, work group members reviewed the group charter, guiding principles, background research and environmental scan. They also heard a presentation from Bailit Health on the experiences of other states in incentivizing social needs screening, and a presentation from OHA staff on the CCO quality incentive program. All four work group meetings were public meetings, so members of the public were invited to attend and provide testimony. Ample time was given at each of the meetings for small and large group discussion of the proposed measure concepts.

Since the four measure concepts from the expanded planning team were presented to the work group at the first meeting in October, work group members had approximately two months to review and evaluate the concepts, and in some cases, members solicited feedback from their key partners and stakeholders. Members were invited to suggest alternative measure concepts for consideration, but they focused their attention on the draft measure concepts prepared by the expanded planning team. After the third meeting, work group members participated in a survey to individually evaluate the measure concepts against the guiding principles of equity, alignment and feasibility, rating concepts on a scale of 1 to 5 (1 was no alignment and 5 was perfect alignment). The results of that evaluation (Chart 1 below) were shared with the work group for discussion before the formal vote occurred at the final meeting. The work group confirmed that the relatively neutral scores across all four measure concepts were reflective of there being "no perfect measure" and careful consideration to the realities of the measures, and not a reflection of neutrality about moving forward.

Chart 1. Evaluation of measure concepts on guiding principles

	Measure 1 All CCO members, any data source	**Measure 2** All children CCO members, any data source	**Measure 3** All CCO members, Z-codes	**Measure 3** All CCO members with a primary care visit, EHR
Overall	3.4	2.8	2.9	3.2
Feasability	3.3	3.3	2.7	3.2
Alignment	3.6	2.8	3.3	3.3
Equity	3.3	2.2	2.9	3.0

While the specific domains to be required for screening was not discussed at length in the work group, members' feedback about priority domains was gathered in the survey. The priority domains identified by the work group (food insecurity, housing insecurity and transportation) matched those identified by OHA as the greatest needs statewide, as well as those identified by the expanded planning team for inclusion in the draft measure concepts.

Chart 2: Prioritization of screening domains
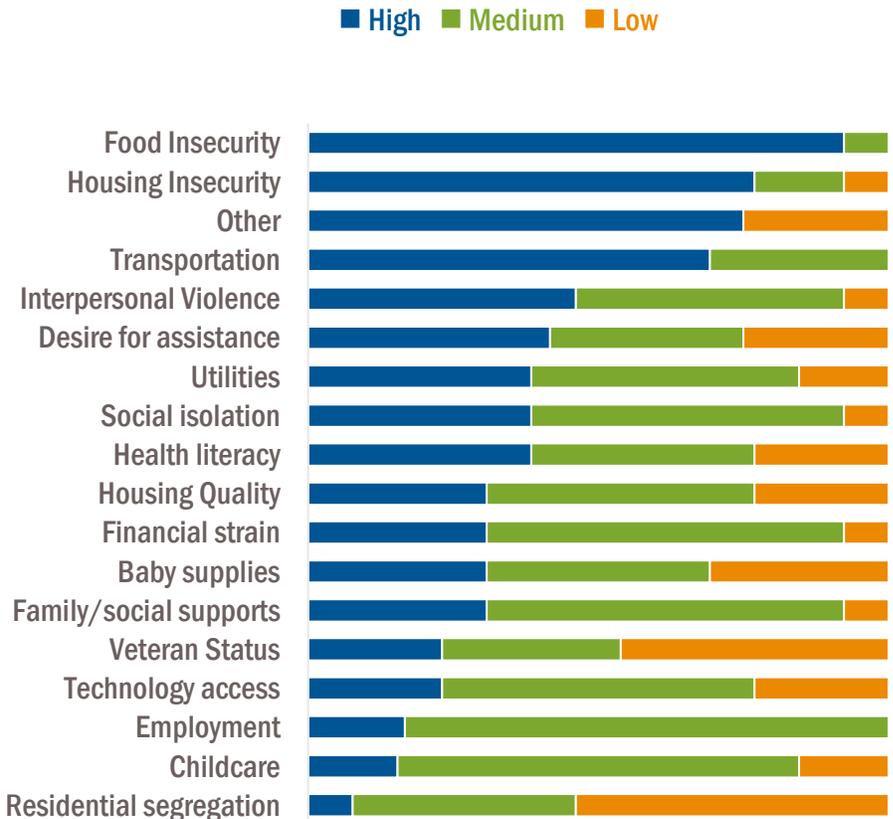
■ High ■ Medium ■ Low

Food Insecurity
Housing Insecurity
Other
Transportation
Interpersonal Violence
Desire for assistance
Utilities
Social isolation
Health literacy
Housing Quality
Financial strain
Baby supplies
Family/social supports
Veteran Status
Technology access
Employment
Childcare
Residential segregation

Measure concept selected for recommendation to Metrics & Scoring Committee

After thorough consideration of the benefits and drawbacks of all measures (described in detail below), the work group selected Measure Concept 1 (*Rate of social needs screening in the total member population using any qualifying data source*) for recommendation to the MSC, with nine of 13 present work group members voting for this option. For more information about the rationale behind the exclusion of the other three measure concepts, see Appendix H.

Work group members stated this concept would incentivize screening of all CCO members, which would promote equity and ensure that no members with social needs are missed. CCOs could report whether members have been screened in multiple settings and via multiple data collection strategies (some possible data sources are shared in Table 4 below), allowing for flexibility and alignment with current systems and practices at the local level (including current screening at community organizations). In the initial stage of the measure implementation, CCOs would submit a plan to identify their approach, including the codes they would use and how they would collect the data. Significant efforts by CCOs and partners would be necessary to ensure coordination to share data, minimize rescreening and ensure availability of screening outcomes at the point of care. This challenge may be addressed in the future by CIE or other systems that support cross-sector data sharing, but these systems are still nascent.

Table 4. Possible data sources for proposed measure concept

Clinics	CCOs	Community-based organizations
SNOMED (clinical coding system) LOINC (clinical coding system) ICD 10 diagnosis code (Z codes)	ICD 10 diagnosis code (Z codes) (for example, if nurse care manager screens) "Other" (specify) in template (for example, data in case management system)	Other codes (non-medical) based on CIE data dictionary/ other standardization efforts

To fully implement the proposed measure concept, a multi-year glide path is proposed (see full description in Appendix G). In the first few years, CCOs would be required to implement the structural measures, which include assessing current systems and practices, planning for data collection and sharing, and aligning with current efforts and community partners. CCOs would be required to report screening data on a sample to OHA starting in the second year of implementation (although all members would be screened, the CCOs would just report on an OHA-determined sample). The sampling period would last three years, and reporting on the full population would start in the fifth year of implementation. This would allow time to identify workable solutions for some of the feasibility challenges with implementation and potential to leverage emerging health information technology approaches.

The work group members noted that, while the proposed measure concept has the most unknowns, it also has the most potential to be transformative and move the Medicaid system toward its desired future state: screening that leads to receipt of needed services, and partnerships across organizations and sectors to share information and support members. The work group noted that while there is no perfect measure, the benefits of moving forward on building a statewide system of screening for social needs would be more beneficial to health and equity than not moving a measure concept forward. In fact, members expressed concern that further delaying inclusion of a social needs screening measure could have detrimental impacts to CCO members, especially given the impact of COVID-19. Some work group members had already been working on advancing related measures like food insecurity for many years.

"Making this as broad as possible has more challenges on the feasibility side, but more potential to make this as transformative as possible." – Work group member

The work group was opposed to any measure that did not include the full CCO population due to equity concerns of not reaching all CCO members. Measure Concept 2, which limited screening to children, was ruled out almost immediately, and Measure Concept 4, which limited screening to those seen in the primary care setting, was mostly of interest only as a first step toward screening the full population. For Measure Concept 3, which relied on z-codes for data, the work group identified numerous barriers, including the increased burden on providers to implement the new systems, inadequacy of current z-codes, lack of alignment with trauma-informed practices, safety

concerns for members and the limits on providers who can code. Ultimately, the proposed Measure Concept was chosen because it was the only measure that included the full CCO population and allowed for screening in any setting (CCOs, clinics and community organizations). This was of high importance to work group members because it was inclusive of community organizations that are currently conducting the majority of screening in communities.

Work group recommendations for measure implementation

The work group noted that the way the proposed measure concept is implemented will be crucial to its success. Implementation should be done in partnership with CCOs and their screening partners to design a community-wide system for sharing data, avoid rescreening, strengthen partnerships, utilize technology solutions to their fullest potential and maximize efficiency. If the implementation process is not well designed and executed, the measure will ultimately be another burdensome requirement not tied to the long-term goal of why we are doing this —to address the social needs of members.

The work group quickly identified several components of the measure that would be crucial to success but were out of scope for this phase of the development process, and could possibly be addressed in the future stages: technical specifications, pilot testing and CCO implementation. For example, members noted that screening without ensuring a referral or provision of services is not an equitable approach. However, tracking referrals and provision of services across the Medicaid system and their community partners is not possible at this time (although it is part of OHA's vision of where this measure could lead in the future). Similarly, the work group noted the success of any measure in addressing social needs would depend on the screening results being available at the point of care for all members, which would require frequent, comprehensive, bi-directional data sharing between a CCO and their contracted partners. Table 5 summarizes some of the components addressed through this measure development process (left column) and some of the important considerations that may be addressed later in the process (right column). Work group recommendations for how to best implement this measure concept while centering equity and aligning with current statewide efforts are presented in the next section.

Table 5. Scope of measure concept development and implementation processes

Measure concept development process	Measure concept implementation process (possibly addressed through technical specifications or CCO plans)
• Numerator • Denominator • Acceptable data sources • Additional time built into the glide path so CCOs can build foundational systems • Domains* • Tools/questions* • Setting (clinical or not) • Structural measures (for example, CCO equity and trauma-informed screening plan; environmental scan)	• Sampling methodology guidelines** • Data collection and submission guidelines** • Frequency of screening** • Ensuring equity, trauma, patient-centered implementation**,*** • Data sharing workflows and agreements between CCOs and their contracted partners*** • Plan for who does the screening (settings and people)*** • Aligning with community resources available***

Due to limited time with the work group, OHA convened a subcommittee of work group members to approve a menu of screening tools and questions. The subcommittee recommendations are presented in Appendix I.
**To be addressed in technical specifications process, estimated to take place in 2021, and updated periodically*
***Could be addressed in CCO plans*

Measure concept strengths, limitations and recommendations

The work group's full analysis and recommendations regarding the proposed measure concept, including strengths followed by limitations listed with accompanying recommendations for mitigation are presented below.

Strengths of proposed measure concept

The measure is the most inclusive as it casts the widest net.

The proposed measure concept is the most inclusive of all organizations and settings currently involved in screening, as it counts screenings conducted by community partners. This enables screening at meaningful points of opportunity, including at member enrollment. Collecting from the broadest number of organizations for the broadest number of CCO members is most equitable. Including community organizations also means the screening could be conducted in settings closer to the delivery of services. Since this measure is the most challenging to implement, keeping intact existing relationships at the community level for addressing social needs (between a CCO and its partners) will be crucial for building toward our desired future system. Work group members participating in the Accountable Health Communities pilot noted that implementing social needs screening has resulted in an increase in formalized partnerships (for example, contracts) between health care and community partners.

The measure is inclusive of the other measure concept options.

Collecting data through any data source means data from EHRs or z-codes are allowable. A CCO would have the flexibility to work with their partners to define the data sources that make the most sense for their community.

The measure has the potential to transform the system.

Unlike other incentive measures that are based in primary care, this measure concept has the potential to catalyze cross-sector partnerships and data sharing systems because the measure would (a) support a path toward developing a new system of data collection across sectors and (b) incentivize cross-sector systems change, not just change in primary care practices. This is more aligned with the desired future state that OHA and partners are working toward.

The measure provides the opportunity to collect both patient-level and population-level data that can inform the health system about broad population needs for services and solutions.

The work group recognizes the importance of both meeting members' social needs and tracking social needs trends statewide. Statewide aggregation of social needs data through this measure could help assess needs and guide community or statewide policy and funding decisions that could ultimately improve the underlying causes of social needs and build a system of supports for the whole population (beyond CCO members). This measure would allow for standardization of data statewide, as well as standardization within specific data sources (like EHRs).

The measure is flexible enough to change and grow as new efforts emerge.

Health-related social needs efforts have been developing at a fast pace in Oregon and nationally in the last few years, and many efforts are still in their infancy. Many EHRs are developing social needs screening options, and CIE initiatives offer the promise of increasing social needs information sharing between organizations, though CIE systems are nascent. The OPCA is currently testing the feasibility of using z-codes in some clinics, and the results of the CMS Accountable Health Communities study are just starting to emerge. Over the next few years, the results of these efforts will start to solidify, yet at this time it is too early to know how to best align with them. Choosing a measure concept with the flexibility to include any data source and any setting will allow for changes to align with these emerging efforts in the future.

Limitations and mitigation recommendations for proposed measure concept

Limitation
Providing screening without referrals to services	The biggest concern about the proposed measure concept (and all the draft measure concepts) is that members would be screened for data collection purposes, and those who screened positive for a social need would not be offered a referral to services. While this is a limitation of all the screening measures, this of great concern in the implementation of a screening measure.

Mitigation recommendation
Identify a process up front for offering referrals to services (Rec. #1)	At the present time, this measure will collect screening data only, but the long-term vision of tracking referrals and provision of services should be kept central to this work. Even if CCOs are not required to report on referrals, they should develop plans with local partners to ensure follow up on positive screens. Screening for the purpose of collecting screening data without offering referrals is not equitable or trauma-informed and will not lead toward the desired future state.

Limitation
Increasing the demand for services without increasing the supply	In the case that referrals are indeed offered to members with positive screens, the burden of providing services would fall on community organizations that would not necessarily be able to increase the amount of services they provide to meet the demand without additional resources. Community organizations are already overburdened, even without all members are currently being screened.

Mitigation recommendations
Invest time up front to align systems and resources in communities. (Rec. #2)	The work group views this measure as a catalyst for aligning the systems, practices and resources across organizations and sectors in communities in advance of the screening implementation. CCOs should assess their current systems, build relationships and define infrastructure needs prior to implementation of the screening measure in partnership with their local clinics and community organizations. The piloting phase of this measure can be used to test that model and identify opportunities and barriers, especially in diverse settings like both urban and rural communities. Rushing into the measure without aligning current efforts would create confusion and duplication of efforts, and risk further overburdening community organizations.
Data should be standardized so statewide information about social needs is available (Rec. #3)	Data should be standardized so statewide information about social needs is available. The work group recognizes the importance of having statewide data available so Oregon can track social needs over time (in addition to tracking needs for individual members), which could help identify and address resource needs across the state.

Limitation	
Rescreening and possibly retraumatization if screening is not coordinated.	Since the proposed measure concept allows for screening in any setting and data to be collected from any source, there is no guarantee that data will be shared among organizations so it's available at various points of care for a member. If data is not shared and available, members could be rescreened and retraumatized, which is highly undesirable from an equity and trauma-informed perspective. Beyond rescreening, if data is not available at the point of care, it will not be integrated into patient-centered care plans, and opportunities to provide services could be missed.
Mitigation recommendations	
Screening data should be made available at the point of care for all members. (Rec. #4)	Regardless of where the screening takes place, a data-sharing system must be set up to enable data to flow bi-directionally between all organizations conducting screening within a community, including the CCO. CCOs should be required to create a plan for building this system as part of the structural measures in the first few years of the glide path. OHA should consider providing support to CCOs to build these data-sharing infrastructures. As CIEs are implemented across Oregon's regions, CCOs could explore them as a potential solution for this data sharing issue, though CIEs are in the very early stages of implementation at this time.
Leverage this measure to accelerate progress toward addressing social needs through emerging technology solutions (Rec. #5)	Leverage this measure to use every opportunity possible to accelerate progress toward addressing social needs through emerging technology solutions in the future, like CIE. Implementing technology solutions offers great promise toward helping to streamline the complexity of cross-sector data sharing.

Limitation	
Increased administrative burden for OHA, CCOs and possibly other partners.	Collecting data from multiple sources will place a higher reporting burden on CCOs, and collecting data from multiple sources as well as all CCOs will place a higher administrative burden on OHA. Depending on the screening tools and questions selected, standardizing the data so it can be aggregated at the state level may place a higher burden on all screening entities.
Mitigation recommendations	
At first, limit the number of screening domains to the highest statewide priorities (Rec. #6)	Limiting screening to a handful of high-priority domains, including food and housing, will allow partners to get systems in place to standardize and aggregate data, at the same time allowing communities to prepare for increased demand for those services.
Consider the magnitude of this measure within the context of the whole measure set. (Rec. #7)	While this measure has the potential to be transformative and positively impact other health measures, the implementation will be a heavy lift for CCOs and should not be considered equal in effort to implementing nationally standardized, primary care-based measures.

Create a menu of screening tools that is inclusive of tools currently in use (Rec. #8)	By approving a limited menu of tools, OHA will be better able to standardize and aggregate the data. Organizations already using screening tools would also have the opportunity to continue using those tools.
Crosswalk the measure requirements with other related CCO requirements (Rec. #9)	Crosswalking the measure requirements with other related CCO requirements like health-related services, health equity, care coordination and case management. Align with statewide efforts to collect race, ethnicity, language and disability data (REALD) so social needs information can be stratified at the state and local level. Look for opportunities for alignment to improve coordination and efficiency and reduce duplication and administrative burden.
Further define measure components in the technical specifications and structural measures, where possible (Rec. #10)	Since implementation will be key to making this measure concept work well, look for ways to integrate the following into the measure specifications as they develop: • Standardization of screening tools and questions; • Detailed requirements for the data sharing and positive screen follow-up plans that are part of the structural measure; • Define equitable and trauma-informed screening practices and require a plan for addressing them (for example, staff training, language access, person-centered screening, increasing trust between the screener and the member, use preferred screening methods like paper); and • Define minimum specifications for each data set that counts for the measure. This will help large health systems that work with several CCOs to standardize practices.

Looking beyond a social needs screening measure

While work group members were enthusiastic about the potential for a social needs screening measure to transform the health system, they also offered suggestions for other ways to advance social needs screening should the measure concept not be selected for the CCO quality incentive program. These suggestions were made within the context of multiple emerging, complementary efforts to identify and address social needs.

- Consider collecting social needs data at Oregon Health Plan enrollment/intake
- Utilize emerging tech platforms, even in the absence of a measure (for example, CIEs, other tools)
- Consider CCO performance improvement projects related to social needs or social determinants of health
- Build from the lessons learned in the Accountable Health Communities pilot
- Leverage existing related CCO requirements to move this work forward (for example, community health improvement plans, health risk screenings)
- Design a method of testing innovative multisector approaches to health that go beyond innovations in the delivery system
- Explore the feasibility of social risk adjustment models for health care payments

Appendix A. SDOH measurement work group members & national advisors

Work group members:

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Appendix C. Environmental scan and background research

Environmental Scan of Social Needs Screening in Oregon

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Overview

Nearly half of the Medicaid population in Oregon has one or more social needs, and communities of color are disproportionately affected.[1] Social determinants of health (SDOH) are factors that affect health risks and outcomes, such as: poverty, poor environment, insufficient infrastructure, and unsafe neighborhoods. Social needs are the downstream effects of social determinants including, for example: sub-standard housing, lack of healthy food, inadequate heat and light, and insufficient transportation.

Screening is a common approach used to identify social needs. Screening tools vary in length, content and method of delivery. The development of multi-domain social needs screening tools for health care is a relatively new phenomenon. In fact, a 2019 study uncovered only 18 non-proprietary evidence-based social needs screening tools, and over half of these were created in the last five years.[2] In Oregon, there are numerous screening tools employed in a variety of settings, including state programs, Coordinated Care Organizations (CCOs), behavioral health, primary care, hospitals, and community organizations. Many of these are "home-grown" tools that have not been substantially studied.

Recently, several states have implemented requirements and financial incentives for accountable care organizations (e.g. CCOs) to screen for social needs. These states have engaged in public processes to determine whether to require specific screening tools, domains, questions, and screening data collection modalities.

Since efforts to address social determinants of health and social needs in Oregon have evolved rapidly, the Oregon Health Authority (OHA) commissioned an environmental scan to describe the current status of social needs screening for Medicaid members. This document is intended to support the work of the OHA-appointed SDOH Measurement Workgroup which is charged with making recommendations to the State's Metrics and Scoring Committee about a social needs screening measure. If adopted, the measure could potentially be included in the CCO Quality Incentive Program (QIP) which enables CCOs to receive funding from a quality pool if they meet certain targets set by OHA.

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[1] Oregon Accountable Health Communities, May 28, 2020.

[2] Elias, R. R., Jutte, D. P., & Moore, A. (2019). Exploring consensus across sectors for measuring the social determinants of health. SSM - Population Health, 7, 100395.

Environmental Scan Methods

To understand the current landscape of social needs screening in Oregon, the authors of this environmental scan conducted 16 interviews with representatives of government programs, community mental health providers, primary care providers, and community partners known to conduct screening. Additionally, a survey about screening practices was sent to all fifteen CCOs and to Health Share CCO's health system partners. These interviewees and survey participants are listed in Table 1 below. Four of the five health system partners and 13 of the 15 CCOs responded to the survey. Information from the interviews and surveys was collected, transcribed, coded, and analyzed by ORPRN researchers. This document is intended to be a high-level summary of efforts statewide, and does not aim to document in detail all Oregon screening efforts.

Table 1. Environmental Scan Interviewees and Survey Participants

INTERVIEWEES		SURVEY PARTICIPANTS	
Federal, State and Local Government Programs	Community Partners	Coordinated Care Organizations	Health System Health Share Partners
Benton County Health Department	Association of Oregon Community Mental Health Organizations	Advanced Health	Kaiser Permanente NW
Jefferson County Health Department	Oregon Food Bank	Cascade Health Alliance	Legacy Health
Oregon Department of Human Services	Oregon Health Leadership Council/HIT Commons	Columbia Pacific CCO	Oregon Health and Science University
Oregon Health Authority (Maternal and Child Health, Women, Infant and Children Program, Office of Health Information Technology, Addictions and Mental Health)	Oregon Pediatric Improvement Partnership	Eastern Oregon CCO	Providence Health
		Health Share of Oregon	
	Oregon Primary Care Association	InterCommunity Health Network CCO	
Oregon Housing and Community Services	Project Access Now	Jackson Care Connect	
Portland VA Medical Center	Virginia Garcia Memorial Health Center	PacificSource- Central Oregon Region	
		PacificSource- Columbia Gorge Region	
		PacificSource- Lane County	
		PacificSource- Marion/Polk Counties	
		Trillium Community Health Plan	
		Yamhill Community Care	

Key Takeaways

Key takeaways from the interviews and survey conducted for this environmental scan include the following:

- Government programs, community mental health providers, primary care providers, community partners, CCOs, and health care systems have numerous social needs screening efforts in place, yet there is wide variation in screening populations, practices, domains, and data collection.

- CCOs, while far from standardized, seem to be emerging with some systematic approaches, perhaps due to a related contractual requirement to screen new members for health risks, and the desire to use social needs information for care coordination, internal analytics, and to identify needs for Health-Related Services.[3] Health systems are similarly moving toward standardization due in part to their contractual relationships with CCOs, and their own analytics and care coordination efforts.

- While there is a desire expressed by many interviewees for a more standardized, coordinated statewide system for screening and data collection, there is also the need to include questions and approaches that meet the unique needs of communities, including those experiencing health inequities.

- A consistent theme from the interviews and surveys is the importance of keeping health equity central to all design decisions.

Given these findings, the workgroup will need to take into account the effect of its design decisions on the numerous social needs screening efforts underway. It will be challenging to develop a consistent, statewide social needs screening measure for a fragmented system. The balance between standardization and local flexibility will also be an important consideration in the measure development process. These considerations underscore the need to keep the larger vision of addressing social needs central to the conversations, and to carefully consider what will be incentivized, and how, and what the impacts on health equity could be.

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[3] Health-related services 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. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx#:~:text=Health-related%20services%20are%20non-covered%20services%20that%20are%20offered,and%20overall%20member%20and%20community%20health%20and%20well-being.

Related Efforts

The HIT Commons, OHA and the Oregon Pediatric Improvement Partnership (OPIP), the Oregon Primary Care Association (OPCA), and the Patient-Centered Primary Care Home (PCPCH) program are all in the initial stages of social needs screening efforts that could have an impact on, or be synergistic with, the development of a social needs screening measure for CCOs. Additional existing screening and/or referral projects include the Accountable Health Communities (AHC) which screens Medicaid members and connects them to resources, and Project Access Now (PANOW) which coordinates Health-Related Services for Health Share members. Finally, existing community health worker-focused social needs interventions are in existence throughout the State of Oregon. See table 2 below for more information about these efforts.

Table 2. Related Efforts

Project	Description
Oregon Community Information Exchange, or CIE (HIT commons)	Technological support and coordination for referrals and two-way communication between community-based organizations and health care providers to ensure that social needs are communicated and the outcomes of referrals are documented. CIEs typically include screening tools, but screening is not required to make a referral. The most common CIEs in use or being deployed in Oregon include Aunt Bertha and Unite Us.
Integrated Care for Kids (OHA & Oregon Pediatric Improvement Partnership)	Early identification and treatment of children with complex behavioral and physical health needs. Combines social needs with medical data. Uses metrics and alternative payment models.
Pathways Hubs	Model used by multiple community based organizations to provide a framework for community health workers to identify social needs, refer members to services, and document outcomes of referrals.
Patient-Centered Primary Care Home Program (PCPCH)	PCPCH is adding a social needs screening and intervention measure to its alternative payment program beginning in January of 2021. The measure increases in value as clinics go from screening-only to screening, tracking referrals, and providing services at the clinic level.
Project Access Now	Community organization that connects members with social needs resources through a referral hub. Some partnerships with CCOs to administer Health-Related Services.
PRAPARE (Oregon Primary Care Association)	Supports use of the PRAPARE social needs screening tool and alternative payment model among Oregon's 32 community health centers (CHCs). Currently testing the use of z codes for sharing social needs information with CHCs and CCOs.
Accountable Health Communities (ORPRN)	Administered by ORPRN with funding from CMS, connects CCOs, clinics and delivery organizations to support social needs screening, warm handoff to social services, and uses patient navigators for high risk patients.

Social Needs Screening in Oregon

Screening Methodologies

All interviewees indicated that their state- or locally-administered programs collect information on social needs. However, there is considerable variation in domains, questions, and screening workflows (see table 3 below).

Table 3. Screening Domains

Department/Program/ CCO	Screening Domains Used								
	Housing	Food	Income	Transport	Safety	Family size	Education	Utilities	Other
Department of Human Services- Self-Sufficiency Programs (TANF, SNAP, Refugee Programs)	x	x	x	x	x		x	x	x
Oregon Housing & Community Services	x	x			x		x		x
OHA Addictions and Mental Health Division	x		x				x		x
OHA Maternal and Child Health	x	x	x	x	x	x	x		x
OHA Women and Infant Children	x		x			x			
OHA Healthy Babies (Home Visiting)	x	x	x	x	x	x	x	x	x
Community Mental Health Organizations	x	x	x		x		x		x
Portland VA Medical Centers	x								
County Health Departments (Benton, Jefferson)	x	x	x	x	x	x	x	x	
PacificSource CCOs (4)	x	x	x	x	x	*	*	x	x
Eastern Oregon CCO	x	x	x	x	x	*	*	x	x
Yamhill Community Care CCO	x	x	x	x	x	*	*	x	x
InterCommunity Health Network CCO	x	x	x	x	x	*	*	x	x
Jackson Care Connect CCO	x	x	x	x	x	*	*	x	x
Columbia Pacific CCO	x	x	x	x	x	*	*	x	x
Advanced Health CCO	x	x	x	x	x	*	*	x	
OHSU (Health Share CCO)	x	x	x	x	x	*	*	x	x
Kaiser (Health Share CCO)	x	x	x	x	x	*	*	x	x
Legacy (Health Share CCO)	x	x	x	x	x	*	*	x	
Providence (Health Share CCO)	x	x	x	x	x	*	*	x	
Virginia Garcia Memorial Health Centers	x	x	x	x	x	x	x	x	
Oregon Food Bank		x							
Community Health Centers	x	x	x	x	x	x	x	x	x

*domain not included in CCO survey

Interviewees describe challenges maintaining consistency in screening implementation even when using common required tools. Similarly, many community partners share that their clinical partners screen, but that many are not doing so consistently.

Clinic and community partner interviewees discuss the importance of having established, trusting relationships in place between the person doing the screening and the member. This yields better screening outcomes, such as receptivity of the member to answer questions and follow through with services. Screening is also viewed as a starting point for better, more nuanced conversations with members about their needs. While many express a desire to screen all members for social needs, most are currently only able to focus on a subset of members due to limited resources and staff.

Multiple organizations describe their screening workflows as evolving processes, with different arms of the organization testing out different workflows to determine what works best. As such, the screening data available within these organizations often varies greatly.

Most of the 13 CCOs report screening members for social needs, predominantly with high-need and high-risk populations. In fact, twelve of the thirteen CCOs (92%) indicate that they conduct social needs screening at the CCO-level, and 60% report plans to expand this work. Methodology of screening includes: telephone calls (77%), member self-report on paper (62%), and in-person interviews (38%). No CCOs report screening members at the CCO-level through online tools. CCOs embed social needs screening in their intensive care management and care coordination programs (77%), Health-Related Services (69%), Health Risk Screenings (62%), and behavioral health programs (62%). There is strong alignment on the domains of those CCOs that report doing screening (see table 3 above).

CCOs are required to screen members for health risks when they are first attributed to the CCO using Health Risk Screenings, however due to challenges, such as invalid telephone numbers and member refusal, they are not always able to do so. Over half of CCOs indicate that they ask social needs questions as part of their Health Risk Screenings. Finally, over half of CCOs surveyed (62%) are attempting to screen members on an annual basis. CCOs also conduct social needs screening when a member is referred for extra support services, such as Intensive Case Management (ICM) and Care Coordination. One CCO notably reports screening for social needs "every time we talk to a member." Many different staff roles conduct social needs screening on behalf of CCOs, including: community health workers, care coordinators, other care management team members, clinic partners, and the members themselves.

The four Health Share health system partners that responded to the survey (Legacy, Kaiser, OHSU and Providence) all currently screen for social needs in some capacity. They accomplish screening in a variety of settings, including primary care clinics, inpatient and outpatient care management, intensive case management/care coordination programs, and behavioral health services. Many have plans to integrate these screening results into their electronic health record (EHR) platforms. All four health systems surveyed have clinic staff perform screening, and three report having members screen themselves. In general, staff such as care managers, care coordinators, patient navigators and medical assistants are performing the screening at the clinic and health system level. Screening occurs in-person, via phone interview, and member self-report online or on paper.

Summary of tools in use and their domains

At the state level it is common for each department and program to have its own unique individual tool. Common domains cited include: income, housing, food, transportation, education, social support, and safety. Some screening instruments and questions are federally mandated while others are unique to Oregon or particular communities. Several of the interviewees express a desire to have alignment across screening tools so that data could be aggregated in a common data warehouse and shared. Some local health departments and community partners report use of the PRAPARE and AHC tools, and others rely on more ad hoc questioning of social needs during intake procedures or as a client accesses services and resources. Multiple respondents describe a high-level of investment in specific screening tools across different organizations, which may result in difficulties in any future alignment around a uniform screening tool. For example, the Department of Human Services has multiple programs, including: TANF, refugee programs, domestic violence programs, employment-related day care, SNAP, foster care, senior services, and disability services that each have their own separate screening tools. Similarly, Oregon Health Authority's Maternal and Child Health program in the Public Health Division, which houses home visiting and Title V programs, among others, has numerous screening tools associated with its many intervention and surveillance programs.

State behavioral health programs collect information on income, employment, education, and living arrangement. Community mental and behavioral health programs collect social needs data as part of intake assessments the content of which is determined locally.

CCOs show a strong affinity to their own home grown tools, rather than to nationally recognized screening tools, such as PRAPARE or AHC. In fact, 10 of the 13 CCOs surveyed (77%) report using a "home-grown tool." Health systems use a variety of screening tools, mostly a mix of home grown and evidence-supported tools (most commonly AHC and PRAPARE).

Data collection & storage

Interviewees from governmental programs, community mental health, primary care, and community partners describe multiple, disconnected systems to collect and store social needs data. Governmental programs also vary as to how much information is collected by state offices versus the local agencies administering the programs. Federally-mandated programs are the most likely to collect standardized information and store it in a central database. Some state programs are working to upgrade their systems, however, upgraded systems will still vary across agencies and programs.

Lack of uniformity in data storage processes has led to inconsistencies in data quality and availability. With data being collected and stored in so many different systems, generating reports on individual- and/or population-level needs is often difficult. Most interviewees also indicate that pulling individual or population-level reports from the data is either not possible, not permissible, or challenging. An exception to this is data that are required for federal funder reporting.

Data sharing is described as a significant challenge among health care, social service agencies, and state programs. Sharing data with partner organizations or across state agencies is not a common practice described by interviewees due to concerns about privacy and lack of infrastructure within and across sectors. Several respondents express a lack of confidence in the data they are able to produce. In order to better understand the overall burden and the required structural changes that could address communities at large, several of the larger organizations communicate the need for regional data on social needs.

CCOs report that they receive social needs data from a variety of sources, including their contracted providers (69%), and through z codes (38%). They report storing social needs data in their care management platforms (69%) and analytics systems (62%). Few CCOs use z code claims information now, but several CCOs discuss an Oregon Primary Care Association (OPCA) pilot as a way that they will be able to test the use of z codes. The OPCA pilot allows CCOs and contracted clinics to select screening domains and test using z codes to submit claims.

When asked about the most feasible way to collect social needs data for a new metric, CCOs describe numerous methods, including: chart review, community information exchange (CIE) data, Z codes, and a stepwise approach from chart data to a CIE or an HIE.

The health systems surveyed report that they are currently storing social needs data in the electronic health record (EHR), and some also store these data in their analytics systems. They collect data through Z codes and other methodologies, including chart notes and referral hand offs to patient navigators, care coordinators, or case managers. Three of the four health systems said that chart abstraction from a sample of clinical charts would be the most feasible way to collect data (75%) for a new metric. Two indicate that z code/claims data would also be feasible.

Referrals, service provision & partnerships

Most of the government programs, community mental health, primary care, community partners, CCOs and health system representatives interviewed say that they use the social needs information collected to provide members with targeted information and referrals to community resources. Internal directories, pamphlets, the 211info directory, and CIEs are all used to identify resources. Some interviewees emphasize the importance of using existing referral pathways, and local knowledge of services to supplement the directories. CCOs often have established referral pathways, funded by the CCO, for common needs such as housing, food, and transportation. While a few respondents have started using CIEs (e.g. Unite Us and Aunt Bertha), most lack resources and organizational capacity to coordinate with partners, track referrals, and ensure adequate services exist in their referral networks.

One bright spot is the success of the use of referral coordinators to connects members to services and follow up to ensure service provision. Coordinators seem to be a key feature of success in several cross-organizational systems.

One community partner expressed concerns about promises being made around the CIE technology, claiming that these platforms will overburden already taxed community-based organizations without providing the additional support needed to handle these referrals adequately. Several organizations expressed the need for better alignment of available resources across communities through formal partnerships and technological solutions.

Equity & trauma

Government programs, community mental health, primary care, and community partners are concerned with the many possible unintended consequences of screening. Many respondents find it ethically irresponsible to identify a need without being able to directly address it or refer to an agency that might be able to help. Additionally, identifying a need without the ability to intervene may erode member confidence, which is of utmost importance to many providers. Interestingly, when asked if screening may be seen as a necessary step in identifying the need in order to better understand how to allocate resources, multiple respondents reply

that the need is often well known to community partners, there just are not any available resources to address it.

Lack of communication between organizations and agencies creates an additional unintended consequence described by multiple respondents. Without being able to see the screening data from partners in the same community, organizations are required to screen members themselves. Oftentimes, members are being screened on the same questions multiple times, despite the data on these questions being available within the community. This rescreening can be traumatizing for members and further deteriorate their relationship with providers and care teams.

Multiple organizations bring up "screening fatigue" as a consideration, as members are often asked to fill out a large number of screenings across health and social sectors. Many organizations cite the importance of highlighting the "why" behind these screenings, which includes describing how it will benefit the whole community.

Opening up and discussing social needs can be sensitive and uncomfortable for both members and screening staff, and can cause grief, trauma, and stigma. Most of the interviewees, including government programs, community mental health, primary care, and community partners, CCOs, and health systems describe conducting training on trauma-informed screening and trauma-informed care. Two interviewees discuss working to ensure they have a diverse workforce and ability to screen in multiple languages. One interviewee questions whether the screening tools themselves are trauma-informed. Multiple respondents express the need to provide autonomy to members and families, letting them decide which needs they want to focus on and in what order. This approach is described as a partnership, driven by member desires and abilities, rather than healthcare incentives.

Future plans

The State of Oregon has some new initiatives that will impact social needs and related systems. These include a joint effort between the Department of Human Services and Oregon Housing and Community Services to implement four pilot housing regions to serve TANF and rural families, and a Maternal and Child Health universally-offered home visiting service that includes screening, referrals, and building networks of community social needs resources.

Clinic and community partners mostly describe plans to improve workflows and screening tools to make them more structured, standardized, and aligned with cross-sector partners. From a technological perspective, many organizations express a desire for better resource directories, better EHR and cross-platform communication, and sustaining efforts that have already been achieved.

CCOs plan to expand their social need screening in the future, and nearly half plan to reach all populations. Several describe plans to expand screening to specific populations, such as members with certain medical conditions, members identified for intensive case management or care coordination, or those identified by analytics. Two of the CCO Health System partners plan to screen specific member populations, and the other two plan to screen all members.

Finally, in the midst of the COVID-19 pandemic, the growing importance of addressing social needs may lead to additional changes to the screening landscape.

Recommendations to the Workgroup

Participants in the interviews and survey were asked for their recommendations and advice for the workgroup. Themes that emerged include increasing alignment across organizations while allowing for flexibility within communities, avoiding screening fatigue, and working to increase equity and reduce screening-related trauma.

Alignment with flexibility

Interest and support for alignment within and across organizations is common across respondents, yet differences in approach are cited. Some respondents emphasize the need for uniform screening protocols and tools while others promote flexibility based on the preference and needs of different communities. The barriers to alignment are cited as organizational culture, silos, worries about money, fear, policies, capacity, lack of common definitions, resources, and concerns that trying to align around any one tool will undo the good work that has already been done. Community partners consistently recommend the creation of high-level structure around screening tools and domains that include local flexibility with which to implement these processes.

Equity and trauma

Several participants cite alignment as a tool to avoid the trauma of rescreening members across various programs and services. Other equitable and trauma-informed practices cited by interviewees include allowing members to define their family structure (if the screening encompasses the full family, or "household"), making sure screening tools are culturally responsive, and considering racial equity and the realities of structural racism in the workgroup's efforts.

Avoiding the "medicalization" of social needs

All community partner respondents expressed the need to move beyond a medical model of screening and instead acknowledge, support, and collaborate with organizations already supporting social needs.

Background Research in Social Needs Screening

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Oregon's State-Designed Transformational Measure Development Process

The Oregon Health Authority (OHA) State-Designed Transformational Measures process is used when the decision has been made to consider adopting a new quality incentive metric for CCOs, but there are not any relevant Healthcare Effectiveness Data and Information Set (HEDIS) or other nationally standardized measures available. The measure development process and timeline for developing a new measure is described in this brief.

State-Defined Transformational Measure Development Process

Conceptualization

The metrics development process begins when the Oregon Health Policy Board (OHPB), Metrics and Scoring Committee (M&S), or Health Plan Quality Metrics Committee (HPQMC) identifies a focus area for a new metric. If appropriate to the topic, OHA may identify and engage internal subject matter experts to conduct a national environmental scan and literature search. OHA may also convene a public workgroup tasked with conceptualizing the metric and answering key questions (see insert).

Specification Development

The public workgroup develops precise specifications for the measure, including: mode of collection, characteristics of the measure, inclusion and exclusion rules, codes and identifiers, time periods and reporting lags, national or local benchmarks, technical aspects of collection, feasibility of data collection, and rules for how the final measure will be calculated.

Testing

The process of testing depends on the nature of the measure. In some cases, OHA convenes a workgroup of experts in analytics and other related disciplines to provide input on the metric concept and its specifications. The metric concept and draft specifications go through an iterative improvement process where they are presented to the HQMPC, M&S, the Metrics and Scoring Technical Advisory Group (TAG), and other relevant stakeholders. Then feedback is obtained, and the measure specifications refined. The refined specifications are then presented again to each of the above groups.

> Conceptualizing a Metric: Sample Key Questions
>
> Define the concept:
> - What are we trying to measure and what do we need to know?
> - How are the measure's related health services organized and delivered, and how do they affect the recipient?
>
> Identify data sources:
> - What information could be realistically collected to show a change in outcomes (e.g. claims, electronic health records, opinion surveys, financial records)?
>
> Determine if it all fits together:
> - Does the measure have a direct link to the service delivery and a direct impact on outcomes?
> - Do the data source and definitions fit well with the rest of the concept?
> - Will the concept work for different types of settings and geographies?

Typical Metrics Development Timeline

Focus Area Identified

Conceptualization, Specification Development, Testing & Feedback

Fine Tune

Include in Measure Set

Initial Scan & Literature Search

Pilot Test

Present to HPQMC for Potential Inclusion
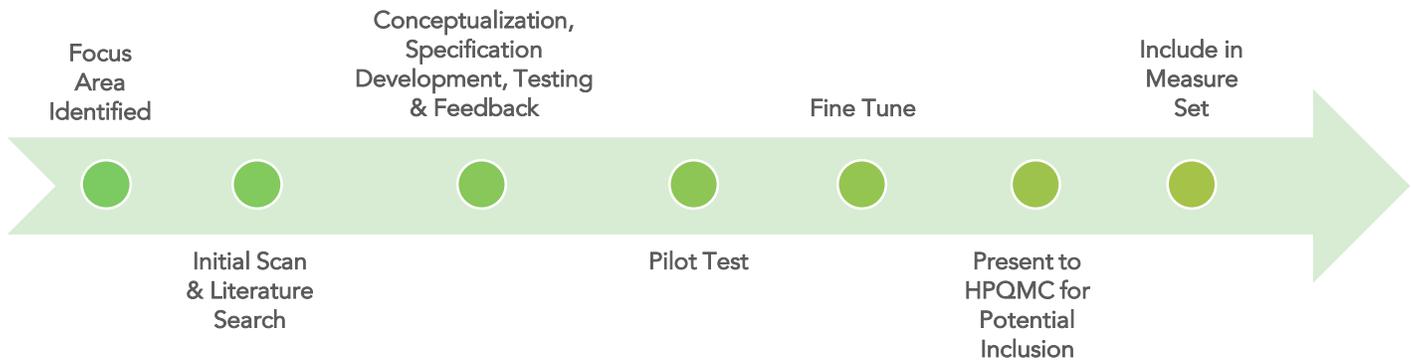
Pilot Test

Pilot testing is used to fine-tune the measure. Pilot testing is conducted using existing available data. A pilot testing plan is presented to HPQMC and M&S for input. The test is implemented and then the results of the test are used to refine the specifications.

Implementation

The final measure and specifications are presented to HPQMC for a decision on whether to include it in the Aligned Measure Menu, the list of measures which the M&S Committee can choose from when selecting CCO Incentive Measures.

The HPQMC evaluates the measure against the following criteria:

1. The measure addresses an HPQMC and/or OHPB health priority topic for which there is a gap in the HPQMC Measures Menu.

2. No measures specific to the topic have been endorsed by HPQMC, by a national metric endorsing body, or the HPQMC has evaluated the nationally endorsed measures as failing to meet other HPQMC measure selection criteria.

3. Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health and/or patient experience. Evidence may include community and consumer experience-informed research.

4. Structured pilot testing or local experience operationalizing the measure has confirmed: operational feasibility, including how the metric is collected, scored and reported, and face validity or perceived positive impact of metric use on a care process or outcome (1).

If selected as a pay-for-performance measure, the measure is then operationalized by OHA. This process involves developing formal tools, such as guidance and specification documents. The OHA Transformation Center works to communicate the measure and its specifications to stakeholders, to answer questions, and to monitor the rollout. The TAG and the Innovator Agents serve as resources during the rollout process.

Utilization, Evaluation & Maintenance

The HPQMC and M&S review metrics every year to refine specifications or other aspects of the work that affect collection of the measure, to update benchmarks, targets or attestations, and to consider inclusion and exclusion codes and rules. Measures are also continuously reviewed by OHA staff using population analysis techniques.

Additional Reading

1. 2020 CCO Incentive Measures: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-CCO-incentive-measures.pdf accessed 5/4/20.

2. HPQMC February 2020 Measure Selection Criteria.
   https://www.oregon.gov/oha/HPA/ANALYTICS/Quality%20Metrics%20Committee%20Docs/selection-criteria-priority-measures-final.pdf

Equity Considerations for Social Needs Screening in Health Care

Nearly half of the Oregon Medicaid population has one or more social need, and racial and ethnic minority groups are disproportionately affected (1). While there is increased momentum to understand and address unmet social needs, screening for social needs requires patient- and community-centered strategies. These strategies are especially critical for priority populations that are more likely to experience complex social, cultural, linguistic, and psychosocial barriers. Considerations from the scientific literature and best practices from health equity experts can help inform screening plans.

Health equity can be defined as the time when all people reach their full health potential (see insert for Oregon Health Authority's definition of health equity). Unfortunately, not enough research has been done about equitable approaches to social needs screening of diverse populations seeking health care. In fact, screening for social needs is a relatively recent phenomenon in some areas of health care. Even in settings serving low-income populations, where unmet social needs are more prevalent, rates of screening are low (2). That said, the scientific literature and experts point to some activities that could increase health equity in social needs screening.

Oregon Health Authority

Definition of Health Equity

Health Equity is where all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, 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 redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Key Factors to Increase Equity in Screening

Design screening with the most marginalized and underserved communities in mind

Experts suggest that to increase equity in a process such as screening for social needs it is best to design the entire process around the most marginalized and underserved communities that the effort may reach. Awareness of how these populations experience health care is key to developing an effective screening strategy. There are multiple studies that demonstrate that diverse populations have a poorer experience of health care and of their physicians than non-diverse populations (3,4). These poorer experiences include the physician's style (thoroughness of examination, listening skills, explanations the patient can understand), and trust (referrals to specialists when needed, unnecessary tests, is influenced by insurance rules) (3). Medicaid or other public health insurance coverage, lack of physician continuity, and fewer visits to physicians are also associated with poorer satisfaction with health care and physicians (3).

Awareness of cultural roles of the family within these populations is also important to screening design. Some

screening tools are intended to capture a nuclear family (i.e. parents and their children) which is not necessarily the unit of measure for diverse families.

Ideally, to design screening that accounts for the needs of marginalized and underserved communities, members of those communities should be meaningfully engaged in measure research and design. The methods of community-based participatory research (CBPR) can support more equitable research design (5). CBPR is a partnership of community member and researchers working to understand and address health inequity.

Engage a diverse screening workforce

Despite effort on the part of medical schools and other training programs, the health care workforce is rarely representative of the patients they serve. Engaging a diverse workforce for screening should support equity efforts. Many clinics and Coordinated Care Organizations in Oregon employ community health workers to support the work of screening for social needs. Community health worker interventions have been shown to have positive health outcomes for chronically ill, uninsured, or Medicaid-insured populations, and positive returns on investment (6). Community health workers can be trained to follow interview protocols to understand patients' social needs, and connect them to appropriate community resources (6).

Train providers

Experts emphasize the importance of cultural responsiveness and cultural sensitivity training for providers in order to promote cultural humility. Cultural responsiveness and sensitivity training can consist of modules on awareness of one's world view and assumptions, cultures and cultural norms of diverse cultures, language barriers, racism, and cross-cultural interviewing skills. Cultural humility, as described in the literature, includes a commitment to: 1. continued learning about the self and the patient, 2. humbleness about one's own beliefs and of the patients' views and beliefs, and actively working to redress imbalances in power between patient and provider, and 3. recognizing the importance of institutional accountability (7).

Address language barriers

In monolingual adults and children, there are significant differences in language proficiency across underrepresented populations (8,9). These differences may contribute to difficulty understanding screening questions, regardless of effectiveness of delivery or translation. Unfortunately, many of the available screening tools have been developed by researchers and tested in limited experiments. Even when translated, these tools may not be linguistically or culturally accessible to patients. This is also true for monolingual speakers with low language proficiency and/or health literacy. Translation of screening tools, however, is likely not enough. In a Canadian trial, non-English speakers were reported to be more likely to refuse to participate in social needs screening, despite the availability of translated surveys (7).

To make social needs screening acceptable and accessible to diverse populations, institutions not only need to ensure that the screening tool is translated effectively into the main languages spoken by community members, but they also should work towards increasing language concordance, where the screener and other providers involved in care are highly proficient in the patient's preferred language.

Ensure sensitivity in approach

Cultural and economic factors such as poverty, immigration, lack of understanding of why questions are asked, and prior experience of trauma can increase reluctance to be screened. Questions including sensitive information, such as interpersonal violence, may cause patients to experience discomfort and underreport stigmatized conditions. For example, teenagers and young adults living in poverty are a particularly vulnerable population reluctant to discuss sensitive issues (10). Ethnic minority women also are less likely to accept support for interpersonal violence due medical mistrust, traditional gender roles, discrimination, and immigration status (11).

Provide resources to address needs

Marginalized and underserved communities face repeated screening for social needs as they attempt to access state and community services. Repeated screening without addressing needs is thought to be traumatic, ineffective, and possibly unethical (12). Others argue, however, that understanding a patient's social needs, even when resources are not available, could still be beneficial as social needs can be factored into treatment plans resulting in better health outcomes (13).

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Taking a Trauma-Informed Approach

While there is no agreement on a precise definition of trauma-informed care, the Trauma Informed Care Project describes it as "an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma-informed care also emphasizes physical, psychological, and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment." (1) While the literature on trauma-informed screening for social needs is nascent, the evidence on trauma-informed approaches to providing care can be informative to the screening design process.

Trauma-Informed Health Care Models

Trauma is caused by events or circumstances beyond one's control, such as: abuse, neglect, violence, racism, accidents, grief and loss, and cultural, intergenerational and historical events (1,2). In the U.S., 61 percent of men and 51 percent of women report exposure to at least one physical or emotional traumatic event during their lifetimes (3).

Research has linked trauma to poorer health outcomes. For example, adverse childhood experiences, such as physical and sexual abuse, neglect, and family dysfunction, among others, have been found to be associated with heart, lung and liver disease, obesity, diabetes, and depression (4).

A trauma-informed approach is "a program, organization, or system that realizes the widespread impact of trauma and...responds by fully integrating knowledge about trauma into policies, procedures, and practices…" (5). Instituting a trauma-informed approach can improve patient perceptions of health care and their ability to self-manage. A 2018 empirical study found that patients receiving a model of equity-oriented health care that included "trauma- and violence-informed, culturally safe, and contextually tailored care" showed improved confidence in the health care services they received, and in their own ability to prevent and manage health problems (6).

Factors to Address in Screening Design

The Substance Abuse and Mental Health Services Administration's (SAMHSA) six guiding principles to a trauma-informed approach to care (6) (see inset) can be helpful when planning for screening implementation. These principles, and the key considerations for trauma-informed screening that they raise, are discussed below (6).

Six Guiding Principles to a Trauma-Informed Approach

Safety

Cultural, historical & gender issues

Trustworthiness & transparency

Empowerment & choice

Peer support

Collaboration & mutuality

SAMHSA, 2014
CDC, 2020
(https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm)
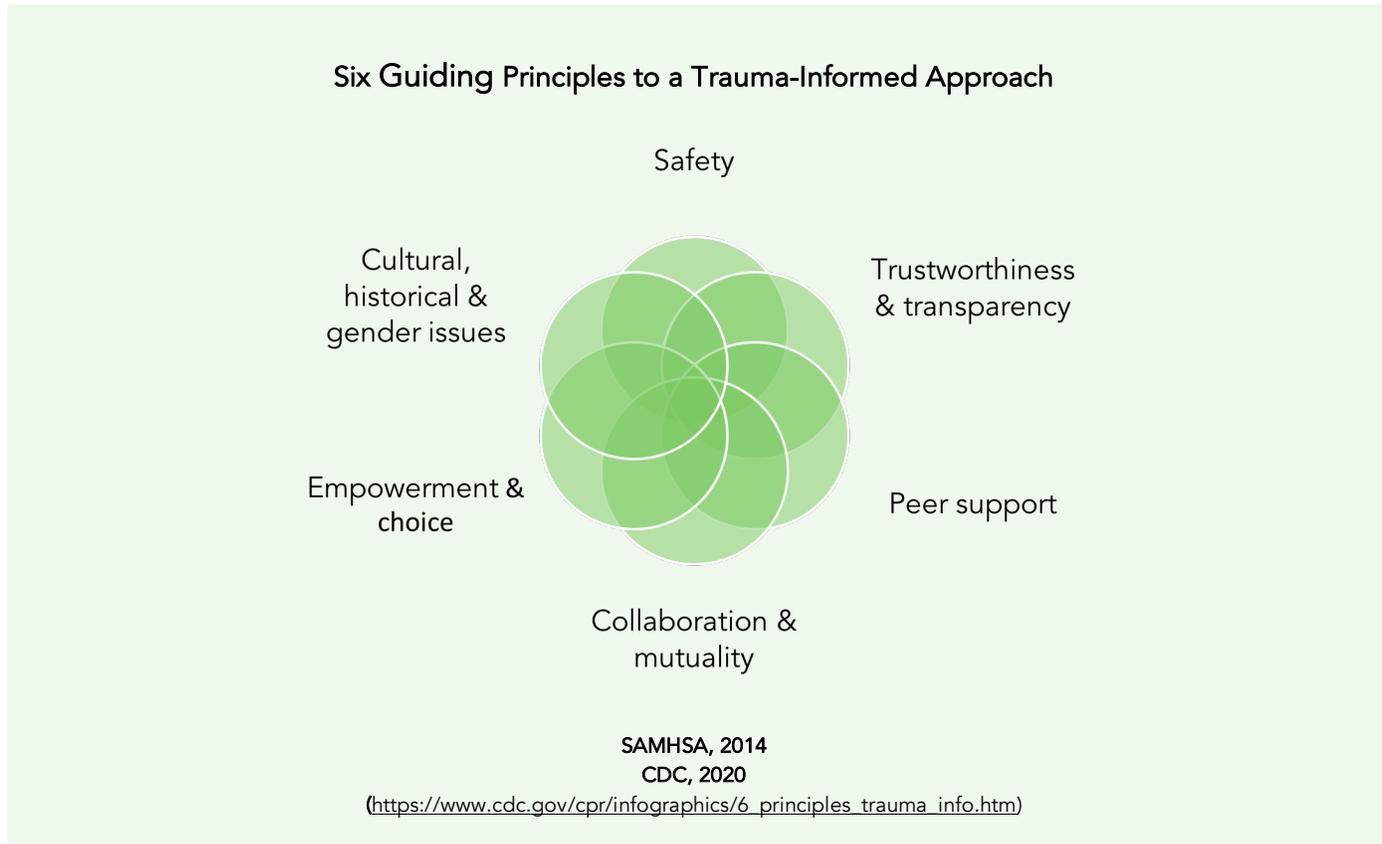
Safety:

The SAMHSA model emphasizes that employees and patients should feel physically and psychologically safe. Questions to ask during the design process include:

- Do the screening questions address safety concerns? If so, are the patients' physical safety and data privacy assured?
- Are there plans in place to support patients who have adverse reactions to the screening?
- Are there efforts to avoid re-traumatizing patients being screened (e.g. a system to avoid unnecessary re-screening)?
- Do the screening questions focus on strengths and avoid stigma?

Trustworthiness and Transparency:

The SAMHSA model emphasizes transparency as a method to build and maintain patient trust. Questions to ask during the design process include:

- Does the screener have an established and trusted relationship with the patient?
- Is there a plan to address the needs of the patient in a timely manner?
- Does the process include an explanation for why questions are asked and how information will be used?

Peer Support:

People with lived experience of trauma can be an effective resource for screening for social needs in a patient-centered way. Key questions to ask in the design process include:

- Is there an effort to include persons with lived experience in design and implementation of screening?
- Have the screening process and questions been reviewed by people with lived experience?

Collaboration and Mutuality:

The SAMHSA model emphasizes the leveling of power differences among the care team, and encourages all care team members have a role in being trauma-informed. A question to ask in the design process includes:

- Are all of the providers and staff trained in trauma-informed care?

Empowerment, Voice and Choice:

The SAMHSA model emphasizes shared decision-making, joint goal setting, and cultivation of self-advocacy skills. Key design questions include:

- Are patients/members given the autonomy to decide what they wish to share about their needs, and whether they want help to address them?
- Are patients given opportunity to decline to answer?
- Do the patients have a voice in their own plans of care?

Cultural, Historical and Gender Issues:

The model points to the importance of recognizing stereotypes and biases, and being responsive to the racial, ethnic and cultural needs of patients. Questions to consider include the following:

- Do the screeners and other providers reflect the races and ethnicities of the people they are screening?
- Are the cultural beliefs and needs of the patients understood?
- Are the screening questions and methodologies culturally acceptable?

Additional Suggested Reading

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Screening Domains & Tools

An array of screening tools have been developed to identify social needs. As with any burgeoning resource, there are many opinions about which tools are best and how to implement them. While many individual social needs screening questions have been scientifically validated, few whole screening tools have been studied for efficacy and patient acceptability. Considerations for selecting a screening tool include: desired domains, available tools, relevant populations, electronic medical record, care management and community information exchange capabilities, staff capacity, and available resources and interventions for positive screens. Also important are the trauma and equity implications of these decisions.

Questions for Screening Tool Selection (1)

1. Is there a tool that has been validated for the selected population that includes the desired domains?
2. Does the tool yield actionable info?
3. Can data be aggregated for reporting if multiple tools are selected?
4. Can the tool be integrated with electronic health records?
5. How easy and costly is the tool to administer?

Domain Considerations

Domains are the topics included in the screening tool. There are several considerations when selecting domains, including the prevalence of social needs in the population that will be screened, whether evidence exists of improved health and/or reduced cost of interventions for the domain within the identified population, and whether resources exist for those interventions in the selected communities (1). Additional considerations for selecting domains include: the costs and potential benefits of addressing the domain, possible duplication of existing efforts, and aligning with community priorities (1).

Domains commonly included in available screening tools include: economic stability, food, housing, neighborhood and safety, transportation, utilities, and social isolation (See attached comparison of social needs screening tools by Social Interventions Research and Evaluation Network, SIREN) (2).

Screening Tools in Use in Oregon

A recent survey showed that at least 80% of Oregon Coordinated Care Organizations (CCOs) conduct social needs screening at the CCO- level, predominantly with high-need and high-risk populations, and 66% report using a home-grown screening tool (4). These tools can include published evidence-based social needs questions compiled into a tool, or questions developed de novo.

Oregon health systems and clinics also use home-grown screening tools, and published tools and questions. The two most commonly used published screening tools in Oregon are the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and Accountable Health Communities (AHC). PRAPARE is implemented at community health centers throughout Oregon and is used for an alternative-payment model that is administered by the Oregon Primary Care Association and the Oregon Health Authority. AHC is used in clinical sites that are part of a project funded by the Centers for Medicare and Medicaid Services (CMS). Both PRAPARE and AHC have substantial overlap in domains, and even share some of the same questions (2). AHC in Oregon is only using the food, housing, transportation, utilities, and safety questions from the screening tool. State agencies

also collect social needs information, much of which is required by federal funders or programs (4).

Selecting a Screening Tool

The development of multi-domain social needs screening tools for health care is a relatively new phenomenon. A 2019 study uncovered only 18 non-proprietary evidence-based SDOH screening tools, and over half of these were created in the last five years (3).

There are many key questions to consider whether one is deciding to implement screening in a clinical setting, at a state agency, through payers, or through other partners. These are discussed in greater detail below.

Is there a tool that has been validated for the selected population that includes the desired domains?

While it is possible to develop new ones, there are already many questions that have been clinically tested and validated. It may save resources to look into existing questions in the desired domains before determining that new ones need to be developed. Note that not all evidence-based screening tools have been tested in all age groups and populations.

Does the tool yield actionable information?

To yield actionable information a tool should provide a specific and timely assessment of the need. Some tools include questions that are high level and require additional clarifying questions. Others provide an historical assessment of need, but do not identify the most current or pressing needs, and do not address whether the patient wants help with identified needs.

Can data be aggregated?

Some states allow multiple questions to be used to survey the same needs. Allowing for multiple screening tools and questions could help sustain existing screening efforts. It could also lead to data that cannot be aggregated, and thus has limited use for understanding need across populations and geographies. For this reason, it is important for states to consider the limitations of allowing multiple tools or considering ways to standardize across tools, questions or domains (e.g. through claims-based z-codes.)

Can the tool be integrated with electronic health records?

Many Oregon health systems have been working on integrating information on social needs into their electronic health records (4). The ease of incorporation of new screening tools into already developed social needs screening modules will likely be an important factor in screening adoption.

How easy and costly is the tool to administer?

Key decisions such as who should screen, how often, and where screening should take place affect both the ease and cost of administering social needs screening. For example, screening during a clinical visit by a provider in an exam room is likely more costly and possibly more challenging to fit into the clinic schedule than patients screening themselves in a clinic waiting room. That said, patient factors, such as where patients feel comfortable being screened, and patient safety, should also be factored into implementation decisions.

References

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Social Needs Screening Workflows

Screening for social needs at the health plan level, clinical level, or both is a fundamental decision that is influenced in part by how the information will be used. Equally important is determining feasible workflows for screening in a health care context. Decisions include: who should conduct the screen, how frequently to screen, whether to screen directly into an electronic health record, whether to have patients screen themselves, and how to follow up on needs identified. Recent research in Oregon provides some insight into the prevalence of social needs, and the challenges of screening in clinical sites. Ultimately, factors such as familiarity with technology, staff availability, length of visit, and patient preferences should be considered when determining a social needs screening workflow.

Health Plan or Clinic or Both?

Many clinical sites in Oregon currently screen for social needs during intake appointments, care coordination visits, annual check-ups, and at other times. At least 80% of Oregon Coordinated Care Organizations (CCOs) screen at the CCO-level, however that screening is seldom universal. Additionally, at least 70% of CCOs report receiving social needs data on some of their members from their contracted providers (1).

Whether to collect social needs information at the health plan level, the clinical level, or both depends in part on what the data will be used for. Reasons to collect this information at the **health plan level** include that the data from multiple contracted clinics need to be aggregated for population health, for risk stratification, or for community needs assessments. It may also be advantageous to screen at the plan level to include people who have not engaged in clinical services. Social needs data collection at the **clinical level** may be preferable if one plans to use the data for prevention and disease management at the point of care. For example, there are health conditions, such as diabetes, for which having social needs information available at the point of care could affect the care plan. Of course, social needs information could be collected at **both the health plan and clinic levels**, and with data agreements and systems in place data could be shared. This methodology may be advantageous if the goal is to avoid re-screening patients.

Patient Acceptability

Although limited, the available literature points to high patient acceptability of social needs screening in a number of settings:

- A 2020 study found that 84% of patients felt screening in a primary care setting for food insecurity was valuable (2).
- Another 2020 study found that 83% of patients feel that it is appropriate to screen for social needs in primary care, and 75% feel that it's appropriate in the Emergency Department (3).
- A 2019 qualitative study of patient opinions of social needs screening in primary care and emergency settings found that screening for social risk was acceptable, important, and increased the patient's sense of whole-person care. Patients also expressed the importance of empathetic and compassionate screening, and confidentiality (4).

Considerations in Selecting Workflows

The workflows selected need to be able to accommodate the volume of work involved in screening, documentation, and interventions. For example, research in Oregon has consistently demonstrated that food insecurity and housing questions result in a high number of positive screens, whereas transportation, utilities, and safety will yield fewer (see data on percent of social needs identified through screening in Oregon below). Thus, workflows need to be tailored to the volume of positive screens anticipated.

Social Needs of Oregon Medicaid Patients (5)

Category	Percent
Food	39%
Housing	27%
Transportation	17%
Utilities	14%
Safety	4%

Medicaid (N=5880)
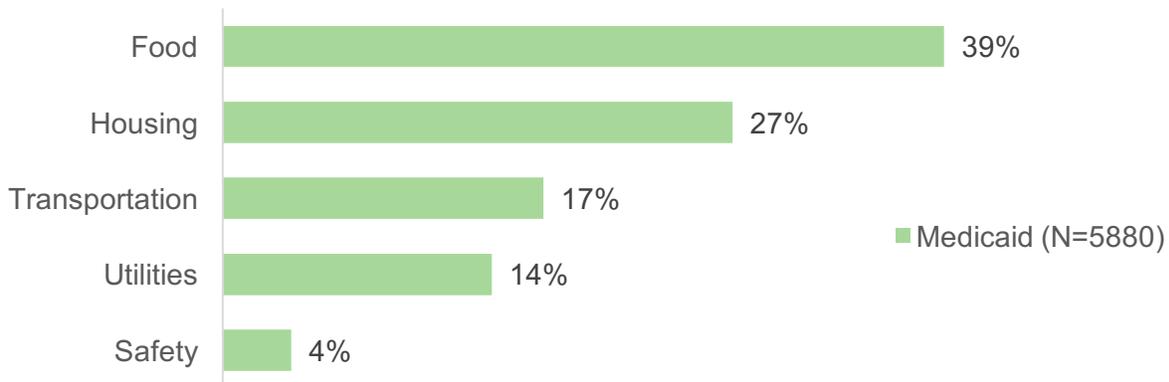
Who Screens

Screening in Oregon health care settings is conducted by medical assistants, care coordinators, community health workers, social workers, nurses, physicians, and others. Key questions to consider regarding the decision of which resource should screen include the following:

- Do the needs being addressed require a screener with an advanced scope of practice?
- Do the staff selected have the ability to screen in languages spoken by the patients?
- Is it possible for patients to screen themselves?

Patient preference can inform the decision regarding who should screen. A recent study on screening in medical clinic for food insecurity found that 41% of patients preferred being asked by a nurse, 34% preferred to screen themselves, and 19% preferred to be asked by a physician. These preferences were the same regardless of food security status (2). The survey did not cover other roles such as community health workers, care coordinators, or medical assistants.

Frequency of Screening

Oregon screening practices point to several schools of thought regarding screening frequency, including: once a year to avoid excess trauma, only when a need is suspected, and whenever the member is encountered by specific staff members, such as care coordinators, behavioral health, or community health workers (5).

Clinical Workflows

Within Oregon clinics, screening is occurring in waiting rooms, exam rooms, and via telephone. It is being administered by a wide range of providers including: physical health providers, behavioral health providers, community health care workers, and social workers. Screening is occurring on paper, tablets, and directly into electronic records.

When developing a workflow, it is important to determine if there will be enough time within the selected workflow to add the screening. For example, adding a 5-minute long screening tool in primary care provider

visits is likely not feasible given that those visits last approximately 15-minutes. However, that same tool may be feasible during the longer annual exams, or if patients screen themselves in the waiting room and bring the data into the provider visit.

The Accountable Health Community study in Oregon is examining the ability of clinics to screen via various workflows. Clinics are allowed to change workflows over the course of the study. Of the over 50 sites, 70% of clinics chose to have patients screen themselves in the waiting room. Selection of screening media by clinics included the following:
- Paper forms (nearly 50%)
- Stand-alone tablets (23%)
- EHR-connected tablets (21%)

Approximately one-quarter of the clinics in the study have switched from tablet to paper screening since the project started. Primary reasons for switching include the time that tablets add to patient check-in process, and patient difficulty using tablets (5).

Finally, although clinics in the study were expected to screen every Medicare and Medicaid patient that entered the clinic, and were provided financial reimbursement for doing so, clinics are screening well below their volume. For example, primary care clinics (N=36) are screening roughly 12% of eligible patients. Staff turnover, lack of buy-in, and competing priorities are the most commonly cited reasons for low screening numbers (5).

Follow Up
There is little research on patient preferences regarding screening follow up. A 2020 study of food insecurity screening found that 76% of patients preferred to receive a list of food bank locations, 72% preferred to receive a list of local community organizations, and 75% preferred to receive a referral to financial assistance programs. There were no differences in preference regardless of food insecurity status (2).

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3. De Marhis & Elena Byhoff, SIREN webinar, 2020.
4. Byhoff et. al. Part II: A Qualitative Study of Social Risk Screening Acceptability in Patients and Caregivers. AJPM. 2019;57(6): S38-S46.
5. Oregon Accountable Health Communities study, May 2020.

Social Needs Data Collection Systems in Health Care

Making social needs information available at the point of care for individual and population health improvement is a high priority for health care. Government agencies, Coordinated Care Organizations, and numerous health care systems in Oregon have developed methodologies to collect, store, and leverage data on social needs, and even more efforts are underway. Data are often stored in stand-alone systems. Recent efforts to collect and share social needs data in Oregon include expansions of electronic health record modules and care management software, and investments in community information exchange platforms.

Social Needs Data Collection

Social needs information is collected by physical, behavioral and mental health care providers, social service agencies, federal and state agencies, health plans, community-based organizations, and patients and caregivers themselves. In Oregon, Coordinated Care Organizations (CCOs) ask social needs questions as part of their required health risk assessments which may be conducted in-person, by telephone, or through the mail. Health risk assessments are also frequently conducted by CCOs as a part of intensive case management/care coordination.

Social Needs Data Storage for Health Care Use

In health care, information on social needs is stored in many types of systems, including electronic health records (EHRs), analytics systems, and care management software. Federal alternative payment programs, such as the Comprehensive Primary Care Plus Initiative (CPC+), have increased the presence of social needs information in EHRs. CPC+ requires that clinics collect psychosocial information about their patients in an accredited EHR. This requirement prompted EHR vendors to build new modules to store screening information, such as social needs, and unhealthy alcohol and drug use.

Bi-Directional Sharing of Social Needs Data

Demand for social service resource directories, and the ability to have bi-directional sharing of information across health and social service sectors, has led to the development of community information exchange software products. A community information exchange (CIE) is a software platform that supports electronic referrals to social service agencies, and provides outcomes information back to the referring partner (i.e. bi-directional communication.) The demand for this type of product over the past few years has resulted in the release of several CIE software platforms with national footprints. Recently in Oregon, the Oregon Health Authority and HIT Commons convened a multi-stakeholder CIE Advisory Group to develop a roadmap for a statewide CIE and determine if CIE efforts can be coordinated, standardized and/or centralized.

Some CCOs and health systems have implemented CIE software already, or are on a path to do so (see Table 1 below). Products in use thus far in Oregon include: Unite Us and Aunt Bertha. Currently some EHR vendors are developing direct links to CIE products, such as Unite Us, Aunt Bertha, and NowPow, to facilitate referrals from the medical record.

Social Needs Data Collection & Storage Advantages and Challenges

Social needs data collection, storage and sharing platforms allow providers to factor patients' social needs into care plans and connect patients in need of support to care managers, community health workers, and social services. Platforms also allow users to avoid repeat screening, and leverage data across patients for population health efforts.

Challenges include a proliferation of software and screening questions, different data standards, difficulty pulling data out of systems, and challenges analyzing data collected using different tools and methodologies.

Table 1. Oregon Health System and CCO SDOH Data Storage Technologies in Use/Planned (as of 7/1/20)*

CCO or Health System	County	Electronic Health Record	Care Management System	Community Information Exchange System
Advanced Health			Implemented	
AllCare CCO	Curry, Douglas		Implemented	Pricing
AllCare CCO	Josephine, Jackson		Implemented	LOI
Asante				
Cascade Health Alliance CCO	Klamath		Implemented	Implementing
Central Oregon Health Council	Deschutes, Crook, Jefferson			Implementing
Columbia Pacific CCO	Clatsop, Columbia, Tillamook		Implemented	Contracting
Community Health Centers	Statewide	Implemented	Implemented	OCHIN pilots
Eastern Oregon CCO	Eastern OR Counties		Implemented	
Health Share CCO	Clackamas, Washington, Multnomah		Implemented	Contracting
Jackson Care Connect CCO	Jackson		Implemented	Contracting
Kaiser Permanente	Washington, Clackamas, Multnomah, Lane, Marion, Polk, Yamhill	Implemented	Implemented	Live
Legacy Health System	Clackamas, Multnomah, Washington, Marion,		Implemented	LOI
Oregon Health & Science University	Multnomah, Washington, Clackamas	Implemented	Implemented	Pricing
PacificSource--Central OR CCO	Deschutes, Crook, Jefferson, Klamath		Implemented	LOI
PacificSource--Gorge CCO	Wasco, Hood River		Implemented	LOI
PacificSource--Lane County CCO	Lane		Implemented	LOI
PacificSource--Marion/Polk County	Marion, Polk		Implemented	LOI
Providence Health System	Statewide	Implemented	Implemented	Pricing
Samaritan Health System/InterCommunity Health Network CCO	Linn, Lincoln, Benton		Implemented	Live
St. Charles Health	Deschutes, Crook, Jefferson	Implemented	Implemented	Implementing
Trillium CCO/Health Net	Lane, Clackamas, Washington, Multnomah		Implemented	Live
Yamhill CCO	Yamhill		Implemented	Pricing

*LOI: Letter of Intent with Vendor to Contract by September 30, 2020

ICD-10 Z-Codes: Advantages and Challenges

Due to growing evidence that social needs influence health, there is substantial discussion regarding how to use existing medical classification systems to document and share social needs data across systems. The ICD-10 system contains standardized diagnostic codes used for documenting health conditions and diagnoses. ICD-10 includes a number of supplemental diagnosis codes called "Z-Codes" to document socioeconomic and psychosocial circumstances (1). Although alternative coding systems have emerged, ICD-10 is the most widely used medical coding system in the world.

ICD-10 Z-Codes

ICD-10 codes are used internationally and are, in essence, a universal language for government, healthcare organizations and providers for documenting diagnoses, billing, and surveillance. The International Statistical Classification of Diseases and Related Health Problems, tenth revision (ICD-10), contains "Health Factor" codes, known as Z-codes. Z-codes classify health-related information, including socioeconomic and psychosocial circumstances. Given the proliferation of Z-codes across the health care and governmental sectors, they have the potential to efficiently integrate social needs information across data systems (1,2,3). While Z-codes offer many advantages, they are not broadly in use in the U.S., and there is not yet alignment on which codes to use.

Z-codes in Oregon

Most social needs data are stored in electronic health records, care management platforms and proprietary databases. Although there has been discussion in Oregon of the potential of Z-codes to align data systems to collect social needs information, according to a recent survey of CCOs, Z-codes have not been widely used (4). A project by the Oregon Primary Care Association is examining the feasibility of using Z-codes to support documentation for alternative payment methodologies (5).

Advantages of Z-Codes to Identify and Share Social Need Information
- Documents social needs through existing claims systems, and could facilitate risk-adjustment and alternative payment methodologies such as value-based payments.
- Creates interoperability for social needs information; facilitates data exchange within and across organizations, institutions and agencies (6).
- The ICD-10 already includes codes to record social needs information (3).
- Individual codes for social needs may be superior to chart notes which have to be disaggregated.

Challenges of Z-Codes
- Lack of synchronicity between screening tools and codes could create complications in linking responses to a code (e.g. screening tool measures with a Likert scale, and corresponding code is binary).
- Screening tools may ask questions about social needs (e.g. transportation, utilities) that do not have a corresponding ICD-10 Z code.
- Some codes are not granular enough and would require additional charting.
- Since some codes are very general and others are more specific, different codes could be used to indicate the same social need (1).

Alternative Coding Systems to ICD-10

- Logical Observation Identifiers Names and Codes (LOINC): designed for observable data; can record genetic, lab, clinical, lifestyle and environmental information.
- Systemized Nomenclature of Medicine- Clinical Terms (SNOMED-CT): systematically organizes and classifies medical terms, codes, synonyms and definitions that are commonly used in healthcare.
- Common Procedural Technology (CPT): codes assigned to tasks and services provided by medical professionals are primarily used for reimbursement, although there is the ability to code that a screening took place (1,6).
- Electronic Health Record (EHR): EHRs, such as Epic, NextGen, eClinical Works, Cerner, and Greenway, include screening tools to capture standardized social needs information (7).

Z-Codes Related to Socioeconomic and Psychosocial Circumstances (Z55-Z65) (8)

Z55 – Z55.9	Illiteracy and low-level literacy; schooling unavailable and unattainable; failed examinations; school underachievement; educational maladjustment and discord	Z61 – Z61.9	Problems related to negative life events in childhood; loss of love relationship; removal from home; altered pattern of family relationships; events resulting in loss of self-esteem; problems related to alleged sexual abuse; problems related to alleged physical abuse; personal frightening experience
Z56 – Z56.9	Unemployment, unspecified; change of job; threat of job loss, stressful work schedule; discord with boss and workmates; uncongenial work; other physical and mental strain related to work	Z62 – Z62.9	Other problems related to upbringing; inadequate parental supervision and control; parental overprotection; institutional upbringing; hostility towards and scapegoating of child; emotional neglect of child; other problems related to neglect
Z57 – Z57.9	Occupational exposure to risk-factors; exposure to noise; exposure to radiation; exposure to dust; exposure to other air contaminants; exposure to toxic agents; exposure to extreme temperature; exposure to vibration; exposure to other risk-factors; exposure to unspecified risk-factors	Z63 – Z63.9	Other problems related to primary support group, including family circumstances; problems in relationship with spouse or partner, parents and in-laws; inadequate family support; absence of family member; disappearance and death of family member; disruption of family by separation/divorce
Z58 – Z58.9	Problems related to physical environment; exposure to noise; exposure to air pollution; exposure to water pollution; exposure to soil pollution; exposure to radiation' exposure to other pollution; inadequate drinking-water supply; exposure to tobacco smoke	Z64 – Z64.9	Problems related to certain psychological circumstances; problems related to unwanted pregnancy; seeking and accepting physical, nutritional and chemical interventions known to be hazardous and harmful; seeking and accepting behavioral and psychological interventions known to be hazardous and harmful; discord with counsellors
Z59 – Z59.9	Problems related to housing and economic circumstances; homelessness; inadequate housing; discord with neighbors/lodgers/landlord; problems related to living in institutions; lack of adequate food; extreme poverty; low income; insufficient social insurance and welfare support	Z65 – Z65.9	Problems related to other psychosocial circumstances; conviction without imprisonment; imprisonment and other incarceration; problems related to release from prison; problems related to other legal circumstances; victim of crime and terrorism; exposure to disaster, war, and other hostilities
Z60 – Z60.9	Problems related to social environment; problems of adjustment to life-cycle transitions; atypical parenting situation; living alone; acculturation difficulty; social exclusion, rejection, discrimination		

Additional Reading

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8. Chapter XXI Factors influencing health status and contact with health services (Z00-Z99), World Health Organization, https://icd.who.int/browse10/2019/en#/Z55-Z65, 2019

APPENDIX. Adult and Multi-Use Screening Tools (click on tool name to link to website)

	AHC-Tool	PRAPARE	Health Leads
Food Insecurity	Within the past 12 months, you worried that your food would run out before you got money to buy more. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more. *Often true* *Sometimes true* *Never true* *ten true* *Sometimes true* *Never true*	In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Food: *Yes/No*	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? *Yes/No*
Employment	Supplemental: Do you want help finding or keeping work or a job? *Yes, help finding work* *Yes, help keeping work* *I do not need or want help*	What is your current work situation? *Unemployed* *Part-time or Temporary Work* *Full-time work* *Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)*	
Housing Insecurity	What is your living situation today? *I have a steady place to live* *I have a place to live today, but I am worried about losing it in the future* *I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)*	What is your housing situation today? *I have housing* *I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)* *I choose not to answer this question* Are you worried about losing your housing? *Yes/No*	Are you worried that in the next 2 months, you may not have stable housing? *Yes/No*
Housing Quality	Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY *Pests such as bugs, ants, or mice* *Mold* *Lead paint or pipes* *Lack of heat* *Oven or stove not working* *Smoke detectors missing or not working* *Water leaks* *None of the above*		
Transportation	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? *Yes/ No*	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply. *Yes, it has kept me from medical appointments or from getting my medications* *Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need* *No* *I choose not to answer this question*	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there? *Yes/NoYes/No*

Interpersonal Violence	Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. **How often does anyone, including family and friends, physically hurt you?** **How often does anyone, including family and friends, insult or talk down to you?** *Never (1)* *Rarely (2)* *Sometimes (3)* *Fairly often (4)* *Frequently (5)* **How often does anyone, including family and friends, threaten you with harm?** **How often does anyone, including family and friends, scream or curse at you?** *Never (1)* *Rarely (2)* *Sometimes (3)* *Fairly often (4)* *Frequently (5)* A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe.	**In the past year, have you been afraid of your partner or ex-partner?**	
Utilities	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? *Yes* *No* *Already shut off*	In the past year, have you or any family members you live with been unable to get any of the following when it was really needed Utilities: *Yes/No* Phone: *Yes/No*	In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home? *Yes/No*
Veteran Status		**Have you been discharged from the armed forces of the United States? Yes/No**	
Desire for Assistance			If you checked YES to any boxes above, would you like to receive assistance with any of these needs? *Yes/No* Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight *Yes/No*

	Health Begins	MLP IHELP	Medicare Total Health Assessment
Food Insecurity	Which of the following describes the amount of food your household has to eat: *Enough to eat* *Sometimes not enough to eat* *Often not enough to eat*		Do you eat fewer than two meals a day? *Yes/No* Do you always have enough money to buy the food you need? *Yes/No*
Employment	Which best describes your current occupation? *Homemaker, not working outside the home* *Employed (or selfemployed) full time* *Employed (or selfemployed) part time* *Employed, but on leave for health reasons* *Employed but temporarily away from my job (other than health reasons)* *Unemployed or laid off 6 months or less* *Unemployed or laid off more than 6 months* *Unemployed due to a disability* *Retired from my usual occupation and not working* *Retired from my usual occupation but working for pay* *Retired from my usual occupation but volunteering*	Please indicate if the following describes a concern you have related to employment. *I am unable to earn income as a result of a disability.*	
Housing Insecurity	In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping? *Yes/No* In the last 12 months, how many times have you or your family moved from one home to another?	Please indicate which of the following describe a problem(s) with your housing situation. You may select none or more than one answer: *Bugs (e.g. roaches) or rodents* *General cleanliness* *Landlord disputes* *Lead paint* *Unreliable utilies (e.g. electricity, gas, heat)* *Medical condition that makes it difficult to live in current house* *Mold or dampness* *Overcrowding* *Threat of eviction* *Other (please specify)* **Are you living in section 8/public housing?** *Yes/No*	Which of the following best describes where you currently live? *Apartment, condo, trailer, house, townhouse, etc. (a living situation where meals and household help are not routinely provided by paid staff)* *Assisted living, retirement facility, etc. (a living situation where meals and household help are routinely provided by paid staff)* *Nursing Home (a living situation where nursing care is provided 24 hours a day)* *Other*
Housing Quality	In the last month, have you had concerns about the condition or quality of your housing? *Yes/No*	Please indicate which of the following describe a problem(s) with your housing situation. You may select none or more than one answer: *Bugs (e.g. roaches) or rodents* *General cleanliness*	Does the place where you live have the following safety concerns? *No working smoke alarm in one or more bedrooms or levels* *Poor lighting or lack of hand rails on stairs* *Slippery flooring in the tub or shower or no grab bars*

		Landlord disputes *Lead paint* *Unreliable utilies (e.g. electricity, gas, heat)* *Medical condition that makes it difficult to live in current house* *Mold or dampness* *Overcrowding* *Threat of eviction* *Other (please specify)*	
Transportation	How often is it difficult to get transportation to or from your medical or follow-up appointments? *Does not apply* *Never* *Sometimes* *Often* *Always*		
Interpersonal Violence	Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? Within the last year, have you been afraid of your partner or ex-partner? Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	Please indicate which of the following describe a problem(s) with your personal and family stability. You may select none or more than one answer. Are you afraid of someone you love? Do you have guardianship or custody issues? Are you concerned about the welfare of one of your children or a child that you live with?	
Utilities			
Veteran Status			
Desire for Assistance			If for any reason you have difficulty or cannot do one or more of these activities of daily living, do you get the help that you need? *I get all the help I need* *I could use a little more help* *I need a lot more help* *I don't need any help*

APPENDIX. Adult and Multi-Use Screening Tools (click on tool name to link to website)

	NAM Domains	WellRx	Your Current Life Situation
Food Insecurity		In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	In the past 3 months, did you have trouble paying for any of the following? (Select ALL that apply) Food In the past 3 months, how often have you worried that your food would run out before you had money to buy more? *Never* *Sometimes* *Often* *Very often* Optional: Are you easily able to get enough healthy food to eat? *Yes* *No*
Employment			
Housing Insecurity		Are you homeless or worried that you might be in the future?	Which of the following best describes your current living situation? (Select ONE only) *Live alone in my own home (house, apartment, condo, trailer, etc.); may have a pet* *Live in a household with other people* *Live in a residential facility where meals and household help are routinely provided by paid staff (or could be if requested)* *Live in a facility such as a nursing home which provides meals and 24-hour nursing care* *Temporarily staying with a relative or friend* *Temporarily staying in a shelter or homeless* *Other* Do you have any concerns about your current living situation, like housing conditions, safety, and costs? *Yes* *No* If YES: *Condition of housing* *Lack of more permanent housing* *Ability to pay for housing or utilities* *Feeling safe* *Other*

Housing Quality			Do you have any concerns about your current living situation, like housing conditions, safety, and costs? Condition of housing
Transportation		Do you have trouble finding or paying for a ride?	In the past 3 months, did you have trouble paying for any of the following? (Select ALL that apply) *Transportation* Has lack of transportation kept you from medical appointments or from doing things needed for daily living? (Select ALL that apply) *Kept me from medical appointments or from getting medications* *Kept me from doing things needed for daily living* *Not a problem for me*
Interpersonal Violence	Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? Within the last year, have you been afraid of your partner or ex-partner? Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?	Do you feel unsafe in your daily life? Is anyone in your home threatening or abusing you?	Optional: In the past 12 months, have you been physically or emotionally hurt or felt threatened by a current or former spouse/partner, a caregiver, or someone else you know? *Yes [Follow-up: Current spouse/partner; Former spouse/partner; Caregiver; Someone else]* *No* Optional: Has a spouse/partner, family member or friend ever been financially abusive towards you? That is, stolen money from you, not paid back a loan, etc.? *Yes* *No*
Utilities		Do you have trouble paying for your utilities (gas, electricity, phone)?	In the past 3 months, did you have trouble paying for any of the following? (Select ALL that apply) Heat and electricity
Veteran Status			
Desire for Assistance			If for any reason you need help with activities of daily living such as bathing, preparing meals, shopping, managing finances, etc., do you get the help that you need? *I don't need any help* *I get all the help I need* *I could use a little more help* *I need a lot more help* Which of the following would you like to receive help with at this time? (Select ALL that apply) *Food* *Housing* *Transportation* *Utilities (heat, electricity, water, etc.)*

		Medical care, medicine, medical supplies
		Dental services
		Vision services
		Applying for public benefits (WIC, SSI, SNAP, etc.)
		More help with activities of daily living
		Childcare/other child-related issues
		Debt/loan repayment
		Legal issues
		Employment
		Other
		I don't want help with any of these

APPENDIX. Pediatric Screening Tools (click on tool name to link to website)

	iHELP	SEEK	SWYC	We Care
Food Insecurity	Do you have any concerns about having enough food? Have you ever been worried whether your food would run out before you got money to buy more? Within the past year has the food you bought ever not lasted and you didn't have money to get more?	In the past 12 months, did you worry that your food would run out before you could buy more? Yes/No In the past 12 months, did the food you bought just not last and you didn't have money to get more? Yes/No	In the past month was there any day when you or anyone in your family went hungry because you did not have enough money for food? Yes/No	Do you always have enough food for your family? If NO, would you like help with this? Yes No Maybe later If yes, do you need food for tonight? Yes No
Employment				Do you have a job? Yes No If NO, would you like help finding employment and/or job training? Yes No Maybe later
Housing Insecurity	Do you have any concerns about being evicted or not being able to pay the rent? Do you have any concerns about not being able to pay your mortgage?			Do you think you are at risk of becoming homeless? If YES, would you like help with this? Yes No Maybe later If yes, is this an emergency? Yes No
Housing Quality	Do you have any concerns about poor housing conditions like mice, mold, cockroaches?			
Transportation				
Interpersonal Violence	[DO NOT ASK IN FRONT OF CHILD 3 OR OLDER OR IN FRONT OF OTHER PARTNER] "From speaking to families, I have learned that violence in the home is common and now I ask all families about violence in the home. Do you have any concerns about violence in your home?"	Do you sometimes find you need to slap or hit your child? Y/N Thinking about the past three months Have you and a partner fought a lot? Yes/No Has a partner threatened, shoved, hit or kicked you or hurt you physically in any way? Yes/No	In general, how would you describe your relationship with your spouse/partner? No tension/Some tension/A lot of tension/Not applicable Do you and your partner work out arguments with: No difficulty/Some difficulty/Great difficulty/Not applicable	

Utilities				Do you have trouble paying your heating bill for the winter? If YES, would you like help with this? Yes No Maybe later If yes, are you at risk of having your utilities shut off in the next week? Yes No
Veteran Status				
Desire for Assistance		Other things you'd like help with today: (fill-in)		

Link to Screening Tools Adult Comparisons: https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/adult-nonspecific
Link to Screening Tools Pediatric Comparisons: https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/peds

Acronyms Cheat Sheet:
- AHC Tool: Accountable Health Communities
- MLP (IHELP): Medical-Legal Partnership (income and insurance, housing and utilities, education and employment, legal status and personal stability)
- NAM domains: National Academy of Medicine
- PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Information in the tables is reproduced with permission from the Social Interventions Research and Evaluation Network (SIREN) https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison/adult-nonspecific, accessed 5/4/20.

Appendix D. Feedback from OHA committees and partners

Health Equity Committee
- The act of screening can be traumatizing, so the tangible benefit to members/people being screened needs to be very clear before the work group considers moving forward a measure.   - The work group should think about implementing data collection measures that ensure people providing the data are benefiting from it.   - Consider if there are other ways to get this data beyond screening or if existing data can be shared.   - Recommend leveraging the pilot phase for the measure to ensure equity in the process.   - This information could help improve existing efforts. For example, CCOs are already providing services and additional data could help them optimize this work.

Medicaid Advisory Committee
- Keep the member front and center.   - Wait to implement until the system is there to support/respond to the data that is gathered.   - Importance/value of having population data (for example, standardized data that can help inform community health improvement plans), but also making sure there is flexibility for community needs.   - Important to offer support/communication around social needs screening to providers — they have a lot on their plates and lack of time could lead to implementation in a non-trauma-informed way.   - Data sharing is important to avoid rescreening.   - Food and housing are key needs, especially in the aging population.   - Health insurance status of family members is an important need and potential stressor for family member being screened (even if the person being screened has coverage).   - Make sure to consider unintended consequences of measurement itself — consider a "balancing measure" that could track this.

Community advisory council coordinators
- Link with community-based organizations that are addressing this on the ground.   - Be intentional about racial equity.   - Screening should be paired with resources/support.   - Make sure the metric/work is patient-centered; meet patient needs and deliver screening in a trauma-informed way.   - Avoid unintended consequences for patients.   - Find a data collection method that integrates a trauma-informed approach.   - Ensure flexibility in approach to accommodate diverse communities.   - Data should be used and not just collected; needs to be shared across organizations.   - Use the process to build bridges between communities, clinics, CCOs.   - Electronic processes (like z-codes) would help lessen burden on members/providers; choose the systems that people will use.

Public Health Advisory Board
- This is an important and worthwhile effort.   - Concerns about screening without follow-up referral or resources.   - Look at what the CCOs are already doing to help inform the development of this measure.   - How can health systems and public health work together to expand this to the whole population in the future? Consider future goals while developing this.   - Be intentional about the needs of communities of color.

Appendix E. Equity checklist

Design for the most underserved/marginalized communities
- Promote equitable distribution of resources and power
- Avoid disadvantaging due to race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class or intersections between these factors
- Recognize, reconcile and rectify historical and contemporary injustices
- Ensure linguistic and cultural appropriateness

Center those screened
- Ensure patient-centeredness (promotes autonomy and respect, focuses on strengths)
- Ensure family-centeredness
- Include people with lived experience in process

Encourage equitable/trauma-informed screening practices
- Prioritize trust between screener and patient
- Ensure clarity and accessibility of questions and format
- Ensure adequate training for screeners
- Avoid inability to address needs identified

Align with and support community initiatives
- Support ongoing work of community-based organizations (CBOs)
- Promote accessibility of information by CBOs
- Avoid overburdening CBOs
- Prioritize local knowledge and allows for local flexibility
- Avoid the potential of re-traumatization due to re-screening

Appendix F. Measure concepts excluded by expanded planning committee

MEASURE CONCEPT	REASONS FOR EXCLUSION
All CCO members using data only from CIE systems	Not all CCOs/communities have CIEs; CIE landscape is rapidly evolving
All CCO members using CCO case management data only	Does not align with vision for future system of integrated social and medical care Barriers to data sharing and thus risk of rescreening
Screening of members with a behavioral health visit	Likely not feasible given problems with data sources (for example, EHR limitations and state behavioral health data collection source)
Screening and referral of CCO intensive care coordination members	CCOs already required to screen this population (OHA cannot incentivize something that is already required in CCO contracts) Doesn't include all members Open rules create uncertainty about who would be screened
Reporting only whether screen was done (not outcome of screen)	Doesn't align with statewide goals for tracking and improving social needs

Appendix G. Measure concepts and comparison summary

OHA SDOH Measurement Workgroup
DRAFT Social Needs Measure Concepts for Consideration

DOMAINS & TOOLS ACROSS MEASURES
Each measure concept (numbered 1-4 below) shares this same approach to domains and tools:
- **Domains screened:** Food & housing required, other domains optional.
- **Tools/Questions:** Tool-neutral, but may require specific questions (To be determined by subcommittee)

MEASURE CONCEPT 1: Rate of social needs screening in the total member population using any qualifying data source

Description: This concept would incentivize screening of all CCO members, which would promote equity and ensure that no members with social needs are missed. CCOs could report whether members have been screened in multiple settings and via multiple data collection strategies, allowing for flexibility and alignment with current systems and practices in place at the local level. CCOs will submit a plan during the first year to identify their approach, including the codes they will use and how they will collect the data.

Denominator: Total CCO membership during the measurement year (continuous enrollment period and exclusion criteria may be defined later in measurement specifications, as done in other states)	**Data source:** Enrollment data (OHA-supplied sample in initial year[s]; full enrollment data in future with collection method/system to be determined).
Numerator: CCO members who received screening using approved tool/questions, including any required domains, during the measurement year	**Data source:** Any qualifying data source that meets OHA-defined criteria (e.g. CCO care management system and/or community information exchange; provider-reported data [e.g. EHR]). Initial years screening to be reported for OHA-provided sample; full population screening data in subsequent years with collection method/system to be determined). OHA will provide a menu of qualifying codes, including the CPT/HCPCS/ICD diagnosis Z-codes/SNOMED/LOINC and other standard codes as identified by the Gravity Project and others.

Measure 1 Policy & Data Considerations

EQUITY

- All members are screened (not just those with a clinic visit), ensuring no one is missed due to lack of contact with the health care system
- Screenings conducted outside of health care settings could be counted, provided CCO is able to capture and report data (for example, through a Community Information Exchange, or CIE). This could also facilitate coordination and reduce rescreening among partners, and lead to referrals more quickly
- No guarantee that screening outcome data is available to prevent rescreening and to be actionable at the point of care, unless there is a system in place to share data with clinics

ALIGNMENT

- Allows integration with current systems and data collection practices (e.g., Community Information Exchange, Health Risk Screening, clinic-based screening practices, etc.), which may mean lower burden on CCOs and providers to build new systems
- Potential for integration of screenings done by all parties, including community-based organizations and clinics
- Potential to move systems towards desired future state of integrated medical and social care
- Could align with other measure development processes given that measure is not prescriptive, for example Integrated Care for Kids project

FEASIBILITY

- Flexible approach to data collection and sharing could allow for use of current systems (e.g. case management system) and multiple avenues to receiving credit for screening
- Depending on current data sharing processes, CCOs and clinics may need to amend existing data agreements
- Administrative challenges for CCOs, clinics, and OHA in matching and combining data across multiple data sources. This challenge may be addressed in the future by Community Information Exchange (CIE) or other systems that support cross-sector data sharing, but these systems are still nascent

Measure 1: Potential glide path

	Year 1	Year 2	Year 3	Year 4	Year 5+

Structure: Self-attestation survey & Data collection plan
 	
• Implement screening in an equitable and trauma-informed way, including:
   o required domains and approved tool;
   o using REALD data to inform culturally responsive and accessible screening practices;
   o patient/member engagement and preferences (e.g. asking patients which need they would like addressed); and
   o Plans for workflows and data sharing to prevent unnecessary rescreening.
• CCOs submit environmental scan and data collection plan:
   o Assess available data systems (claims/EHR/CIE) used by the provider network and community-based organizations in the service area, that contain qualifying codes identified by OHA and can be systemically extracted
   o Assess population covered by data systems with OHA identified qualifying codes
   o Identify and propose additional non-standard data systems with information aligns with the required SDOH screening domains
   o Propose data integration and information exchange plan					

	Year 1	Year 2	Year 3	Year 4	Year 5+
Reporting (SAMPLE) • OHA provides **sample list** of members to CCO (considering any population exclusions) • CCO reports data in required format utilizing qualifying and/or approved list of codes to OHA (i.e. excel spreadsheet) o Member-level flags for (a) screening completion and (b) positive needs by domain • OHA to calculate rates based on CCO's member-level data submission: (a) screening rate; (b) of those screened, % with need					

Outcome/Performance (SAMPLE)
 	
• CCO reports data in required format (i.e. excel spreadsheet) to OHA
    o Member-level flags for (a) screening completion, (b) positive needs by domain and (c) referral based on identified needs
• OHA to calculate rates (a) screening rate; (b) of those screened, % with need; (c) of those with a need, % with a referral made
    o Benchmark / to meet measure:
        ▪ Report (a), (b), (c)
        ▪ Meet target on (a) - % screened*
 	
Note: Metrics & Scoring to determine whether pay-for-performance begins in year 3 or 4.					

Goal: Outcome/Performance (FULL POPULATION) • Logistical elements (e.g. data submission/system to capture data) still to be determined					

MEASURE CONCEPT 2: Rate of social needs screening in target population (children 0-21) using any qualifying data source

Description: This measure concept would incentivize CCOs to focus efforts on a target population, in this case children 0-21, but would still incentivize screening across the full population of the target group (as opposed to just those in the target group with a clinic visit). CCOs would be responsible for ensuring screening is conducted and for reporting on this target population. CCOs could report whether members have been screened through multiple methods, allowing for flexibility and alignment with current systems and practices in place at the local level. CCOs will submit a plan during the first year to identity their approach, including the codes they will use and how they will collect the data.

Important note: Measure concept 2 is focused on a target population, which is a subset of the total population. This measure concept could be moved forward either as a stand-alone option that stays focused on a target population, or as a stepping stone to Measure concept 1 with a longer glide path.

Denominator: Total CCO members ages 0-21 (continuous enrollment and exclusion criteria may be defined later in measurement specifications, as done in other states) *	**Data source:** Enrollment data (OHA-supplied sample in initial year[s]; full enrollment data in subsequent years with collection method/system to be determined)
Numerator: CCO members ages 0-21 who received screening using approved tool*	**Data source**: Any qualifying data source that meets OHA-defined criteria (e.g. CCO care management system and/or community information exchange; provider-reported data [e.g. EHR]). Initial years screening to be reported for OHA-provided sample; full population screening data in subsequent years with collection method/system to be determined) OHA will provide a menu of qualifying codes, including the CPT/HCPCS/ICD diagnosis Z codes/SNOMED/LOINC and other standard codes as identified by the Gravity Project and others.

* Other target populations are possible, but each would have to be considered in terms of the data sources available, the settings in which the screening could occur, or both.

Measure 2 Policy & Data Considerations

EQUITY

- Targeted approach has potential to have a greater impact on equity for priority groups, yet members outside of the priority population would not be counted in the measure
- A focus on children would direct resources upstream, which could prevent future health and social risks and health care costs
- Screenings conducted outside of health care settings could be counted, provided CCO is able to capture and report data (for example, through a Community Information Exchange, or CIE). This could also facilitate coordination and reduce rescreening among partners, and lead to referrals more quickly.
- No guarantee that screening outcome data is available to prevent rescreening and to be actionable at the point of care, unless there is a system in place to share data with clinics
- Would not allow statewide tracking of social needs over time for the full population (but would for sub-population)

ALIGNMENT

- Allows integration with current systems and data collection practices (e.g., Community Information Exchange, Health Risk Screening, clinic-based screening practices, etc.), which may mean lower burden on CCOs and providers
- Potential for integration of screenings done by all parties, including community-based organizations and clinics
- Potential to move systems towards desired future state of integrated medical and social care
- Could align with other measure development processes given that measure is not prescriptive and the target population aligns with the state's Integrated Care for Kids project

FEASIBILITY

- Flexible approach to data collection and sharing could allow for use of current systems (e.g. case management system) and multiple avenues to receiving credit for screening
- Depending on current data sharing processes, CCOs and clinics may need to amend existing data agreements
- Administrative challenges for CCOs, clinics, and OHA in matching and combining data across multiple data sources. This challenge may be addressed in the future by Community Information Exchange (CIE) or other systems that support cross-sector data sharing, but these systems are still nascent

Measure 2: Potential Glide Path**

	Year 1	Year 2	Year 3	Year 4	Year 5+

Structure: Self-attestation survey and Data collection plan
 	
• Implement screening in an equitable and trauma-informed way, including:
    o required domains and approved tool;
    o using REALD data to inform culturally responsive and accessible screening practices;
    o patient/member engagement and preferences (e.g. asking patients which need they would like addressed)
    o Plans for workflows and data sharing to prevent unnecessary rescreening
• CCOs submit environmental scan and data collection plan, focused on the target population:
    o Assess available data systems (claims/EHR/CIE) used by the provider network and community-based organizations in the service area, that contain qualifying codes identified by OHA and can be systemically extracted
    o Assess population covered by data systems with OHA identified qualifying codes
    o Identify and propose additional non-standard data systems with information aligns with the required SDOH screening domains.
    o Propose data integration and information exchange plan					

	Year 1	Year 2	Year 3	Year 4	Year 5+
Reporting (SAMPLE) • OHA provides **sample list** of members to CCO (considering any population exclusions) • CCO reports data in required format (i.e. excel spreadsheet) to OHA utilizing qualifying and/or approved list of codes o Member-level flags for (a) screening completion and (b) positive needs by domain • OHA to calculate rates based on CCO's member-level data submission: (a) screening rate; (b) of those screened, % with need					

Outcome/Performance (SAMPLE)
 	
• CCO reports data in required format (i.e. excel spreadsheet) to OHA
  o Member-level flags for (a) screening completion, (b) positive needs by domain and (c) referral based on identified needs
• OHA to calculate rates (a) screening rate; (b) of those screened, % with need; (c) of those with a need, % with a referral made
  o Benchmark / to meet measure:
    ▪ Report (a), (b), (c)
    ▪ Meet target on (a) - % screened*
 	
Note: Metrics & Scoring to determine whether pay-for-performance begins in year 3 or 4					

Goal: Outcome/Performance (FULL TARGET POPULATION) • Logistical elements (e.g. data submission/system to capture data) still to be determined					

**Please note: Glide path will be scaled to match the population size. For example, if a larger target population (such as all CCO members age 0-21) is chosen, the glide path may more closely resemble the glide path for Measure 1, which reports on sample data in years 1-4 and the full population (in this case full target population) in Year 5.

MEASURE CONCEPT 3: Rate of social needs screening in the total member population by any Medicaid billing provider using claims data

Description: This concept would incentivize screening of all CCO members, including those with any type of healthcare visit and those for whom a CCO-employed nurse care manager or other provider conducts the screening. A key difference in this measure is that information would be collected using claims data (i.e. customized modifier codes, ICD diagnosis z-codes and HCPCS/CPT codes) and not other sources, which would limit collection to clinical settings of any type, CCO clinical staff, and/or community-based setting with the capacity to bill for Medicaid services (e.g. through the use of Traditional Health Workers). An advantage of claims data is that it offers a standard set of diagnosis codes (i.e. z-codes) that may be used to identify positive screening results and specific social needs identified. On the other hand, if the screening does not result in needs being identified, the positive diagnosis z-codes cannot be used in claims. Therefore, a different method needs to be explored for capturing social needs screening when a person has no identified social needs. Currently, the most feasible way it to define a customized modifier code (or a set of modifier codes).

Because claims offers a standard set of codes to identify social needs, this measure begins with two numerators. The first rate (Numerator A) would be incentivized to improve screening rates, and the second rate (Numerator B) would provide us a standardized way to better understand social needs statewide.

Denominator A: Total CCO membership during the measurement year (continuous enrollment and exclusion criteria may be defined later in measurement specifications, as done in other states)	**Data source:** Enrollment data
Numerator A: CCO members who received screening using approved tool in a healthcare visit during the measurement year or conducted by a CCO-employed nurse care manager or other provider	**Data source**: Claims (including a combination of a CPT/HCPCS + unique modifiers for all qualifying screening)
Denominator B: CCO members who received screening using approved tool in a healthcare visit or conducted by a CCO-employed nurse care manager or other provider	**Data source:** Claims (including a combination of a CPT/HCPCS + unique modifiers for all qualifying screening)
Numerator B (subset of numerator A): Members who received screening in a healthcare visit during the measurement year <u>and</u> are identified as having social need in required domain(s)	**Data source:** Claims (i.e. CPT/HCPCS + unique modifiers + appropriate ICD diagnosis z-code)

Measure 3 Policy & Data Considerations

EQUITY

- All members are considered for screening (that is, the population to be measured is not limited to those with a clinic visit), ensuring no one is left out of the measure. Screenings that occur outside a healthcare setting or outside a qualified healthcare professional employed by a CCO or Medicaid-billing community-based organization, however, cannot be captured for numerator credit.
- ICD Z-codes don't currently cover all social needs that may be present, which may create gaps in care or ability to identify, track and address certain needs.

ALIGNMENT

- Offers promise of universal system of coding for social needs
- Some large health systems use this approach already
- Alignment with statewide pilot to test out approach (OPCA) & national project to align social needs data use in clinical settings (the Gravity Project)

FEASIBILITY

- ICD diagnosis Z-codes not widely used at present, so implementation would be burdensome for OHA, CCOs and clinics
- Captures social need, but z-codes do not capture whether *screening* was conducted, which would necessitate using a combination of procedure (CPT/HCPCS) and modifier codes. This may be complex for clinics and require additional outreach and technical assistance by the state.
- Would need to standardize how z-codes are linked to screening tools, including provider education.
- Potentially more upfront burden in terms of dropping codes that don't have clear benefit to providers (e.g. payment) and may have less specificity to be meaningful for patient services; however, likely less burden in terms of calculating the rate and reporting data than the EHR measure or other two measures.
- There is a huge range in how z-codes are applied to outbound medical claims, from semi-automatic (coded observations from clinical encounter) to completely manual (done by clinical or administrative reviewer when processing). There may be a 1:1 match between some EHR codes and ICD diagnosis z-codes, but this would only benefit data collected from clinical encounters.

Measure 3: Potential glide path

	Year 1	Year 2	Year 3+

Structure: Self-attestation survey
 	
• Process to increase use and accuracy of ICD diagnosis z-codes
• Process to define/customize unique modifier codes for identifying screening activities alone
• Implement screening in an equitable and trauma-informed way, including:
    o required domains and approved tool;
    o using REALD data to inform culturally responsive and accessible screening practices;
    o patient/member engagement and preferences (e.g. asking patients which need they would like addressed)
• Plans for workflows and data sharing to prevent unnecessary rescreening			

Reporting (FULL POPULATION) • OHA to calculate rates and provide data to CCOs in monthly dashboard: (a) screening rate; (b) of those screened, % with need			
GOAL: Outcome/Performance (FULL POPULATION) • OHA to calculate measure and provide data to CCOs in monthly dashboard • OHA to calculate rates (a) screening rate; (b) of those screened, % with need o Benchmark / to meet measure: Meet target on (a) - % screened			

MEASURE CONCEPT 4: Rate of social needs screening for members with a primary care visit using Electronic Health Records (EHR)

Description: This measure would incentivize CCOs to be responsible for ensuring screening happens at the clinic level, specifically as a part of a primary care. While this may seem like a less attractive option because not all members are screened, there are some benefits to centering screening in clinics, including coordination among the care team and better assurance that screening information will be available at point of care. This could build on existing efforts in primary care, such as in FQHCs (e.g. PRAPARE) and Patient-Centered Primary Care Homes (for example, the PCPCH program recently adopted a new social needs screening standard).

Note: To date, OHA's EHR data collection has focused on collecting data from primary care. We would need to address significant barriers in certain clinical settings (e.g. limited/varied EHR use in behavioral health) and unknowns in other settings (e.g. emergency departments) to be able to feasibly collect from these settings.

Denominator A: CCO members with primary care visit* during the measurement year (exclusion criteria may be defined later in measurement specifications, as done in other states) *Note: One option would be to borrow the denominator definition from the existing depression screening/SBIRT metrics in the Quality Incentive Program. This would create consistency with these other existing EHR-based metrics; however, this would limit the denominator to members ages 12 and over.*	**Data source:** EHR + Enrollment data
Numerator A: CCO members who received screening using approved tool during the measurement year	**Data source**: EHR
Denominator B: CCO members who received screening using approved tool during the measurement year	**Data source**: EHR
Numerator B: CCO members who received screening using approved tool during the measurement year **and** had an identified social need	**Data source**: EHR

Measure 4 Policy & Data Considerations

EQUITY

- Not all members screened, only those seen in clinics. Members who don't have a clinic visit aren't considered in the measure/ counted in the denominator.
- Results from the screening available at point of care
- Promotes coordination among member care team in clinic
- Focusing on a single type of care setting (e.g., primary care) may make it easier to standardize tools and questions, and train staff in trauma-informed approaches
- Doesn't account for screenings that occur outside the clinic (e.g., in CCOs or CBOs or even in clinics outside of primary care) so increases potential for rescreening in other clinical and non-clinical settings

ALIGNMENT

- Potential to build on existing efforts in FQHCs, PCPCHs (e.g. align with new PCPCH standard)
- Does not account for or capture existing CCO or CBO screening efforts

FEASIBILITY

- Huge diversity in EHR systems and capabilities, including uncertainty about screening/referral tracking capabilities
- Currently, members who are seen at multiple clinics can't be deduplicated in reporting. At present, each clinic or organization/ health system would generate a report from its EHR. There is no method to match up the data, so the member would be independently counted by each clinic or organization.
- Increased burden on both clinic staff and CCO (for data collection and aggregation)
- Depending on current data sharing processes, CCOs and clinics may have or perceive a need to amend existing data agreements.
- Some Electronic Health Records (EHRs) may already link specific observations to LOINC and/or SNOMED codes, which are the preferred standards for capturing clinical observations, but these codes are usually hidden from the user and often difficult to extract.

Measure 4: Potential glide path

	Year 1	Year 2	Year 3+

Structure: Self-attestation survey
 	
• Report on CCOs' plans to work with clinics to ensure data elements are captured and can be reported
• Implement screening in an equitable and trauma-informed way, including:
    o required domains and approved tool;
    o using REALD data to inform culturally responsive and accessible screening practices;
    o patient/member engagement and preferences (e.g. asking patients which need they would like addressed)
    o Plans for workflows and data sharing to prevent unnecessary rescreening			

Reporting • CCO must report data from primary care clinics where 25% of the CCO's members are assigned.			

GOAL: Outcome/Performance
 	
• Benchmark / to meet measure:
    ▪ Report (a) and (b)
    ▪ Meet target on (a) - % screened
• Use year 2 performance to inform benchmarks and to set improvement targets
• Population threshold for reporting increases over time, with goal to reach reporting from clinics where 75% of CCO members are assigned			

Social Determinants of Health Measure Concepts Summary

SDOH Measurement Workgroup, October 2020

MEASURE CONCEPTS	1	2	3	4
	Rate of social needs screening in the total member population -- any data source	Rate of social needs screening in children 0-21* -- any data source	Rate of social needs screening by any Medicaid billing provider -- Z-codes	Rate of social needs screening for members with a primary care visit --Electronic Health Records (EHRs)
Denominator	Total CCO membership	Total CCO members ages 0-21	Total CCO membership	CCO members with a primary care visit
Numerator	CCO members screened	CCO members ages 0-21 screened~	CCO members screened	CCO members screened
Data Source (Numerator)	Any qualifying source (Data must be reported in required excel format. OHA to provide list of qualifying codes)	Any qualifying source (Data must be reported in required excel format. OHA to provide list of qualifying codes)	Claims data: Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Technology (CPT) code + Z-codes and customized modifier	EHRs
Data Source (Denominator)	Enrollment data	Enrollment data	Enrollment data	EHR + Enrollment data
Availability of data to support member care, avoid unnecessary rescreening, and support referrals (e.g. outcome data is available at point of care and/or sharable across multiple settings)	Depends on workflows & data sharing. Most, but not all, CCOs are using or planning to use Community Information Exchanges or a similar system to support social needs data sharing. Referral data may be available, but not standardized	Depends on workflows & data sharing. Most, but not all, CCOs are using or planning to use Community Information Exchanges or a similar system to support social needs data sharing. Referral data may be available, but not standardized	Use of standard z-codes could facilitate data sharing across clinic sites that participate, but would require chart review and/or Health Information Exchange. No codes to capture closed loop referrals.	Available at point of care in primary care offices; coordination with CCO and non-clinical partners depends on workflows & data sharing, including use of Community Information Exchange (CIE), Health Information Exchange (HIE) or other system. No codes to capture closed loop referrals

MEASURE CONCEPTS	1	2	3	4
	Rate of social needs screening in the total member population -- any data source	Rate of social needs screening in children 0-21 -- any data source	Rate of social needs screening in the total member population -- z-codes	Rate of social needs screening for members with a primary care visit --Electronic Health Records (EHRs)
Allows for population-wide tracking of social needs at state or local level to inform community health improvements	Yes, captures data from full population. Aggregation depends on standard domains, questions, and coding, via sample in initial years.	Partially, includes a subset of the full population with/without a health care visit, yet standard, domains, tools and coding could support widespread implementation.	Partially, includes only those with a health care visit, yet standard, domains, tools and coding could support widespread implementation.	Partially, but only for those with a primary care visit, yet standard, domains, tools and coding could support widespread implementation.
Screening outside the clinical setting "counts"	Yes, provided CCOs collect data from partners	Yes, provided CCOs collect data from partners	Yes, but only from those who can bill Medicaid	No, and only screening in primary care settings counts
Potential burden on CCOs, clinics and OHA for full implementation	Lower burden, due to ability to use current systems & practices. Higher burden to build systems to aggregate and share data.	Lower burden, due to ability to use current systems & practices, and smaller total population. Higher burden to build systems to aggregate share data	Higher burden for implementation of multiple codes and workflows; Lower burden for data reporting	Possible increase burden on clinical staff to conduct screen; Higher burden for EHR integration; depending on level of standardization, lower burden for reporting once systems built
Potential to align with other emerging & existing efforts, like CIEs	High, "no wrong door" approach to data collection allows alignment with existing efforts.	High, "no wrong door" approach to data collection allows alignment with existing efforts; proposed population aligns with state goals and programs	Medium, some pilots tests underway, but generally low use of z-codes	Medium, alignment limited to clinical efforts, but clinics could certainly use CIE to access closed loop referrals and share data

* Important note: Measure concept 2 is focused on a target population, which is a subset of the total population. This measure concept could be moved forward either as a stand-alone option that stays focused on a target population, or as a stepping stone to Measure concept 1 with a longer glide path.
~ Other target populations are possible, but each would have to be considered in terms of the data sources available, the settings in which the screening could occur, or both.

Appendix H. Measure concepts excluded by work group

MEASURE CONCEPT	REASONS FOR EXCLUSION
2. Rate of social needs screening in target population (children 0–21) using any qualifying data source	Members outside of the priority population would not be counted in the measure. It would not allow for statewide tracking of social needs over time for the full CCO population.
3. Rate of social needs screening in the total member population by any Medicaid billing provider using claims data (z-codes)	The use of z-codes would limit data collection to those with the capacity to bill for Medicaid services. ICD z-codes don't currently cover all social needs that may be present. It is unknown to what extent z-codes are currently used, and implementing a new coding system for social needs could be burdensome for all involved — providers, community organizations and CCOs.
4. Rate of social needs screening for members with a primary care visit using EHRs	Members not seen in primary care in the last year would be excluded.

Appendix I. Recommendations for screening tools and questions

A subcommittee of the Social Determinants of Health Measurement Work Group met in December 2020 and January 2021 to review and recommend screening domains, tools and questions to be used to receive credit for the measure. To accommodate the recommended measure concept of screening all CCO members using any data source, the current plan is for OHA to approve a menu of allowable screening tools that meet specific criteria. These subcommittee recommendations will help inform the OHA-approved menu.

The subcommittee recognized that there were some limitations with the current subcommittee tool review process. First, the tools that were considered were mostly developed in a health care context and many tools currently in use by community-based organizations are still unknown to OHA and subcommittee members. To address this gap, OHA plans to continue engaging community-based organizations to learn about additional tools. In addition, OHA may need to revisit the full menu over time in consideration of (a) the tools and questions that are most used in the field, and (b) established inclusion criteria. OHA will define a process to add more tools to the menu, based on specific criteria. At the time of this report, it is too early for OHA to define that process, but they plan to consult with stakeholders through public meetings to help further define and then implement that process at the appropriate time.

Despite these limitations, the subcommittee offered some initial domain recommendations and reviewed a list of tools. The list of tools that the subcommittee reviewed is shared below. As described above, this list is not an official approved menu of tools; the approved menu of tools will be created and shared by OHA at a later time.

As a first step, the subcommittee defined criteria to evaluate the tools. The subcommittee prioritized the following tool criteria, which OHA will use to inform the final tool-approval criteria:
- Tools that yield actionable information, both at the point of care (patient/system level) and when data is aggregated (state level)
- Tools that are culturally responsive, absent of apparent equity concerns, available in multiple languages, appropriate for the population being screened, trauma-informed, and designed at a lower relative reading level
- Consideration of any potential barriers to integration with electronic health records
- Tools that are already in use in Oregon
- Tools that have some level of reliability or validity established
- Tools that capture the highest social needs in Oregon (food and housing insecurity, and others prioritized by the work group)

The subcommittee made recommendations with the assumption that data collected from CCO screenings will be reported to OHA for two variables: 1) Was a screening conducted?, and 2) The outcome of the screen on each domain in a Yes/No format.

The subcommittee offered the following recommendations after carefully reviewing screening tools currently in use, and aligning questions with the criteria above and the work group's recommendations on domains.

Recommendations for screening domains

The subcommittee recommended that the measure be initially launched by encompassing screening on three to five domains. The subcommittee's discussions focused on four domains: (1) food insecurity, (2) housing insecurity, (3) transportation and (4) interpersonal violence, with strong consensus on the first two domains. Interpersonal violence was ultimately excluded from the final domains recommendation due to potential trauma, safety, and legal concerns with screening on that domain. Food insecurity, housing insecurity and transportation align with the state's greatest social needs documented in the recent Accountable Health Communities study data, and the statewide priorities of CCO 2.0 and the State Health Improvement Plan. Subcommittee members determined that these are also common domains with current screening practices across the state, offering the opportunity for the new measure to align with current efforts. In recommending three to five domains, the subcommittee aimed to start with a small core set (which is more feasible during the first few years of implementation), which the possibility of expanding to other social needs over time. Subcommittee members suggested strategically adding domains in groups in the future, as there was concern that the implementation burden would be great if new individual domains were added too frequently.

Review of screening tools and questions

The subcommittee reviewed screening tools for each domain (and individual questions within each tool) by considering extensive information about tool characteristics compiled by the Social Interventions Research & Evaluation Network (SIREN) at the University of California, San Francisco. SIREN is a national leader in social needs screening research, and has developed a robust compendium of health-related social needs screening tools. As mentioned above, the subcommittee acknowledged that a limitation of this process was that not all the tools currently in use by community-based organizations in Oregon are known at this time, and so were not considered in this initial conversation. In the future, OHA will need to consider how additional tools can be gathered and assessed.

Overall, the subcommittee felt that three tools — Accountable Health Communities (AHC), North Carolina Medicaid (NC Medicaid) and the Protocol for Assessing Patients' Assets, Risks and Experiences (PRAPARE) — best met the prioritization criteria above (i.e., provides actionable information, meets equity and trauma-informed standards, aligns with current tools in use in Oregon, etc.). The broader list of screening tools that the subcommittee identified as aligning with the criteria above are presented in Tables 1 and 2 below. Considerations for the questions in each domain are presented here.

Domain-specific questions

The subcommittee made additional recommendations about the specific questions in each domain. This information may be helpful when organizations are making decisions about using specific questions for the three recommended domains.

Food insecurity

The two-item Hunger Vital Sign (see Box 1) is a widely used screen for food insecurity. The questions are taken from the U.S Household Food Security Survey, and the questions have been validated for use in the health care setting. The subcommittee recommends the use of these question in Oregon's social needs screening efforts for quality data and consistency with current practices.

Box 1. Hunger Vital Sign questions

> Within the past 12 months, you worried that your food would run out before you got money to buy more.
> - Often true
> - Sometimes true
> - Never true
>
> Within the past 12 months, the food you bought just didn't last, and you didn't have money to get more.
> - Often true
> - Sometimes true
> - Never true

Several screening tools (American Academy of Family Physicians [AAFP], AHC, Boston Medical Center [BMC] Thrive, NC Medicaid and iHELP) use the Hunger Vital Sign set of two questions to assess food insecurity, and several other tools use variations of the Hunger Vital Sign or other questions the subcommittee felt would be sufficient to assess food insecurity status. See Tables 1 and 2 below for tool recommendations.

Housing insecurity

The subcommittee did not recommend a specific screening question for housing insecurity. While the subcommittee agreed that housing insecurity was an important social need to screen for and address in CCO members, members also recognized that housing insecurity is a more complex and multifaceted concept to assess than food insecurity. This complexity is reflected in the screening questions across the different tools, which are more varied. For example, some questions ask about housing status in the past and others ask about concern for stable housing in the future. Additionally, housing needs can be more difficult to address when identified compared with other social needs. The Housing Vital Sign series of three questions that have been tested and validated (analogous to the Hunger Vital Sign) is in Box 2 below, but the use of the Housing Vital Sign is not widespread, and when the questions are used, they are often modified.

Box 2. Housing Vital Sign questions

> 1. Was there a time when you were not able to pay the mortgage or rent on time? Yes/No
> 2. How many places have you lived? Yes = 3 or more places
> 3. Was there a time when you did not have a steady place to sleep or slept in a shelter (including now)? Yes/No

The subcommittee felt that all the tools listed in Tables 1 and 2 below had acceptable transportation screening questions, but they also expressed a preference for questions that ask about both medical and non-medical transportation (this includes AHC, Arlington, NC-Medicaid, PRAPARE, Your Current Life Situation [YCLS]). No transportation screening questions were available for screening in pediatric populations, so further discussion on transportation screening in the pediatric population is needed if this recommendation advances.

Table 1. Adult screening tools reviewed for selected domains

	Food insecurity	Housing Insecurity	Transportation
American Academy of Family Physicians (AAFP)	✓	✓	✓
Accountable Health Communities (AHC)	✓	✓	✓
Arlington	✓	✓	✓
Boston Medical Center Thrive (BMC Thrive)	✓	✓	✓
Health Begins	✓	✓	✓
Health Leads	✓	✓	✓
North Carolina Medicaid (NC Medicaid)	✓	✓	✓
Protocol for responding to and assessing patients' assets, risks and experiences (PRAPARE)	✓	✓	✓
Your Current Life Situation (YCLS)	✓	*Question not recommended*	✓

Table 2. Pediatric screening tools reviewed for selected domains

	Food insecurity	Housing Insecurity	Transportation
iHELP	✓	✓	*No question on this domain*
Survey of Well-being of Young Children (SWYC)	✓	*No question on this domain*	*No question on this domain*
WeCare	✓	✓	*No question on this domain*

The subcommittee offered these additional recommendations for screening tools and questions:
- ⇒ Provide entities who will be conducting the screening (including health care providers) information about the research supporting the tools, questions and approach so they can better understand the rationale for the measure and the question. Provide resources to support screening implementation.
- ⇒ From an equity perspective, consider making icon-based screeners (for example, checklists with icons representing social needs) available to accompany the selected screening tools or questions. This will ensure the questions are as accessible to CCO members as possible.

To make a more robust recommendation about icon-based screeners, OHA will initiate further discussion with partners currently using icon-based screeners to better understand how they work, for which populations, and how they intersect with data collection needs.

⇒ Review questions from a trauma-informed perspective. Share examples of trauma-informed explanatory statements that can be used to introduce questions to members.

⇒ Provide entities who will be conducting the screening with information about organizations that are working in the areas screened. For example, for food insecurity, look to local and/or regional food banks to get more information on what food resources are available.

⇒ Plan to accommodate low literacy and language-access needs. Ensure questions asked are at a literacy level of eighth grade or below. Screening questions should be available in languages of populations served and translations validated with local communities.

⇒ If questions from domains are asked using entire tools, questions should be omitted that duplicate or contradict data already collected to avoid screening fatigue. For example, race/ethnicity data may be collected by CCOs at other times, and the race/ethnicity questions in the screening tools is reviewed may not be REALD compliant.

HEALTH POLICY AND ANALYTICS

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