Aligning Social Determinants of Health (SDOH) Initiatives in Oregon

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ORPRN Health Policy Program & Systems Innovation

The Oregon Rural Practice-based Research Network (ORPRN) is a statewide network of primary care clinicians, community partners, and academicians dedicated to studying the delivery of health care, improving the health of Oregonians and reducing rural health disparities. **ORPRN's health policy team works on both research and technical assistance around health systems innovation, including Medicaid innovation, primary care quality improvement, and value-based payment models.**

- *Claire Londagin, MPH, is a Health Policy Manager at ORPRN. Claire manages technical assistance programming on social needs screening and referral for Coordinated Care Organizations, Community Based Organizations, and state agencies. Previously, Claire worked on the Accountable Health Communities study screening patients across Oregon for social needs and connecting them with resources. Her background is in environmental health and food systems, and she has extensive experience connecting people with resources through diverse community health interventions.*
- *Mari Tasche, MPH, is a Health Policy Coordinator with the Health Policy team at ORPRN. She implements a quality improvement program that provides technical assistance to health care organizations throughout the state to develop their social needs screening and resource referral processes. She has worked with over twenty organizations in the last three years, including primary care clinics and public health departments.*

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Agenda

- **Social Needs Screening Initiatives in Oregon**
  - Screening & Connecting Patients to Resources
  - SDOH Screening and Referral CCO Incentive Metric
  - MBQIP & IQR Social Drivers of Health Measure
- **Universal Social Needs Screening in Practice**
  - SDOH-HE program overview and impact
  - Clinic Experiences
- **Best Practices**
  - Social needs screening
  - Referral processes
  - Workflow examples
- **Q&A**
- **Useful resources**

Social Needs Screening Initiatives in Oregon

Social Needs Screening Landscape in Oregon

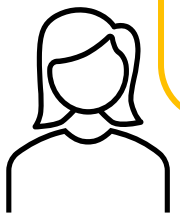
- Coordinated Care Organization (CCO) SDOH social needs screening and referral quality incentive metric
- CMS Inpatient Quality Reporting (IQR) metric Screening for Social Drivers of Health
- Patient Centered Primary Care Home Health Equity (PCPCH-HE) measure
- Center for Medicaid & Medicare Services (CMS) MIPS Clinical Quality Measure: Screening for Social Drivers of Health
- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) SNS-E (Social Needs Screening and Intervention) Measure
- Uniform Data System (UDS): Health Center Data Reporting Requirements
- Health Related Social Needs (HRSN) covered services

CCO Social Needs Medicaid Initiatives

Individual Supports

SDOH Social Needs Screening and Referral Incentive Metric
Screen OHP Members for food, housing, and transportation needs, refer patients to community based social service providers.

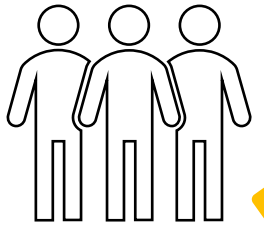
Health Related Services (HRS) Flexible Services
Pay for resources that supplement covered services for individual OHP Members, like a Veggie Rx program membership or temporary housing and hygiene supplies.



1115 Waiver Health Related Social Needs (HRSN) Benefit
If in a life transition, HRSN benefit pays for 6 months of food, housing, and outreach and engagement services.

Community Investments

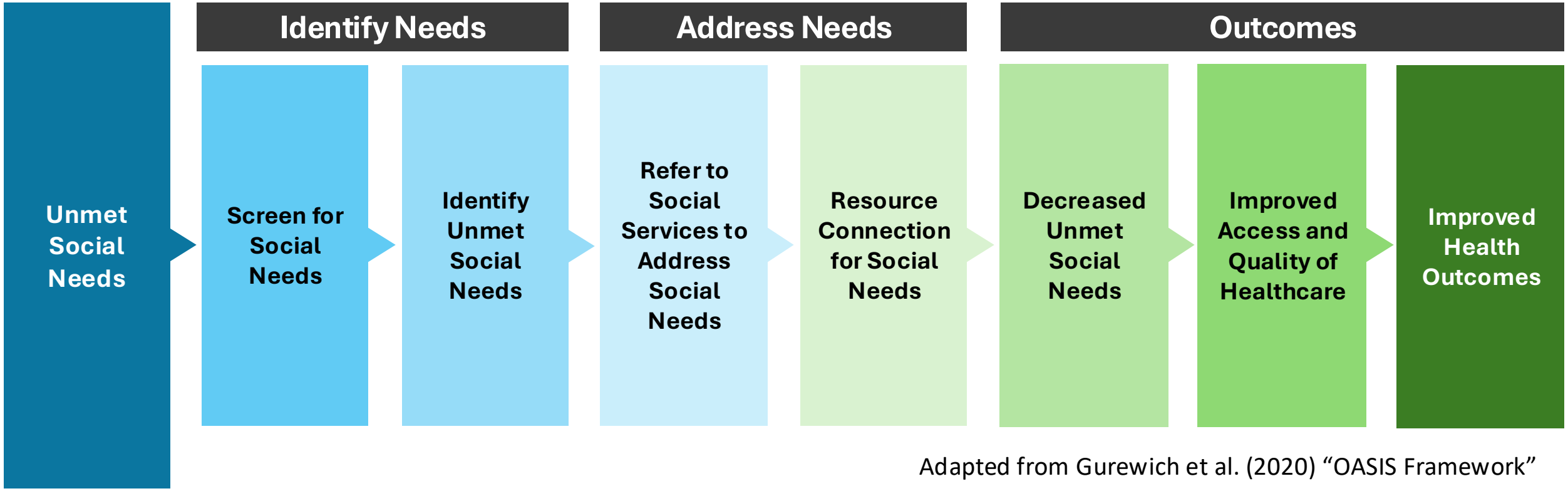
Supporting Health for All throughREinvestment (SHARE): COs must spend a portion of their net income on services to address health inequities and the social determinants of health and equity (SDOH-E) at a community level.



Health Related Services Community Benefit Initiatives (HRS CBI) are community-level interventions focused on improving population health and health care quality.

1115 Waiver Community Capacity BuildingFunds (CCBF): can be used to improve the technology, systems, workforce, and engagement activities of community-based organizations to enhance and expand health related social needs resources.

Social Services Connections Pathway



Adapted from Gurewich et al. (2020) “OASIS Framework”

Connecting Patients to Resources

CIE is a **network of collaborative partners** using a **multidirectional technology platform** to connect people to the services and support they need.

- Partners may include social services, health care systems and clinics, health departments, CCOs, and community-based organizations
- Technology functions include closed-loop referrals, a shared resource directory, informed consent, screening and reporting

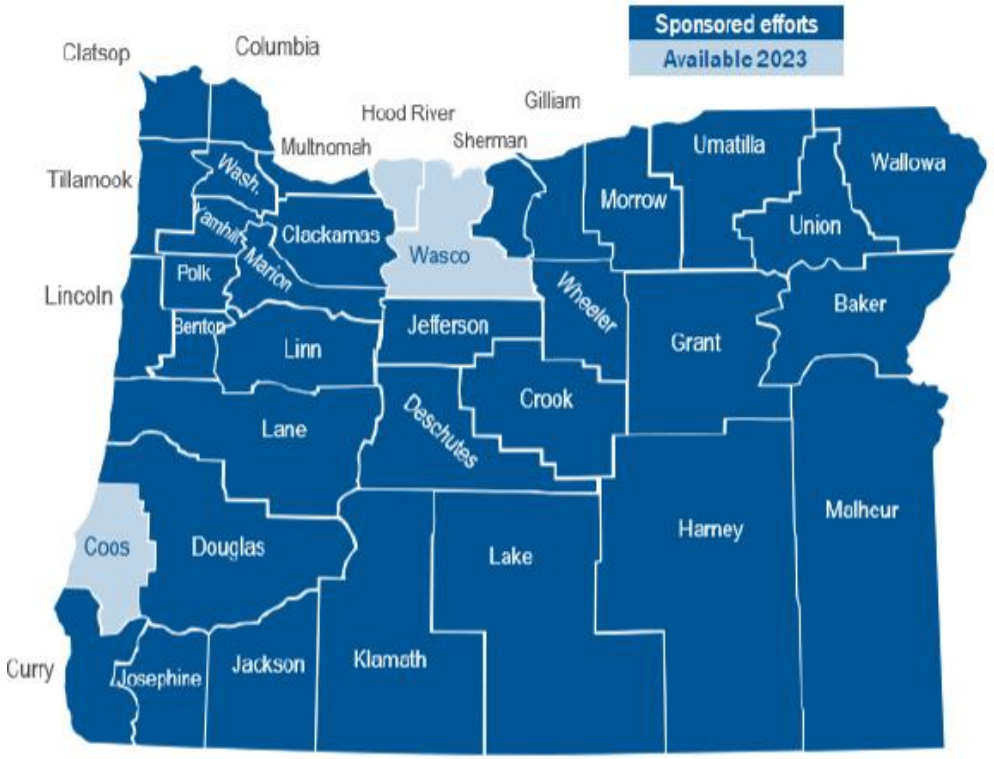
There are numerous state-wide efforts in Oregon to encourage the use of CIE.

HIT COMMONS
Accelerating Health Information Technology

Oregon CIE Advisory Group Charter. (2020). Community Information Exchange (CIE) in Oregon: Emerging landscape, key concepts, and future needs. https://orhealthleadershipcouncil.org/wp-content/uploads/2021/09/HIT-Commons-CIE-Advisory-Group-Report-Final-Report-December-2020-1.pdf

Connecting Patients to Resources

Oregon CIE Maps: Status of sponsored efforts as of December 2022



UNITE US

CONNECT OREGON

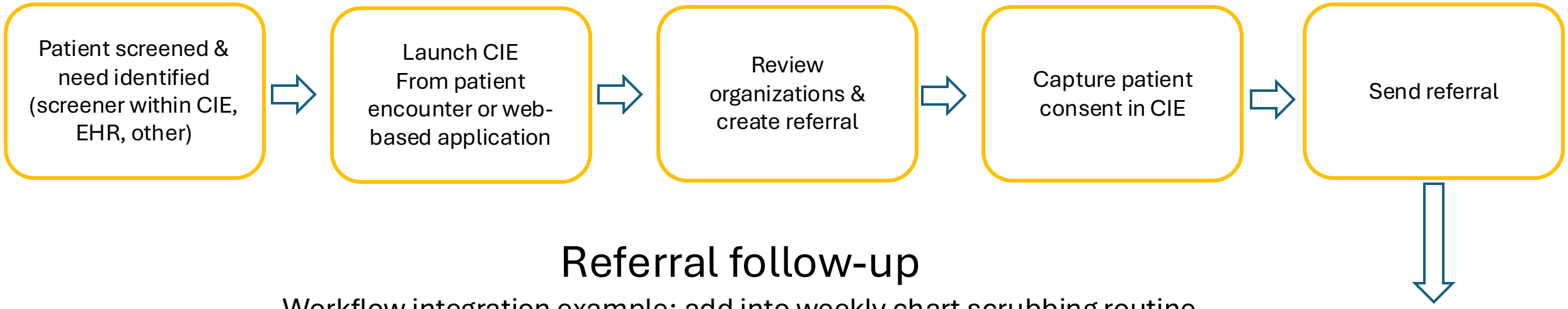
findhelp

Health Information Technology Oversight Council. House Bill 4150 Final Report: Supporting Statewide Community Information Exchange. Portland, Oregon. January 2023. https://www.oregon.gov/oha/HPA/OHIT-HITOC/Documents/HB4150FinalReport.SupportingStatewideCIE.pdf

Connecting Patients to Resources

Screening and sending referral

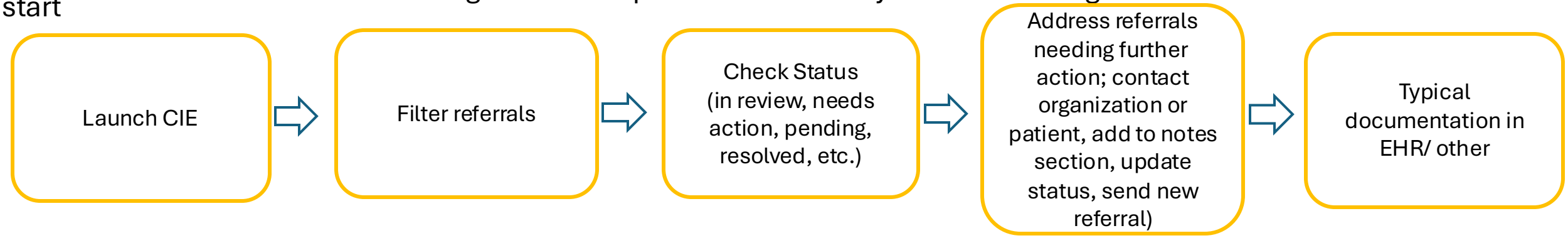
start



Referral follow-up

Workflow integration example: add into weekly chart scrubbing routine

start



Social Determinants of Health (SDOH) Screening and Referral CCO Incentive Metric

Background

- **What is an Incentive Metric?**
  - Incentive metrics are a **measuring tool** that the Oregon Health Authority uses to show how well Coordinated Care Organizations (CCOs) are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care for their Medicare and Medicaid patients.
  - Oregon Health Authority Coordinated Care Organization Quality Incentive Program provides bonus funds to Coordinated Care Organizations based on their performance on incentive measures.

- The **Social Determinants of Health: Social Needs Screening & Referral Metric** aims to acknowledge and address Oregon Health Plan members' social needs.

- **Social needs** this measure addresses:
  - **Food insecurity**
  - **Housing insecurity**
  - **Non-medical Transportation needs**

Component 1 - Structural Measure 2023-2025

Screening Practices

- Develop social need screening policies and training protocols
- Assess what social needs screening tools are used
- Assess where members are being screened for social needs

Referral Practices and Resources

- Assess capacity of local resources and gap areas
- Develop plan to help increase CBO capacity in CCO service area
- Form agreements with CBOS that provide housing, non-medical transportation, and food services

Data Collection and Sharing

- Conduct environmental scan of data systems used in CCO service area
- Develop data systems for collecting and using REALD data
- Support data-sharing among organizations within CCO service area

Social Needs Screening & Referral Incentive Measure
Specifications: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2025%20specs%20SDOH%202024.12.31.pdf

Component 2

- Intended to measure the percentage of CCO members screened and referred to services
- Beginning in 2025 CCOs will report on a sample of members
- Hybrid model - multiple sources of data can be used including MIS/DSSURS, EHR, community information exchange (CIE), health information exchange (HIE), and other data sources

Rate 1: % who were screened

Numerator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Denominator: All members who meet continuous enrollment criteria except those who decline to be screened in all 3 domains

Rate 2: % who screened positive

Numerator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

Denominator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Rate 3: % who screened positive and received a referral

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

Denominator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

Social Needs Screening & Referral Incentive Measure Specifications: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2025%20specs%20SDOH%202024.12.31.pdf

CCO implementation activities that may impact healthcare organizations:

You may be asked…

- ➔ To screen patients for specific social needs and refer them to resources
- ➔ To share data about social needs screening and referral with your CCOs
- ➔ What social needs screening tool your clinic is using
- ➔ To use a specific social needs screening tool
- ➔ What training policies and protocols you have in place around screening for social needs
- ➔ To use a Community Information Exchange platform to input screening results and make referrals
- ➔ You may get suggestions from your CCOs around training their employees, etc.

Medicare Beneficiary Quality Improvement Project (MBQIP) and the CMS Inpatient Quality Reporting (IQR) Social Drivers of Health Measures

Background

- The **Medicare Beneficiary Quality Improvement Project (MBQIP) and the CMS Inpatient Quality Reporting (IQR) Social Drivers of Health Measures** assesses whether a hospital implements screening for all patients that are 18 years or older at time of admission for unmet social needs.

- **Social needs** this measure addresses:
    - **Food insecurity**
    - **Housing instability**
    - **Transportation needs**
    - **Utility difficulties**
    - **Interpersonal safety**

Reporting

1. **Screening for Social Drivers of Health**
    - Screen all inpatients aged 18+ for 5 domains: food, housing, transportation, utilities, safety.
    - Reported as a rate: patients screened / total eligible admitted patients.
    - Patients can opt-out or be excluded if screening is not possible.

2. **Screen Positive Rate**
    - Of those screened, how many screened positive for each domain (reported as 5 separate rates).
    - Reported as a rate: screened positive for one or more need / patients screened
    - Patients can opt-out or be excluded if screening is not possible.

1. Screening Rate

Numerator: The number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all five HRSNs during their hospital inpatient stay.

Denominator: The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

2. Screen Positive Rate

Numerator: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately)

Denominator: The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission and are screened for all five HRSN during their hospital inpatient stay.

Screening for Social Drivers of Health Data Submission Guide: https://www.telligen.com/wp-content/uploads/2025/03/Data_Submission_Guide_Screening_for_SDOHv2_508.pdf

Screen Positive Rate for Social Drivers of Health Data Submission Guide: https://www.telligen.com/wp-content/uploads/2025/03/DataSubmissionGuide_ScreenPositiveRate_SDOHv2_508.pdf

Universal Social Needs Screening in Practice

At the clinic level

SDOH-HE Program Overview

Background

- Funded by the Oregon Health Authority, Public Health Division, Health Promotion & Chronic Disease Prevention sections
- 4th year of the program
- Runs annually, about 10 months

Purpose

- Provide technical assistance to healthcare clinics across Oregon to develop or improve social needs screening and referral processes

Process

- Assess workflows to identify improvement areas
- Assist clinics in setting goals and creating action plans
- Offer guidance, EHR support, and resource provision
- Track monthly metrics to inform progress

SDOH-HE Program Impact

Key Achievements

- Formalized social needs screening workflows
- Established and improved referral processes
- Utilized EHR tools for screening and tracking
- Improved reporting capabilities

Impact on Clinics and Patients

- Increased screening rates and early identification of needs
- Improved connections to community resources
- Sustainable systems for ongoing use
- Greater clinic-wide engagement in addressing social needs

Screening & Referral Data Snapshot

2023-24 Program

- 7 clinics
- January–June 2024 (6 Months)
- 5,000 patients screened
- 550 patients referred

2024-25 Program (so far)

- 7 clinics
- January–March 2025 (3 Months)
- 1,600 patients screened
- 220 patients referred

AHRQ Agency for Healthcare Research and Quality

Clinic Experiences

Challenges

- Workflow inconsistencies
- EHR setbacks and limitations
- Screening data not reportable
- Screener only in English
- Patients declined screening or referral to resource
- Staff turnover and continued buy-in
- Bandwidth constraints

Workflow Strategies

- Workflow map to streamline process across roles
- EHR workarounds, engage EHR staff, and vendor resources
- Switch to an OHA- approved screener that is already built into EHR
  - Allows for reportable data
  - Screener available in multiple languages

Staff Strategies

- Develop scripts to guide sensitive conversations
- Workflow and education PowerPoint incorporated into onboarding trainings
- SDOH and screening topics built into standing monthly meeting agendas

Best Practices

Initial Considerations in Workflow Development

- There is no "one size fits all" approach
- What are your organizations reporting requirements?
- Ensure there is a mechanism to capture structured data in each main step of the process
- Consider capacity and engage the right team members
- Reflect on workflows already in place for existing screeners
- Build on processes you already have in place

Main Steps In Screening and Referral Process

Choosing a Social Needs Screener

Review Current Practices

- Check if social needs questions are already asked (e.g., under Social History)
- Ask other departments or partner clinics if they are screening and which tool they use

Evaluate EHR and Reporting Capabilities

- Review existing screening tools available in your EHR
- Explore process to build custom screeners or reports if needed
- Crosswalk current tools against reporting requirements

- **Is there an option for patients to decline screening and to accept or decline offered resources?**

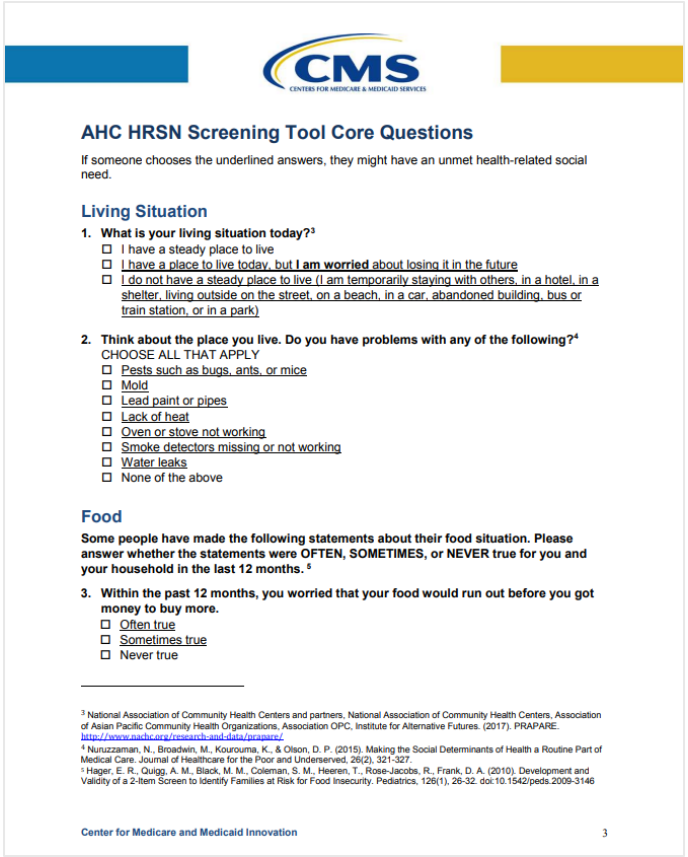
Choosing a Social Needs Screener

Social Needs Domains

- **MBQIP/IQR measure:** Does *not* require a specific screening tool
  - Emphasis on using **validated tools** is expected in future updates
  - Domains: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- **CCO metric:** Requires use of an OHA-approved or exempted screening tool
  - Domains: food, housing, and transportation
- **Additional Considerations**
  - Assess other **health-related social needs** relevant to the patient population (e.g., childcare, social isolation, financial strain)
  - Consider both staff comfort with administering screening questions and the literacy, cultural, and language needs of the patient population

Choosing a Social Needs Screener

- Tools that fulfil the requirements for both metrics:
  - Accountable Health Communities (AHC)
  - Arlington
  - North Carolina Medicaid (NC Medicaid)
  - Protocol for responding to and assessing patients' assets, risks and experiences (PRAPARE)
  - WellRx Questionnaire



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ 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)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   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

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **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

[3] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/
[4] Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.
[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

Center for Medicare and Medicaid Innovation 3

Screening for Social Needs

Patient population and visit types

- **CCO metric:** All Medicaid patients
- **MBQIP/IQR measure:** All adult patients 18 y/o+ admitted to hospital

Avoiding Over-Screening

- Repeated screening in a short timeframe or across settings may be retraumatizing
- Conversational follow-up (e.g., asking if a past referral helped) is appropriate
- Strategies:
  - Check screening history before re-screening
  - Screen at household level when relevant
  - Use empathic inquiry or motivational interviewing to gauge comfort and prior experience of patient

Screening Cadence

- **CCO metric:** Screen once per year
- **MBQIP/IQR measure:**
  - Screen during each hospital stay – for frequent admissions, confirm or update prior screening
  - Use outpatient screening data if appropriate

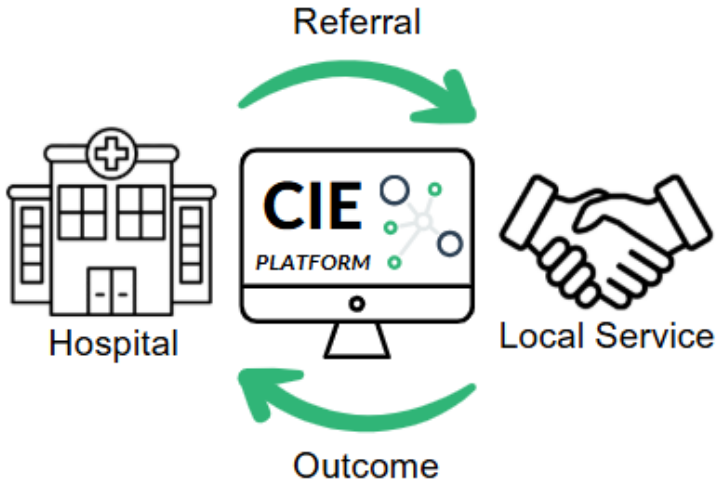
Referring Patients with Positive Screens

Internal Referral Approaches

- Direct referral to in-house CHW, care manager, or social worker
- Patient is connected to staff through a warm hand-off or phone call

External Referral Approaches

- Community Information Exchange (CIE) platforms such as UniteUs/Connect Oregon or findhelp
- If the patient does not want a referral, provide a customized resource list (e.g., from 211info.org)
- Facilitate direct outreach to social services when possible



Referral Tracking and Follow-up

- Consider establishing a **follow-up procedure** to document referral outcomes
- CIE platforms facilitate referral tracking and communication with service providers
- To document the full process in the EHR, a referral order offers an effective solution

UniteUs in Practice

Clinic Experiences

- Ability to see real-time referral updates
- Improved communication with local resource providers
- Reduced time looking up resources and connecting patient
- Increased staff confidence in following up with patients
- Helps identify referral and resource gaps
- Ability to pull reports including Cases, Clients, Notes, Referrals, Users, Assessments, and Screenings

Clinic Example of Monthly Data

Screening Rate

37% (172/465)

UniteUs Referral Rate

53% (121/227)

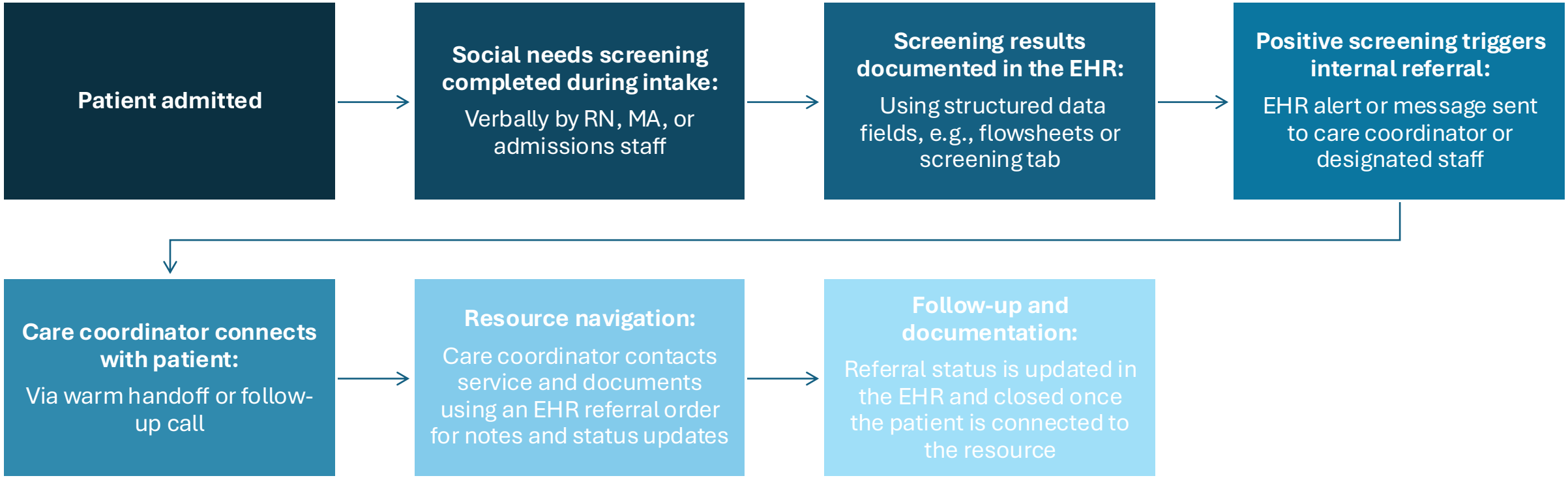
UniteUs Closed-loop Referral Rate

67% (81/121)

Addressing Common Challenges

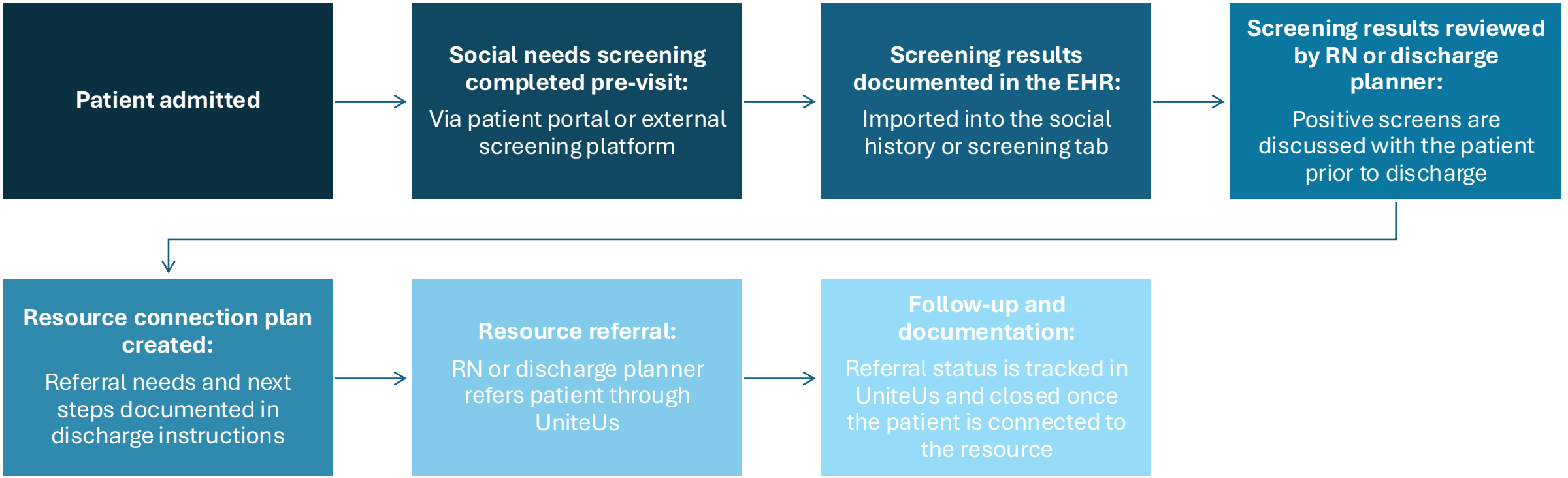
- **Outdated resource directory** → Integrated with 211; updates occur daily
- **Limited resources** → Use Out of Network cases; assign referrals internally to track and close the loop
- **Staff buy-in and engagement** → Pilot process; highlight time saved through streamlined referral workflows
- **Double data entry / added platform burden** → Interoperability options to integrate with the EHR system

Workflow Example 1



*Assumption: patient screens positive and indicates they would like assistance connecting to services or resources

Workflow Example 2



*Assumption: patient screens positive and indicates they would like assistance connecting to services or resources

Questions?

Additional Resources

- OHA Social Needs Screening Tools
- CCO SDOH Metric FAQ
- MBQIP/IQR measure Social Drivers of Health Measure
- Staff Training for Social Needs Screening Guidance Document
- Social Interventions Research & Evaluation (SIREN)
  - Social Needs Screening Toolkit
  - Social Needs Referrals Toolkit

Contact Information

- Individualized Technical Assistance: Mari Tasche, MPH
  tasche@ohsu.edu
- Help connecting with your CCOs: Claire Londagin, MPH
  londagin@ohsu.edu

Thank You!

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