Forum on Rural Population Health

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OREGON OFFICE of RURAL HEALTH

Building a Statewide Social Needs Screening and Referral System 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 Research Project 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.*

ORPRN OHSU

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We have no other relevant financial relationships to disclose.

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We will not discuss off label use or investigational use in this presentation.

Agenda

Health Related Social Needs in Oregon

- Introduction to social determinants of health and a shared statewide vision for addressing unmet health related social needs.

The System

- See the key influences and players within the Oregon health related social needs screening and referral system.

Coordinated Care Organization (CCO) Quality Incentive Metric

- Hear an example of an incentive to build universal screening, referral, and data sharing system in Oregon led by CCOs, Oregon's Medicaid managed care organizations.

Healthcare Organizations/Primary Care Clinics

- Learn current practices, challenges, and strategies for building screening and referral processes in rural clinics across the state.

Reflection and Q&A

- Reflect on your role in moving this system forward and ask presenters questions.

Learning Objectives

- Understand the state of social needs screening and referral systems in Oregon
- Learn about two current efforts in the system
- Understand your organization's role in this system and how you can make progress towards the shared statewide vision
- Share ideas of how we can move this system forward together

Health Related Social Needs in Oregon

Background – Social Determinants of Health

Social Determinants (Drivers) of Health (SDOH) - the conditions in the environments where people are born, live, learn, work, play, and age that affect a wide range of health outcomes.[1]

- SDOH have been shown to have a greater influence on health than either genetic factors or access to healthcare services.[2]
- Often refers to community-level factors.

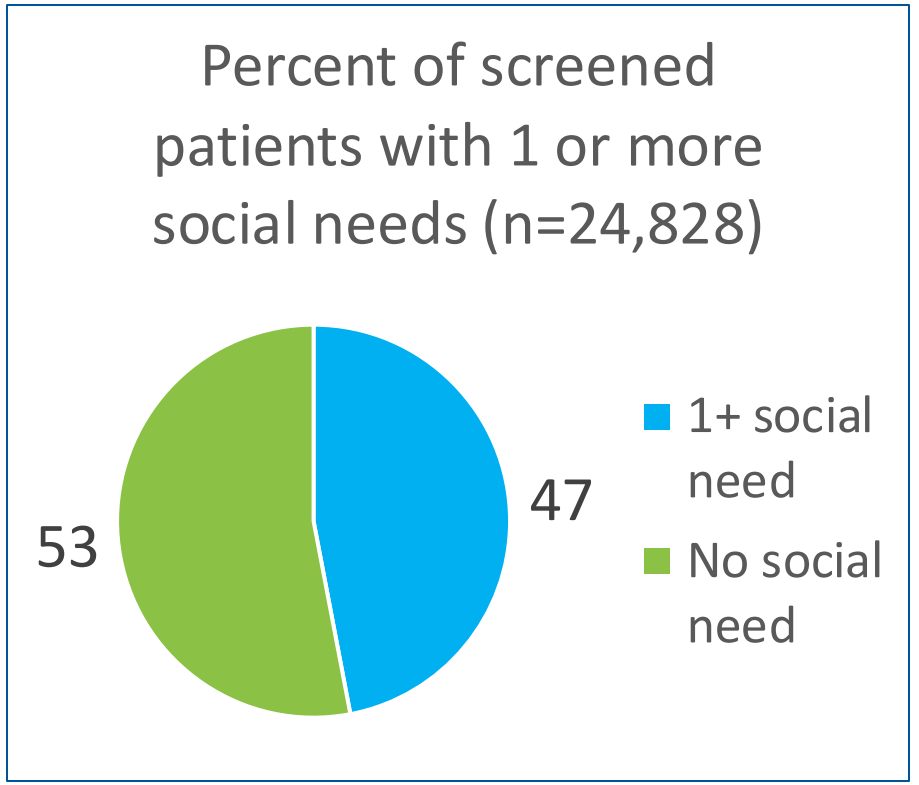
Health Related Social Needs - social and economic needs that individuals experience that affect their ability to maintain their health and well-being.[1]

- Factors such as financial instability, lack of access to; healthy food, affordable and stable housing and utilities, health care, and transportation.
- Often refers to individual-level factors

1. Centers for Medicaid and Medicare Services. *Social Drivers of Health and Health Related Social Needs,* (February 27, 2025) - https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs
2. Centers for Disease Control and Prevention, *Social Determinants of Health* (January 17, 2024) - https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html

Oregon Accountable Health Communities (AHC) Study

- Nearly 25,000 Oregon Medicaid and Medicare members were screened for the Oregon Accountable Health Communities project. [1]
- 47% of members screened reported a food, housing, transportation, utilities and/or safety need.[1]
- Communities of color are disproportionately affected.[1]



1. Oregon Rural Practice-based Research Network, Oregon Accountable Health Communities study. (2022)

Social Needs and Health Outcomes

Supportive **housing** can reduce…

- Inpatient care
- Emergency department visits
- Hospitalizations
- Hospital days
- Long-term care utilization

Nutrition support is associated with…

- Lower healthcare expenditures
- Lower odds of hospitalization for some populations
- Improved maternal and child health outcomes
- Reduced elevated HbA1C
- Lower body mass indices

Transportation…

- Facilitates access to other health related social resources
- Rural Oregonians must travel long distances for food and medical care
- Public transportation resources are limited in non-urban areas
- 17% of patients screened in the Oregon AHC study did not have reliable access to transportation[2]

1. Office of Health Policy. (April, 2022). *Addressing the Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*. (HP-2022-12). U.S. Department of Health & Human Services. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf
2. Oregon Accountable Health Communities study, May 2020. *Social Determinants of Health Measurement Work Group Final Report*

Initiatives in Oregon

Oregon has been leading the efforts to turn this knowledge into action through implementing state and federal policies, incentives and funding mechanisms to encourage creation of a universal social needs screening system.

- Medicaid spending flexibilities
- Community investment initiatives
- Covered services
- Incentives for systematic screening and data sharing

ORPRNs roles in the system

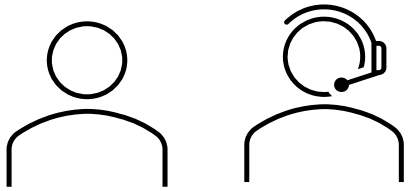
ORPRN Health Policy, Research, and Education programs all contribute to building the social needs screening, resource navigation and referral, and resource provision systems in Oregon.

- Accountable Health Communities research
- Technical Assistance with Oregon Health Authority
  - SDOH Quality Incentive Metric for CCOs
  - Social needs screening and referral for clinics
  - Health related social needs (HRSN) service providers
- Screening, navigation, and referral for CCO members
- Oregon ECHO series for healthcare professionals

Statewide Vision

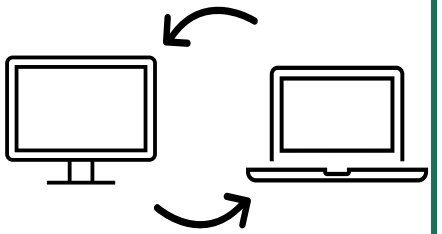
All Oregonians have their health related social needs acknowledged and addressed through systematic screening, individualized resource navigation, clear funding pathways for resource provision, and strong data sharing systems. Clinical and community organizations will become partners in providing comprehensive healthcare leading to improved health equity, individual, and community level health outcomes.

Systematic screening



Individualized resource navigation

Clear funding pathways



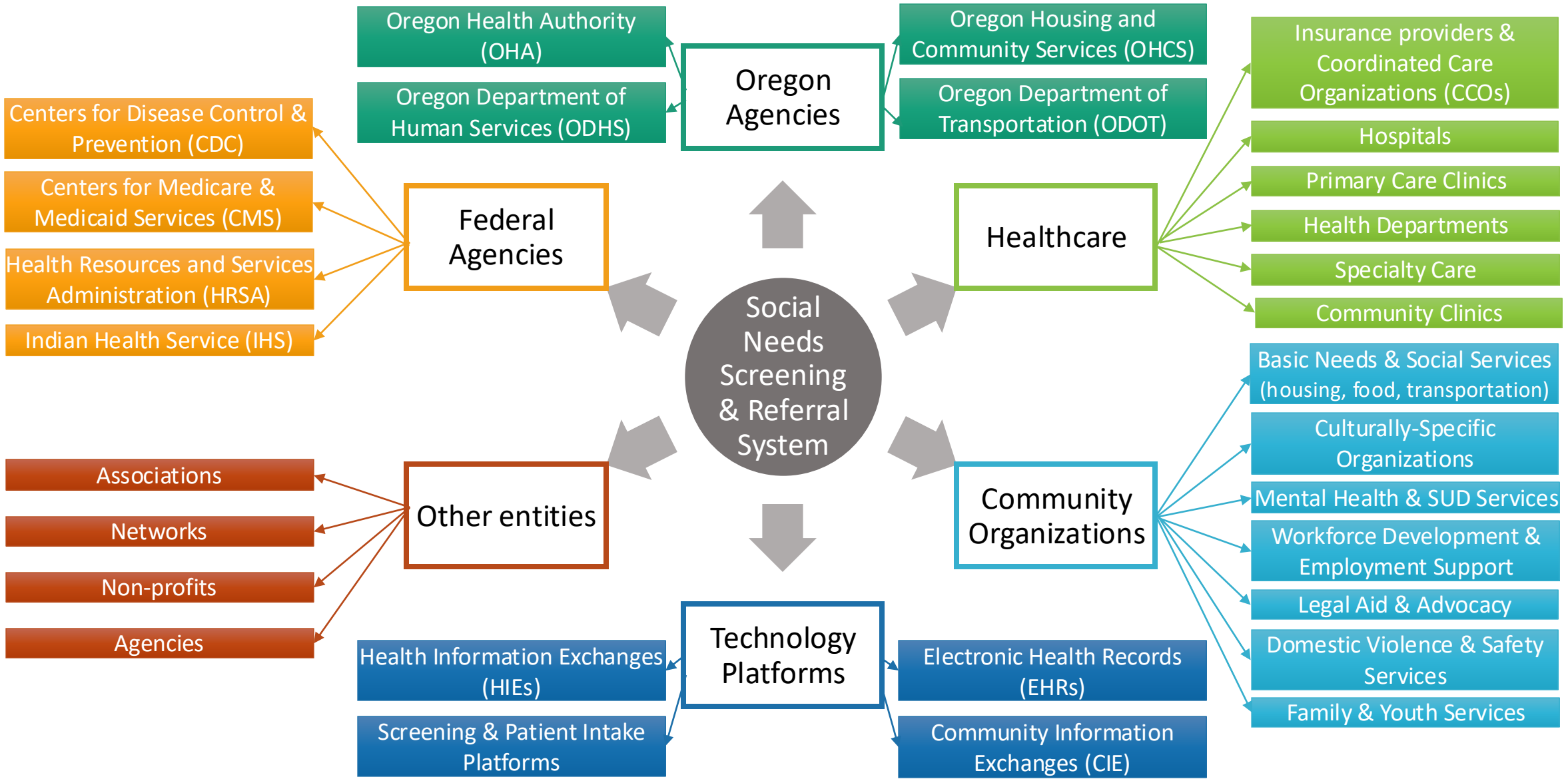
Strong data sharing systems

The System

Social Needs Screening and Referral System Diagram

- High-level visual overview of key sectors involved in Oregon's social needs screening and referral efforts
- Integrates components from multiple complex and rapidly evolving systems—including healthcare, social services, public health, and technology
- Highlights the interconnected roles and importance of cross-sector collaboration to address social determinants of health
- While this overview captures major components, it does reflect the full depth of each sector's work and related parts

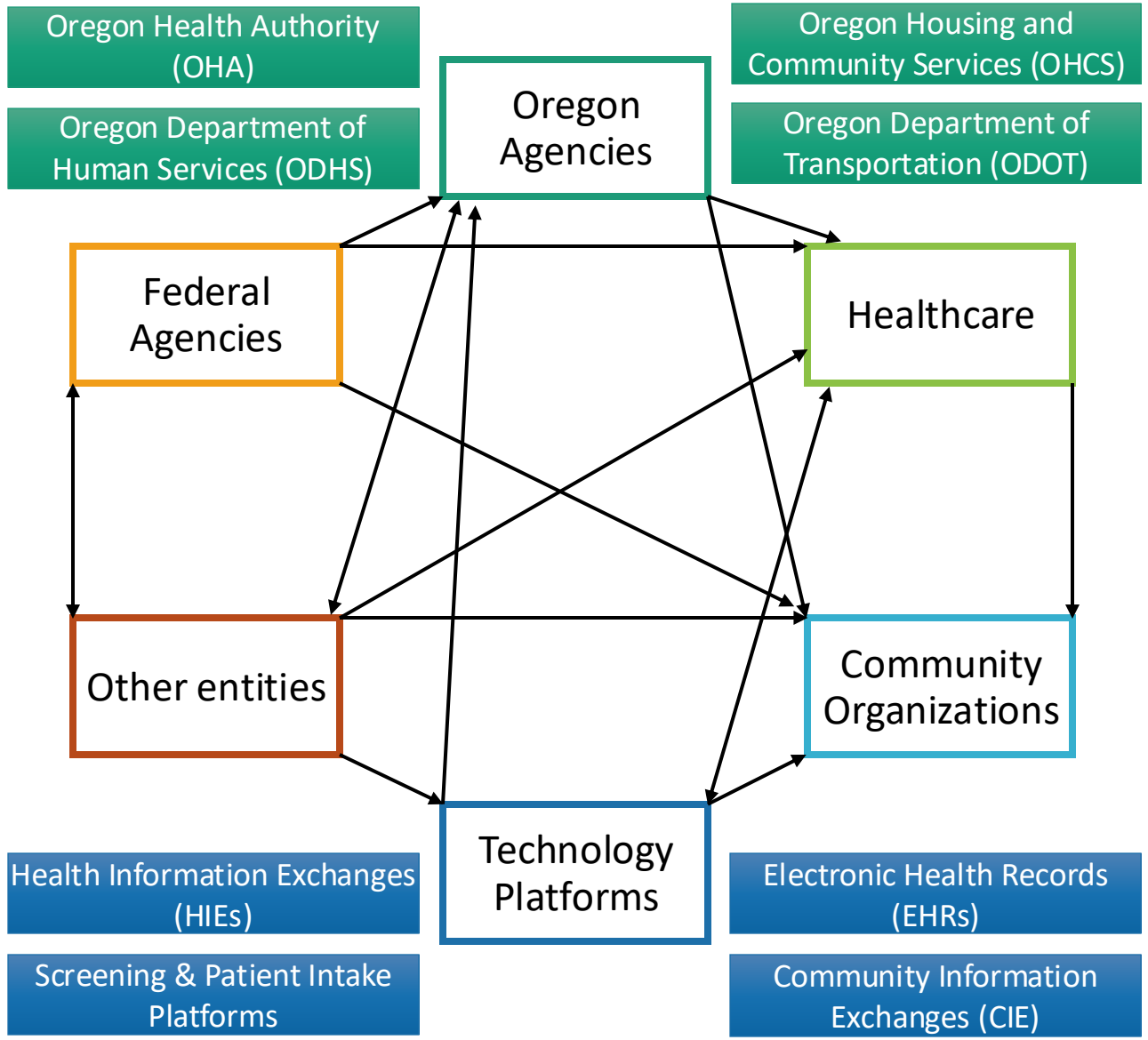
High-Level Overview



High-Level Overview: Key Connections

- Centers for Disease Control & Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)

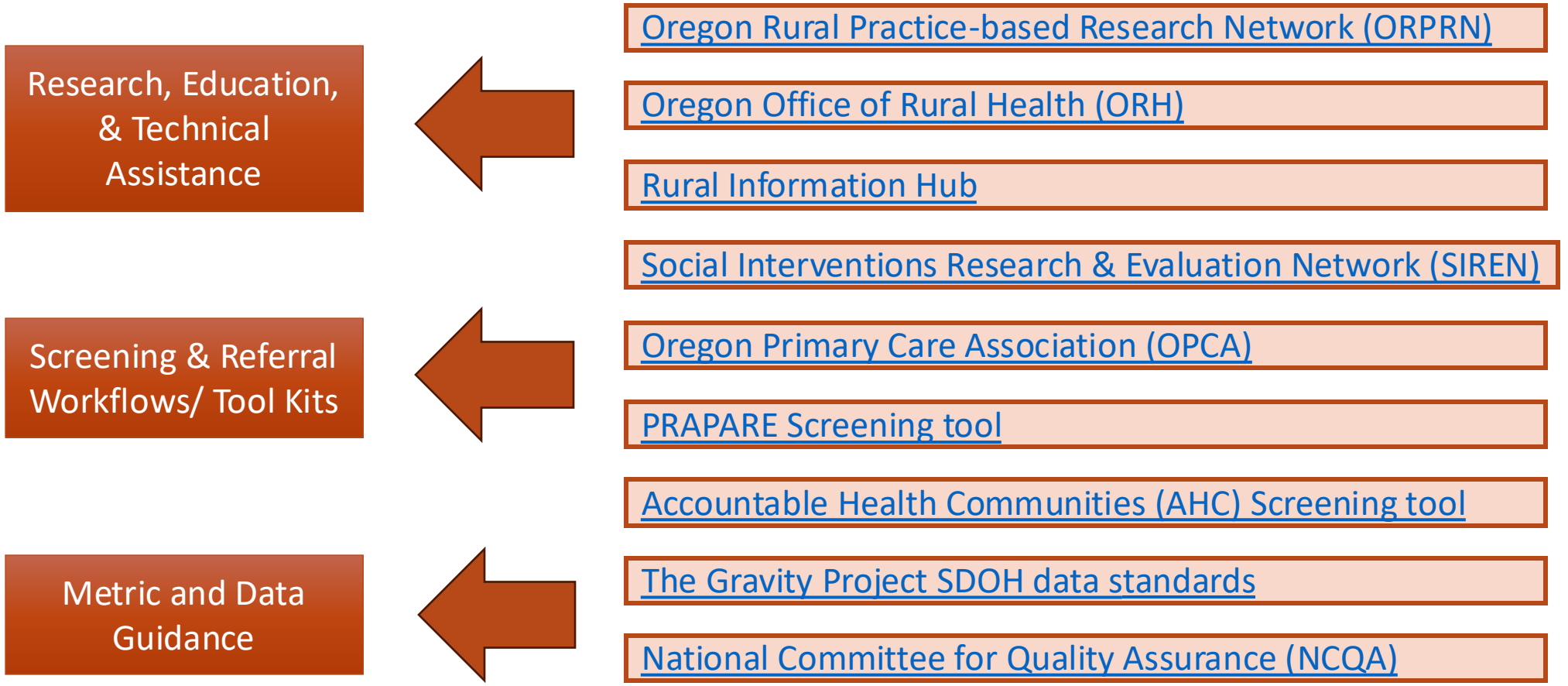
- Associations
- Networks
- Non-profits
- Agencies



- Insurance providers & Coordinated Care organizations (CCOs)
- Hospitals
- Primary Care Clinics
- Health Departments
- Specialty Care
- Community Clinics

- Basic Needs & Social Services (housing, food, transportation)
- Culturally-Specific Organizations
- Mental Health & SUD Services
- Workforce Development & Employment Support
- Legal Aid & Advocacy
- Domestic Violence & Safety Services
- Family & Youth Services

Spotlight: Examples of Other Entities



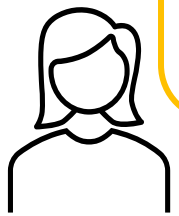
System Highlight: Social Need Integration Through Medicaid

Federal Agency	Oregon Agency	Healthcare	Community Organizations
Centers for Medicare & Medicaid Services (CMS)	Oregon Health Authority (OHA)	Coordinated Care Organizations (CCOs)	Basic Needs & Social Services
• Oversees Medicaid and Medicare programs nationally • Approves state Medicaid waivers that include social needs initiatives • Provides funding, policy guidance, and reporting requirements related to SDOH	• Administers Oregon's Medicaid program (Oregon Health Plan- OHP) • Works with CMS to implement waivers, oversee Medicaid SDOH initiatives, and support statewide efforts to address social needs	• Organize and deliver care for OHP members within regional networks • Carry out OHA policies and Medicaid SDOH initiatives at the community level • Coordinate with healthcare providers and community partners to address social needs and whole-person care	• Provide services or navigation for needs such as housing, food, transportation, and utilities • Collaborate with and receive support from CCOs • Receive referrals from healthcare providers

Social Needs Medicaid Initiatives

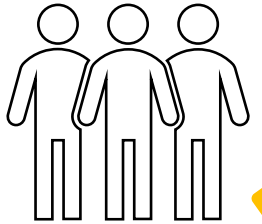
SDOH Social Needs Screening and Referral Incentive Metric
Screen OHP Members for food, housing, and transportation needs, refer patients to community based social service providers.

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.

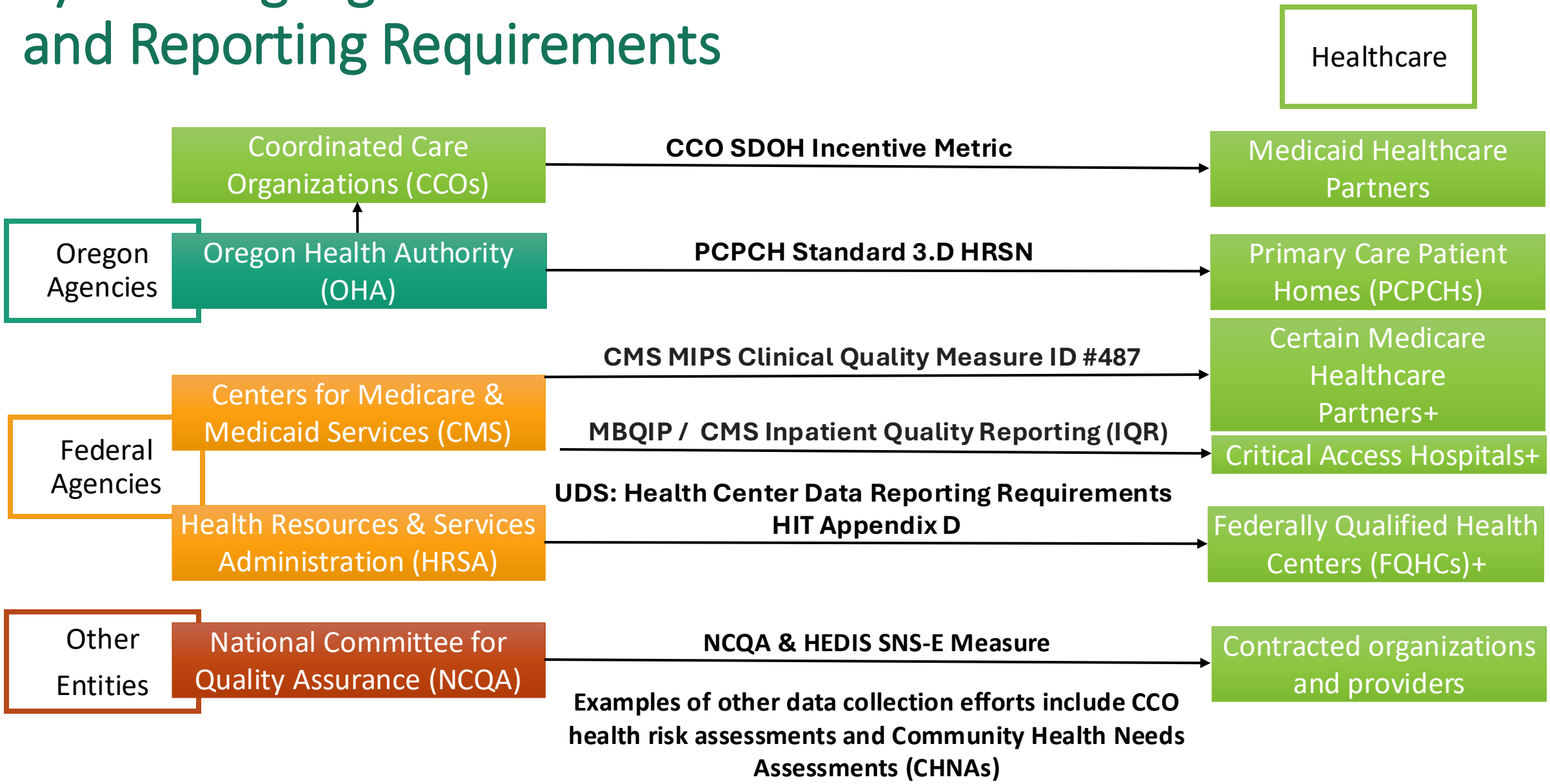
Supporting All through REinvestment (SHARE): CCOs must spend a portion of their net income on services to address health inequities and the social determinants of health and equity (SDOH-E) at a community level.



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.

System Highlight: SDOH-Related Metrics and Reporting Requirements



System Strengths: A Growing Foundation for Progress

Shared Priorities & Direction

- Widespread recognition of the impact of social determinants on health outcomes
- Federal and state-supported initiatives focused on addressing SDOH
- Engaged CCOs leading regional screening, partnerships, and community investments
- Community-based organizations have been at the forefront of this work for years and continue to serve as essential, trusted leaders in their communities

Cross-Sector Collaboration

- Improved collaboration and discussions across sectors
- Community Health Needs Assessments (CHNAs) and Implementation Plans (CHIPs) foster cross-sector dialogue and planning

Healthcare & Technology Efforts

- Clinics working towards streamlined process and expanding care management roles
- Improvements to referral platforms and resource directories, including UniteUs, findhelp, and 211info
- Ongoing work to improve interoperability between CIEs and EHRs
- Improved data collection to assess needs and evaluate impact

System Challenges: Opportunities for Improvement

Capacity & Operational Gaps

- Fragmented systems and communication across sectors
- Disconnect between expectations and capacity, including what is being asked of certain entities and what is feasible given current systems and resources
- CBO capacity constraints limit ability to respond to increased demand
- Care team burden, with limited time and resources to follow up

Funding & Sustainability Issues

- Billing and reimbursement gaps for screening, resource navigation, and services
- Sustainability concerns, including reliance on short-term grants or pilot funding

Standardization & Technology Capabilities

- Inconsistent screening practices and lack of standardized processes
- EHR limitations in capturing, tracking, and reporting social needs data
- Lack of interoperability between EHRs, CIEs, and other platforms

- Equity concerns, including trauma, mistrust, and culturally appropriate processes

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

Background

- **What is a CCO Quality Incentive Metric?**
  - Quality incentive metrics are a **measuring tool** that the Oregon Health Authority (OHA) uses to show how well CCOs are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care for their members.
  - The OHA CCO Quality Incentive Program provides bonus funds to CCOs based on their performance on incentive measures.
  - While CCOs may ask their contracted clinical and community partners to implement this work, the CCO is responsible for the implementation approach and reporting data to OHA.

- 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**

Background

- ➔ **Collaboration** across sectors to provide wrap-around care
- ➔ **Connection** of patients to needed services, improved individual health
- ➔ **Collection** of both patient and population-level data to inform broader community solutions

Component 1 - Measure Year 2023 – 2025:
Coordinated Care Organizations evaluate and develop systems for implementation of universal social needs screening and referral in an equitable, trauma-informed manner; ensures groundwork is laid for data sharing and reporting.

Component 2 – Measure Year 2025 - 2026:
Measures the percentage of Coordinated Care Organization members screened and, as appropriate, referred to services.

Component 1

- **Screening**
  - CCOs must evaluate and support systematization of activities around social needs screening across their DSN and community partners, including screening tools used and approaches to conducting screening
  - Specific screening tools must be used, in order for the screening and referral data to be reported to OHA by CCOs and counted towards the metric requirements.
- **Referral**
  - CCOs must evaluate capacity and support systems for referral to and provision of social needs resources for OHP members
- **Data Collection & Sharing**
  - CCOs must evaluate data systems in use across the DSN, set up data systems to clean and use REALD, and support a data sharing approach in their service area

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 too

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

How might this impact you?

CCOs may be asking their contracted clinical and community partners...

- ➔ To screen patients for 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 organization 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 or resources from your CCOs around training.

Universal Social Needs Screening at the clinic level

The Clinic's Role in Addressing SDOH

- Clinics reach many of the most vulnerable patients, making them a key access point for identifying social needs
- Healthcare providers have a strong voice in advancing systems change and advocating for equity
- Infrastructure already exists- screening workflows, EHRs, and Health IT systems can support documentation and tracking
- SDOH directly impact health outcomes- addressing social needs improves chronic disease management, preventive care, and overall well-being

End Goals:

- **Clinic level:** Connect patients to resources, improve quality of life, and support health management
- **System level:** Capture and use data to improve care coordination, reduce silos, and strengthen resource availability

Current Clinic Practices

- Clinics are at different stages- some have screened informally for years
- Growing recognition of the need for structured workflows to improve communication, role clarity, and efficiency
- External drivers (e.g., CCO metric, clinic quality measures) are accelerating progress
- **No single approach-** strategies vary based on:
  - Reporting requirements
  - Screening tools and workflows
  - EHR systems and data/reporting capabilities
  - Leadership, staffing, and clinic priorities
  - Relationships with CCOs and community partners
- **Screening Practices:**
  - Typically universal, not limited to specific populations (e.g., not just Medicaid patients)
  - Common in primary care, internal medicine, behavioral health, CHW programs, and during specific visits (e.g., new patient, annual wellness exams)
  - Often combined with other assessments (e.g., PHQ-9, health history)

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

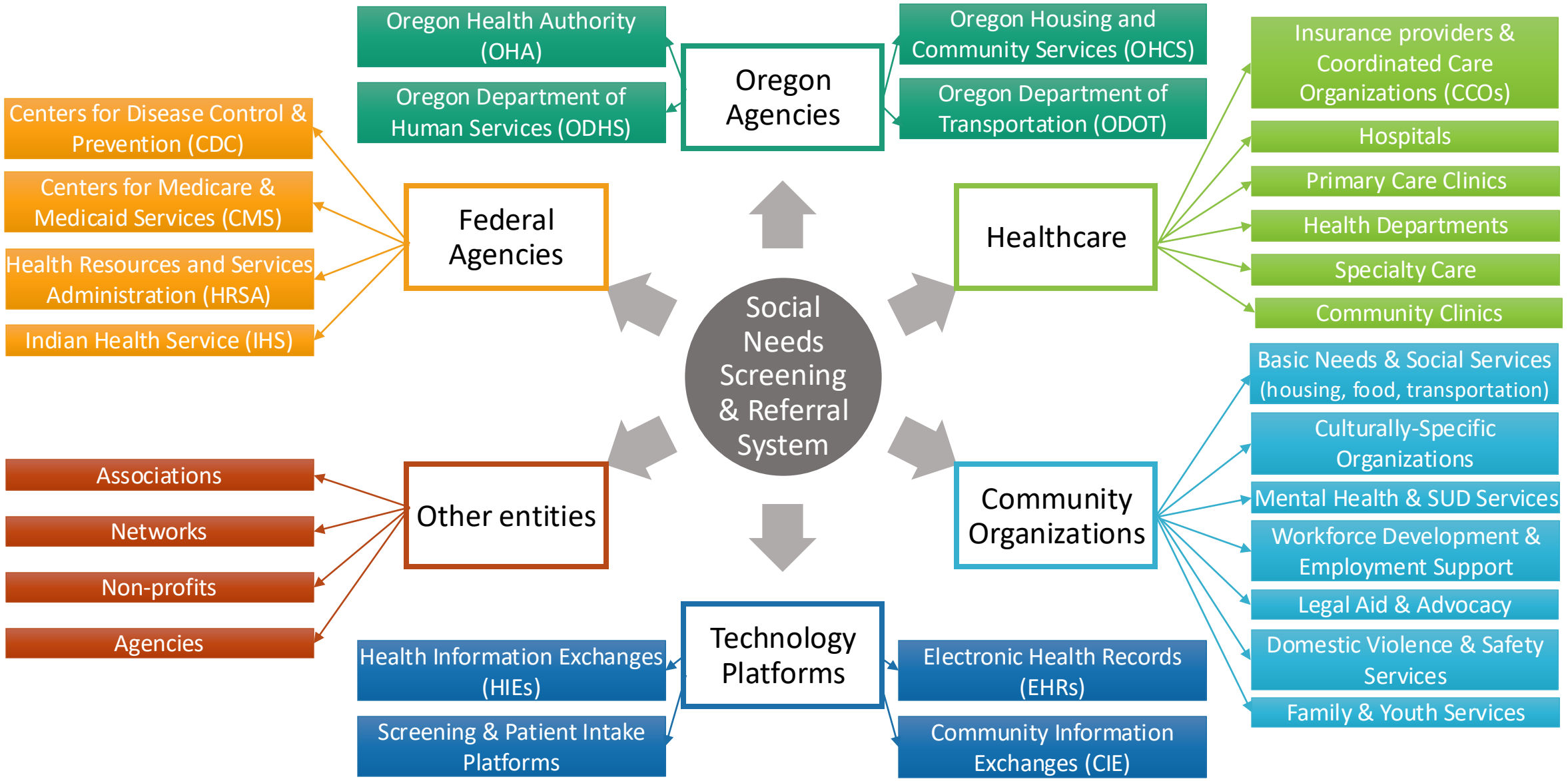
2023-24 Program

- 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

Reflection and Q&A



Additional Resources

- CCO SDOH Quality Incentive Metric OHA Approved Social Needs Screening Tools
- CCO SDOH Quality Incentive Metric FAQ
- Training for Social Needs Screening Guidance Document

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

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Thank you to the 2025 Forum partners!

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