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

Learning Together for Better Health, Better Care and Equity

Measure Year: 2023

Oregon Health Authority

ORPRN
Oregon Rural Practice-Based Research Network

OHSU

How to use this Playbook

Thank you for your participation in the Social Determinants of Health (SDOH) Screening and Referral Metric Learning Collaborative. **The SDOH Metric technical specifications outline the requirements for the measure.** This Playbook is designed as an optional tool that your CCO may choose to use as a complement to each Learning Collaborative and the technical specifications. The playbook provides suggestions, and it can help your CCO think through practical steps to take related to the 2023 measure goals in the following areas.

- **Section 1:** Screening Practices
- **Section 2:** Referral Practices and Resources
- **Section 3:** Data Collection and Exchange
- **Section 4:** Infrastructure (Community Information Exchange Platforms)

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

Managing the Change Within Your Network

This new measure represents a tremendous opportunity for CCOs and their community partners to have a significant impact on the needs of members and advance health equity. Implementing this measure will also require significant systems change for CCOs and their community and provider partners. Some steps or "plays" to engaging and sustaining the needed systems change with your external partners and within your network may include:

- ✓ Organize an advisory coalition of community, provider and member partners
- ✓ Engage partners at every level
- ✓ Develop a communication and outreach plan to engage internal and external partners – identify the "why" behind the change
- ✓ Conduct listening sessions to gauge community and provider partner readiness
- ✓ Develop and share a roadmap for the metric implementation

Managing the Change Within Your CCO

Play One: Build Your Team

Measurement Year (MY) 2023 is a glide path year where CCO leaders and project leads start the foundational work for SDOH screening and referrals. Since this involves assessing and changing workflows, CCOs may feel somewhat uncertain about exactly how to implement this significant system change. To achieve the incentive measure, CCOs are responsible for meeting the "must pass" elements in the technical specifications. CCOs can choose how to meet each "must pass" element; this playbook is meant to offer suggestions on how to meet each "must pass" element and is not required.

The playbook assumes that the change process will likely involve building a cross-functional team that understands the need for change. These team members may report to different leaders and might represent areas such as:

- Quality improvement
- Care management
- Provider relations
- Data, analytics, and health information technology
- Community outreach, health equity, and diversity, equity and inclusion (DEI)

Change Management Frameworks to Consider:

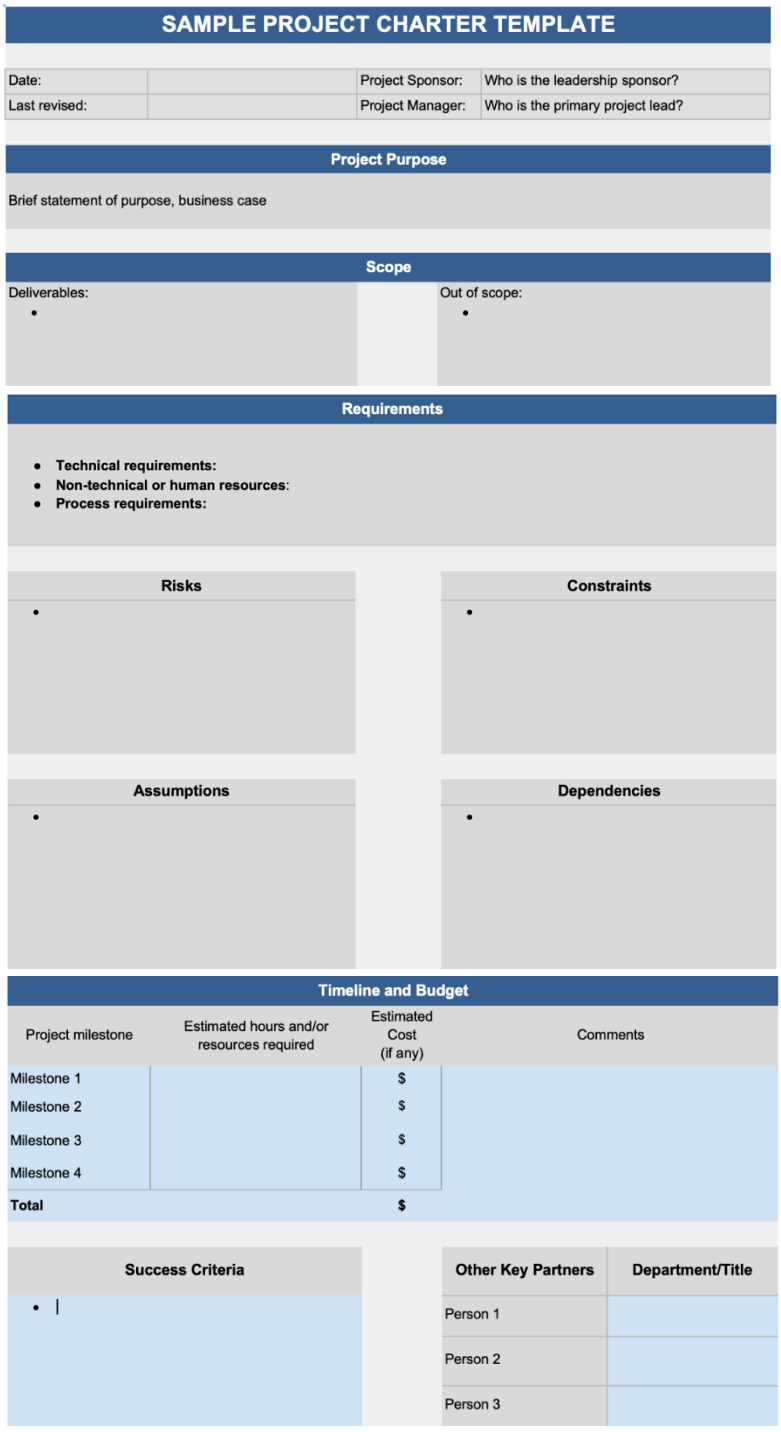
- The ADKAR framework (Awareness, Desire, Knowledge, Ability and Reinforcement) is *one* popular model that many organizations utilize to address this type of change management work. It helps equip leaders with the right strategies and tools, and individuals with the motivation and ability to see change through. Under this framework, project leads ensure that the managers of individuals involved are equal owners of the outcome and allot the appropriate amount of time for their employees to support the work.
- Another popular change management framework is the Prosci 3-Phase Process (Phase 1 – Prepare Approach, Phase 2 – Manage Change, Phase 3 – Sustain Outcomes). While the ADKAR Model enables successful change at the individual level, the Prosci 3-Phase process provides framework for achieving change at the organizational level.

It is important to note that these are just a couple of change management frameworks your CCO can reference as you plan this work. Your CCO may choose to use a different model.

Play Two: Create Agreements for the Work

Informal or formal agreements among your team and leadership can help to orchestrate complex projects like the SDOH Screening and Referral Metric. The project charter template to the right is an optional tool that may be useful when working through this process. If you do choose to use these tools or templates when developing policies and procedures it may be helpful to include:

- Purpose and business case (what's the change and what's on the line)
- Project goals
- Related or dependent CCO work
- Team: project lead, management sponsor, cross-department team members and other collaborators (potentially external to organization)
- Roles and responsibilities of various staff
- Outline of scope of work
- Timeline/approximate schedule
- Anticipated risks and constraints
- Resources required
- How success will be defined



SAMPLE PROJECT CHARTER TEMPLATE

Date:		Project Sponsor:	Who is the leadership sponsor?
Last revised:		Project Manager:	Who is the primary project lead?

Project Purpose

Brief statement of purpose, business case

Scope

Deliverables:	Out of scope:
•	•

Requirements

- **Technical requirements:**
- **Non-technical or human resources:**
- **Process requirements:**

Risks	Constraints
•	•

Assumptions	Dependencies
•	•

Timeline and Budget

Project milestone	Estimated hours and/or resources required	Estimated Cost (if any)	Comments
Milestone 1		$	
Milestone 2		$	
Milestone 3		$	
Milestone 4		$	
Total		**$**	

Success Criteria	Other Key Partners	Department/Title
•	Person 1	
	Person 2	
	Person 3	

Find this template in Appendix B.

Section 1: Screening Practices

MY 2023 Must-Pass Elements

A. Collaborate with CCO members on processes and policies
B. Establish written policies on training
C. Assess whether/where members are screened
D. Establish written policies to use REALD data to inform appropriate screening and referrals
E. Identify screening tools or screening questions in use
F. Establish written protocols to prevent over-screening

Worksheet A: Collaborate with CCO Members on Processes and Policies

Overview (from specifications[1])

To meet this element, CCOs must collect and incorporate input from members on written policies for screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.

Key Play	Steps our CCO could take:
Identify how your CCO will gather and document member input in written policies and procedures and what timelines should be associated with this activity.	☐ Engaging the Community Advisory Council ☐ Convening a separate member advisory group ☐ Conducting a member survey ☐ Conducting focus groups with members ☐ Other (describe)

Questions to Consider:

- How will your CCO ensure engagement of members experiencing the greatest health disparities/inequities?
- Who specifically will you engage, and how will you make sure you include diverse perspectives?
- How will you recruit members to participate?
- What will you do to ensure that barriers to member input are addressed (e.g. providing interpreters, childcare needs or subsidies, and travel stipends for an in-person meeting) in written policies for screening, referral, and data sharing?
- What will members need to know about the transportation, housing, and food screenings and referrals to be able to offer input?
- How specifically will member guidance/input be integrated into the written policies for screening, referral, and data sharing, and where?
- What is your plan to ensure that policies and procedures are kept up-to-date? How will you engage members in this process ongoing?
- What other actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Worksheet B: Establish Written Policies on Training

Overview (from specifications[1])

To meet this element, CCOs will need to establish and maintain a written policy on the training for CCO staff members and share the policy with partners conducting social needs screening. Training may be provided through electronic/online training modules, presentations, classroom formats, and structured coaching and mentoring. Topics addressed must include patient engagement, empathic inquiry and motivational interviewing, trauma-informed practices, and cultural responsiveness and equitable practices. The training policy also should be clear that members may decline to be screened or to accept referrals.

Key Play	Steps our CCO could take:
Develop training modality and curriculum policy manual to meet measure requirements.	☐ Develop CCO policy language appropriate for internal staff and external partners ☐ Determine how new policy fits within existing CCO policy manual ☐ Determine best pathway for sharing new policy with internal staff and external partners

Questions to Consider:

- Who will be conducting screening? (list all possible sources of screening you plan to leverage for the metric)
- How will you create written policies that effectively prevent over screening?
- How do you want to train each of these groups? (e.g. online, classroom, coaching/mentoring, peer sharing?)
- What resources or expertise does your CCO require to deliver the training? Do you need additional support?
- Do your partner providers and Community Based Organizations (CBOs) have existing trainings or manuals? If so, how will you use those to inform/align with your work?
- How will you use best practices and each of the required topic areas to inform the training curriculum?
- How often will CCO trainings take place? How will CCO staff and partners access them? How will you communicate with your partners about training opportunities?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Worksheet C: Assess Whether/Where Screenings Are Occurring

Overview (from specifications[1])

To meet this element, CCOs will need to conduct a systematic assessment of screenings that are done by (1) CCO staff, (2) all provider organizations listed in the CCO's Delivery System Network (DSN) report and (3) any Community Based Organizations (CBOs), social service agencies, or other social determinants of health and equity partners with which the CCO has contracts, memoranda of understanding (MOUs), grants, or other agreements for addressing social needs. This assessment should identify where members are predominantly being screened for unmet social needs (e.g., at primary care clinics, upon enrollment with the CCO, at a local housing resources organization). The CCO must be able to determine, at a minimum, whether organizations are screening members for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

Key Play	Steps our CCO could take:
Develop, communicate, and deliver screening assessment tool (e.g. survey) that is inclusive of housing, food and transportation needs for all known screening partners. See Appendix C.	☐ Develop the assessment. See Appendix C. ☐ Communicate the requirement to screening partners ☐ Identify key partners to gather information from ☐ Develop and communicate a plan for ongoing reporting from partners

Questions to Consider:

- How is your CCO identifying its network of screening partners (for example, providers, CBOs, social service agencies)?
- What will you include in your assessment? What information will you need to know from these partners?
- How will you gather and store (e.g. in data systems) the information for the assessment from partners?
- How will you keep the assessment current over time?
- Once you have completed your systematic assessment of where and how screening is occurring, how can you use this information to strengthen existing relationships and forge new ones to support universal screening of your members for the metric?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Worksheet D: Establish Written Policies for Using Disaggregated REALD Data to Inform Work on Social Needs Screening and Referrals

Overview (from specifications[1])

To meet this element, CCOs will need to develop and distribute written policies for analyzing and using disaggregated race and ethnicity, disaggregated language, and disaggregated disability data to understand the populations served. The policies should describe how disaggregated REALD data is used to inform training, screening, and referral practices and to develop relationships with culturally specific CBOs and other resources to meet members' needs.

Key Play	Steps our CCO could take:
Create (or update) policy for how to use disaggregated REALD data, including using the data to improve social needs screening and referral practices. Develop a plan to act on the information to enhance your networking with culturally specific CBOs. Consult the resources for REALD implementation on the OHA REALD website. Explore additional resources or guides, if they exist, at your CCO or community partners to support the development of policies.	☐ Update current REALD data policies to include social needs screening OR create a new policy ☐ Ensure the policy is distributed and communicated across the CCO ☐ Engage data teams to support disaggregation and analysis ☐ Develop a plan for outreach to enhance CBO networks serving historically marginalized groups

Questions to Consider:

- How does your CCO plan to address this component? For example, incorporating into existing REALD policies or in the overarching screening policy as outlined in Element A?
- How can you leverage your existing partnerships around REALD to further the screening requirements of the metric?
- How will you get feedback on the policy from partners currently doing the REALD screening?
- When do you aim to complete/distribute written policies regarding REALD data?
- How will you ensure this policy is communicated to screening partners?
- Who will draw insights from REALD data, and what kind of training do they need?
    - How will they separate individuals' experiences from group-level experiences?
    - How will they partner with CBOs to make meaning from the data results?
    - How will they ensure that insights are authentic to social groups' experiences and desires?
- Who will decide how insights from the analysis should translate into changes in practices?
- How will you engage with culturally-specific CBOs to ensure the changes you make to screening and referral practices are specific and appropriate responses to the disparities that you find during analysis?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Worksheet E: Identify Screening Tools or Screening Questions in Use, Including Available Languages

Overview (from specifications[1])

To meet this element, CCOs will need to review screening tools or questions used by CCO staff *and* systematically contact 1) the provider organizations listed in the CCO's DSN report and 2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs to inquire about screening tools or questions used at these organizations. CCOs should also track the language(s) used for each screening tool or set of questions.

Key Play	Steps our CCO could take:
Scan screening partner environment to document and compare screening tools/questions for social needs related to food, transportation, and housing and how these are being employed via culturally and linguistically appropriate methods. See Appendix C.	☐ Consider incorporating this into Section 1, Worksheet C assessment (above) and the environmental scan in the data collection and sharing domain. See Appendix C. ☐ If available, pull data from Community Information Exchange (CIE) Platforms or Health Information Exchange (HIE) Platforms that provide data on social needs screening ☐ Keep up-to-date tracking tools to monitor screening tools and questions in use in screening partner network

Questions to Consider:

- What data sources are readily available to help your CCO inventory screening questions in use (e.g. CIE, HIE, Care Management Platform)? How can you leverage activities in worksheet C (above) and the environmental scan in the data collection and sharing section of the technical specifications to collect this information?
- How does your CCO plan to assess the various questions being utilized among screening partners? How might your CCO provide feedback to the partner using the questions?
- How will this systematic screening tool assessment be used to create buy-in to the OHA approved screening tools across the DSN?
- How will your CCO keep track of screening questions over time and share out with screening partners?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Worksheet F: Establish Written Protocols to Prevent Over-screening

Overview (from specifications[1])

To meet this element, CCOs will analyze factors that might lead to over-screening, develop strategies to mitigate risk of harm, writes protocols, and distributes them to staff who engage in screening. These protocols may be incorporated into the CCO's training policy (see Element 2, establish written policies on training).

Key Play	Steps our CCO could take:
Map out screening protocols that avoid over-screening; Incorporate into overall screening and training policies and include the voice of members.	☐ Review assessment (see Element 2/Worksheet B, establish written policies on training) to identify where members are being screened ☐ Work with screening partners (CCO, providers, CBOs/agencies) to identify high over-screening risks and make plans to mitigate ☐ Engage with CCO members (e.g. via CAC, direct outreach) to listen and document their experience with social needs screening

Questions to Consider:

- Who are the members/groups most at risk for over-screening? What are some strategies you can use to mitigate those risks? How will you obtain their input/feedback?
- How will your CCO use technology and/or support your screening partners to utilize technology (e.g. data sharing) to mitigate over-screening?
- What strategies will you use to mitigate over-screening in pediatric settings?
- If working with CIE, how will your CCO establish a standard screening tool/protocol with your CIE partner?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Section 2: Referral Practices and Resources

MY 2023 Must-Pass Elements

A. Assess capacity of referral resources and gap areas
B. Enter into agreement with at least one CBO that provides services in each of the three domains (housing, food, transportation)

Worksheet A: Assess Capacity of Referral Resources and Gap Areas

Overview (from specifications[1])

To meet this element, CCOs will conduct an inventory of CBOs and other resources in the CCO service area that provide services to reduce or eliminate food insecurity, housing insecurity, and transportation needs and then compare the available resources with estimated unmet needs among CCO members.

Key Play	Steps our CCO could take:
Draw on information from Community Health Assessment (CHA), Data from CHA, from HIE, from CIE or other referral system, and/or existing CBO agreements. Where there are information gaps, consult with CBOs and other resources that provide relevant services. Consider referring to the datasets below for regional and local data related to the three domains… • CDC Environmental Public Health Indicator Tool • CDC Needs and Services Data Sets • Oregon Housing Stability Counsel Dashboard • SNAP Access & WIC Participation • US Department of Transportation • 211info	☐ Identify information sources that could be used for estimating population-level member needs ☐ Identify information sources for available social services ☐ Compare sources (e.g. CIE, existing MOUs, CHA) and identify gaps in services or information ☐ Ensure assessment includes services for members with cultural and/or linguistic needs (e.g., available interpretation, culturally specific services for BIPOC members and people with disabilities)

Questions to Consider:

- What data are already available (county level, statewide), local assessment findings (e.g., CHA), or Health Equity Plans, to allow your CCO to estimate: 1) the prevalence of members' social needs, 2) the resources and services available in your region and statewide to meet those needs, and 3) the rate of unmet social needs?
- What additional data may be needed, and how would you collect it?
- How will your CCO ensure referrals resources are culturally responsive and linguistically appropriate? How will REALD data play into this assessment?
- What tool or format will your CCO use to compile or track this information?
- How will your CCO and make sense of this data on capacity and needs?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Worksheet B: Enter Into Agreement With at Least One CBO that Provides Services in Each of the 3 Domains

Overview (from specifications[1])

CCO has a fully executed contract, MOU, LOA, grant or other agreement in place with (1) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing food insecurity; (2) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing housing insecurity; and (3) at least one CBO, social service agency, or other social determinants of health and equity partner for transportation needs. Such agreements may include contracts for case management services or navigation to assist members in applying for SNAP or other benefits to address identified needs.

Key Play	Steps our CCO could take:
Assess current agreements (e.g. MOUs, grants) in place – your CCO may already have agreements to meet this element. Ensure all three domains have associated CBO, social service agency and/or SDOH partner providing services to address insecurities for the three domains.	☐ Assess current agreements ☐ Conduct outreach and establish or expand agreements where there may be gaps in addressing all three domains ☐ Consider outcomes-based funding arrangements that draw on available sources to support the CBO or social service agency where capacity may require a funding stream ☐ Consider data exchange and/or Data Use Agreements (DUAs) where appropriate

Questions to Consider:

- Which CBOs in your region offer housing, food, and transportation services?
- What existing agreements does your CCO have in place with CBOs that do or could provide services in these domains?
- Which CBOs will your CCO build or expand partnerships with to address gaps?
- How can your CCO work with other CCOs to standardize or align agreements with CBOs that provide services and resources across more than one CCO service area?
- What payment structure does your CCO use to fund CBOs/social service agencies providing social services to members (e.g. grants, outcome-based payment, fee for service)? What is your plan to replicate these structures to support CBOs in building capacity?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)

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

Section 3: Data Collection and Sharing

MY 2023 Must-Pass Elements

A. **Conduct environmental scan** of data systems used in the CCO service area to collect information about members' social needs, refer members to community resources and exchange social needs data.

Worksheet A: Conduct Environmental Scan of Data Systems Used in Your Service Area

Overview (from specifications[1])

To meet this element, CCOs must systematically review how any social needs screening and referral data is captured and/or exchanged at (1) the provider organizations listed in the CCO's DSN table and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs. The review identifies any standardized codes being used to capture data about screening and referrals (e.g., LOINC, SNOMED, ICD10, CIE data dictionary). Questions in the template for CCO Health Information Technology (HIT) Roadmaps are a good starting point for the environmental scan.

Key Play	Steps our CCO could take:
Your CCO may be well on its way. Consider referencing your CCO's HIT Roadmap and Data Reporting as a place to start. Identify gaps and plan to gather missing information.	☐ Incorporate data capture and exchange questions into Section 1, Worksheet C assessment. See Appendix C. ☐ Ensure environmental scan identifies data collection and exchange processes ☐ Analyze information collected from environmental scan and create a plan for data collection and exchange

Questions to Consider:

- What data sources does your CCO already have (or have access to) to use in conducting an environmental scan?
- What method/tool does your CCO plan to employ to conduct the environmental scan?
- What actions do you need to take to achieve this element? (Record in an action plan, sample provided in Appendix A)
- Looking ahead, what tools will be needed for data standardization and sharing across organizations? How will you integrate these technology needs into the environmental scan?
- How will this systematic screening tool assessment be used to create buy-in for data sharing of screening results and referrals across the DSN providers, CBOs and other partners?
- If your CCO is using CIE, how will you use the data collected through the platform to inform the metric?
- How will you create common language and support coordination among traditional health care providers (who are familiar with health care information exchange) and community-based partners?

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

Spotlight: Infrastructure (CIE)

Why Community Information Exchange (CIE)?

Community information exchange (CIE) is a network of collaborative partners using a multidirectional technology platform to connect people to the services and supports they need. Partners may include human and social service, health care, and other organizations. Technology functions must include closed loop referrals, a shared resource directory, and informed consent. CIE networks are foundational elements to building a more equitable system in Oregon. Connecting health care and social services sectors across Oregon supports meaningful efforts to address social determinants of health in communities impacted by historical and current structural disparities. When people's needs are met, such as housing, food, and transportation, health outcomes improve. CIE enables health care and social service organizations to coordinate more efficiently to address needs and can help address health equity at multiple levels in Oregon. For more information about CIE in Oregon, click here. This playbook section on CIE intended as a support for implementation of this metric because many communities, CCOs and partners across Oregon are using CIE to meet technology needs.

Worksheet:

Overview (from specifications[11])

There are no metric requirements related to CIE in measure year 2023. However, CIE might be a useful tool to screen, refer and track data used to calculate the measure numerator and denominator, as well as other related CCO efforts.

Key Play	Steps our CCO could take:
Decide if your CCO will leverage CIE to support measure requirements (screenings and referrals) and begin planning for how data will be gathered, extracted and reported.	☐ Use CIE to track both screening and referral data related to the metric ☐ Build or enhance the CIE network to include CBOs and agencies that serve members in the food, housing and transportation domains

Questions to Consider:

- Does your CCO plan to use a CIE (i.e., Connect Oregon/Unite Us, findhelp, or another vendor) or another tool to set up your screening and referral system? If so, what progress has been made so far to implement CIE in your region?
- How will you integrate REALD data into the way information is collected and referrals are made in your CIE?
- If using CIE, do you have partnerships/agreements with CBOS in your network that are providing services for all three social needs domains (food, housing and transportation)?
- What strategies could you use to increase adoption of CIE by partners? Consider identifying champions and supporting them to conduct outreach, or providing education, training or other support. Please refer to the CIE: Community Engagement Findings & Recommendations Report for CBO feedback and recommendations related to CIE adoption.

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

Appendix A. Sample Action Planning Tool

Action planning tools ask you to think about activities, responsibilities, deadlines, and statuses to fully meet deliverables of a project. This action planning tool may be a useful project management tool for CCOs to utilize to support successful implementation of the SDOH Screening and Referral Metric. The action plan is an optional tool and not required in the measure specifications to meet the Must Pass items for MY2023.

Activity Item	Person(s) Responsible	Due Date	Status	Notes

Appendix B. Sample Project Charter Template

The project charter template is an optional tool that may be useful when working through Play Two: Create Agreements for the Work.

SAMPLE PROJECT CHARTER TEMPLATE

Date:		Project Sponsor:	Who is the leadership sponsor?
Last revised:		Project Manager:	Who is the primary project lead?

Project Purpose

Brief statement of purpose, business case

Scope

Deliverables:	Out of scope:
•	•

Requirements
• **Technical requirements:** • **Non-technical or human resources**: • **Process requirements:**

Risks	Constraints
•	•

Assumptions	Dependencies
•	•

Timeline and Budget			
Project milestone	Estimated hours and/or resources required	Estimated Cost (if any)	Comments
Milestone 1		$	
Milestone 2		$	
Milestone 3		$	
Milestone 4		$	
Total		$	

Success Criteria	Other Key Partners
•	Person 1 Person 2 Person 3 Person 4

Appendix C. Sample Survey Questions for Social Needs Screening Partners

Multiple Must Pass Elements for Measure Year 2023 require CCOs to collect information from CBOs and DSN organizations. This includes:

- Screening Element 3. assess whether/where members are screened (Section 1, Worksheet C),
- Screening Element 6. identify screening tools or screening questions in use (Section 1, Worksheet E)
- Data Collection and Sharing Element 13. conduct an environmental scan of data systems used in your service area (Section 3, Worksheet A).

The sample survey questions below may be helpful for you when planning and conducting the systematic assessment, environmental scan, and data systems inventory, but it is not a required tool and can be adapted to meet the CCO needs. This data is not required to be submitted as part of the metric attestation.

A good starting point for conducting the environmental scan is to review the CCO Health information Technology (HIT) Roadmap. In addition, the screening practices component of the metric has three areas in the specifications where CCOs are expected to reach out to CBOs and provider organizations in the CCO's DSN. These activities may be a combined effort, to allow for optimal efficiency.

Sample Survey Questions for Social Needs Screening Partners

1. Entity or organization type:

   - ☐ CCO staff
   - ☐ Provider organization from DSN table
   - ☐ Community Based Organization
   - ☐ Social service agency
   - ☐ Other (social determinants of health and equity partner)

2. Entity or organization name:_____

3. Does your organization screen patients, clients, or participants for housing, food, or transportation needs?

   - ☐ Yes
   - ☐ No

4. If yes, which ones?

   - ☐ Housing
   - ☐ Food
   - ☐ Non-Medical Transportation

5. Where and when are patients, clients, or participants screened for these needs in your system?

_____

_____

_____

6. How frequently is screening administered for each individual?

   - ☐ Only once
   - ☐ Annually
   - ☐ Every 6 months
   - ☐ Other: _____

7. Who conducts screenings? (e.g., providers, Community Health Workers, clinic managers, CCO staff, other staff)

_____

_____

_____

8. What screening tools or questions does your organization currently use?

_____

_____

_____

9. What languages are these tools or questions available in?

_____

_____

_____

10. What systems and processes do you use to capture and share data about SDOH screening?

_____

_____

_____

11. What systems and processes do you use to capture and share data about SDOH referrals?

_____

_____

_____

12. What standardized codes are being used to capture data about screening and referrals?

_____

_____

_____