Social Determinants of Health: Social Needs Screening and Referral Measure – MY 2026

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a Social Determinants of Health Measurement Workgroup Screening for Social Needs.

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐PQI ☐Survey ■Other Specify: Workgroup and OHA-developed

Measure Utility:

■CCO Incentive ☐State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Member Type:

■CCO A ■CCO B

Data Source: hybrid measure: sample reporting using MMIS/DSSURS, EHR, community information exchange (CIE), health information exchange (HIE), and other data sources

Measurement Period: December 15, 2025 to December 14, 2026

Note the cut-off date is on December 14 so referral can occur by the end of 2026.

Benchmark for OHA measurement year	**2024**	**2025**	**2026**
Component 1* – minimum points from must pass questions	CCO must attest to completion of all recommended MY2024 must-pass elements in Table 1 (see previous specifications)	CCO must attest to completion of all recommended MY2025 must-pass elements in Table 1 (see previous specifications)	N/A
Formerly Component 2* – reporting method and data collection requirement	Not required	Sample with 90% completeness threshold	TBD
Formerly Component 2* – % of members screened and % of members who received a referral	Not required	Not required	TBD
Source:	Committee consensus	Committee consensus	TBD

*For MY 2023 through 2025, the SDOH measure had two components. In Component 1, CCOs self-attested to completing structural components needed to implement screenings and referrals for the metric. Starting in 2026, Component 1 is no longer a part of the measure and was removed. Component 2 is the quantitative screening and referral measure and will continue from 2025 forward.

Note on telehealth: This measure is telehealth-eligible. The Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in specification from MY2025 to MY2026:

Component 1: Removed section and reference to two components throughout the measure specifications.

Component 2: No longer referred to as component 2 since component 1 has ended. Updated community information exchange in Appendix 4 Definitions.

Measure Components and Scoring

In accordance with OHA's commitment to work toward an equitable, transformative healthcare delivery system that addresses social factors impacting members' health status, this measure is intended to examine the percentage of CCO members screened and, as appropriate, referred to services for three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

In MY 2025 and 2026, CCOs will report on an OHA-identified sample of members who met continuous enrollment criteria. The sample size will be 1,067 members for each CCO.[1] The sample will be designed to ensure that children and adults are included in roughly the same proportions as in the overall CCO membership; for example, if children compose 40% of that CCO's membership and the sample is 1067, then the sample would include 427 children.

Appendix 1 Template provides additional information on how and what to report. For MY 2026, the CCO must complete data collection for at least 90% of the sample (the completeness threshold). CCOs are strongly encouraged to complete the full sample. The CCO must gather and provide screening and referral information in the sample reporting template provided by OHA (see Appendix 1). All required fields must be completed in each of the domains to receive credit towards the completeness threshold. This includes confirming if no screening and referrals were made. Unknown will also count towards the completeness threshold if a good faith effort is made (see Appendix 3). Records, where required fields are blank, will not count.

Rate 1: The percentage of CCO members from the OHA-identified sample who were screened for each of the three required domains using an OHA-approved or exempted screening tool at least once during the measurement year; and

Rate 2: Of the sample population screened, the percentage of CCO members with a positive screen for any of the three required domains.

Note: Performance on Rate 2 is not intended to be benchmarked; rather, it is calculated to understand the prevalence of identified needs in the CCO. In addition, Rate 2 is a necessary step in the process to calculate Rate 3.

Rate 3: Of the sample population with an identified need, those who received at least one referral for each identified need.

Note: Rate 3 measures referrals made, not closed loop referrals.

Screening (intake) period: December 15 of the year prior measurement year, to December 14 of the measurement year.[2]

[1] OHA used a stratified random sample with a 95% confidence level and a three percent margin of error with an assumed a screening rate (rate 1) of 50%. The sample size will allow for preliminary race, ethnicity, language, and disability (REALD) results to be examined.

[2] Note the cutoff date is December 14th so the 15 calendar day referral period can occur by the end of the measurement year. This change ensures that all measurement activities will be completed by the end of the measurement year.

Continuous enrollment criteria: Continuously enrolled with the CCO for at least 180 days[3] during the screening period.

Allowable gaps in enrollment: None.

Anchor Date (if applicable): Not applicable.

Denominator – Rate 1: All CCO members who meet continuous enrollment criteria. OHA will provide CCOs with the sampling frame for data collection.

Denominator Exclusions – Rate 1: None.

Denominator Exceptions – Rate 1: Member declines to be screened in all three domains with an OHA -approved or exempted screening tool. If a member declines one or two of the three domains, they will not qualify for a denominator exception. The member will remain in the denominator and must be screened in the domains not declined to meet the numerator criteria.

Numerator – Rate 1: Members who were screened at least once during the screening period for all three required domains using an Appendix 2: Social Needs Screening Tools Process.

Denominator – Rate 2: Rate 1 numerator

Denominator Exclusions and Exceptions– Rate 2: None.

Numerator – Rate 2: Members who screened positive for one or more needs in the required domains during screenings for the three domains.

Denominator – Rate 3: Rate 2 numerator

Denominator Exclusions – Rate 3: None.

Denominator Exceptions – Rate 3: Member declines all referrals. If a member does not decline all referrals, they will not qualify for a denominator exception and must receive referral(s) for all remaining positive social need(s).

Numerator – Rate 3: Members who received a referral within 15 calendar days[4] for each domain in which they screened positive.

See Appendix 1: Template for Reporting for data collection specifications and guidance.

[3] The 180 days requirement is a minimum. If a member switched from one CCO to another and had 180 continuous days with both CCOs, this member will qualify for denominator for both CCOs in the same year. If the member is only continuously enrolled with one CCO for 180 days or more, the member only counts once towards the denominator. OHA anticipates that for the vast majority of CCO members, each member will only count once.

Appendix 1: Template for Component 2 Reporting

Based on the sample list of CCO members provided by OHA, CCOs will input data separately for each of the members identified. The fields required for each member are outlined in the table below.

The screening can occur at any point during the screening period and the subsequent referral for all positive domains has to be made within 15 calendar days of the screening. This measure does not require screening to occur more frequently than once per measurement year, and CCOs should work to avoid re-traumatization through over-screening. Screening for each domain can occur at separate times, but members must be screened in all three domains during the measurement year to meet the Rate 1 criteria. OHA encourages screening for all three domains at the same time.

The name of the screening tool must be documented in the record; however, OHA does not require that information in the data collection template, just that an OHA-approved or exempted screening tool was used. For the screening to count as complete, the measure does not require a specific score to be documented in the record, only that the result is positive or negative for each screened domain. Positive or negative results should be calculated based on the instructions in the approved or exempted screening tool. If the result is unknown, the screening is considered incomplete and will not count towards the numerator for Rate 1.

This measure is member-based and is required once per year, not at all encounters with the member. OHA encourages CCOs to report the most recent screening for the measurement year. However, CCOs can choose which screening and referral episode to record for each domain. A member will only be counted once during the measurement year for the metric. Domains will be assessed discretely for each domain's screening episode since screening for all three domains is not required to occur at the same time. However, screening and referral episodes within a domain cannot be mixed. This means referrals must be within 15 days of the screening for each domain.

A referral must be made for each positive domain to qualify for Rate 3 numerator. Whether the referral was made or the patient declined for each positive domain must be documented. A member can choose to decline any or all referrals.

OHA strongly encourages CCOs and participating providers to document the screening and referral in alignment with measure specifications within two business days of when each occurs. At this time, OHA does not require documentation within a certain timeframe CCOs and providers should follow all applicable state and federal requirements for documentation.

Field	Valid Input Value	Definition	Sample Reporting[5]
Coordinated Care Organization name		Corresponds to Health Analytics reporting CCO Name	OHA
Date loaded	YYYYMMDD	Date OHA pulled the sample data	OHA, Sample Only
Member ID	Member's Medicaid ID		OHA

[5] For full population reporting, CCOs would be required to report OHA assigned fields for coordinated care organization and member ID. All other OHA assigned fields will be removed from the full population template.

Member name	Last Name, First Name MI		OHA
Member date of birth	YYYYMMDD		OHA
Match flag	Yes, No	This field is to be reported by the CCO and only for hybrid reporting. CCOs must report 'Match Flag' (Yes/No) field for all visits sampled by OHA. 'Yes' – was a member of the CCO for 180 consecutive days or more. 'No' – was not a member of the CCO for 180 or more consecutive days.	CCO, Required, Sample Only (If match flag = no, CCOs do not have to complete Screened for Social Needs question and the Housing, Food, and Transportation domains.)
Screened for Social Needs	Yes, No, Unknown	Yes – a social needs screening occurred during the measurement year for food, housing, or transportation. Indicate even if member declined the screening in full or part of the screening. No – a social needs screening did not occur during the measurement year. This can be indicated if a member had a known interaction and no record can be found for a screening for food, housing, or transportation. Unknown – member did not interact with a screening or referral partner CCOs should leave blank when member was not reviewed by CCO staff to determine if screening and referral occurred or when a good faith effort was not made to screen and collect data for sample.	CCO, Required, Sample Only
Housing Domain			
Screened for housing insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed housing screening with member	CCO, Required

		No – CCO or partner did not complete screening for housing need with member and member did not decline Declined – Member declined the housing screening or declined to finish the housing screening. Unknown – Not known whether member completed or declined housing screening	
Approved or exempted housing screen offered	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted housing screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the housing domain. No - Age appropriate and OHA-approved or exempted housing screening tool was not offered to member. The tool was not on OHA-approved screening tool list and the organization did not have an exemption from OHA for use of a different housing screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA approved screening tool list in the housing domain.	CCO, Required if screened for housing insecurity 'Yes' or 'Declined'
Date of housing screen	YYYYMMDD	Date of housing screening completed or declined	CCO, Required if screened for housing insecurity 'Yes' or 'Declined'
Result of housing screening	Positive, Negative, Unknown	Positive – Housing screening completed and indicated housing need. Negative – Housing screening completed and did not indicate housing need. Unknown – Result of housing screening is not known.	CCO, Required if screened for housing insecurity 'Yes'
If positive, received housing referral	Yes, No, Declined,	Yes – Member received a referral to an organization and/or provider that can assist with housing resources.	CCO, Required if result of housing

	Unknown	No – Member did not receive a referral to an organization and/or provider that can assist with housing resources. Declined – Member indicated that they did not want and/or need a referral for housing resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received housing referral.	screening 'Positive'
Date housing referral made	YYYYMMDD	Date housing referral made or declined	CCO, Required if received housing referral 'Yes' or 'Declined'
Food Domain			
Screened for food insecurity	Yes, No, Declined, Unknown	Yes – CCO or partner completed food screening with member No – CCO or partner did not complete screening for food insecurity with member and member did not decline Declined – Member declined the food screening or declined to finish the food screening Unknown – Not known whether member completed or declined food screening	CCO, Required
Approved or exempted food screener offered	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted food screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the food domain. No - Age appropriate and OHA-approved or exempted food screening tool was not offered to member. The tool was not on	CCO, Required if screened for food insecurity 'Yes' or 'Declined'

		OHA approved screening tool list and the organization did not have an exemption from OHA for use of a different food screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA approved screening tool list in the food domain.	
Date of food screen	YYYYMMDD	Date of food screening completed or declined	CCO, Required if screened for food insecurity 'Yes' or 'Declined'
Result of food screening	Positive, Negative, Unknown	Positive – Food screening completed and indicated food need. Negative – Food screening completed and did not indicate food need. Unknown – Result of food screening is not known.	CCO, Required if screened for food insecurity 'Yes'
If positive, received food referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with food resources. No – Member did not receive a referral to an organization and/or provider that can assist with food resources. Declined – Member indicated that they did not want and/or need a referral for food resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received food referral.	CCO, Required
Date food referral made	YYYYMMDD	Date food referral made or declined	CCO, Required if received food referral 'Yes' or 'Declined'
Transportation Domain			

Screened for transportation needs	Yes, No, Declined, Unknown	Yes – CCO or partner completed transportation screening with member No – CCO or partner did not complete screening for transportation need with member and member did not decline Declined – Member declined the transportation screening or declined to finish the transportation screening Unknown – Not known whether member completed or declined transportation screening	CCO, Required
Approved or exempted transportation screener used	Yes, No, Unknown	Yes – Age appropriate and OHA-approved or exempted transportation screening tool was offered to member. The tool must either be on the OHA approved screening tool list or has been exempted for use by OHA for the specific organization/provider in the transportation domain. No - Age appropriate and OHA-approved or exempted transportation screening tool was not offered to member. The tool was not on OHA approved screening tool list and the organization did not have an exemption from OHA for use of a different transportation screening tool. Unknown – Screening tool cannot be identified or it is not known if the tool has been exempted for use by OHA or on the OHA-approved screening tool list in the transportation domain.	CCO, Required if screened for transportation need 'Yes' or 'Declined'
Date of transportation screen	YYYYMMDD	Date of transportation screening completed or declined	CCO, Required if screened for transportation need 'Yes' or 'Declined'
Result of transportation screening	Positive, Negative, Unknown	Positive – Transportation screening completed and indicated transportation need. Negative – Transportation screening completed and did not indicate transportation need.	CCO, Required if screened for transportation need 'Yes'

		Unknown – Result of transportation screening is not known.	
If positive, received transportation referral	Yes, No, Declined, Unknown	Yes – Member received a referral to an organization and/or provider that can assist with transportation resources. No – Member did not receive a referral to an organization and/or provider that can assist with transportation resources. Declined – Member indicated that they did not want and/or need a referral for transportation resources. Declined can also be used for members who indicate they are already working with a provider or organization to have their social need and do not need an additional referral. Unknown – Not known whether member received transportation referral.	CCO, Required if result of transportation need 'Positive'
Date transportation referral made	YYYYMMDD	Date transportation referral made or declined	CCO, Required if received transportation need 'Yes' or 'Declined'

Appendix 2: Social Needs Screening Tools Process

Background

To systematically review and evaluate new screening tools, selection criteria are necessary. In 2021, a subcommittee of the Social Determinants of Health Measurement Workgroup first met to review and recommend screening domains, tools, and questions to be used to receive credit for Rate 1 (percent of members screened). This Subcommittee initially developed five criteria to be used by OHA to approve new screening tools.[1]

In Spring 2023, a new Screening Tool Committee was convened to 1) review and provide recommendations to improve the current evaluation criteria and 2) discuss the approval process for CCO submitted tools. Committee members included academic subject matter experts, clinical practice based subject matter experts, community based organization representatives, and one Oregon Health Plan (Medicaid) member. Two members of the 2023 Screening Tool Committee were also members of the original 2021 SDOH Workgroup Subcommittee. The 2023 committee met twice to create recommendations that helped to create this SDOH Screening Tool Form and exemption/approval process.

OHA Approved Screening Tool List

OHA strongly encourages CCOs and organizations that are conducting SDOH screenings to use tools from the OHA approved SDOH screening tools list. Having a common screening tool across the CCO population can streamline the process administratively and lead to better coordination of care. The approved SDOH screening tool list contains tools that have housing, food, and/or transportation questions that automatically qualify as acceptable for use for the identified SDOH metric domains. These tools do **not** need to be submitted to OHA for exemption to be used by a CCO, practice, CBO, or other SDOH screening partner.

As new tools are added, OHA will post the tools on the Social Needs Screening Tools website and notify CCOs through the CCO TAG (Technical Advisory Group) Listserv and the technical assistance contractor. To be added to the CCO TAG Listserv, please send an email to Metrics.Questions@odhsoha.oregon.gov.

Approved screening tools are no longer separated by adult and pediatric to prevent potential confusion and over screening within the same household. The screening tools should be used for the population the tool was developed. For example, the Accountable Health Communities (AHC) tool can be given to a child's caretaker on behalf of the child.

Screening Tool Review Process

OHA will review new social needs screening tools annually. Two types of reviews may be conducted through this process: 1) exemption to use the tool for a limited group of providers and community partners and 2) addition to the statewide approved SDOH screening tool list. During the tool review, OHA will only examine the domains relevant to the metric, and only those questions identified for the

metric domain require exemption or approval to meet Rate 1 percent of members screened requirements.

The deadline for submitting additional tools for a given measurement year is June 30th of the previous year. For example, the tool submission deadline for MY2026 is June 30th, 2025. If providers and community partners wish to submit a tool - including "home grown" tools, they can do so by submitting the tool to their CCO. The CCO will collect the tools and submit them to OHA through an online form. It is recommended that providers and community partners consult their CCO for guidance on evidence-based and approved tools within the CCO system.[2] OHA strongly encourages CCOs and organizations that are conducting SDOH screenings to use tools from the OHA approved SDOH screening tools list.

When submitting new tools, the CCO will need to complete the SDOH Screening Tool Form on behalf of the organization. The form will be available online for submission to OHA. CCOs must include the screening tool in the format that the CCO member receives the tool. If the screening is conducted verbally, OHA requires CCOs to submit any instructions read to the member, the questions asked, and each response option. The information requested in the form is vital to aligning with the measure intent and incomplete submissions will be denied.

Organizational Level Exemption:

Requirements for screening tool exemption at the organizational level:

1. Tool applies to at least one of the following domains:
    a. Both housing insecurity and houselessness
    b. Food insecurity
    c. Transportation needs
2. Cultural competency and understandability by population
    a. At a minimum, a 6th grade reading level or less
3. Trauma-informed language and screening methodology (e.g., timing)
4. Tool provides option for member to decline all relevant domains
5. Tool provides clear indication of positive result for all relevant domains

OHA Approved List Additions:

Below is a list of desired qualifications list for all screening tools. To be added to the OHA approved screening tool list, the tool must meet all organizational level exemption requirements as well at least three of the four items listed below.

1. Useable in medical and non-medical settings
2. Tested for validity and reliability
3. Available in multiple languages
4. Input from community and/or OHP members in the development and use of the screening tool

Appendix 3: Good Faith Effort

Good faith effort is required when using unknown values to count towards the completeness threshold for each CCO's sample. The following information should be used to complete the template in Appendix 1.

Unknown, No, and Blank Values

Completing data collection is vital to inform SDOH metric quality improvement strategies and, in future years, goal setting by the Metrics and Scoring Committee. Below is clarification on when unknown, no, and blank should be used in the Appendix 1 template.

- An **"unknown"** response should only be used when the data collection method failed to find the information needed. Unknowns will count towards the completion threshold as long as a good faith effort (as defined below) is made.
- A **"no"** response should be used when it is reasonable to assume the activity did not occur or there is documentation that activity did not occur. For example, it would be reasonable to assume that no screening occurred if a visit occurs and no screening was documented. If a screening occurred and no record of a referral can be found, it is reasonable to assume a referral did not occur. However, if a screening and/or referral did occur and an aspect related to a specific field was not documented, unknown should be used.
- Data fields should be left **blank** when a good faith effort has not been made to collect the data. Any required field that is left blank will invalidate the record from counting towards the competition threshold.

Defining Good Faith Effort

To meet the requirements of a good faith effort for data collection, each of these four characteristics must be present:

1. ***CCO must have an established screening and referral process for housing, food, and transportation*.** The sample data collection for screening and referral began in MY 2025, the third year of the measure. CCOs should have established screening and referral processes by the beginning of MY 2025. Screening only in primary care clinics will not be enough to meet the measure as it progresses and goals set for performance. CCOs should continue to build screening and referral processes that will achieve universal screening of all members once a year.
2. ***CCO must have data collection and workflow protocols to gather screening and referral information aligned with reporting data in line with the template*** *(Appendix 1).* The first three years of the metric, MY 2023 through MY 2025, required CCOs to establish policies, workflows, and data collection through component 1 must pass requirements. CCOs should continue to expand these activities as they work towards universal screening.
3. ***CCO must provide and/or support access to a tool or tools that enable screening and referral data to be shared in their network*** *(previously known as component 1 item 15 requirements).*

CCOs should have established protocols and platforms to track and share data needed for the sample per component 1 MY 2024 and MY 2025 requirements.

4. ***CCO must gather data from partners with whom they have an established relationship to complete SDOH measure screening and referrals, and from sources internal to the CCO.*** For example, if a CCO has established plans to complete screenings and referrals with a community-based organization and a health care clinic, CCOs will need to make a systematic effort to collect data from those groups. CCOs should be working with screening and referral partners throughout the year to ensure data will be received in the correct format. Establishing automated processes and protocols that streamline data collection can reduce administrative burden on CCOs and their partners.

CCOs are **not** required to collect data from those with whom the CCO does **not** have an established relationship to complete SDOH metric screening and referrals.

Appendix 4: Definitions

Culturally Responsive: providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Providers must demonstrate awareness of, and sensitivity to, cultural differences and similarities, and the effect on the member's care.

Community Information Exchange: A technology system used by a network of collaborative partners to exchange information for the purpose of connecting individuals to the services and supports they need. CIE functionality must include Closed Loop Referrals, a shared resource directory, and documentation of consent to the use of technology by the Member or other individual being connected to services.

Data Sharing: allows doctors, nurses, pharmacists, case managers, other health and social care providers and members to appropriately access and securely share a person's health and service information electronically improving the speed, quality, safety, and cost of services provided.

Environmental Scan: a process of engaging with relevant stakeholders to gain a thorough and comprehensive understanding of experiences, opportunities, barriers, risk, challenges, and successes to inform future planning.

Empathic Inquiry: relating to patients, from a place of non-judgmental curiosity and understanding. Empathic Inquiry is intended to facilitate collaboration and emotional support for both patients and screeners through the social needs screening process, as well as evoke patient priorities relating to social determinants of health needs for integration into subsequent care planning and delivery processes.

Health Equity: 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, age, 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 redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.

Over-screening: includes processes and practices that purposely or inadvertently lead to members repeated or duplicate completion of social needs screenings in a short time period, commonly due to a lack of data sharing across the member's care providers. Changes in life circumstances, loss of employment, and other factors may indicate the need for additional screening. Frequent screening done in a non-traumatizing, patient centered way that supports autonomy to decline is not over-screening in these circumstances.

REALD Data: a type of demographic information that stands for race, ethnicity, language, and disability. Additional information and implementation resources are available: https://www.oregon.gov/oha/OEI/Pages/READLD.aspx

Referral: a documented exchange of information, with the member's permission, to social services that could reasonably address the social need of food, housing and/or transportation identified from the screening. Ideally, member should be given information on the social service as well. The member may opt to receive contact information to the social services only.

A referral should contain information about the member's contact information and their housing, food, and/or transportation needs. If approved by the member, the referral should also include language and cultural preferences. If a member opts to receive contact information for the social service agency, the referral should have the agency's contact information and what services the agency can provide in relation to the member's social need.

A member may decline to receive a referral for one or all identified social needs. To receive numerator credit for rate 3 percent of members referred, the referral must be made for all identified social needs that the member wants referrals for within 15 days of the screening.

Re-traumatization: a person who has experienced previous trauma has heightened vulnerability to further traumatization. They may experience an adverse reaction to services provided that do not recognize and modify practices to account for the past trauma.

Screening Tools: assessment questionnaires, either in electronic or paper formats, for identifying individuals' unmet social needs.

Screening Questions: individual questions related to assessing individuals' unmet social needs.

Social needs include things like housing instability, food insecurity, and transportation. *Health*-related social needs make clear that these social needs impact a person's health.

Timely Referral: refers to the reasonable connection of members to available community resources capable of meeting their social needs in a timeframe consistent with the member's expectations and a timeframe that optimizes their overall health and well-being.

Trauma-informed Practices: (1) Realize how trauma affects the experiences and behaviors of the family, groups, organizations, communities, and individuals. (2) Recognize the signs of trauma. These signs may be specific to gender, age, or setting. (3) Respond using language, behaviors, and policies that respect children, adults, and staff members who have experienced traumatic events. (4) Resist re-traumatization. Stressful environments or specific practices can trigger painful memories, interfering with recovery and well-being. Organizations must review and change practices as needed to avoid re-traumatization.