SDOH Screening & Referral Metric FREQUENTLY ASKED QUESTIONS

Updated October 2025

Purpose

The purpose of this FAQ is to address questions related to SDOH Screening & Referral Metric must-pass elements and describe how CCOs can implement the measure. Additional guidance and technical assistance can be found on OHA's SDOH Incentive Metric webpage. [i] This FAQ will be updated as additional questions are addressed. Please email questions to Metrics.Questions@odhsoha.oregon.gov.

Background

In 2015, Oregon started exploring the possibility of an incentive measure focused on social determinants of health (SDOH) by developing a clinic-level food insecurity screening measure, which was considered but not adopted by the Metrics & Scoring Committee (MSC). In 2018, the Oregon Health Policy Board made recommendations for the next coordinated care organization (Coordinated Care Organization) contract or Coordinated Care Organization 2.0. Per direction from the Governor, those recommendations included a specific focus on addressing SDOH and health equity.

In 2018, with support from community-based organizations, the measurement governing bodies — the Metrics & Scoring Committee (MSC) and the Health Plan Quality Metrics Committee (HPQMC) — revisited the idea of a broader, plan level SDOH measure that would include, but not be limited to, food insecurity. The MSC requested that the Oregon Health Authority develop a measure concept that includes social needs screening completion and reporting of data, and possibly referral data. In response to these requests and priorities, Oregon Health Authority started the process of developing a broader social needs screening measure concept in 2019 and convened a public work group in 2020 which led to a screening measure pilot program in 2021. The work group published a final report in 2021. The measure passed in 2022. CCOs began measure implementation in January of 2023. [ii]

Definitions

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

Social Determinants of Equity: Systemic or structural factors that shape the distribution of the social determinants of health in communities.

Health-Related Social Needs (HRSN): An individual's social and economic barriers to health, such as housing instability or food insecurity.

All new questions are indicated by a star ★

Contents

Screening

1. **What is the process for CCOs to request other forms/sources be added to the OHA approved list of SDOH screening tools?**

   OHA reviews new social needs screening tools annually. Two types of reviews are conducted: 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 only examines the domains relevant to the metric, and only those questions identified for the metric domain require exemption or approval to meet Component 2 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 MY2025 is June 30th, 2024. Please see Appendix 2 Social Needs Screening Tools Process in the most recent technical specifications on the SDOH TA Website or the CCO Quality Incentive Resource website for more information.

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2. **If a CCO submits a screening tool for OHA to review and the tool is exempted, does the CCO need to resubmit that tool for exemption annually?**

   Once an exemption has been granted to use a tool, the exemption does not have to be submitted annually.

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3. **If a screening tool is exempted by OHA, but minor changes such as the title and formatting are changed, does the tool need to be submitted for exemption again?**

   If the question language and answer options remain the same, and there are no changes to the instructions for administering the tool, you do not need to re-submit for exemption. If your tool has changed, please contact Metrics.Questions@odhsoha.oregon.gov first with a description of the changes to determine whether a full application needs to be completed.

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4. **If a social needs screening tool that a clinic is using is approved for one CCO, can that tool be used by the clinical system even when they are operating in another CCO service region?**

   Yes, once a screening tool has exemption status, an organization can use it for members of various CCOs. For instance, Advantage Dental, which operates numerous clinics statewide, worked with a CCO in southwestern Oregon to get a screening tool approved for exemption by OHA. This tool with exemption status can be used in any of the Advantage Dental clinics across multiple CCO service areas. However, a tool that has been granted exemption status cannot be used by different organizations without OHA approval. In this example, other dental clinics cannot the same tool that was approved for Advantage Dental without seeking OHA exemption status through a CCO in their service area.

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5. **On the approved social needs screening tools webpage, the American Academy of Family Practice (AAFP) tool question for transportation domain is labeled as "Question not recommended". If this question is used for screening members for transportation needs, will it count for Component 2 reporting?**

   All tool domain questions with "question not recommended" do not count towards Component 2. The AAFP transportation question does not count towards Component 2.

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6. **Do the standard screening tools found in EPIC count if they contain the three domain questions related to the metric?**

   This metric asks health systems to use evidence-based screening tools. OHA strongly recommends using screening tools from the OHA-approved screening tool list. CCOs should consider collaborating with other CCOs and their network providers to update EPIC systems to include approved screening questions or tools. If a provider wants to use EPIC questions that are not on the approved screening tool list, the CCO can submit the questions for exemption. Please refer to Appendix 2 in the most recent technical specifications on the SDOH TA Website or the CCO Quality Incentive Resource website for more information.

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7. **Can an organization submit a single screening tool approval form for multiple CCOs that they manage, or must they submit a form for each CCO?**

   Yes, an organization that manages multiple CCOs may make one submission for screening tool approval on behalf of multiple CCOs.

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8. **Can clinics submit their "home grown" tools to OHA for approval directly or will the CCO need to collect tools and submit them to OHA?**

   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. OHA strongly encourages CCOs and organizations that are conducting social needs screenings to use tools from the OHA approved SDOH screening tools list. If providers do not know their CCO, see this map that shows where CCOs serve in Oregon and also see the list of contact information for each CCO in Oregon.

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9. **What is the minimum age to be counted in the eligible population for this metric?**

   There is no minimum age to be counted for Component 1 or Component 2 reporting of the metric. All ages are eligible. Adequate food and housing resources are very important for infants and toddlers.

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10. **For the pediatric population, there are not any approved screening tool questions about transportation. Do we have to ask pediatrics about this domain? Of the two approved pediatric screening tools that include questions about food and housing, the pediatric population may not be able to understand the forms. Are there other options for screening pediatric patients for social needs?**

    To be counted for the metric, members must be screened for food, housing, and transportation, including pediatric patients.

    These screening tools are intended for and will be understandable to the caregiver of the child, which counts as screening the child. For example, the Accountable Health Communities (AHC) can be given to caregivers. Please see page 6 of the Guide for Using the AHC Social Needs Screening Tool for examples of screening tool locations.

    For more information about social needs screening in pediatric populations, see the resources below that are provided by OHA as part of technical assistance for this metric.

    - Webinar: Documenting and Sharing Social Needs Information in Pediatric Care Settings
      - Slides / Recording (6/10/25)
    - 2025 paper by Dr. Aditi Vasan with the Children's Hospital of Philadelphia: Considerations for Documenting and Sharing Health-related Social Needs Information in Pediatric Care Settings.

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11. **Some clinicians would like to screen patients ages 12-17 and have the patient answer for themselves, as they might have different answers than their patient or caregiver would provide. Do we need to get an additional screening tool approved to fulfill this need?**

    The OHA-approved screening tool list includes many screening tools that are appropriate for children ages 12 to 17. The clinical system can decide if they want to have the parent or guardian answer the questions from the preferred screening tool or pose the questions directly to the patient.

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12. **A previous version of the OHA approved screening tools memo divided tools by adults and pediatrics. Why are tools no longer divided by these populations?**

    The previous approved screening list created a false dichotomy between pediatrics and adults. OHA does not specifically approve tools for pediatric versus adults. Providers and CCOs are responsible for ensuring that the tool is appropriate for the population and should reference the tools' specifications and directions. An example of the previous list's incorrect classification is the

Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool. This tool was listed as only for the adult population. However, one of AHC's target demographics includes caregivers of pediatric patients. Therefore, AHC would count towards the measure for the specific child if given to the caregiver, as it is common for caregivers to respond on behalf of the child. In addition, many pediatric providers also highlighted the lack of transportation questions on the pediatric screenings in the original list.

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13. **If CCOs pick a screener that has questions on topics other than housing, food, and transportation, are they required to ask the other questions as well?**

    As part of the metric requirements, CCOs are not required to ask questions on topics other than food, housing, and transportation. However, CCOs or their network providers may choose to screen members for other needs appropriate to the individual or population.

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14. **Some clinics have made minor changes to questions from approved tools to make them more accessible to patients (e.g., improve literacy, cultural acceptability.) Is that okay and does OHA need to approve those questions?**

    If the clinic has the screening tool translated into a language not already available, OHA does not need to approve the translation of the tool. Many of the tools already have translations available and CCOs should use these translations. With the exception of translations, adjustments to the screening tool would need to go through the annual screening tool approval process. Please see Appendix 2 in the most recent technical specifications on the SDOH TA Website or the CCO Quality Incentive Resource website for more information. OHA strongly encourages clinics to use the screening tools as written and will grant approvals for screening tool adjustments through the annual tool approval process. OHA recommends CCOs and providers reach out directly to the authors of approved screening tools with feedback on tool language.

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15. **There are a variety of different screening tools, approaches, and settings where screening for social needs occurs. How can the CCO simplify so that members are not over-screened? How can we ensure providers are appropriately screening for each of these programs and not passing a limited dataset to obtain services in the easiest way possible?**

    CCOs can use the measure specifications, particularly the systematic assessment of screening (must-pass element 3), to identify what tools are used in what settings. OHA welcomes feedback on where different OHA programmatic requirements may be leading to over-screening. Please submit feedback to Metrics.Questions@odhsoha.oregon.gov.

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16. **What do the best practices/national guidelines say about how much screening is too much? How often is ideal?**

    To satisfy the metric requirement CCO members must be screened in all three domains (housing, food, and transportation) once a year. The NCQA HEDIS Social Need Screening and Intervention Measure also requires that members be screened for social needs annually. There is emerging research contributing to the field around best practices for health-related social needs screening frequency. OHA is tracking national trends and will release additional guidance as needed.

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17. **Can singular questions be used from a screening tool, or must the entire approved tool be used to meet metric requirements?**

    The OHA approved screening tool list contains screening tool names and the domains for which the tool can be used. To satisfy the metric requirement that CCO members must be screened in all three domains (housing, food, and transportation) once a year, CCOs must use an OHA-approved tool. For example, if a CCO chooses to use *Your Current Life Situation's* Food Insecurity questions, the CCO must ask all food insecurity questions in the tool. The CCO does not have to use questions from the tool that are not specific to the identified domain. Different tools may be combined to meet all three domain requirements. If a tool covers all three domains, OHA strongly encourages the CCO to use only that tool and not mix and match domains from other tools.

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18. **If we use the Self-Administered Food Security Survey Module for Children Ages 12 Years and Older tool for questions on the food domain, do we need to ask all 9 questions to count as screening for food insecurity?**

    Yes, if that is the tool you are using to qualify for nutrition screening for the SDOH metric, all nine questions need to be asked.

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19. **Are there any OHA-approved SDOH screening tools that include photos?**

    Yes, there are two OHA-approved social needs screening tools that include a visual component. The Boston Medical Center Thrive (BMC Thrive) and the WeCare Survey both use icons and text to communicate the topic of the screening questions.

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20. **A few clinics are implementing a visual pre-screener which would be entered into the EHR as yes/no responses. Clinics are implementing this to save time on screening all patients as well as addressing patient barriers to screening such as literacy. If a patient has a need, they are referred to a THW and the THW implements the full PRAPARE screener and then supports the patient with navigation and referrals. Is it necessary for these clinics to separate out housing, food, and transportation from this visual screener and ask approved screening questions for those 3 domains?**

If the visual screener is not on the approved list, the workflow would not meet the measure specifications for component 2. To qualify, patients need to receive screening with an approved screening tool for all three domains (housing, food, and transportation). For more information on currently approved screening tools see the OHA-approved screening tool list.

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21. **If a patient is unable to answer a screening question, should this be treated the same as if the patient declined to answer? Can "Patient Unable to Answer" be categorized as "Patient Declined" exception?**

    If a patient indicates they are unable to answer a question and cannot communicate due to a health condition, and the screening entity cannot assist them in communicating, their parent, guardian, or other legal representative should answer the questions on their behalf. If the person is unable to answer and is in a long-term care or inpatient facility for the foreseeable future and unable to answer at the time of the screening, the situation can be treated as a decline.

    However, if a patient is unable to answer because they do not understand a question, the screening entity should make efforts to help the patient answer the question. This includes providing translation services, connecting the patient with a culturally responsive provider, and using empathic or motivational inquiry.

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22. **It would be helpful to get an understanding of which screening tools or questions are used in some of the EHRs. Which questions are built into specific EHRs?**

    Element 13 requires that CCOs conduct an environmental scan of data systems used in the CCO service area to collect information about the member's social needs. This was a Measure Year 2023 must-pass element and requires updates in Measure Year 2024 and Measure Year 2025. We recommend that CCOs collect this information as part of their environmental scan. Technical assistance providers have asked some EHR vendors for this information in the past, but it has been considered proprietary information that can only be shared with contracting partners.

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23. **If re-screening is happening based on an identified need, does the whole screening tool need to be used again?**

    Screening for each domain can occur at separate times, but members must be screened in all three domains one time during the measurement year to meet the Rate 1 criteria. OHA encourages screening for all three domains at the same time. However, if the member only needs to be re-screened for food, the clinic can administer the food insecurity domain only. If screening for a given domain happened twice in a measurement year as described in this example, CCOs must choose which screening and subsequent referral to report for the domain. OHA encourages CCOs to report the most recent domain's screening for the measurement year. However, CCOs can choose which screening and referral episode to record.

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24. **Regarding Must Pass Element 3, do CCOs have to survey their entire network of providers or just provider offices for the systematic assessment of screening? Also, providers include hospitals, pharmacies, Durable Medical Equipment (DME) providers, etc. that are unlikely to be screened. Is it necessary to survey them?**

    CCOs are required to systematically assess current screening by provider organizations. The intent of this requirement is to assist CCOs in developing a plan to fill screening gaps and limit over-screening. Since the measure requires every member to be screened, regardless of whether they receive health care services in any given year, CCOs must survey provider organizations in the Delivery System Network (DSN) and community organizations. This will allow CCOs to develop a comprehensive screening plan.

    Provider organizations that do not have direct patient contact do not have to be included in the survey. In addition, provider organizations that currently do not screen and are not anticipated to screen members, such as durable medical providers, do not have to be included in the Element 3, 6 or 11 survey/environmental scan. OHA would anticipate that hospitals and pharmacies are potential screening partners, especially in rural areas, and should be included in the survey. OHA has not required or mandated that hospitals or other entities do social needs screening.

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25. **If a CCO makes a good faith effort to collect information from all organizations in their Delivery System Network (DSN) and all contracted CBOs and social service agencies, but some organizations do not complete the survey, are requirements for must-pass elements 3 and 6 still fulfilled?**

    Yes, CCOs are expected to make a good faith effort to collect the needed information to understand the capacity within their network and service area. If CCO partners do not respond to a survey, this non-response may be recorded and reported as such.

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26. **Are CCOs expected to reach out to every single provider organization in their DSN report to assess social needs screening practices, including providers who are located outside of the CCOs service area? In cases where providers outside of the CCO service area are already being surveyed by other CCOs, how can we reduce duplicating efforts and over-surveying provider organizations that may be contracted with multiple CCOs?**

    CCOs are expected to make a good faith effort to connect with all provider organizations in their DSN to conduct the environmental scan and screening survey.

    In order to reduce duplicate efforts and over-surveying of provider organizations, OHA encourages collaboration among CCOs who share service areas or have adjacent service areas. OHA encourages CCOs to share surveying tools, approaches, and data when conducting these provider organization surveys.

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27. **(Updated 10/1/25) Will providers be paid for screening patients for social needs? Typically, Z codes are not billable. What guidance does OHA have for billing?**

Under the CCO model, CCOs enter into payment arrangements with providers. CCOs should work with clinical and community-based providers to establish payment arrangements for screening (and referral) services including reimbursement, payment, value-based payment models, and other funding sources.

As part of the HRSN benefit, enrolled HRSN providers can bill outreach and engagement services and these services do not include screening payments; however, HRSN Service Providers can bill for activities such as collecting required documentation on behalf of the Member and supporting the Member in requesting services from their CCO. For more information on HRSN outreach and engagement activities that are billable, see the HRSN Outreach and Engagement Factsheet. To learn more about payment for HRSN services, visit the webpage for HRSN providers and review the fee schedules and other resources.

Some, but not all, Z codes are billable. If a CCO anticipates needing specific Z codes, OHA can determine if the codes are allowable. CCOs should contact their OHA Account Representative to connect with the appropriate OHA subject matter expert for billing consultation.

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28. **(Updated 10/1/25) Dental subcontractors have shared that there are no dental specific codes related to social needs screening. How can dental providers code/bill for screening and referral?**

Currently no dental specific billing codes exist for social needs screening. If a CCO chooses for their dental subcontractors and dental providers to offer social needs screenings, the CCO can establish value-based payment arrangements or other incentive payments to encourage participation.

The intent of the metric is to encourage providers to screen and refer members for social needs. Identified members can be directed to resources by internal staff or be connected to point-of-care staff, organizations or resources. Community Health Workers employed by or subcontracted by CCOs are especially qualified for referral and resource navigation and can be leveraged to support social needs screenings and referrals in dental settings.

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29. **(Updated 10/1/25) Can the HRSN Benefit Outreach and Engagement procedure code be used to bill for time spent screening members for social needs?**

HRSN Outreach and Engagement cannot be used to bill for *screening* members for social needs. However, if an organization is an HRSN Outreach & Engagement (O&E) service provider, the organization can support OHP members that have been screened for social needs in alignment with the SDOH screening and referral metric. When this occurs, the organization may be able to use a HRSN O&E procedure code to bill for time spent supporting eligible members.

Examples of activities enrolled HRSN O&E service providers supporting Members can bill for include:

- Reaching out to OHP members that you think are in a HRSN covered population.
- Supporting Members understanding eligibility requirements and if they qualify for the HRSN benefit.
- Helping presumed HRSN eligible OHP member with submitting materials to keep their OHP, SNAP, or other benefits.
- Sending HRSN request forms to a member's health plan (CCO or Open Card).
- Connecting members to places where basic needs can be met, such as showers, laundry, shelter, and food.
- Travel time to and from location where support was provided to a presumed HRSN eligible member (up to 3 hours per member per day).

For a full list of what can be billed for O&E, please see the O&E Fact Sheet (English, Spanish) or OAR 410-2005 Table 9.

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30. **(Updated 10/1/25) Will there be any billing codes added for Community Health Workers (CHWs) to complete this work related to social needs screening?**

No new billing codes are being added specific to the SDOH social needs screening quality metric. Existing Fee-for-Service billing codes for CHW services related to the SDOH social needs screening quality metric can be located in the CHW billing guide. Helping members navigate community support systems is included in selected covered services. CCOs can consult with OHA if they have additional CHW codes they would like to use. CCOs should contact their OHA Account Representative to connect with the appropriate OHA subject matter expert for CHW billing code consultation.

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31. **To meet must pass element 1, should a CCO incorporate member voice in the policies and processes established by CCOs must-pass elements 2, 5, 8, and 10 as well as data sharing and data collection processes?**

Yes, member voices should be incorporated into all policies and procedures related to screening, referrals, and sharing members' information and data – including must-pass elements 2, 5, 8, and 10 regarding screener training, over-screening policy, referral protocols, and the use of READ data to inform screening and referrals. Must pass element 1 also requires that member input is gathered on the sharing of member's information and data to improve care and services. One way to include member voice across all these policies is: sharing policies with your Community Advisory Council (CAC), gathering feedback, and incorporating CAC input into the policies.

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32. **If a CCO is not making any changes to their metric related policies and procedures, does the CCO still need to gather feedback and collaborate with members on the policies and procedures (element 1) on an annual basis?**

Yes, CCOs need to gather input from members annually to inform processes and policies. Authentic community engagement not only happens when new requirements are introduced, but also occurs through iterative feedback throughout the development of this metric. Even if feedback does not result in changes to processes and policy, it is important to understand members needs related to social needs screening and referral, which may change over time. Feedback allows for improvements to processes in response to member experience with social needs service provision.

- CCOs are encouraged to think creatively about how they can use data collection updates to share information with members. Consider sharing what domain of needs are being met and which are not, identifying resource gaps in the service area, and what populations are connecting to resources, especially those that have historically experienced inequities.
- We also know that a lot is asked of Community Advisory Councils (CACs) and it is reasonable to be protective of CAC time. Some thoughts on how to engage members without burdening a CAC:
    - Reach out to CBOs, and particularly culturally specific CBOs, to create focus groups and solicit feedback on policies and procedures for the metric, as well as implementation approach.
    - Request feedback from CAC members (or a subset of members) through an email survey format which would not require time on the CAC's full agenda
    - CCOs could request their CAC create a workgroup to act as a focus group via a separate meeting once per year related to the metric. This workgroup could also be asked to work on or give feedback on other SDOH initiatives, including the HRSN benefit roll out.

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33. **Regarding meeting must-pass element 3, what are examples of social services OHA would suggest being included in the assessment?**

Must-pass element 3 requires a CCO to conduct a systematic assessment of screenings done by a variety of entities including community-based organizations (CBO), social service agencies and/or other SDOH partners with whom CCOs have *current* agreements in place. Social services may include those offered by governmental, tribal and/or private organizations, including CBOs. The types of social services may include services that support members to meet their needs related to housing, food, or transportation.

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34. **What is the CCOs role in tracking screening and referrals, especially in the case of small clinics that do not have the capacity for tracking this? What aspects of this new social needs screening metric implementation fall to the CCO and what aspects fall to partners?**

CCOs are responsible for metric implementation and needed coordination to ensure social needs screening.

Screening and referral does not have to happen at the clinic level because the measure is not a visit based measure. Screening and referral strategies beyond clinic settings can involve a variety

of approaches. These approaches may include: CCO-offered screening, collaboration with community partner agencies for on-site screenings, using health risk assessments, distributing screening tools via mail, conducting screenings over the phone, and implementing text-based screening approaches. To ensure coordination, it is recommended that CCOs develop policies, training, and data sharing systems that are responsive to clinical and community provider capacity and needs. For data sharing and tracking, CCOs should set up systems that allow them to collect information on their member population and communicate across clinical providers and community partners who are conducting social needs screening.

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35. **Which clinic staff are eligible to give the screenings? Will this screening be able to engage with THW's workforce?**

    The measure specifications do not require specific staff to administer screening. OHA encourages CCOs to provide training for screeners regardless of their role in the clinical delivery system. The traditional healthcare workforce (THW) is particularly well suited to screen members for social needs given their training and expertise.

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36. **If CCO staff are not conducting screening what is the expectation for staff to be trained?**

    Must pass element 4 requires CCOs to review the training policies of its partners and, if needed, provide training resources to partners. CCOs need to ensure that training is adequate and meets the requirements of the CCO policy in line with element 2 to establish written policies on training. After the review of the partners training policies, the CCO should adjust its own training policies for assessing members' unmet social needs annually.

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37. **We have received feedback from community partners who work with individuals who are facing SDOH challenges, such as those accessing emergency shelter, or emergency food boxes. There is an understandable concern about whether it is appropriate to ask these individuals to screen for food or housing needs, and that it would feel inappropriate to make this request. How would OHA suggest an approach to assessing and documenting screenings for this population in a trauma informed way that aligns with the reporting requirements of the metric?**

    Talking about social needs can be sensitive for patients with both highly visible needs and needs that are not immediately apparent. Communicating transparently about why these questions are asked and using techniques like empathic inquiry and motivational interviewing to have a genuine conversation with the patient about their social needs beyond the screening questions alone is the recommended trauma-informed approach for all members. Without asking about social needs directly, concurring needs that are not visible may be missed, and formal documentation and opportunity for follow-up may be lost.

    Current social needs screening research has shown that a majority of patients and patient caregivers find social needs screening acceptable, and members who trust their providers are

more likely to have a positive perception of social needs screening (Brown et al., 2023) Please find the full article here: Patient & Patient Caregiver Perspectives on Social Screening: A Review of Literature.

A 2022 qualitative study, examining Oregon Medicare and Medicaid beneficiaries' experiences being screened and referred for social needs, showed that transparency, respect for autonomy, kindness, and attentiveness are essential to effective social needs screening. These qualities along with genuine intention to connect patients with resources, left members hopeful, even if they did not ultimately access resources. (Steeves, et al., 2022) See link for A Qualitative Study to Foster Positive Patient Experiences during Phone-Based Social Needs Interventions the full article.

To support trauma-informed screening:

- Prioritize patient comfort and choice. Screening tools should offer the option for an individual to decline to answer.
- Follow specific administration guidelines for the screening tool used, ensuring questions are asked and approached as intended by those that developed, and in some cases validated, the instrument.
- Use techniques like motivational interviewing and empathic inquiry to foster trust and engagement. A real conversation can make the process more meaningful for members and help practitioners understand the patient's needs.
- CCOs should collaborate with screening partners to develop workflows, ensure proper documentation for quality improvement, provide guidance, and connect providers to training to support trauma-informed practices. Refer to the Social Needs Training Resources on trauma-informed practices, empathic inquiry, and motivational interview training resources.

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38. **Regarding must-pass element 2 (establishing written policies on training), what is the role of CCOs for facilitating the training and what is expected of providers? Is OHA planning to create a set of trainings for CCOs to share with providers?**

CCOs are responsible for creating and distributing training policies to staff and partners. Topics addressed in the trainings must include trauma-informed practices, empathic inquiry or motivational interviewing, culturally responsive and equitable practices, and clear protocols for referring members to available community resources.

A list of free training resources on the methods and topics required by the metric has been developed and can be found here: Social Needs Training Resources. CCOs have the option to incorporate these training resources in their written policies and procedures. These resources can be used to share with partners if the CCO identifies gaps in training policies or practices.

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39. **Can CCOs use the Health Risk Assessment referred to in Care Coordination rules to screen members for social needs for Component 2?**

For Component 2, if the questions in the Health Risk Assessment are questions from the OHA-approved screening tool list or the organization has received an exemption for the Health Risk

Assessment for a given metric domain, the Health Risk Assessment can be used to screen members for that domain. Please note that Rate 1 requires that members be screened in all three domains (food, housing, and transportation).

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Referral Practices & Resources

1. **What is the definition of a referral under this metric?**

   See the definition of referral in Appendix 4: Definitions in the latest technical specifications on the SDOH Technical Assistance website or the CCO Quality Incentive Program Resources website.

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2. **When an unmet need is identified through use of an OHA approved or exempted screening tool, does giving a patient a list of resources count as a referral?**

   If an unmet need is identified and the patient would like to be connected to resources, a referral is a documented exchange of information, with the member's permission, to a social service agency. Information given to a patient and not the social service agency would not count as a referral unless the member opts to receive contact information to the social services only. In this case, providing the patient with a list of social service organizations and contact information that is tailored to their unmet needs and specific life situation counts as a referral under the metric.

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3. **(Updated 10/1/25) If a social needs referral is made outside of a Community Information Exchange (CIE) platform, and the patient only wants a list of resources and does not want clinic staff to make a referral, how should this type of referral be documented?**

   If unmet needs are identified when screening a member and the member declines sharing the data with a community partner and does not want a referral it is acceptable to only give the member a resource list. Under these conditions, this activity counts as a referral and should be documented as one. To retrieve data for reporting, the referral should be recorded in a way that can be connected to the individual member's social needs screening activity and results.

   In a clinical setting, it is good practice to document referrals using a referral order or similar structured data field within the EHR, even when the referral is only sharing a list of resources with the patient. This approach enables automated data queries and reduces the need for manual chart reviews.

   In a community-based setting, capturing the members screening results, and documenting the referral in the same way other referrals are documented is a good practice. This could be a CIE platform, client relationship manager, spreadsheet, or other data sharing system that you have with your partner CCO.

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4. **What does the measure specifically require for referral documentation? What does OHA define as documentation of a patient accepting or declining a referral?**

As part of element 15, CCOs must provide and/or support access to tool(s) that enable(s) screening and referral data to be shared in their network. Tools may include a CIE, HIE, or other screening and referral data systems that enable data sharing among network providers. Accepted or declined referral documentation can be documented in any of these data sharing systems. Depending on the data sources and types of data used to document screening and referral by providers within a CCOs network, a CCO may be using different types of data to document if a referral happened and whether it was accepted or declined. Some sources may be procedure codes, diagnostic codes, clinical observation (e.g., Structured data entry or free text), referral or referral order, and CIE data which may include some medical codes or other data. If documenting a referral through a clinical note or encounter entry it is advised to include a structured data field rather than free text for reporting purposes. Best practices around referrals indicate at a minimum a person's record has their name, identified need, contact information, the social service provider(s) referred to, and date of the interaction.

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5. **(Updated 10/1/25) If a patient screens positive for housing, nutrition, and/or transportation needs and is referred to an HRSN O&E service provider for HRSN application support, does that count as a referral for the metric?**

   An HRSN O&E provider is an intermediary and can't provide housing or nutrition services to an OHP member unless they are also enrolled as an HRSN Housing or HRSN Nutrition Provider, however if the HRSN O&E service provider connects the member with an organization that could reasonably address their unmet social needs within 15 days, the referral would count under the metric. An OHP member that has an unmet housing or nutrition need is not necessarily eligible for HRSN services and transportation is not an HRSN covered service.

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6. **(Updated 10/1/25) If a patient screens positive for housing and is referred to an online HRSN housing service request form, does that count as a housing referral under the metric?**

   This does not count as a referral under the metric. Completing an HRSN service request form does not guarantee that an individual is connected to resources to meet their housing needs. HRSN eligibility is complex. An individual must have an unmet need and fulfill additional clinical and population eligibility criteria. HRSN services require authorization by the managed care plan of the individual OHP member.

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7. **If a member has needs identified through an OHA-approved screener, does referring that member to an in-clinic Community Health Worker or other resource navigation service count as a referral under the metric, or does that member need to be referred to a food, housing, or transportation service provider directly?**

   If the clinic or organization conducting the screenings also has social services that can reasonably address the identified social need (food, housing, and/or transportation) then this counts as a referral. If those social services do not exist in-house, the connection of a member to a social worker, community health worker, or other staff does not count as a referral. For additional

referral criteria, see the definition of referral in Appendix 4: Definitions in the latest technical specifications on the SDOH TA Website or the CCO Quality Incentive Program Resources website.

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8. **If the community-based organization screening has the capability to meet the member's needs, would a warm hand off to another team within the organization count as a referral?**

   Yes, a warm handoff to another team within the community-based organization can count as a referral, as long as the organization has the capability to meet the members identified needs. For example, if a CBO screens a member and identifies a need, connecting the member to an in-house team that provided food assistance would meet the criteria as a referral. Refer to the definition of referral in Appendix 4: Definitions in the latest technical specifications on the SDOH Technical Assistance website or the CCO Quality Incentive Program Resources website.

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9. **If a CCO has existing contracts with community-based housing, food, and transportation vendors (e.g., for SHARE investments) can those contracts or agreements also count toward this metric?**

   Yes, if these contracts:

   - Are in place as of December 31st of the measurement year; and
   - The scope of work outlined in the contract or agreement aligns with the metric requirements.

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10. **Regarding must-pass element 12 (enter into agreement with at least one Community Based Organization (CBO) that provides services in each of the 3 domains), can current CBO partners work for meeting this metric element? Or does it have to be new partners?**

    Existing CBO partners may be able to meet this element, but it depends on what types of services those partners are providing. If their services support the three domains (housing, transportation, and/or food) of this metric, the element would be met. If one or two domains are not covered by the partner, additional agreements should be made with the existing CBO or a new CBO.

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11. **What is required to include in written agreements with CBOs to meet the SDOH Screening and Referral Metric requirements?**

    To meet must-pass element 12 for the SDOH Screening and Referral Measure, CCOs must have a written agreement with at least one CBO, social service agency, or other social determinants of health and equity partner for addressing food insecurity, housing insecurity, and non-medical transportation services by the end of each measurement year. OHA does not prescribe what CCOs have in partner agreements.

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12. **What is recommended to include in written agreements with CBOs? Are there examples or templates of MOUs that CCOs can use?**

OHA recommends that agreements include specific services members will receive, payment arrangements, billing arrangements, any approval processes that may be required around referral, and provision of services. These agreements could be centered on delivering services in the three domains (housing, food, and transportation) to members.

OHA also recommends that CCOs establish agreements with vendors who will administer screening on behalf of the CCO. These agreements could include payment arrangements, billing arrangements, and any approval processes that may be required around referral. These agreements could include a scope of work that includes how often a member is screened, how to get approval for the service, and payment provisions.

Lastly, OHA recommends that agreements with providers are put in place around social needs screening. This is in part to reward providers for doing the screenings, but primarily to outline payment for social needs services. See the guidance document for more detail about written agreements for provision of social needs service provision, as well as examples of MOUs.

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13. **Is there a mechanism by which CBOs can be paid for providing, housing, food, and non-medical transportation services?**

The metric specifications require CCOs to have contracts with CBOs to support identified housing, food, and transportation needs of members identified through the measure. Depending on the specific services or programs being offered by the CBO, payment for provision of services could be supported via one of the CCO spending programs:

- Health Related Services (HRS); or
- Supporting Health through REinvestment (SHARE)

As part of the 1115 Medicaid Waiver Health Related Social Needs (HRSN) benefit, HRSN providers can be paid for eligible services including outreach and engagement in addition to the housing and nutrition benefits.

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14. **(Updated 10/1/25) What is the role of value-based payments in the context of the metric?**

The metric does not include any must pass elements related to payment or reimbursement for screening, referral or provision of social needs services. The metric is currently included in the CCO Quality Incentive Program, which provides bonus payments to CCOs based upon quality performance. CCOs have flexibility in how to use money earned in the program, including making value-based payments to providers, community-based organizations, and others who participate in the SDOH metric. OHA recognizes that CCOs need to pay or reimburse partners for the services for social needs screening, referral and/or provision of services, and that value-based payment arrangements are one way a CCO may choose to support partners to perform these

activities. If you have interest in learning more about value-based payment in relation to this metric, please contact Summer Boslaugh at SUMMER.H.BOSLAUGH@oha.oregon.gov.

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15. **North Carolina developed a fee waiver; are we collaborating with them?**

OHA is learning from and with North Carolina's 1115 waiver demonstration. Dr. Elizabeth Tilson from the North Carolina Department of Health and Human Services gave an OHA-sponsored presentation on Payment Arrangements for Social Needs Screening and Referral in January 2023. For more information, view the Slides / Recording.

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16. **How will 1115 Waiver language be supportive and not restrictive of what is required of the metric?**

The SDOH quality incentive metric asks CCOs to screen and refer ALL CCO members, while the 1115 Medicaid waiver Health-Related Social Needs (HRSN) benefit will serve specific transition populations. Therefore, the SDOH quality incentive metric work is broader. The three health-related social needs defined in the HRSN benefit are housing, nutrition and needs related to home changes for health during extreme weather. The SDOH quality incentive metric social needs domains are housing, food, and transportation. OHA is working across different divisions to align and integrate the various policy and program efforts that support Medicaid members social needs, including both the SDOH quality incentive metric and the HRSN benefit. For updated information about the 1115 Medicaid waiver visit this website: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/waiver-renewal.aspx and for information specific to the HRSN benefit visit this website: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/HRSN.aspx.

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17. **For must-pass element 12, what are the definitions of community-based organization, social service agency and other social determinants of health and equity partner?**

Related to the SDOH incentive metric and must-pass element 12, a community-based organization, a social service agency and/or other social determinants of health and equity partners are entities with whom a CCO would enter into a formal agreement to provide services in each of the three domains as outlined in the specifications. OHA does not specify the business type of these entities. Any entity with whom a CCO establishes a formal agreement must be qualified to provide the services outlined in an agreement as determined by the CCO establishing the agreement.

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18. **Does an agreement with a medical transportation provider that includes providing transportation for housing and food related needs fulfill the requirements around must-pass element 12 for transportation services?**

OHA recognizes that there may be a gap in community partners who can provide certain social services, including transportation services, and that this may be particularly the case in rural

areas. As part of the metric must pass element 12, a CCO may choose to enter into a partner agreement with a medical transportation provider for the purpose of providing social needs related transportation as long as the agreement and/or contract delineates the scope of work and budget for the different types of transportation supports provided including:

- medical transportation;
- non-emergency medical transportation (NEMT); and
- transportation to support social needs like food and housing.

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Data Collection & Sharing

1. **How would a CCO be expected to standardize the ways that data are reported to them? We understand that there are approved screening tools, but those tools do not report the same data elements in the same manner, so how would a CCO be expected to format that data as it is received from varied sources?**

   OHA has provided a standard reporting template in Appendix 1 (Template for Component 2 Reporting). Please see Appendix 1 in the most recent specifications posted on the SDOH Technical Assistance website or the CCO Quality Incentive Program website. Individual survey responses from the list of approved screening tools are not required to be collected and submitted to OHA. However, CCOs may choose to collect this data to improve member services and referrals.

   CCOs will be responsible for indicating whether an individual screened was positive or negative for each of the three domains: housing insecurity, food insecurity, and transportation. Administrators of the questionnaire should follow the tools guidance on what qualifies as a positive or negative finding. Beyond the data elements that will be required in the Component 2 reporting templates, CCOs should standardize data according to their internal needs.

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2. **For sample data collection, what will the list of CCO member data look like? Will the sample list provided by OHA include a member's name, ID, or other identifying information? It seems like this list won't be tied to a specific date of service, as members may have multiple visits within a single year.**

   For Measure Year 2025, OHA will provide CCOs with the sample data or fields for the 1067 CCO members as follows:

   - CCO's name
   - Member ID
   - Member Name
   - Member DOB

   The above data elements or fields are in Appendix 1 of the 2025 measure specifications (Template for Component 2 Reporting), specifically in the right column, labeled "Sample

Reporting. This measure is member-based and screening is required once per year, not at all encounters with the member. A member will only be counted once during the measurement year for the metric. The sample is not tied to a date of service. For more details on Component 2 sample reporting, refer to the latest technical specifications on the SDOH Technical Assistance website or the CCO Quality Incentive Program website for more information.

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3. **For future data and reporting requirements and planning purposes, will the metric eventually require reporting for the full population rather than the sample size of 1,067 members?**

   In future years the metric will be benchmarked, and the current plan is for CCOs to report on the full population. However, full population reporting is not expected to begin until 2027 or later. Benchmarking is suggested to start in 2027. Both the timeline for benchmarking and whether the SDOH screening and referral measure stays in the measure set in future years is at the discretion of the Metrics and Scoring Committee.

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4. **If the member had two screenings in a year and the first one has the results documented, which would count as a numerator hit for Rate 1, but the second one doesn't have the results documented, which screening episode should be reported?**

   The measurement specifications are agnostic on which screening and referral episode to use for the measure, meaning CCOs can choose which episode to report by domain. However, screening and referral episodes, cannot be mixed. For example, if a screening occurs in April and another in September, CCOs can choose to report the April screening, results, and referral or the September screening, results, and referral. CCOs cannot report the April screening results and the September referral and get numerator credit for the September referral.

   Central to the measure is that the screenings are done in a trauma informed manner. Screening an individual and failing to document the results can potentially re-traumatize them and is an important situation to identify and rectify through quality improvement processes. The CCO should work with the screening organizations to ensure workflows prevent this from occurring and potentially provide guidance to prevent over-screening.

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5. **(Updated 10/1/25) For component 2, will MY2026 of data collection (12/15/25-12/14/26) be setting a benchmark for future years? What is the process for developing benchmarks for future years?**

   The timeline for benchmarking the metric is ultimately determined by the Metrics and Scoring Committee (MSC). Currently, OHA's recommendation is that CCOs have two years of report only for MY2025 and MY2026. This is because benchmarking for each measurement year uses data that is two years old. For example, if MSC chooses to create benchmarks for MY2027 performance, they will use MY2025 data. Similarly, if MSC chooses to create benchmarks in MY2028, they will use MY2026 data.

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6. **What format will the Component 2 reporting template be? Will it be an Excel, or similar spreadsheet file?**

   At this time, the reporting template will most likely be in Excel. It will follow the format outlined in Appendix 1 of the measurement specifications for each given year.

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7. **For component 2, if a clinic/provider does not use an OHA-approved or exempt screening tool, does the CCO still include the clinic's reported data in the denominator? Is this exclusion just for numerator hits? Or does the clinic's data need to be excluded completely?**

   CCOs must still include a clinic's data even if they are not using an OHA approved or exempted tool. The reporting template includes fields for each social need asking whether an approved or exempted tool was used to screen the member for each need. All required fields must be completed for each individual in the sample to count towards the completeness rate. To receive numerator credit for the metric, all members must be screened for social needs using an OHA approved or exempted screening tool.

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8. **(Updated 10/1/25) If a member screens positive for a need, for example, transportation, but there are no transportation services available in the area, and this referral attempt is documented, does this referral count towards rate 3?**

   When a food, housing, and/or transportation need has been found through screening and no services exist to meet the need, documenting that no services exist does not count as a referral. For example, if a transportation need has been identified and no services exist to provide transportation, the need should be documented, but no credit will be given for meet rate 3 percent screened numerator.

   For a list of statewide public transportation resources and approaches to addressing transportation needs, refer to the Transportation Resource List: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Transportation-Resource-List.pdf

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9. **(Updated 10/1/25) What programs or resources are available at the state level to address transportation-related needs? Are there successful evidence-based transportation programs or initiatives implemented in rural areas that could be modeled?**

   The Transportation Resource List can help CCOs understand statewide resources and programs available to CCO members with transportation resources. The list also outlines investment opportunities for CCOs and examples on how to expand transportation access.

   On page 4 of the Transportation Resource List, there are examples of how CCOs can or have invested in transportation needs for CCO members and communities, as well as specific examples of how CCOs invested in transportation through SHARE and HRS-CBI.

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10. **In regard to Component 2, how will Rate 3 (referrals made) account for multiple positive screenings? Will the individual count multiple times in the denominator?**

    An individual counts once for the Rate 3 denominator. Members who receive a referral within 15 calendar days after screening positive in each domain count toward the Rate 3 numerator. For example, an individual could be screened only for housing in April and screen positive for an unmet housing need. Then, in June, the same individual is screened for food and transportation needs but only screens positive for an unmet transportation need. To be counted once in numerator 3, this individual must receive a referral within 15 days of the April screening for housing and another referral within 15 days for the June screening for transportation.

    OHA strongly encourages screening for all three domains at the same time. However, screenings may need to occur at separate times for each domain. Individuals may need to be screened again for only one domain due to change in life circumstances and other factors. However, screenings may need to occur separate times for each domain and the reporting template in Appendix 1 of the measurement specifications allows for this type of activity. Appendix 1 can be found in the latest technical specifications on the SDOH Metric Technical Assistance Webpage or the CCO Quality Incentive Program Resource website.

    Please note that an individual may need to be screened again for only one domain due to a change in life circumstances and other factors even if a full screening has been done previously in the year.

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11. **During data collection for component 2 sample, what criteria should be used for a “no” response and an “unknown” response?**

    If the CCO is unable to locate documentation after reviewing all available data sources from CCO screening and referral partners, the response would be categorized as "unknown". An "unknown" response should only be used when the data collection method failed to find the information needed.

    A "no" response can be used when it is reasonable to assume that the screening did not occur or there is documentation that the screening did not occur.

    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 completion threshold. Completing data collection is vital to inform SDOH metric quality improvement and in future years goal setting by the Metrics and Scoring Committee. Please refer to Appendix 3 Good Faith Effort in the latest technical specifications on the SDOH Technical Assistance website or the CCO Quality Incentive Program Resources Website.

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12. **For Rate 3, if a patient receives a referral for 2 out of 3 of their positive factors within 15 days, would the patient not count towards the metric since they did not get all 3 referrals?**

Members must receive referrals for all positive screens for which they want a referral. If a patient only receives a referral for 2 out of 3 of their identified needs within 15 days, that patient would not count towards the rate 3 numerator. However, if the member received two referrals and declined the other referral, the member would count towards the rate 3 numerator.

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13. **How can CCOs and clinics coordinate and work together to identify and screen patients who have not been seen in the clinical setting in the measurement year?**

    The scientific evidence on screening suggests that patients prefer to be screened by people with whom they have a trusted relationship. For those members not seen in clinical settings in a measurement year, CCOs and clinics can work together to identify where there is a trusted relationship and delegate outreach to that member for screening accordingly.

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14. **When it comes to SDOH data sharing, we have been working with HIPAA, but CBOs may not have familiarity with HIPAA protocols or PHI privacy requirements. Is there any guidance especially for CBOs or when working with CBOs regarding data sharing?**

    CCOs should obtain their own legal advice about data sharing with CBO partners to determine and maintain compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Protected Health Information (PHI) privacy requirements.

    To determine whether and how a CCO can share member data with a CBO partner, the CCO must determine:

    - The type of relationship they have with the CBO (business associate, HIPAA covered entity or neither)
    - The purpose of information/data sharing (treatment, payment, health care operations or other purpose)
    - If member/patient consent is needed to share information, CBOs would also benefit from consulting with an attorney about data sharing. CBOs may be HIPAA covered entities, business associates of a HIPAA covered entity, or neither. This should be determined by each CBO in consultation with the applicable CCO and legal counsel for both considering the type of services they provide and the data/information that is shared. HIPAA covered entities are health care providers, health insurers, and health care clearing houses. Business associates are entities doing something “on behalf of” the covered entity.

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15. **(Updated 10/1/25) How can CCOs use the REALD data repository and the data that OHA sends to CCOs monthly to support SDOH metric implementation?**

OHA expects CCOs to use the data that OHA is sharing bi-monthly from the REALD & SOGI data repository for quality improvement, population health monitoring, to identify and address disparities and inequities in their member populations, to understand the social needs of CCOs' member population and for other CCO initiatives.

In the future, as a result of HB 3159, CCOs will be required to collect and report to OHA, primary member level REALD & SOGI data when OHA completes a registry development sometime in 2027(estimated timeline). The registry will receive the data and release such data into the current repository for further data processing.

For questions around the REALD repository data, please contact the REALD SOGI team at ohareald.questions@odhsoha.oregon.gov.

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16. **What will reporting for the metric look like? Will OHA provide a survey for CCOs to attest to each of the structural requirements, or will OHA be requiring CCOs to submit actual data (e.g., of tools used, contracts with CCOs, etc.)?**

For Component 1, CCOs will attest to completion of must pass elements. The self-attestation survey is administered in Survey Monkey and available on the SDOH Technical Assistance website and at CCO Metrics Program Resources. The self-attestation will require CCOs to answer yes or no to achieving each must pass element for Component 1 by December 31st of the measurement year. Submitting supporting documentation is optional.

For the CCO Quality Incentive Program, OHA will not require submission of additional information for Component 1 must pass elements for Measure Year 2024. However, beginning with the 2025 contract year and forward, CCOs will be required to submit the reports to the Office of Health Information Technology (OHIT) and Analytic Infrastructure. For the updated HIT Roadmap due in 2025, CCOs must report information for the following Component 1 elements of the metric for the 2024 measurement year:

- Element 3: Systematic assessment of whether and where screenings are occurring by CCO and provider organizations, including whether organizations are screening members for food, housing insecurity, and transportation needs.
- Element 6 & 7: Identification of screening tools or screening questions in use by CCO and provider organizations, including available language and whether tools and questions are OHA-approved or exempted.
- Element 13: Environmental scan of data systems used in the CCO service area to collect information about the members' social needs, refer to members to community resources, and exchange social needs data.

The HIT Roadmap submission process should be followed for these elements. This process is separate from the Component 1 self-attestation survey for the CCO Quality Incentive Program.

For questions about the HIT Roadmap requirements go to the CCO Health Information Technology Advisory Group webpage or contact CCO.HealthIT@odhsoha.oregon.gov.

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17. **Regarding there being no requirement to submit additional information with the metric attestation for Component 1: What is OHA hoping for? Will it be a best practice to include extra information? How will OHA use the extra information included, if included?**

    Submission of supplemental materials for Component 1 is not related to passing or failing the metric, but rather would serve as a way for OHA and technical assistance providers to support CCOs and learn along the way as this metric is implemented.

    However, starting in 2025 contract year, CCOs will be required to submit the reports for elements 3, 6, 7, and 13, to the Office of Health Information Technology and Analytic Infrastructure.

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18. **If a CCO has multiple service areas, should they complete separate self-assessments for each region or assessment for the entire CCO?**

    Yes, each CCO should complete a separate self-assessment, one for each distinct service area or region where the CCO operates.

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Accessibility

You can get this document in other languages, large print, braille or a format you prefer. Contact Rachel Burdon at Rachel.E.Burdon@oha.oregon.gov.

References

[i] OHA SDOH Incentive Measure Website: https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

Definitions per OAR 410-141-3735:
https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285449

[ii] SDOH Measurement Workgroup Final Report:
https://www.oregon.gov/oha/HPA/ANALYTICS/SDOH%20Page%20Documents/3.%20SDOH%20measurement%20work%20group%20final%20report.pdf