Social Determinants of Health: Social Needs Screening and Referral Measure

Component 1, Structural Measure – MY 2023

Introduction

The goal of the Social Determinants of Health: Social Needs Screening and Referral measure is that CCO members have their social needs acknowledged and addressed. Starting in Measurement Year (MY) 2023, Component 1 of the measure assesses CCOs' action plans to ensure social needs screening and referral is implemented in an equitable and trauma-informed manner. It also ensures CCOs lay the groundwork for data sharing and reporting as required in Component 2.

As stated in the measure specifications, CCOs must attest to all required components of the measure that took place as of December 31 of the measurement year. CCOs must complete all of the required must-pass items for the measurement year. No partial credit will be given.

The following questions attest to completing the nine must-pass elements for MY 2023. CCOs have the option to describe or attach example activities they completed for each must-pass element.

Please review each question and answer accordingly for your CCO.

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Respondent Information

* Name:

* CCO:

* Email:

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Screening practices: Collaborate with CCO members on processes and policies (Element A.1.)

Intent: CCO member voices are reflected in the policies and processes established by CCOs regarding screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services.

1.a. Required: *Answer yes if the CCO collected and incorporated input from members on written policies for screening for unmet social needs, referrals to available community resources, and sharing members' information and data to improve care and services. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO collected and documented member input on social needs screening and referral processes through its Community Advisory Council or member focus groups at least annually.
- The CCO conducted a member survey with open-ended questions on screening, referral, and data-sharing practices that are analyzed, synthesized, and incorporated into final written policies.

Examples of activities *not* meeting this element:

- The CCO engaged with its members but no documentation of member input on social needs screening, referral, and data sharing practices.
- The CCO engaged with community members generally but no input from CCO members specifically.

1.b. Optional: Describe or attach an activity meeting this element.

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Screening practices: Establish written policies on training (Element A.2.)

Intent: Training is well planned, and CCO staff and partners – including contractors, innetwork providers, and CBO partners – have access to written protocols and best practices for assessing members' unmet social needs.

2.a. Required: *Answer yes if the CCO established and maintained a written policy on the training for CCO staff members and shared the policy with partners conducting social needs screening. Topics addressed must have included patient engagement, empathic inquiry and motivational interviewing, trauma-informed practices, and cultural responsiveness and equitable practices. The training policy also should be clear that members may decline to be screened or to accept referrals. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- A CCO policy manual shared with staff and partners, including a dedicated section on assessing members' unmet social needs.
- An online website or application displaying CCO policies for staff and partners, including a dedicated section on assessing members' unmet social needs.

Examples of activities *not* meeting this element:

- Trainings on assessing members' unmet social needs which did not include clear written policies for staff and partners.
- An online training program which did not have links to or otherwise share written CCO policies on assessing members' unmet social needs.
- Written CCO policies which did not address critical considerations for assessing members' unmet social needs, including: (1) trauma-informed practices, (2) empathic inquiry or motivational interviewing, (3) culturally responsive and equitable practices, and (4) clear protocols for referring members to available community resources.

2.b. Optional: Describe or attach an activity meeting this element.

Screening practices: Assess whether/where members are screened (Element A.3.)

Intent: CCOs understand where screenings occur, so they can coordinate screening and referral activities, identify gaps, and share policies and resources.

3.a. Required: *Answer yes if the CCO conducted a systematic assessment of screenings that are done by (1) CCO staff, (2) all provider organizations listed in the CCO's Delivery System Network (DSN) report and (3) any CBOs, social service agencies, or other social determinants of health and equity partners with which the CCO has contracts, memoranda of understanding (MOUs), grants, or other agreements for addressing social needs. This assessment should have identified where members are predominantly being screened for unmet social needs (e.g., at primary care clinics, upon enrollment with the CCO, at a local housing resources organization). The CCO must have determined, at a minimum, whether organizations are screening members for (1) housing insecurity, (2) food insecurity, and (3) transportation needs. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- In addition to assessing screenings done within the CCO, the CCO did any of the following:
    - Annually surveyed provider organizations listed in the CCO's DSN report, CBOs, social service agencies, and other organizations on social needs assessments,
    - Collected regular reporting from provider organizations listed in the CCO's DSN table, CBOs, and social service agencies specifically on the prevalence of social needs assessments, or
    - Maintained a real-time or near real-time list of services offered by all provider organizations in the DSN table, CBOs, and social service organizations in their service area, with a specific indication for social needs assessments.

Examples of activities *not* meeting this element:

- A survey of network providers that asked about social needs screenings in general, but not about screening specifically for (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
- Information reported (through a survey or regular reporting) prior to the measurement year.
- An assessment of screenings occurring in the service area by network providers that did not include an assessment of CBOs and social service agencies.

3.b. Optional: Describe or attach an activity meeting this element.

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Screening practices: Establish written policies for using disaggregated race, ethnicity, language and disability (REALD) data to inform work on social needs screening and referrals (Element A.5.)

Intent: CCOs use disaggregated REALD data to help understand and respond to members' needs in a culturally responsive way.

5.a. Required: *Answer yes if the CCO has developed and distributed written policies for analyzing and using disaggregated race and ethnicity, disaggregated language, and disaggregated disability data to understand the populations served. The policies should describe how disaggregated REALD data is used to inform training, screening, and referral practices and to develop relationships with culturally specific CBOs and other resources to meet members' needs. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO established and distributed written policies, as outlined in Element A.2., including protocols for analyzing and using disaggregated REALD data.

Examples of activities *not* meeting this element:

- Generic written CCO policies on use of REALD do not specifically address use of REALD data in social needs screening and referral practices.
- Policies address only aggregated REALD data use.

5.b. Optional: Describe or attach an activity meeting this element.

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Screening practices: Identify screening tools or screening questions in use, including available languages (Element A.6.)

Intent: CCOs understand how screening is occurring so they can coordinate screening, trainings and other resources.

6.a. Required: *Answer yes if the CCO reviewed the screening tools or questions used by CCO staff and systematically contacted (1) the provider organizations listed in the CCO's DSN report and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs to inquire about screening tools or questions used at these organizations. The CCO should have also tracked the language(s) used for each screening tool or set of questions. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO conducted a survey of these organizations (may be part of the same survey as Element 3, assess whether/ where members are screened) during the measurement year and inquired about screening tools or questions used at these organizations.
- The CCO combined survey data with relevant, current (within the measurement year) data pulled from a community information exchange system (CIE), health information exchange (HIE), or other system that included CCO and/or partner information on social needs screening.
- The CCO maintained real-time or near real-time electronic systems for tracking screening tools and questions in use in the service area.

Examples of activities *not* meeting this element:

- CCO did not collect information about whether screening tools and questions are able to assess all three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.
- CCO did not collect information about languages in which the screening tools or questions are available.

6.b. Optional: Describe or attach an activity meeting this element.

Screening practices: Establish written protocols for preventing over-screening (Element A.8.)

Intent: CCOs establish, implement and maintain processes to prevent over-screening. Over-screening, which could be retraumatizing, may occur if a member is asked to complete screening processes multiple times and in multiple settings in a relatively short period, such as several months.

> **Note:** Conversational follow-up questions are not considered over-screening. For example, if a member screened positive for food insecurity and was given assistance in applying for SNAP benefits, then it would be appropriate follow-up to ask the member if the assistance helped resolve the need.

> **8.a. Required: *<u>Answer yes</u>** if the CCO analyzed factors that might lead to over-screening, developed strategies to mitigate risk of harm, wrote protocols, and distributed them to staff who engage in screening. These protocols may be incorporated into the CCO's training policy (Element A.2., Establish written policies on training). **<u>Otherwise, answer no.</u>**
>
> ◯ Yes
>
> ◯ No

> Examples of activities meeting this element may include:
>
> - The CCO used its data about where members are screened, worked with partners to identify situations when members are most likely to be over-screened, and developed strategies to avoid potential harm. The strategies were reflected in protocols that are distributed to the CCO's partners. Strategies might include:
>   - technology, such as use of data sharing to check CCO members' social needs screening history prior to conducting a new screening;
>   - processes, such as screening at the household level if, for example, a parent or guardian answering the screening questions indicates that the answers are applicable to multiple children in the household; and
>   - training resources, such as empathic inquiry or other motivational interviewing techniques to determine members' comfort level and history with being screened for unmet social needs.

> Examples of activities *not* meeting this element:

- The CCO skipped analysis of potential risk areas, for example, by failing to assess current screening practices before writing its policy.
- The CCO wrote a policy but did not distribute it or did not include strategies to be used in the screening process to avoid the risk of harm.

8.b. Optional: Describe or attach an activity meeting this element.

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Referral practices and resources: Assess the capacity of available resources and gap areas (Element B.9.)

Intent: CCOs understand capacity and gaps in available resources so they can connect members to culturally responsive community resources and they can prioritize investments in building capacity.

9.a. Required: *Answer yes if the CCO conducted an inventory of CBO and other resources in the CCO service area that provide services to reduce or eliminate food insecurity, housing insecurity, and transportation needs and then compared the available resources with estimated unmet needs among CCO members. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO created an inventory of available resources by drawing on information sources such as
    - The CCO's shared Community Health Assessments (CHAs),
    - Data from a CIE, HIE or other resource or referral system or
    - Consultation with organizations that support connections with community resources.

  The CCO compared that inventory with other data on needs. In the first year, this may be county-level or statewide data and subsequently, CCOs might use baseline data from the prior year. These data are compared with available resources to estimate the rate of unmet social needs among CCO members.
- The CCO has data sharing arrangements that enable a real-time or near real-time dashboard showing available community resources at the time of referrals, with capabilities for exporting reports on available community resources. The CCO compared that dashboard with other data to estimate the rate of unmet social needs among CCO members.

Examples of activities *not* meeting this element:

- The CCO maintained contracts and/or MOUs with CBOs for housing, food, and transportation needs but did not assess the timeliness and availability of resources for referred members with unmet social needs.

- The CCO referred all members to generic community resources without ensuring the resource had capabilities to provide culturally responsive services.

9.b. Optional: Describe or attach an activity meeting this element.

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Referral practices and resources: Enter into an agreement with at least one CBO that provides services in each of the three domains (food, housing, transportation) (Element B.12.)

Intent: CCOs build partnerships with community organizations to expand capacity and better meet members' needs.

12.a. Required: *Answer yes if the CCO has a fully executed contract, MOU, LOA, grant or other agreement in place with (1) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing food insecurity; (2) at least one CBO, social service agency, or other social determinants of health and equity partner for addressing housing insecurity; and (3) at least one CBO, social service agency, or other social determinants of health and equity partner for transportation needs. Such agreements may include contracts for case management services or navigation to assist members in applying for SNAP or other benefits to address identified needs. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO has only one or two agreements in place, but the CBO, social service agency, or other social determinants of health and equity partner is able to address more than one type of need. In this case, the same agreement may be counted toward each need addressed.
- The CCO received a grant award for one of the SDOH domains with a specific CBO identified as the SDOH service provider.

Examples of activities *not* meeting this element:

- Only verbal or informal agreements with CBOs exist between the CCO and CBOs.
- Agreements with CBOs, taken together, do not address all three domains.

12.b. Optional: Describe or attach an activity meeting this element.

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Data collection and sharing: Conduct an environmental scan of data systems used in the CCO service area (Element C.13.)

Intent: CCOs understand how social needs screening and referral data is collected and exchanged so they can promote effective data-sharing practices.

13.a. *Answer yes if the CCO systematically reviewed how any social needs screening and referral data was captured and/or exchanged at (1) the provider organizations listed in the CCO's DSN table and (2) any CBOs with whom the CCO has contracts for addressing food insecurity, housing insecurity, or transportation needs. The review identified any standardized codes being used to capture data about screening and referrals (e.g., LOINC, SNOMED, ICD10, CIE data dictionary). Questions in the template for CCO Health Information Technology (HIT) Roadmaps may have been a good starting point for the environmental scan. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO conducted a survey (may be part of the same survey as Element A.3., Assess whether and where screenings are occurring) of provider organizations and CBOs during the measurement year and asks about data systems used for social needs screening and referral.
- The CCO collected annual reporting from provider organizations and CBOs with specific requirements for reporting social needs screening and referral data.

Examples of activities *not* meeting this element:

- The CCO collected information on what data systems are used by providers and CBOs without identifying data collection and data exchange processes.
- The CCO conducted their latest environmental scan of data systems before the start of the measurement year.

13.b. Optional: Describe or attach an activity meeting this element.

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OPTIONAL – Elements for future years

CCOs are **not** required to complete this section. The following questions describe the six must-pass elements that will be added in future years. CCOs are encouraged, but not required, to provide this information for the self-attestation they completed for MY 2023.

This section may be skipped. All questions in this section are optional.

OPTIONAL – Screening practices: Assess training of staff who conduct screening (Element A.4.)

Intent: CCOs ensure that partners – including contractors, in-network providers, and CBO partners – provide training to staff who conduct screenings.

4.a.: **Answer yes** if the CCO reviewed the training policies of its partners and, if needed, provided training resources to partners. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO surveyed its partners about training policies and practices. If a partner had a gap in policies or practices, the CCO suggested resources, such as the CCO's training policy as a model or training opportunities such as webinars on trauma-informed screening practices.

Examples of activities *not* meeting this element:

- The CCO inquired about training policies or practices, but offered no recommendations to partners who lack policies or training resources.

4.b. Optional: Describe or attach an activity meeting this element.

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OPTIONAL – Screening practices: Assess whether OHA-approved screening tools are being used (Element A.7.)

Intent: CCOs understand whether approved screening tools are being used.

> **Note:** Component 2 of this measure requires the use of an OHA-approved screening tool for data reported about screening and referrals. During an annual specifications update process, interested parties will have an opportunity to propose changes to the approved list.

7.a.: Answer yes if the CCO compared the information collected in Element A.6. with the list of OHA-approved screening tools in Appendix 1 of the measure specifications. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

OPTIONAL – Referral practices and resources: Establish written procedures to refer members to services (Element B.10.)

Intent: The CCO has a clear process so that when a member screens positive for one or more unmet needs, the member is referred to culturally responsive services to address their needs.

10.a.: Answer yes if the CCO had written procedures for referring members in a timely manner to services that are culturally responsive and can address their needs. Referrals should occur when a CCO member screens positive for one or more unmet needs in the domains of food insecurity, housing insecurity or transportation needs and the member is interested in receiving a referral (that is, the member is offered and does not decline a referral). **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO used the data from its inventory (Element 9, Assess capacity of referral resources and gap areas) to understand available resources and maintains policies or contractual agreements with partners that detail specific responsibilities and protocols for referring members to available, culturally responsive resources.

Examples of activities *not* meeting this element:

- The CCO referred all members to generic community resources without ensuring the resource has capabilities to provide culturally responsive services.

10.b. Optional: Describe or attach an activity meeting this element.

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OPTIONAL – Referral practices and resources: Develop a written plan to help increase the capacity of CBOs in CCO service area (Element B.11.)

Intent: CCOs made and implemented plans to close gaps in available, culturally responsive resources to meet members' housing, food, and transportation needs.

11.a.: Answer yes if the CCO developed a written plan to meet members' unmet needs in the domains of food insecurity, housing insecurity, and transportation needs. The plan built off the CCO's assessment of capacity and included information about how the CCO will provide resources such as financial or staffing resources to increase CBO capacity. The plan aligned with related work such as the use of Health-Related Services funds and the Supporting Health for All through REinvestment (SHARE) Initiative. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO published a detailed plan, which incorporated the assessment of capacity among CBOs in the service delivery area, that outlined specific financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members' housing, food, and transportation needs.
- The CCO updated or expanded an existing plan or assessment to include annually updated financial, infrastructure, and staffing strategies to help increase CBO capacity to meet members' housing, food, and transportation needs.

Examples of activities *not* meeting this element:

- Written plans that did not incorporate specific findings from the assessment of capacity relative to housing, food, and transportation needs.
- Written plans that did not outline specific financial, infrastructure, and staffing investments planned for increasing CBO capacity.

11.b. Optional: Describe or attach an activity meeting this element.

OPTIONAL – Data collection and sharing: Set up data systems to clean and use REALD data (Element C.14.)

Intent: CCOs set up data systems so they can effectively use REALD data received from OHA and other sources to inform processes for screening and referrals for social needs.

14.a.: **Answer yes** if the CCO used disaggregated REALD data to understand the populations served by your CCO and identified resources to meet members' needs. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

Examples of activities meeting this element may include:

- The CCO used disaggregated REALD data to tailor training on how to provide culturally responsive screening and referrals and to work with community partners to address any gaps in culturally responsive services to meet members' social needs.

Examples of activities *not* meeting this element:

- The CCO collected and stored disaggregated REALD data, but did not used the data to modify or add new community engagement and/or social needs screening and referral practices.

14.b. Optional: Describe or attach an activity meeting this element.

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OPTIONAL – Data collection and sharing: Support a data-sharing approach (Element C.15.)

Intent: CCOs support networked providers to have access, at the point of care, to screening results and referral(s) made, even if the screening or referral occurs at the CCO level or at another clinic.

15.a.: **Answer yes** if the CCO provided access to a tool or tools that enable screening and referral data to be shared among networked providers who care for members or if the CCO otherwise ensured that networked providers use tools to share screening and referral data. Tools may include, for example, a CIE, HIE, or other screening and referral system for networked providers that enabled screening and referral data to be shared. **Otherwise, answer no.**

- ◯ Yes
- ◯ No

15.b.: Briefly identify the approach used and its availability to networked providers (e.g., our CCO pays for a subscription to ABC CIE, which has onboarded X# of clinics and Y# of CBOs in our service area).

Examples of activities meeting this element may include:

- The CCO paid, incentivized, or subsidized network providers' subscription to a community information exchange (e.g., Unite Us, findhelp, etc.).
- The CCO established agreements with network providers that required them to connect to a tool that enables sharing and receiving screening and referral data.

Examples of activities *not* meeting this element:

- The CCO participated in a HIE or CIE collaborative, but the CCO had not entered into agreements with network providers to enable sharing social needs data or invested in infrastructure for network providers.
- The CCO is connected to a tool that enabled sharing of social needs data, but the CCO had neither made agreements with network providers for their use of the tool nor instituted incentives, subsidies, or other investments in network providers' use of the tool.

15.c. Optional: Describe or attach an activity meeting this element.