SDOH Screening & Referral Metric FREQUENTLY ASKED QUESTIONS

Updated March 2024

Purpose

The purpose of this FAQ is to address questions related to SDOH Screening & Referral Metric must-pass elements and describe how CCOs might 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 identified 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.

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.

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 measure passed in 2022. CCOs began measure implementation in January of 2023. [ii]

Contents

Screening

1. **Will there be a process for CCOs to request that other forms/sources be added to the OHA approved list of SDOH screening tools?**

   OHA will review new social needs screening tools annually. Two types of reviews will be 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 will only examine 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 for more information.

   Back to top

2. **(Updated 3/27/24) 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.

   Back to top

3. **(Updated 3/27/24) If a social needs screening tool that a clinic (for example Advantage Dental) 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 given 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.

   Back to top

4. **(Updated 3/27/24) Do the standard screening tools found in EPIC count if they contain the three domain questions related to the metric?**

   The metric prompts the 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 of the measure specifications for more details on the process.

Back to top

5. **(Updated 3/27/24) 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.

Back to top

6. **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 SDOH 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.

Back to top

7. **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, and adequate food and housing resources are very important for infants and toddlers.

Back to top

8. **For pediatrics, 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 members.

   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.

Back to top

9. **(Updated 3/27/24) 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.

Back to top

10. **(Updated 3/27/24) 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.

Back to top

11. **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.

Back to top

12. **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 Social Needs Screening Tools Process for more information. OHA strongly encourages clinics to use the screening tools as written and will make limited approvals for screening tool adjustments. OHA recommends CCOs and providers reach out directly to the authors of approved screening tools with feedback on tool language.

Back to top

13. **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.

Back to top

14. **(Updated 3/27/24) 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.

Back to top

15. **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.

Back to top

16. **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 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.

Back to top

17. **(Updated 3/27/24) 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.

Back to top

18. **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. The most recent screening for each domain should be reported separately.

Back to top

19. **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.

Back to top

20. **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.

Back to top

21. **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. See screening question 20 in the FAQ.

    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.

Back to top

22. **Will providers be paid for screening patients for social needs? Typically, Z codes are not billable. What guidance does the state have for billing?**

    There are codes in the measure specifications that are billable. Under the CCO model, CCOs enter into payment arrangements with providers. OHA is not typically responsible for paying for services needed to meet incentive measures. As HRSN benefits begin, there will be a payment structure for outreach and engagement services which may include some screening. 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 Representation to connect with the appropriate OHA subject matter expert for billing consultation.

Back to top

23. **Will there be any billing codes added for Community Health Workers (CHWs) to complete this work?**

    There are approved Fee-for-Service billing codes for CHW services that are explained 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.

Back to top

24. **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 REALD 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.

Back to top

25. **Regarding meeting must-pass element 3, what are examples of social services OHA would suggest being in contact with?**

    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.

Back to top

26. **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.

Back to top

27. **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.

Back to top

28. **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.

Back to top

29. **(Updated 3/27/24) 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.

Back to top

30. **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).

Back to top

31. **Can CCOs use the same screening questions they are using for the measure with the 1115 waiver HRSN benefit transitions populations?**

    For the metric, CCOs are asked to use or ensure that their network providers use a tool from the OHA approved screening tool list. These approved screening tools ask information about a person's social needs that can help CCOs or service providers identify someone who may be eligible for the Health-Related Social Needs (HRSN) benefit. The information collected from the OHA approved screening tools for the metric may include some of the required information/data needs for the HRSN benefit, but a CCO will need additional information to determine service eligibility for the HRSN benefit. Please see OAR 410—120-2000 for more information on information/data needs related to the HRSN benefit.

Back to top

Referral Practices & Resources

1. **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.

Back to top

2. **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) for Measure Year 2023, 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 health-related social needs 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.

Back to top

3. **(Updated 3/27/24) 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.

Back to top

4. **(Updated 3/27/24) 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.

Back to top

5. **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, food and climate benefits.

Back to top

6. **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. OHA recognizes that CCOs need to pay or reimburse partners for these types of 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. Also, please see the response to question 4 above on page 15.

Back to top

7. **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.

Back to top

8. **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 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 climate-related needs while 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.

Back to top

9. **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.

Back to top

10. **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.

Back to top

Data Collection & Sharing

11. **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 the most recent specifications posted on the SDOH Technical Assistance 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.

Back to top

12. **(Updated 3/27/24) In regard to Component 2, how will Rate 3 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 counts 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.

    The reporting template in Appendix 1 of the measurement specifications allows for reporting of the most recent screening results and referrals for each domain separately. OHA strongly encourages screening for all three domains at the same time. However, screenings may need to occur 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.

Back to top

13. **Regarding approved screening tools, many of the approved tools are laid out in such a way that they could be delivered to a member electronically for completion or filled out on paper during intake at a clinic, and then followed up on when they are reviewed by staff. However, much of the language in the measure also refers to the need for empathy and trauma-informed care when doing screenings. To count for the measure, do screenings have to be wholly delivered verbally by staff? Or can they be completed by the member and then reviewed afterward? If so, will there be a timeline or threshold associated with this follow up for the encounter to count for the measure?**

    - The approved screening tool should follow the data collection protocol outlined in the chosen tool's instructions.
    - No timeline for when the referral is made is currently listed in the technical specifications. As part of the work on Component 1 of the metric, CCOs should set up policies to ensure timely referrals are made.
    - Thresholds, or scoring algorithms, listed in the approved screening tool for housing, food insecurity and transportation needs should be used to determine who qualifies for a referral for each type of social need.

Back to top

14. **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.

Back to top

15. **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 HIPPA 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.

Back to top

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. A pdf of the survey attestation form will be available as each year's technical specifications are finalized. The self-attestation will require CCOs to answer yes or no to achieving each must pass element by December 31st of the measurement year. Submitting supporting documentation is optional.

Back to top

17. **(Updated 3/27/24) 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.

Back to top

18. **Regarding there being no requirement to submit additional information with the metric attestation: 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 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 the systems change metric work is implemented.

Back to top

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