CareOregon

Social determinants of health: social needs screening & referral

OHA technical specifications[1]

Who: All patients assigned to the CCO who are continuously enrolled for at least 180 days in the year.

Why: In recent years, recognition has grown of the profound impact social factors like income, environmental conditions and racism have on a person's health. The goal of the Social Needs Screening and Referral measure is that CCO members have their social needs acknowledged and addressed in an equitable and trauma-informed way.

What: Component 1 of the measure assesses CCOs' action plans to ensure social needs screenings and referrals are implemented in an equitable and trauma-informed manner.

Component 2 is intended to measure the percentage of CCO members screened and, as appropriate, referred for services for three domains: (1) housing insecurity, (2) food insecurity, and (3) transportation needs.

How:
Component 1: the CCO must: (1) answer all self-assessment questions and (2) attest to having accomplished all "must-pass" elements required for that year. These elements assess how well CCOs identify and coordinate services for members with social needs in the domains of:

1. Food insecurity
2. Housing insecurity
3. Transportation needs

CCOs will complete a self-assessment that includes questions about social needs screening tools and methods, data collection mechanisms, trauma-informed practices, and protocols for referring CCO members to community resources.

Component 2: the CCO will report the percentage of screened CCO members through hybrid measure reporting. The data for this component will be pulled using a variety of sources:

- MMIS/DSSURS – this is OHA's repository of claims where zcodes represent identified social needs.
- EHR – we can work with your organization to build this reporting capacity. Reach out to your PCIS.
- Community Information Exchanges (CIE) – CareOregon is supporting the utilization of the UniteUs platform.
- Health Information Exchanges (HIE)
- Any other qualifying alternative data sources (to begin 2024 and continuing on through 2026).

Social determinants of health: social needs screening & referral

Performance Measure Set:
☒ CCO Incentive Metric ☐ Medicare Star Measure

Quality Measurement Type:
☐ Structure ☒ Process ☐ Outcome ☐ Patient Experience Data

Data Type:
MY 2023+: ☒ Survey MY 2024+: ☒ Claims ☒ Chart documentation ☒ eCQM ☐ Other

State Benchmark: Meet all required 2023 self-assessment elements.

[1]*https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Final-2023-SDOH-Screening-Specifications.pdf*