



Social Determinants of Health (SDOH) Screening and Referral Metric: Learning Collaborative Playbook

**Learning together for better health, better care and
equity**

Measure Year: 2025



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How to use this playbook

This playbook is designed as an optional resource for coordinated care organizations (CCOs) as a complement to the technical specifications of the social determinants of health (SDOH) social needs screening and referral measure (referred to as SDOH metric throughout).

The [2025 SDOH metric technical specifications](#) outline the cumulative reporting requirements for the metric since its launch in the CCO Quality Incentive Program. Measurement Year 2025 includes the only time Component 1, CCO self-attestation, and Component 2, identifying social needs and referring members, will overlap. Actively screening and referring members for social needs represents the next step in the metric’s progression — using the Component 1 workflows, policies, and infrastructure to report Component 2 activities.

The playbook provides practical suggestions to help CCOs plan for 2025 and beyond in the following areas:

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Change management tips for 2025 reporting

This measure represents an opportunity for CCOs and their partners to meaningfully address members' social needs and advance health equity. Implementing the SDOH metric requires significant systems changes for CCOs and their community and clinical partners. Some key plays for success in 2025 include:

- ✓ **Maintain an advisory group** – Engage community, provider and member partners, including people with lived experience, to continue to guide implementation.
- ✓ **Develop and share a data-sharing framework** – Prepare CCO staff and external clinical and community partners for the data-sharing needs essential for 2025 reporting.
- ✓ **Create reporting resources** – Provide tools and guidance to align screening and referral data collection with Component 2 of the 2025 metric specifications, while planning for full population implementation in future years.

For more guidance, please access the previous 2023 and 2024 SDOH Metric Playbooks on the [OHA Transformation Center SDOH Metric Webpage](#).

Laying the foundation: 2025

2025 is an important time for coordinated care organizations (CCOs) implementing the SDOH metric. 2025 serves as the foundation for long-term, systems change — establishing the necessary infrastructure, data pathways, and partnerships that support a comprehensive and sustainable approach to addressing social needs across all Oregon Health Plan (OHP) CCO members.

By implementing the SDOH metric, CCOs are:

- **Paving the way for systems change:** The work in 2025 sets the stage for embedding social needs screening and referral practices into the routine CCO operations. It has the potential to influence health more broadly in the health care and community care system. By testing and refining workflows, data collection methods, and automated data reporting processes, CCOs can help lay the groundwork for a coordinated system where addressing social needs is a standard part of health care. This systems approach is critical for ensuring that future metric work achieves the intended impact at scale.

- **Establishing a baseline for continuous improvement:** 2025 reporting generates baseline data for evaluating current social needs screening and referral practices. These data can guide improvements in service delivery, highlight gaps in care coordination, and help to identify areas where more training or resources are needed. The lessons learned this year will shape the evolution of the SDOH metric and inform other statewide strategies for addressing social needs.
- **Aligning with national health and social care integration trends:** Oregon's work aligns with broader efforts at the national level, including measures such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Social Need Screening and Intervention (SNS-E) measure. By staying in step with these national frameworks, Oregon Health Authority (OHA) is ensuring Oregon's efforts are part of a larger movement to standardize and integrate social care into health care delivery.
- **Promoting equity in health care delivery:** Universal screening is a cornerstone of equity in health care as it ensures that all individuals, regardless of background, are assessed for social needs that impact their health. In 2025, collection of complete and accurate data is a focus of SDOH metric work. This focus helps uncover disparities in screening and referral rates and aligns with OHA's goals to eliminate health inequities. Consider reviewing the [2024 SDOH Metric Playbook](#) (page 3) for suggested approaches to centering equity.

Component 2 overview

In 2025, CCOs actively identify and refer members for food, housing and transportation resources for Component 2, while continuing to meet Component 1 elements. Component 1 focuses on establishing policies, workflows and data-sharing infrastructure to support social needs screening and referrals and is covered in detail in 2023 and 2024 playbooks. This playbook focuses on Component 2, building a foundation to track and report social needs screening and referrals across three domains:

- Housing insecurity
- Food insecurity
- Transportation needs

The aim of the SDOH metric is to identify and meet social needs of all CCO members. In 2025, CCOs report on an OHA-identified sample of 1,067 members who meet continuous enrollment criteria and whether they were screened and then referred to services to meet any identified need. The sample is stratified to reflect the proportions of children and adults in the overall CCO membership.

Key dates

Screening period:

- December 15, 2024–December 14, 2025
- This timeframe ensures referrals can be made before the end of the measurement year.

Data submission deadline:

- March 2026
- Please note: OHA will provide further guidance on reporting timelines.

Sample parameters

Sample size:

- 1,067 members per CCO

Selection criteria:

- Members must meet continuous enrollment criteria (at least 180 consecutive days of enrollment).

The sample includes children and adults in proportions matching CCO membership demographics.

Rates reported

Rate 1: % of sample who were screened

Numerator: Members screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool.

Denominator: All members who meet continuous enrollment criteria except those who decline to be screened in all three domains.

Rate 2: % who screened positive

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

Denominator: Members screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool (rate 1 numerator).

This rate is for data purposes only, not benchmarking.

Rate 3: % who screened positive and received a referral

Numerator: Members who received a referral within 15 calendar days for each domain in which they screened positive.

Denominator: Members screened positive for one or more needs in the required domains during screenings for the three domains (rate 2 numerator) except those who declined all referrals.

This measure tracks referrals made, not closed-loop referrals

For more information, see the 2025 SDOH screening and referral metric measure specifications: [Appendix 1: Template for Component 2 Reporting](#).

Section 1: Preparing for reporting

To prepare for sample data collection and reporting, CCOs can plan proactively to establish efficient workflows, allocate resources and ensure data accuracy. The SDOH measure is agnostic about who conducts screenings and referrals to allow CCOs to align with efforts across social needs programs such as HRSN and other efforts. A CCO may conduct all screenings and referrals or choose to work with clinical and community partners. The following “plays” will help CCOs prepare for 2025 reporting and set the stage for long-term success:

- ✓ **Establish clear processes:** Develop standardized workflows for collecting and reporting screening and referral data. Ensure that all teams involved — including provider networks, data teams and community partners — understand their roles and responsibilities.
- ✓ **Test strategies for automation:** Explore data automation solutions to streamline reporting and reduce need for manual chart reviews. This may include integrating

electronic health records (EHRs), guiding partners to use data collection practices to allow queries and reports in an EHR, data-sharing agreements with clinical partners, and using community information exchange (CIE) platforms to capture screening and referral data more efficiently.

- ✓ **Plan resources for chart review (if needed):** Depending on completeness of data collected from automated reporting sources, some CCOs may need to complete a full or partial chart review. Determine the level of effort required for manual chart review and plan accordingly. Allocate staff time and technology resources in advance to prevent delays during reporting periods.
- ✓ **Monitor data quality:** Regularly review collected data to identify gaps, inconsistencies or missing fields before the reporting deadline. Establish internal CCO quality checks to ensure all required fields are completed and meet the 90% completeness threshold.
- ✓ **Coordinate across CCO and external partner teams:** Strong collaboration between CCO teams, provider organizations and community partners is key to accurate and timely reporting. Establish regular communication channels to share best practices, address challenges and align data collection efforts.
- ✓ **Evaluate and adjust:** Use the 2025 reporting cycle as a learning opportunity. Analyze data trends, assess workflow efficiency and refine processes based on real-time feedback. Adjust strategies to improve data collection and referral tracking for future reporting years.

Section 2: Measuring screening and referral

This worksheet breaks down each Component 2 rate, suggesting key “plays” and specific questions for CCOs to consider as they plan to capture the required data for reporting. These optional worksheets are designed to guide CCOs in effectively gathering and analyzing the information outlined in the [technical specifications](#).

Worksheet A: Screening completion (rate 1)

Overview (from [technical specifications](#))

For rate 1, CCOs must quantify the percentage of CCO members from the OHA-identified sample who were screened for each of the three domains using an OHA-approved or exempted screening tool at least once during the measurement year. Performance on this rate is largely dependent on 1) ensuring all screening partners are using questions from approved or exempted tools and 2) ensuring screening partners are assessing for all three metric domains.

Key “play”	Steps your CCO could take:
Use data gathered about where screenings occur and what tools are used (element 3 and 6) and compare information with OHA-approved screening tools (element 7) to understand gaps in metric compliant screening practices. Develop a strategy to ensure that your CCO staff, clinical and community partners are consistently using the OHA-approved or exempted screening tools during every member screening interaction.	☐ Assess if screening processes are integrated into routine intake or care coordination workflows, including health risk assessments, ensuring checking whether a member has been screened and completing screenings is part of regular member touchpoints. ☐ Review written policies on training (element 2) and include material that emphasizes the importance of using approved tools and systematically documenting screening and referral activity. ☐ Connect with clinical or community partners identified in your screening tool gap analysis (element 7). Ask about their systems, workflows and barriers to aligning with the metric. Help those partners address barriers through training resources, information sharing and screening tool exemption if appropriate.

Questions to consider:

- How is your CCO ensuring that CCO staff and all providers are consistently using an OHA-approved screening tool?
- How are screenings documented, and is the process standardized across CCO staff and providers and settings?
- How is your CCO using information gathered through partner survey responses (element 3, element 4, element 13) to update training policies (element 2) to address gaps in training?
- What guidance or training does your CCO provide to clinical and community partners to support consistent and accurate capture of screening data in the systems your CCO uses to track this information?
- How does your CCO define “correct” and “consistent” data entry for social needs screening and referrals, and how is this communicated to partners?
- What are the workflow barriers affecting screening rates for clinical and/or community partners? (for example, time constraints, training gaps, inconsistent screening practices, inconsistent documentation) and how can the CCO help by providing technical assistance or other resources?
- What technologies, such as data sharing systems (element 15), processes, training or other strategies is your CCO using to minimize the risk of over-screening? How is your CCO using data or partner feedback to inform these strategies and identify situations where over-screening may occur (element 8)?
- What protocols is your CCO developing to connect initiatives that ask members about and address unmet social needs to prevent over-screening (element 8)?
- How can data-sharing improvements (for example, CIE, health information exchange) help capture more complete screening information?
- In addition to the tools that you provide access to for sending screening and referral data (element 15) what tools are being used by clinical and community partners?
- What decision support tools do your clinical partners have to identify patients to be screened

Worksheet B: Positive screens (rate 2)

Overview (from [technical specifications](#))

For rate 2, CCOs must quantify the percentage of CCO members with a positive screen for any of the three required domains. This worksheet assumes performance on this rate is largely dependent on content in the previous worksheet as well as 1) consistency of screening activities and 2) reliability of data. This worksheet is an optional tool.

Key “play”	Steps your CCO could take:
Establish a clear, consistent process for data collection and reporting.	☐ Periodically conduct data quality checks to ensure reliable and correct entry, focusing on consistency in reporting positive screens. ☐ Ensure all clinical and community partners are familiar with training policies and resources (element 2, element 4) and they understand how to correctly conduct and document screenings in a way that allows data sharing systems to generate automated and accurate reports. ☐ Connect all partners and CCO staff conducting screening with resources to build their skills in motivational interviewing, empathic inquiry, trauma informed care, and using patient-centered language beyond the required written training policies (element 2) to ensure they are equipped to support a member when a need is identified.

Questions to consider:

- What are your CCO’s most reliable data sources for capturing positive screens (for example, EHR, claims, CIE, paper charts)?
- Beyond reviewing and updating written policies on training (element 2), how does your CCO offer ongoing support or refresher training to
 1. Ensure data is entered correctly and consistently?
 2. Build skills to speak with members about sensitive and potentially stigmatizing topics?

Worksheet C: Referrals for positive screens (rate 3)

Overview (from [technical specifications](#))

For rate 3, CCOs must quantify those members from the sample population who received at least one referral for an identified need. This worksheet assumes performance on this rate is largely dependent on content in the previous worksheets as well as consistency of reporting referrals for positive screens. This worksheet is an optional tool.

Key “play”	Steps your CCO could take:
Develop strategies to strengthen referral reporting and follow-through.	☐ Standardize referral documentation by ensuring referrals are consistently recorded in EHRs, CIEs and other systems with clear processes. ☐ Enhance coordination between clinical and community partners by establishing referral agreements, aligning workflows and creating feedback loops to track referral outcomes. Consider providing referral tools and sample workflows to community partners. ☐ Use the inventory, or other assessment, of available resources (element 9) and disaggregated race, ethnicity, language and disability (REALD) data (element 5) to update policies or contractual agreements and specify responsibilities and procedures for referring members to culturally responsive resources (element 10) that are responsive to current need in the service area. ☐ Monitor and improve data quality through regular review of referral data, addressing missing information and using dashboards to track trends. ☐ Support member engagement by reducing barriers to referral acceptance and implement follow-up strategies to confirm service connections.

Questions to consider:

- How are referrals documented across different provider types and systems, including CCO systems, if applicable (for example, EHR, CIE, manual logs)?
- What processes are in place to ensure that all referrals are recorded, even when provided outside of clinical settings? How can your CCO update policies on training (element 2) to guide consistent documentation practices across partners that make referrals, including referral practices of CCO staff?
- How does your CCO monitor referral timeliness to ensure members receive referrals within 15 days of screening?
- How does your CCO ensure that organizations conducting screening are offering referrals to culturally and linguistically responsive services? How does your CCO monitor the member requests for and availability of these services? What is your CCO's plan to address gaps in culturally and linguistically responsive services in the region?
- What percentage of members decline referrals, and how is this documented? Are certain groups captured through REALD data collection more likely to decline? What trends or barriers exist around member referral acceptance?
- How does your CCO ensure alignment between screening sites and referral partners to improve closed-loop referrals and tracking? Do EHRs allow for tracking of closed-loop referrals? (Please note: closed loop referrals are not required for 2025 reporting.)

Worksheet D: Unknown values and good faith effort

Overview (from [technical specifications](#))

To meet Component 2 requirements, CCOs must ensure at least 90% of the sample population has complete data, completing required fields and minimizing unknown values while demonstrating a good faith effort in data collection. According to Appendix 3 of the measure specifications, a good faith effort requires CCOs to have:

- Established screening and referral processes for housing, food and transportation.
- Clear data collection workflows aligned with the reporting template.
- Tools for sharing data within the provider network.
- Active data collection from partners with whom the CCO has established relationships for the SDOH measure.

A good faith effort means taking systematic, verifiable steps to collect complete and accurate data. Unknown values should only be used when data collection methods fail despite structured efforts to retrieve missing information.

Key “play”

Strengthen data completeness and establish a solid process for your CCO’s good faith effort.

Steps your CCO could take:

- ☐ Clarify data entry standards with partners to ensure valid values are reported in alignment with the template. “Unknown” is only used when all reasonable efforts to collect data have failed. Partners should understand why a field cannot be left blank.
- ☐ Ensure CCO staff, providers and partners consistently record screenings and referrals in EHRs, CIEs and other reporting systems. Screening responses and referral information are ideally captured as structured data and available through an embedded tool that can report on or query individual and population-level data.
- ☐ Establish agreements with clinical and community partners (element 12) that require timely data sharing, allowing them to review trends and reduce missing or incomplete data.
- ☐ Use tools (EHR, CIE) to periodically report or query individual- and population-level data and provide information to clinical and community partners.

- Maintain records of outreach, workflow improvements and systematic data collection efforts to document good faith efforts and demonstrate compliance.

Questions to consider:

- What is your CCO's process for following up on missing information?
- Where are unknown values most frequently occurring (screening, positive screens or referrals)?
- What strategies can your CCO implement to improve data-sharing timeliness with partners, allowing for data quality checks and follow-ups on unknown values?
- How are screening and referral data being documented across different systems (EHR, CIE, claims, health risk assessments), and are there any gap trends specific to the system(s)?
- What internal processes within your CCO and/or for partners (for example, audits, provider training) can help reduce unknown or incomplete values before reporting on the sample population occurs?
- How is your CCO documenting its good faith data collection efforts? How is your CCO identifying and prioritizing areas for improvement in data completeness?
- What guidance or expectations has your CCO communicated to clinical and community partners about how data should be documented to support scalable reporting systems that have a query or data report tool embedded?
- How is your CCO preparing for future population-wide measurement, including through structured documentation guidance, supporting a data sharing approach (element 15) through tools that have functions that streamline data collection and extraction, standardized data collection methods, or partner agreements that address data workflows (element 12)?
- What quality improvement processes are in place to address unknown values when identified, and how will your CCO track progress over time?
- How will you use unknown data found in the sample year to improve data collection and reporting systems?

Section 3: Quality improvement

As CCOs implement Component 2 reporting, a strong focus on data quality improvement (QI) ensures accurate, actionable insights that drive better outcomes for CCO members. The following “plays” can help CCOs enhance data reliability and use their findings for QI:

- ✓ **Ensure data quality for claims and EHR-sourced social needs screening and referral data:** Standardizing claims and EHR data collection is critical for ensuring accuracy and consistency in social needs screening and referral documentation. Review coding practices — including the use of Z-codes, procedure codes and structured EHR fields — to align with best practices and avoid data fragmentation. For more information on how CCOs can ensure uniform coding across provider networks and minimize missing or misclassified data, see the recording and slides from the [EHR, Chart Review and Claims-Related Data Learning Collaborative \(January 21, 2025\)](#).
- ✓ **Improve data quality for community information exchange (CIE):** For CCOs using CIE platforms to capture social needs data, ensuring data completeness and interoperability is essential. CCOs can:
 - Establish standardized data entry processes for screening and referrals.
 - Ensure alignment with CIE data dictionaries to maintain consistency.
 - Work with CIE network partners and technology vendors to identify and address gaps in screening and referral tracking.
- ✓ **Engage clinical and community partners in QI efforts:** Improving social needs screening and referral data requires collaboration with clinical and community partners. CCOs can:
 - Provide training and feedback loops to help partners improve screening and documentation practices.
 - Establish regular QI meetings to discuss data trends, challenges and opportunities for improvement.
 - Support bidirectional data sharing so CCO screening and referral staff and clinical and community providers can track outcomes and adjust workflows.

- ✓ **Use data to learn:** Beyond reporting and compliance, social needs data can inform strategic decision-making. CCOs can analyze trends to:
 - Identify specific populations or geographies where social needs are prevalent and deploy resources accordingly.
 - Assess screening disparities across populations and develop interventions.
 - Use data to demonstrate impact and advocate for policy changes or funding.
- ✓ **Plan for scaling to full population:** While 2025 focuses on a sample of 1,067 members per CCO, future efforts will require scaling up to full-population screening and referral tracking. CCOs can:
 - Develop long-term strategies for universal screening and referral workflows.
 - Strengthen data-sharing agreements with clinical and community partners.
 - Invest in automation and interoperability to streamline full-population data collection.

Section 4: Partner engagement and education

Successful implementation of Component 2 depends on strong partnerships among the CCO, especially staff conducting screening and referrals, and its clinical and community partners. While partners play a vital role in social needs screening and referrals, they each have their own unique challenges to engaging in this work. Below are suggested key “plays” to foster collaboration, ensuring that both clinical and community partners are equipped to collect, share and act on social needs data effectively. For foundational reading on cultivating strong partnerships, see page 5 of the [2024 Playbook](#).

- ✓ **Build awareness and buy-in**
 - For clinical partners: Emphasize how standardized social needs screening and referral workflows improve patient care, reduce provider burden and align with quality metrics.

- For community partners: Highlight the role of accurate data collection in securing funding, demonstrating impact and strengthening service coordination with health care partners.
- For both: Facilitate joint learning sessions to align expectations, share insights and establish common goals.

✓ **Incentivize participation**

- For clinical partners: Provide performance-based incentives and/or workflow supports (for example, EHR integration funding) to improve screening and referral documentation.
- For community partners: Explore financial and/or operational arrangements (for example, capacity-building grants, incentives for adopting and using data-sharing platforms based on percentage of screenings and referrals completed in CIE) to enhance participation in data systems, collection and reporting.
- For both: Consider shared incentives for closed-loop referrals, rewarding both clinical and community partners for seamless care coordination.

✓ **Provide ongoing training**

- For clinical partners: Offer training on social needs screening tools and EHR or CIE screening and referral documentation best practices.
- For community partners: Offer training on social needs screening tools and screening and referral documentation best practices (for example, using CIE). Ensure training covers data-sharing expectations, referral tracking and the use of electronic data sharing platforms to document service connections.
- For both: Review written policies on training (element 2) and use survey data (elements 3, 6 and 13), initial social needs screening and referral data, and informal partner feedback to update training responsive to the gaps in the system and needs of partners. Create cross-sector training opportunities so clinics and community partners understand each other's workflows and can improve coordination. Free training resources that meet element 4 training requirements for all partners and CCO staff conducting social needs screening can be found in the [SDOH metric social needs training resource document](#).

✓ **Develop feedback loops**

- For clinical partners: Establish mechanisms for community partners to provide feedback on referrals, ensuring clinics are aware of service availability and member outcomes.
- For community partners: Facilitate getting data from clinics to refine service delivery and track unmet needs more effectively. Support community partners on how to use and analyze available data.
- For both: Set up regular check-ins or a shared dashboard to monitor data trends and resolve workflow issues. Support this data sharing system by providing a tool or requiring through written agreements that partners use a tool that enables data sharing.

✓ **Support with tools and templates**

- For clinical partners: Provide EHR templates, screening scripts and workflow guides to streamline documentation.
- For community partners: Assist with technical support, reporting tools and funding opportunities for participation in data collection and referrals.
- For both: Ensure access to real-time service directories to improve referral success rates. Expand support of a data sharing tool.

✓ **Encourage engagement with and active use of CIE**

- For clinical partners: Promote real-time data sharing via CIE to avoid over-screening, find social needs referral sources and ensure efficient referral tracking.
- For community partners: Support training for CIE use to ensure community partners can document and report referral outcomes effectively. For more information on how CCOs can facilitate increased CIE use among community partners, see the recording and slides from the [Building Community-based Organization \(CBO\) Capacity and Engagement with CIE webinar \(October 23, 2024\)](#).

- For both: Encourage bidirectional data exchange to ensure both clinical and community providers and CCO staff can access relevant social needs data. Assess whether the tool(s) that enable screening and referral data to be shared among networked providers (element 15) and CCO staff are being used and address barriers encountered by clinical and community partners.

✓ **Collaborate to minimize “unknown” data values**

- For clinical partners: Implement standardized documentation processes to ensure screenings and referrals are recorded consistently.
- For community partners: Improve referral tracking and follow-up processes to capture service utilization data.
- For both: Align data-sharing practices to reduce missing or incomplete records and improve reporting accuracy.

✓ **Celebrate success**

- For clinical partners: Recognize high-performing teams among CCO staff and providers who demonstrate strong screening and referral practices.
- For community partners: Highlight stories showing how social needs interventions improved member outcomes.
- For both: Share success stories that show collaboration among clinical and community partners to inspire continued engagement.



Spotlight: Meaningful navigation and resource referral processes for people with social and/or medical complexity

A growing body of research shows the importance of addressing both complex health conditions and social needs to reduce unnecessary health care utilization. For example, a recent study published in Journal of the American Medical Association found that social risks were associated with more inpatient admissions, emergency department visits and mental health

visits during a 1-year period.¹ Understanding the interconnectedness of medical, behavioral and social complexities is crucial for developing effective social needs screening and referral strategies. By using population health data, CCOs can create a foundation for more targeted interventions that differentiate between levels of complexity within their member population. This approach allows for more tailored resource navigation and allocation, paving the way for efforts that not only reduce the overall cost of care but also enhance quality and efficiency and improve population health outcomes.

A simplified way to think about this is represented in Figure 1. Consider the matrix as representing a CCO's full OHP population.

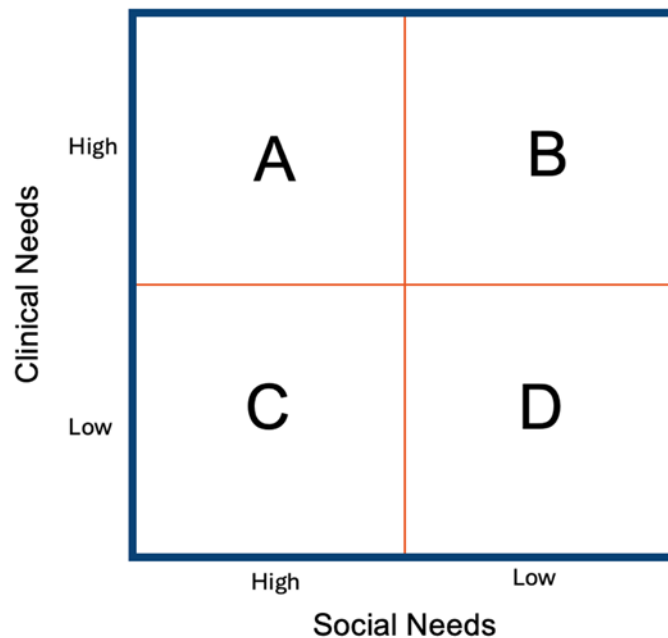
- Quadrant A: Members with high clinical needs/high social needs
- Quadrant B: Members with high clinical needs/low social needs
- Quadrant C: Members with low clinical needs/high social needs
- Quadrant D: Members with low clinical needs/low social needs

For people in Quadrant A — those with both high clinical and high social needs — intensive care coordination, integrated care teams and proactive outreach may be necessary to ensure they receive comprehensive medical and social support. In contrast, people in Quadrant B, who have high clinical needs but fewer social needs, may benefit most from enhanced chronic disease management and streamlined access to specialty care. For those in Quadrant C, where social risks are high but clinical needs are lower, partnerships with community partners and robust referral systems can help address housing, food insecurity and other social needs. Finally, people in Quadrant D, who experience fewer health and social challenges, may require only minimal navigation support, with a focus on preventive care and maintaining well-being.

This framework is not intended to create a one-size-fits-all approach but rather to provide a structured way for CCOs, providers and clinical partners to think about how to integrate screening and referral practices with a person's health care.

¹ [Tucher EL, Steele AL, Uratsu CS, McCloskey JK, Grant RW. Social Risks and Health Care Use in Medically Complex Patients. JAMA Netw Open. 2024;7\(9\):e2435199. doi:10.1001/jamanetworkopen.2024.35199](#)

Figure 1. Designing social needs screening and referral practices to scale, based on clinical and social complexity



Potential “plays” to support members with medical and social complexity

- ✓ **Tailor screening and referral approaches:** Use approved screening tools and referral pathways that take into account the unique medical complexities of members. Adapt processes based on a person’s health conditions, service needs and level of vulnerability. Ensure the screenings are both comprehensive and sensitive to medical and social needs, recognizing the intersection of these factors.
- ✓ **Coordinate across care teams:** Implement a collaborative, team-based approach to care, ensuring all care team members (CCO staff, primary care providers, specialists, care coordinators, social workers, etc.) are informed and involved in screening, referrals and follow-up. This coordination ensures that medical needs and social needs are addressed together.
- ✓ **Address access issues:** Identify and remove barriers to accessing services, including transportation, communication, language and literacy challenges. Consider telehealth and mobile outreach as tools to reach people who might face physical or logistical barriers.

- ✓ **Ensure culturally and linguistically responsive care:** Provide screenings, referrals and services that are culturally appropriate and in the language people understand. Partner with trusted community organizations to improve engagement and tailor services to meet members' cultural and language needs.
- ✓ **Enhance referral tracking:** Implement systems for tracking referrals to ensure they are followed up on and no referrals are missed due to informal or disorganized tracking. Use integrated systems that allow care coordinators to track and communicate progress on referred services, ensuring timely and appropriate interventions.
- ✓ **Provide ongoing support:** Establish processes for maintaining contact with members after referral to ensure they receive the support they need. This includes regular follow-ups, check-ins and proactive outreach so people stay connected to needed resources.
- ✓ **Monitor outcomes:** Develop metrics and monitoring tools to track the effectiveness of referrals, both from a medical and a social perspective. This could include tracking improvements in health outcomes, housing stability, food security, transportation access or other social needs. Use outcomes data to refine and improve screening and referral processes, and to share successes with screening and referral partners to maintain their participation.

Aligning the SDOH metric and HRSN benefit to advance equity

As OHA and CCOs are implementing both the Health-Related Social Needs (HRSN) benefit and the SDOH metric, there are many opportunities to align systems and operational efforts to strengthen both. Members who are not HRSN eligible can be connected to other available social services and benefits. CCOs can consider the following:

- ✓ **Align screening and HRSN benefit determination** so members can easily access the social services they need without encountering administrative delays. Ensure that workflows within the CCO, such as on care coordination teams, are streamlined to support anyone with unmet needs.
 - Reference the eligibility screening template for each HRSN benefit provided to your CCO and OHA HRSN [housing request form](#), [nutrition request form](#) and [home changes for health \(formerly climate\) request form](#) as you consider what

information about members' social needs is collected and sent for the HRSN benefits.

- ✓ **Streamline agreements with community partners:** Establish and streamline agreements with community partners (element 12) to ensure that processes for assessing unmet need, making a referral and receiving a referral are efficient and effective. Work with community partners to standardize processes across these initiatives, ensuring they are clear, actionable and responsive to the needs of members.
- ✓ **Align data sharing systems** used across incentive metric social needs screening and referral and HRSN eligibility screening and referral. Coordinate internally to understand the closed-loop referral systems used for the HRSN benefit. Establish use of a singular data sharing system for social needs referrals across these initiatives. Using singular or interoperable platforms for social needs screening and referral can help to:
 - Support an effective data sharing system (element 15)
 - Reduce the number of systems a community partner needs to use
 - Provide a single data source for individual and population level queries and reports
 - Prevent over-screening (element 8)
- ✓ **Align SDOH metric with HRSN outreach and engagement (O&E) activities:** Link the SDOH metric with [HRSN outreach and engagement service](#) activities to ensure consistency in how needs are screened, identified and met. This could include using the OHA-approved SDOH metric screening tools during initial O&E service interactions for CCO members presumed eligible for HRSN services. This alignment:
 - Helps reinforce the importance of social needs in the broader health care context;
 - Promotes continuity of care and services across different sectors; and
 - Supports expanded agreements with HRSN service providers that enable them to refer members to resources outside of HRSN if presumed eligible members are not found to be HRSN eligible.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Transformation Center at Transformation.Center@odhsoha.oregon.gov or 503-367-1314. We accept all relay calls.

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