SDOH Measure Reporting Frequently Asked Questions

Social Needs Screening and Referral (SDOH) Measure Reporting

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Social Needs Screening and Referral (SDOH) Measure Reporting

1. What is the Social Needs Screening & Referral (SDOH) Measure?

The Social Needs Screening & Referral (SDOH) Measure was developed by the state of Oregon with the intent to create a transformative healthcare delivery system that ensures people's social needs are acknowledged and appropriately addressed. The SDOH Measure is an 'upstream' systems-level measure in the CCO/Medicaid Incentive measure set, charging CCOs to develop equitable screening & referral practices, policies, data sharing processes, and value-based payment models to help build the capacity of communities to provide SDOH screenings and SDOH resources/services.

In 2025, an additional measurement/data collection component was added to the SDOH measure which captures the percentage of patients who were screened for **housing, food, and transportation** needs during the measurement period (12/15/24-12/14/25) using an OHA approved or exempted SDOH screening tool and were referred to services for any identified/positive need(s).

The SDOH measure rate calculation is as follows:

Screening Rate

Numerator: Number of CCO members screened for each of the three required SDOH domains (housing, food, transportation) during the measurement period using an OHA approved or exempted screening tool

Denominator: Total number of CCO members in the eligible population

Referral Rate:

Numerator: Number of CCO members with a positive screen who received at least one referral for each identified need within 15 calendar days of the SDOH screening encounter(s)*

Denominator: Number of CCO members in the screening rate numerator with a positive screen for any of the three required SDOH domains (housing, food, transportation)

**Screening encounters for the required SDOH domains (housing, food, and transportation) can occur on different dates. A patient must be screened for all three required SDOH domains during the measurement period to count as a complete SDOH screening.*

2. What does SDOH measure reporting look like for 2025?

For 2025, the SDOH measure will collect screening and referral data for a random sample of 1,067 adult and pediatric CCO members, called the '**hybrid sample'**. OHA will measure performance on the hybrid sample by report completion; there is no benchmark or target rate set for the SDOH measure for 2025. The report completion threshold OHA has established for the SDOH measure is 90%, which means screening and referral data must be reported for at least 90% of members included in the hybrid sample.

As long as CCOs and reporting partners make an effort to collect SDOH screening data from all available data sources, an 'unknown' or 'undetermined' member SDOH screening or referral status will count toward the hybrid sample completion threshold. More information on the SDOH data collection "Good Faith Effort" requirements can be found in Appendix 3 of the 2025 SDOH Measure specifications.

3. Who needs to complete SDOH Measure reporting?

EOCCO will ask all contracted dental, mental/behavioral, and physical health partners to participate in SDOH measure reporting. Contracted partners will receive a reporting template which includes EOCCO members in the hybrid sample that had a visit at their clinic/practice during the 2025 measurement period (12/15/24-12/14/25). Contracted partners will conduct chart reviews to determine if any members included in their reporting template received a social needs screening and referral(s) to services for any identified needs and report that data back to EOCCO.

4. When is the SDOH Measure reporting due?

SDOH measure reporting is due to EOCCO on **March 13th, 2026**. Complete SDOH reporting templates should be submitted securely to the EOCCO metrics inbox EOCCOmetrics@modahealth.com.

Reporting partners are expected to report SDOH screening and referral data for at least 90% of members included in their reporting template to 'pass' the reporting threshold requirement for 2025. An 'unknown' screening status counts toward the template completion threshold as long as an effort is made to collect SDOH screening/referral data from available clinical data sources.

SDOH Measure Component: Screening

5. What is an OHA approved SDOH Screening tool?

An OHA approved SDOH Screening tool is an SDOH Screening tool that has been reviewed by OHA and meets certain validity and reliability standards. All OHA approved SDOH screening tools are listed on OHA's Social Needs Screening Tools website. SDOH Screening tools on OHA's list are approved for use for both adult and pediatric populations.

To submit an SDOH Screening tool for addition to the statewide SDOH screening tool list, a clinic or CCO can complete the SDOH Screening Tool Request Review Form. Organizations must submit the tool by June 30th of the current measurement year for the tool to be reviewed and included in the statewide screening tool list for the following measurement year if approved.

6. What is an OHA exempted SDOH Screening tool?

An OHA exempted SDOH screening tool is an SDOH Screening tool that has been reviewed by OHA and is approved for use for specific organization or a limited group of providers. If an organization wants to submit an SDOH Screening tool for exemption, they must work with their CCO to submit that tool through OHA's SDOH Screening Tool Request Review Form.

To be approved for exemption at the organizational level, a screening tool must meet the following requirements:

1) The tool applies to at least one of the following domains:
    a. Both housing insecurity and houselessness
    b. Food insecurity
    c. Transportation needs
2) Cultural competency and understandability by population
    a. Tool must be at a minimum 6th grade reading level or less
3) Trauma-informed language and screening methodology
4) Tool provides option for a member to decline answering for all included SDOH domains
5) Tool provides clear indication of positive results for all included SDOH domains

If your organization is interested in submitting a developed SDOH screening tool for exemption, please reach out to EOCCOmetrics@modahealth.com. The tool must be submitted by June 30th of the current measurement year to be reviewed for exemption.

7. What if a patient received multiple SDOH screenings during the measurement period?

If a patient received multiple SDOH screenings during the measurement period (12/15/24-12/14/25) at your organization, you are only required to report one screening encounter per patient in the reporting template. OHA encourages reporting the most recent SDOH screening encounter for a patient, however, organizations can ultimately choose which screening encounter to report. A patient will only be counted once in the SDOH measure denominator.

If a member received screenings for different SDOH domains (i.e. housing, food, transportation) on separate dates, the date and result for each SDOH domain screening should be documented in the reporting template. A patient must be screened for all three required SDOH domains, housing, food, and transportation, during the measurement period to qualify as a complete SDOH screening.

8. What if a patient declined an SDOH screening or declined to be screened for a particular SDOH domain (housing, food, or transportation)?

All patients have a right to decline an SDOH screening. In order to avoid harm and prevent over-screening of patients for social needs, patients should always be informed of their right to refuse an SDOH screening or to refuse to answer any of the SDOH domain screening questions during a screening encounter.

If a patient declines an SDOH screening in full, this should be documented in the SDOH reporting template as:

- "Yes" in ***Screened for Social Needs*** Column
- "Declined" in ***Screened for Housing Insecurity***
    - List the Approved or Exempted Housing Insecurity screening tool used and tool name if applicable
    - Document date of housing insecurity screening refusal
- "Declined" in ***Screened for Food Insecurity***
    - List the Approved or Exempted Food Insecurity screening tool used and tool name if applicable
    - Document date of food insecurity screening refusal
- "Declined" in ***Screened for Transportation Needs***
    - List the Approved or Exempted Transportation needs screening tool used and tool name if applicable
    - Document date of transportation needs screening refusal

An SDOH screening declined in full qualifies as a denominator exception for the Screening rate of the SDOH measure.

If a member declines to answer screening questions for a particular SDOH domain, that should be documented in the SDOH reporting template as:

- "Declined" in the appropriate SDOH domain(s) field [Housing insecurity, food insecurity, transportation needs]
    - List the Approved or Exempted SDOH domain(s) screening tool used and tool name if applicable
    - Document date of SDOH domain(s) screening refusal.

9. What if a patient was not screened for SDOH needs during the measurement period or SDOH screening status is unknown?

If a patient was seen at your health care system or clinic during the measurement period but there is no record of an SDOH screening encounter, this can be documented in the SDOH reporting template as:

- "No" in the ***Screened for Social Needs*** Column. All other columns in the reporting template can be left blank

Alternatively, if a patient did not interact with your health care system or clinic during the measurement period and their SDOH screening status is unknown or undetermined after a good faith effort is made to collect from all possible/available clinical SDOH data sources, this can be documented in the SDOH reporting template as:

- "Unknown" in ***Screened for Social Needs*** Column. All other columns in the reporting template can be left blank

10. How do I report SDOH screening data if the patient included in the reporting template is a young pediatric patient?

For young pediatric patients, it's typical that an SDOH screening will be administered to a parent or caregiver to respond on behalf of the child or the family unit. The SDOH screening encounter in which the parent or caregiver provided responses on behalf of the child or family unit should be reported in the SDOH measure reporting template.

For pediatric patients aged 12-17 years old, the SDOH screening may have been completed by the patient themselves or by a parent/caregiver who was present during the appointment/visit. Either SDOH screening encounter scenario (patient self-completing

screening or parent/caregiver completing screening) should be reported in the SDOH measure reporting template as a qualifying SDOH screening for the pediatric patient.

SDOH Measure Component: Referral

11. What qualifies as a Referral for the SDOH measure?

Within the SDOH measure specifications, a referral is defined as a documented exchange of information, with the patient's consent, to social services/resources that could reasonably address the need(s) identified from the screening. The information exchange method for an SDOH referral will depend on the referral receiving organization. A referral could be sent electronically, via phone, fax, warm hand-off, etc, and the mode of information exchange should be documented. To note, the SDOH measure only captures referral placement and does not track whether or not the referral receiving organization responds to, or provides services to, the patient (i.e. a closed loop referral).

A patient may decline a referral for any, or all, identified SDOH needs. Any declined referral should be documented in the patient's chart or applicable data platform.

If a patient accepts a referral for any identified SDOH needs, the referral(s) must be placed **within 15 calendar days of the screening encounter date** to qualify for the Referral Rate numerator of the SDOH measure.

11a: Does Referral to a staff Traditional Health Worker or Community Health Worker qualify?

Traditional Health Workers (THWs) or Community Health Workers (CHWs) are often integral to clinical SDOH screening and referral workflows. If a patient with a positive SDOH screening is referred to a staff THW/CHW for support with addressing the identified needs, the connection to a THW/CHW would not qualify as a referral for the SDOH measure. However, if the THW/CHW works with the patient to send a referral to an external organization that provides the services/resources that can reasonably address the patient's identified need(s) that would qualify as a referral as long as the referral is placed within 15 calendar days of the screening encounter and is appropriately documented in the patient's chart or applicable data platform.

If your organization provides social services/resources in-house that could reasonably address a patient's identified SDOH needs, a warm hand-off or internal referral to the team or department that provides the service/resource would qualify as a referral for the SDOH measure.

11b: What if a patient opts to receive a resource guide and contact information for organizations that can address identified housing, food, or transportation needs?

If a patient opts to receive a tailored resource guide and contact information (instead of a referral) for organizations that can address any of their identified SDOH needs so they can do the resource navigation/outreach themselves, this **will qualify as a referral for the SDOH measure.** If a patient is not given the option for a referral placement for any identified SDOH needs and is just provided with a resource guide/contact information that would **NOT** qualify as a referral for the SDOH measure.

12. What if a patient declined a referral for any or all needs (housing, food, transportation) they screened positive for?

A patient may decline a referral for any identified SDOH needs for a variety of reasons, and their decision not to accept a referral should always be respected.

If a patient declines a referral for ALL positive SDOH needs, this should be documented in the SDOH reporting template as:

- "Declined" in ***If positive, Received Referral*** column for each SDOH domain where ***Result of Screening***= Yes
    - Document date if referral declination in ***date referral made or declined*** column

If all referrals for every positive SDOH need are declined, this qualifies as a denominator exception for the Referral Rate of the SDOH measure. Note: if a patient declines offered referral(s) and instead opts to receive a resource guide/contact list for organizations that can reasonably address their SDOH needs, this scenario qualifies as a referral. See question 11b above.

If a member declines a referral for a particular positive SDOH need, that should be documented in the SDOH reporting template as:

- "Declined" in ***If positive, Received Referral*** column for the applicable SDOH domain where ***Result of Screening***= Yes
    - Document date if referral declination in ***date referral made or declined*** column

13. What if no resources/services exist to meet a patient's identified SDOH needs?

Part of the work of the SDOH Measure at the CCO level involves implementing strategies to help bolster the capacity of community organizations to address prevalent social needs. However, there might not always be an appropriate or available resource/service to refer a patient to depending on their needs or current situation.

If there are no resources/services available at the local or state level to refer a patient to address their identified SDOH needs, documentation that no resources exist does not qualify as a referral for the SDOH measure.

This scenario should be documented in the SDOH reporting template as:

- "No" in If ***Positive, Received Referral*** column for the applicable SDOH domain where ***Result of Screening***=Yes

Some resources that can be referenced to help identify SDOH resources/services at the local and state levels include:

- **EOCCO's Community Resource Guide**: https://www.eocco.com/-/media/EOCCO/PDFs/providers/EOCCO-Community-Resource-Guide-2023.pdf
    - Lists the housing, food, and transportation resources that exist across Eastern Oregon's 12 counties
- **211info**: https://www.211info.org/
- **FoodFinder [Oregon Food Bank]:** https://foodfinder.oregonfoodbank.org/
- **Oregon Transportation Resource List**: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Transportation-Resource-List.pdf
- **Unite Us [Connect Oregon]:** https://uniteus.com/
    - Nonprofits, FQHCs, RHCs, public health departments, and critical access hospitals are able to receive free Unite Us platform licenses. EOCCO covers the cost of Unite Us licenses for any providers that do not qualify for a free license.
    - If your organization is interested in getting connected to Unite Us, please email: EOCCOmetrics@modahealth.com

14. What if a patient's referral status is unknown?

If a patient completed an SDOH screening during the measurement period and screened positive for one or more SDOH domains (housing, food, transportation) but there is no

record of referral placement to address any identified needs, this can be documented in the SDOH reporting template as:

- "Unknown" in ***If Positive, Received Referral*** column for the applicable SDOH domain where result of screening=Yes

Additional Questions

15. How can I use Unite Us to report on the SDOH measure?

If your clinic actively uses the Unite Us (Connect Oregon) platform to screen patients for SDOH needs or place SDOH referrals, you can utilize the screening/referral information stored in your clinic's Unite Us account as a data source for SDOH measure reporting.

To access Unite Us screening and referral data, log-in to your Unite Us account and click the "Exports" tab on the top of the screen. In the Exports tab, select "New Export". Once in the "New Export" window, you can create a custom export for any Export Type (Referrals, Screenings, Cases, Resource List Shares, etc) and date range. For the 2025 SDOH Metric reporting period, select a Custom date range of **12/15/24-12/14/25**.

The custom export request will then be listed in your export dashboard and may take up to 48 hours to generate depending on the size of the data file. Once complete, the data file will be available for you to download as a .csv file.

If your clinic needs assistance with pulling Unite Us screening/referral data, you can reference the Unite Us "Help" chat feature in the bottom right-hand corner of the screen. You can also contact EOCCO's Unite Us representative Momone Maley (Momone.Maley@uniteus.com) for additional support.

16. Who do I contact for more information on SDOH measure reporting or to offer feedback?

EOCCO is dedicated to making the SDOH reporting process as easy as possible for clinics. If you have any questions or would like to provide feedback on the SDOH reporting process, please contact Mikayla Briare at EOCCOmetrics@modahealth.com.