Social Determinants of Health Screening & Referral Metric: Member Feedback Process

Charissa Young-White

July 10, 2023

Goal

CCO members have their social needs acknowledged and addressed

Component 1: assesses action plans to ensure social needs screening and referral is implemented in an equitable and trauma-informed manner. Lays the groundwork for data sharing and reporting.

Component 2: self-assessment that includes questions about social needs screening tools and methods, data collection mechanisms, trauma-informed practices, and protocols for referring members to community resources.

These elements assess how well CCOs identify and coordinate services for members with social needs in the domains of:

Food insecurity	Housing insecurity	Transportation needs

InterCommunity Health Network CCO

Centering Equity and Ensuring the Member Voice Informs Policies & Procedures

- Member privacy concerns are addressed
- Screening is provided in appropriate language, format & health literacy level
- Screening takes place in the settings where members experiencing health inequities are most likely to get care
- CCOs use data to identify, screen, refer and follow up with members experiencing the greatest inequities (REAL-D)
- CCOs form partnerships with community organizations that offer culturally-specific services
- Service provision is prioritized for members with the greatest social needs
- Prioritization of screeners that are trusted members of the communities they are screening (e.g., Community Health Workers)
- Training protocol includes cultural sensitivity, trauma-informed practices

Potential Pathways for Feedback

One or both over the next three years

1. Conduct a member survey with open-ended questions on screening, referral, and data-sharing practices that are analyzed, synthesized, and incorporated into final written policies

2. Collect and document member input on social needs screening and referral processes through the Community Advisory Council