Translating SDOH Data Standards into Quality Practice

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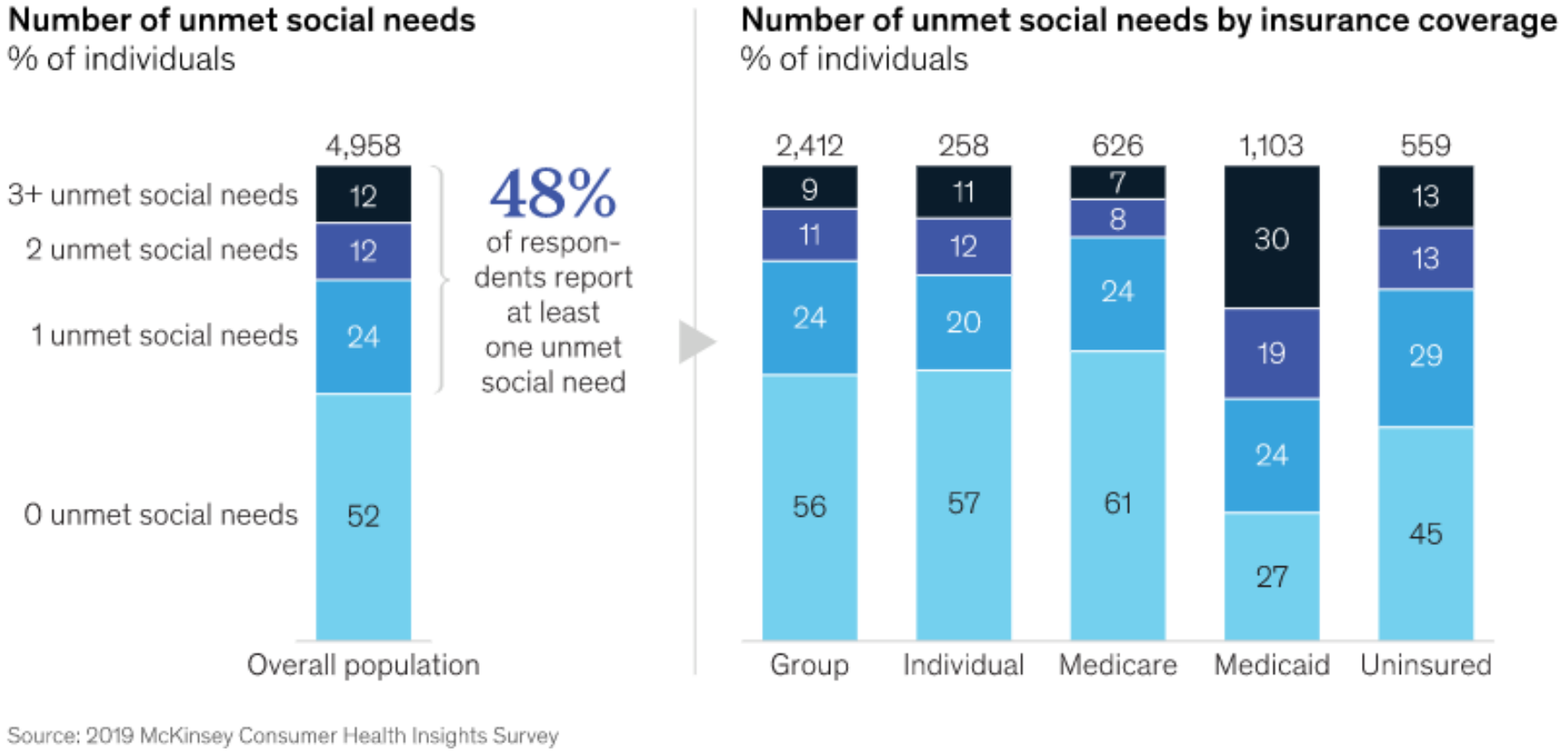
Wide-Ranging Impact

Unmet social needs broadly felt, regardless of payer type

Don't assume needs are limited to specific populations.

48% of overall population report unmet social needs

44% of members under group commercial insurance



Source: 2019 McKinsey Consumer Health Insights Survey

McKinsey & Company, 2020. https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/understanding-the-impact-of-unmet-social-needs-on-consumer-health-and-healthcare

Transformation of Health Care Expectations

Medicaid

- As of 2021, 33 states with some sort of SDOH-related requirement
- 24 states require screening for social needs, though only 11 require use of uniform screening tool
- Common theme of Section 1115 Medicaid waivers

Medicare

- CHRONIC Care Act expands ability to offer SDOH-focused supplemental benefits
- Medicare Part C plans in 2022:
  - 68% offer meals
  - 39% offer transportation
  - 30% offer nutrition
  - 11% offer in-home support

CMS Universal Foundation

"(…) *measures focus on care coordination after hospitalization, patient experience, and screening for social drivers of health (we also intend for them to eventually cover follow-up to address identified social needs).*"

KFF 2022 https://www.kff.org/medicaid/issue-brief/medicaid-and-racial-health-equity/
Avalere 2021. https://avalere.com/insights/more-medicare-advantage-plans-will-offer-non-medical-benefits-in-2022
CMS 2023. https://www.nejm.org/doi/full/10.1056/NEJMp2215539

Data and Intent

The priorities we set determine the questions we ask.

The questions we ask determine the data we need.

The data we have determine the questions we can answer.

Improving Data through Healthcare Quality Levers

Incentivize collecting and managing data using best practice terminology

Examples:
- Accreditation (structural) standards
- Quality measures of data completeness
- Score organizational quality on data maturity

Leverage standardized terminology to re-define “high quality care” targets

Examples:
- Measures of social needs
- Revised measure population definitions
- Stratification using standardized terminology

Example: Social Needs Screening and Intervention (SNS-E)

HEDIS Measure Specification

Measure Description

The percentage of members who, during the measurement period, were screened at least once for unmet food, housing and transportation needs using a pre-specified screening instrument and, if screened positive, received a corresponding intervention.

Six Indicators:

Screening for:

1. Unmet Food Needs
2. Unmet Housing Needs
3. Unmet Transportation Needs

Intervention for:

4. Unmet Food Needs
5. Intervention for Unmet Housing Needs
6. Intervention for Unmet Transportation Needs

Product Lines

Commercial, Medicaid, Medicare

Data Source

Electronic Clinical Data Systems

Exclusions

Hospice
I-SNP
LTI

Age Stratification

- ≤17
- 18-64
- 65+

Standards Alignment

Gravity Project

- A national public collaborative that develops consensus-based data standards involving social determinants of health (SDOH).
- NCQA's Social Needs measures was developed to align with Gravity Project data elements

Standards Alignment

Making it Tangible

Codified data generation for both screening and intervention.

Screening Tool	Screening Question	Positive Finding	Related Intervention
Accountable Health Communities (AHC) Health-Related Social Needs	**LOINC 88122-7:** Within the past 12 months, you worried that your food would run out before you got money to buy more.	**LOINC LA28397-0:** Often true **LOINC LA6729-3:** Sometimes true	**SNOMED 713109004:** Referral to community meals service (procedure)

https://confluence.hl7.org/display/GRAV/The+Gravity+Project?src=sidebar

HEDIS SNS-E Screening Indicators

Translating into Practice

Numerator: Members with 1+ documented result (positive or negative) on food/housing/transportation screening

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Denominator: All members 0+ continuously enrolled during MY

Screening Instruments:

- Accountable Health Communities
- AAFP Social Needs Screening Tool
- Health Leads Screening Panel®1
- Hunger Vital Sign™
- PRAPARE
- Safe Environment for Every Kid (SEEK)
- We Care Survey
- WellRx Questionnaire
- Housing Stability Vital Signs™
- Comprehensive Universal Behavior Screen (CUBS)
- PROMIS
- USDA Food Security Survey

Documented via LOINC codes

HEDIS SNS-E Intervention Indicators

Translating into Practice

Interventions defined by Gravity Project Intervention Categories

- Assessment
- Assistance
- Coordination
- Counseling
- Education
- Evaluation of eligibility
- Provision
- Referral

Numerator:
Members who received a corresponding intervention within 30 days of first positive screen

Denominator:
Members with at least 1 positive result for food, housing, transportation insecurity

Documented via CPT, SNOMED, HCPCS codes

Putting Social Needs Screening into Practice

Qualitative Themes from Health Plan Interviews (Fall 2023)

Process and Workflow	• Screening documented via case management • Follow-up is being done but not captured
Facilitators	• The more measures that leverage standardized data and mapping, the easier it is to implement infrastructure
Barriers	• Multiple data sources and mapping to LOINC difficult • Pulling EHR data difficult, especially SNOMED codes • State requirements built around specific tools not reflected in current data standards
Feedback to Consider	• Consider updating the measure to include Z codes

Example: Accreditation Standards

NCQA Health Equity Accreditation Plus

3-Year Standards-based program

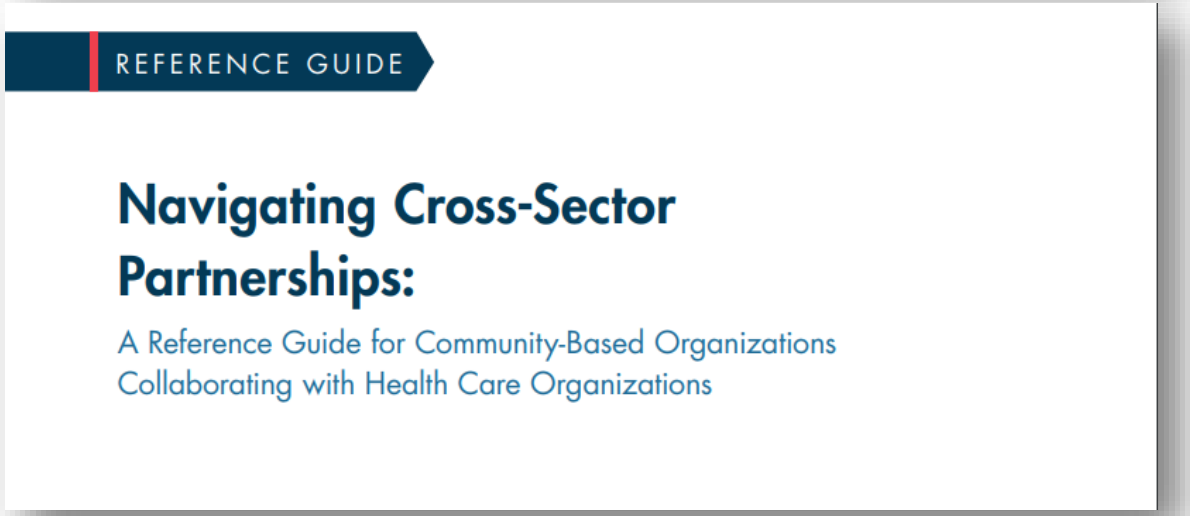
- **Builds on NCQA's Health Equity Accreditation** (its prerequisite).
- **Designed for organizations progressing to the next step of their health equity journey.**
- Focused **on partnering with community-based organizations and cross-sector partners to address social needs** of individuals served and **mitigate social risks of the community.**

Cross-Sector Partnerships to Address Health-Related Social Needs

Qualitative program to develop companion tools to support healthcare and community-based organizations build sustainable, equitable partnerships.

- **Data sharing as a key element of success** from both healthcare and CBO perspectives.
- Care should be taken to **set shared expectations** – data needs, capabilities, and requirements will vary by perspective.

How will data standards support (or impede) these efforts?



Methods: Qualitative analysis synthesizing findings from:

- CBO focus groups
- Healthcare organization semi-structured interviews
- Content analysis of NCQA Health Equity Accreditation Plus surveys.

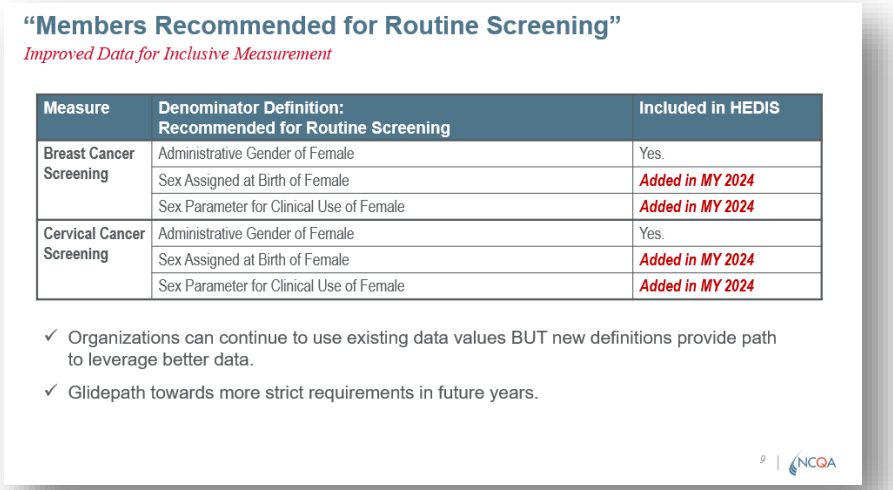
1. https://www.ncqa.org1wp-content/uploads/NCQA-CBO-Reference-Guide.pdf 2. https://www.ncqa.org/wp-content/uploads/NCQA-HCO-Toolkit.pdf

Expanding Beyond Social Needs

Intersecting Equity Measurement, Quality Standards and Data Standards

Gender-Affirming and Inclusive Approaches to Quality

https://www.ncqa.org/blog/hedis-my-2024-whats-new-whats-changed-whats-retired/



"Members Recommended for Routine Screening"

Improved Data for Inclusive Measurement

Measure	Denominator Definition: Recommended for Routine Screening	Included in HEDIS
Breast Cancer Screening	Administrative Gender of Female	Yes.
	Sex Assigned at Birth of Female	***Added in MY 2024***
	Sex Parameter for Clinical Use of Female	***Added in MY 2024***
Cervical Cancer Screening	Administrative Gender of Female	Yes.
	Sex Assigned at Birth of Female	***Added in MY 2024***
	Sex Parameter for Clinical Use of Female	***Added in MY 2024***

- ✓ Organizations can continue to use existing data values BUT new definitions provide path to leverage better data.
- ✓ Glidepath towards more strict requirements in future years.

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Stratification and accountability for racial and ethnic disparities

https://blog.hl7.org/topic/race-and-ethnicity

HL7 International

The Standard

The Official Blog of Health Level Seven® International

Race and Ethnicity: The Importance of Standardized Data Collection and Management

May 8, 2023 5:21:01 PM / by Health Level Seven posted in HL7, health IT, health equity, race and ethnicity, standardized data collection