Exploring New Social Care Quality Measures: How Do We Define and Measure Social Needs and High-Quality Social Care?

January 26, 3:00 to 4:00 p.m. ET

Please stand by--the webinar will begin shortly.
Exploring New Social Care Quality Measures: How Do We Define and Measure Social Needs and High-Quality Social Care?

January 26, 2023

siren
Social Interventions Research & Evaluation Network

STATE Health & Value STRATEGIES
Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

https://sirenetwork.ucsf.edu/

www.shvs.org
About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.
About the Social Interventions Research & Evaluation Network (SIREN)

SIREN’s mission is to improve health and health equity by advancing high quality research on healthcare sector strategies to improve social conditions. To achieve this goal, SIREN funds, conducts, and translates research on policies, practices, and programs designed to better integrate health and social care services. The network also plays a national convening role to bring together diverse stakeholders investing in this field. SIREN is supported by Kaiser Permanente and the Robert Wood Johnson Foundation and housed at the Center for Health and Community at the University of California, San Francisco.

Learn more at https://sirenenetwork.ucsf.edu/

Questions? Email SIREN at SIREN@ucsf.edu.
Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box.

After the webinar, the slides and a recording will be available at www.shvs.org and https://sirenetwork.ucsf.edu/.
Agenda

- **Introduction (5 mins)**

- **Panelist Introductions and Presentations (20 mins)**

- **Discussion (25 mins)**
Introduction: The Bell Curve of Social Care Integration
Introduction: The Bell Curve of Social Care Integration
Introduction: Social Care Policymaking

Policymakers

Policy
Guidelines
Practices
Standards
Rules
Regulations
Quality Measures
Today's Panelists

Emily Carrier, MD
Senior Advisor
Manatt Health

Taressa Fraze, PhD
Assistant Professor
Department of Family and Community Medicine
University of California, San Francisco

Chris DeMars, MPH
Director, Delivery System Innovation
Oregon Health Authority

Sarah Paliani, MPH
Senior Research Associate
National Committee for Quality Assurance (NCQA)
## Overview: NCQA

<table>
<thead>
<tr>
<th>Agency/Org (program)</th>
<th>NCQA (HEDIS)</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Description**      | Social Need Screening and Intervention | • % of members screened at least once for each domain.  
• % of those with an identified need who received a corresponding intervention, by domain.  
• Reported using electronic clinical data systems. |
| **Population**       | All ages     | • All members continuously enrolled during the measurement period, excluding members in hospice, I-SNPs or long-term care. |
| **Setting**          | Health plans | • Medicare, Medicaid and commercial plans |
| **Domains**          | Food, housing, & transportation security | • Housing encompasses housing instability, homelessness or housing adequacy. |
| **Intervention**     | Intervention by 30 days post screening | • Intervention may include assistance, assessment, coordination, counseling, education, evaluation of eligibility, provision or referral. |
| **Instruments**      | Pre-specified list of instruments | • Gravity Project-identified instruments, with terminology available. |
## Overview: CMS Programs

<table>
<thead>
<tr>
<th>Agency/Org (program)</th>
<th>CMS Programs</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>% of patients screened for 5 HRSN; some programs also include % of screened who screen positive for each risk</td>
<td>Measures are based on approach used in Accountable Health Communities intervention</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>Adults 18+ who do not opt out of screening and who are able to (or have a guardian who is able to) complete the screen</td>
<td>Participants are expected to report data for their entire adult population, not only Medicare-enrolled individuals</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>MIPS: Eligible outpatient providers (voluntary) IQR: Hospitals (voluntary for 2023, mandatory for 2024)</td>
<td>MIPS programs require only screening; HIQR program also requires reporting of positive screens. Measures are under consideration for ESRD QIP, Inpatient Psychiatric Facility PPS and PPS-Exempt Cancer Hospital Quality Reporting Programs in current MUC cycle.</td>
</tr>
</tbody>
</table>
### Overview: CMS Programs Continued

<table>
<thead>
<tr>
<th>Agency/Org (program)</th>
<th>CMS Programs</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domains</strong></td>
<td>Food, housing, transportation, &amp; utilities, security and interpersonal violence</td>
<td>Because different screening programs may use varying instruments, type/degree of need captured by positive screen may vary as well</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>None required</td>
<td>• Measures capturing connection to a community service provider and resolution of at least one health need are under consideration for MIPS in the current MUC cycle</td>
</tr>
<tr>
<td><strong>Instruments</strong></td>
<td>None specified</td>
<td></td>
</tr>
</tbody>
</table>
## Overview: Oregon Health Authority (OHA)

<table>
<thead>
<tr>
<th>Agency/Org (program)</th>
<th>OHA</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Coordinated care organization (CCO) self-attestation: screening, referrals, data collection; % screened, % positive, % positive who received a referral</td>
<td>• Multi-year build-up to full population data collection. CCO self-attestation includes policy and practices for screening, referral, and data collection (starts year one). Quantitative data collection as sample with eventual move to full population (starts year two).</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>All ages</td>
<td>• Member with a CCO for 180 days or more</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Health plans</td>
<td>• CCO: Oregon’s Managed Medicaid Organizations</td>
</tr>
<tr>
<td><strong>Domains</strong></td>
<td>Food, housing, and transportation</td>
<td>• Screening required for the three domains</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Referral</td>
<td>• Does not require closed-loop referral</td>
</tr>
<tr>
<td><strong>Instruments</strong></td>
<td>Pre-specified list of screening instruments</td>
<td>• Approved screenings by domain and age group</td>
</tr>
</tbody>
</table>
# Overview: Three Quality Measure Sets

<table>
<thead>
<tr>
<th>Agency/Org (program)</th>
<th>NCQA (HEDIS)</th>
<th>CMS IQR</th>
<th>Oregon Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>% of members screened at least once; % of those with need who received intervention, by domain</td>
<td>% of patients screened for 5 HRSN; % of screened who report risk</td>
<td>% of members screened, % positive, % positive who received a referral (multi-year phase-in)</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>All ages</td>
<td>Adults 18+</td>
<td>All ages</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Health plans</td>
<td>IQR: Hospitals</td>
<td>Health plans</td>
</tr>
<tr>
<td><strong>Domains</strong></td>
<td>Food, housing, &amp; transportation security</td>
<td>Food, housing, transportation, &amp; utilities security and interpersonal violence</td>
<td>Food, housing &amp; transportation</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>Intervention by 30 days post screening (inc. referral)</td>
<td>None required</td>
<td>Referral</td>
</tr>
<tr>
<td><strong>Instruments</strong></td>
<td>Pre-specified list of screening instruments</td>
<td>None specified</td>
<td>Pre-specified list of screening instruments</td>
</tr>
</tbody>
</table>
Getting Started

--Be pragmatic
--What can you leverage?
--Where are your touch-points?
Scaffolding
--Increasing accountability over time with support and coaching
Delicate balance
--Resource intense for everyone
--Competing priorities
Discussion

Note that the slides and a recording of the webinar will be available at www.shvs.org and https://sirenetwork.ucsf.edu/ after the webinar.
Thank You

Laura Gottlieb, MD, MPH
Co-director, Social Interventions Research and Evaluation Network (SIREN)
Professor, Department of Family and Community Medicine
University of California, San Francisco
https://sirenetwork.ucsf.edu/

Heather Howard, JD
Director
State Health and Value Strategies
heatherh@Princeton.edu
609-258-9709
www.shvs.org