



*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.

siren

Social Interventions Research & Evaluation Network

STATE
Health & Value
STRATEGIES

*Driving Innovation
Across States*

A grantee of the Robert Wood Johnson Foundation



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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://sirenetwork.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/>.

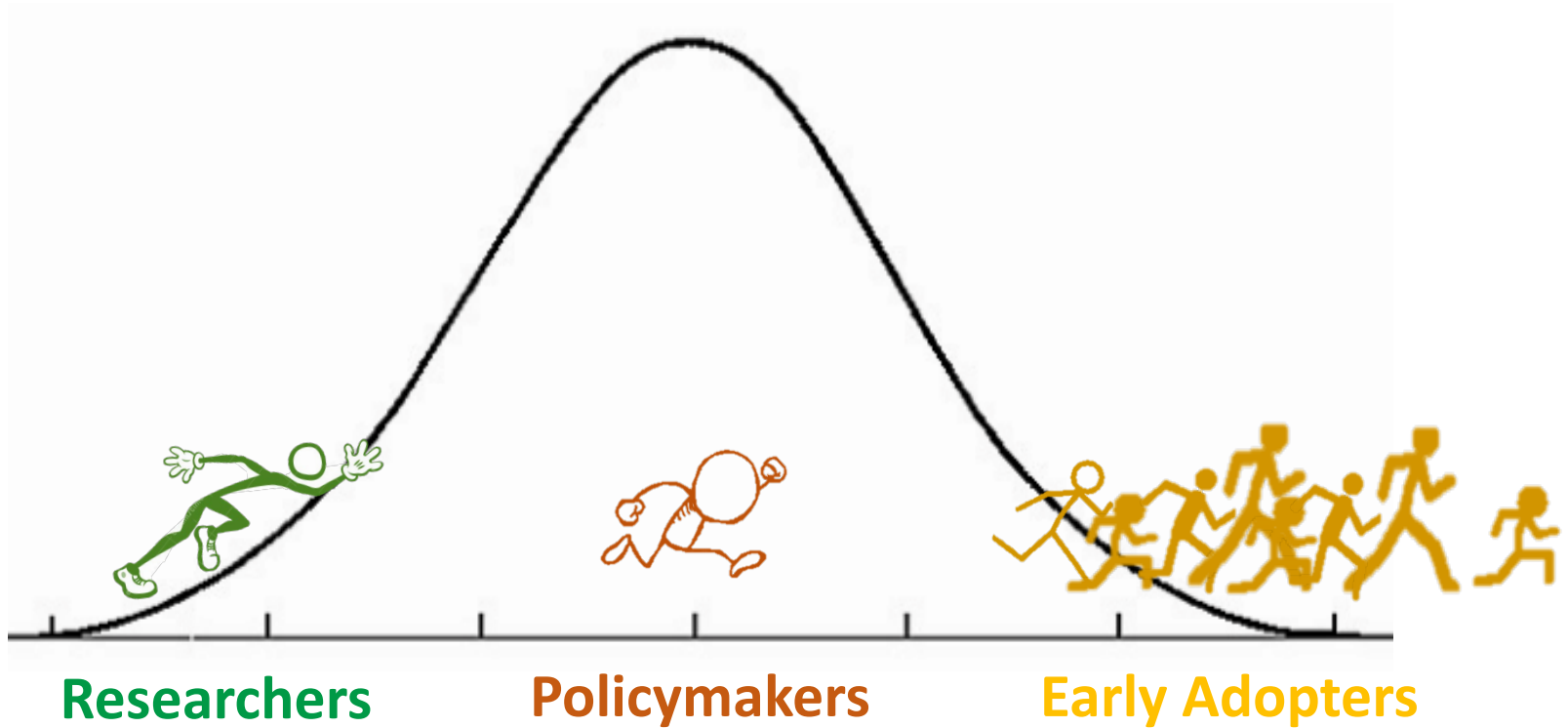
Agenda

- ***Introduction (5 mins)***
-

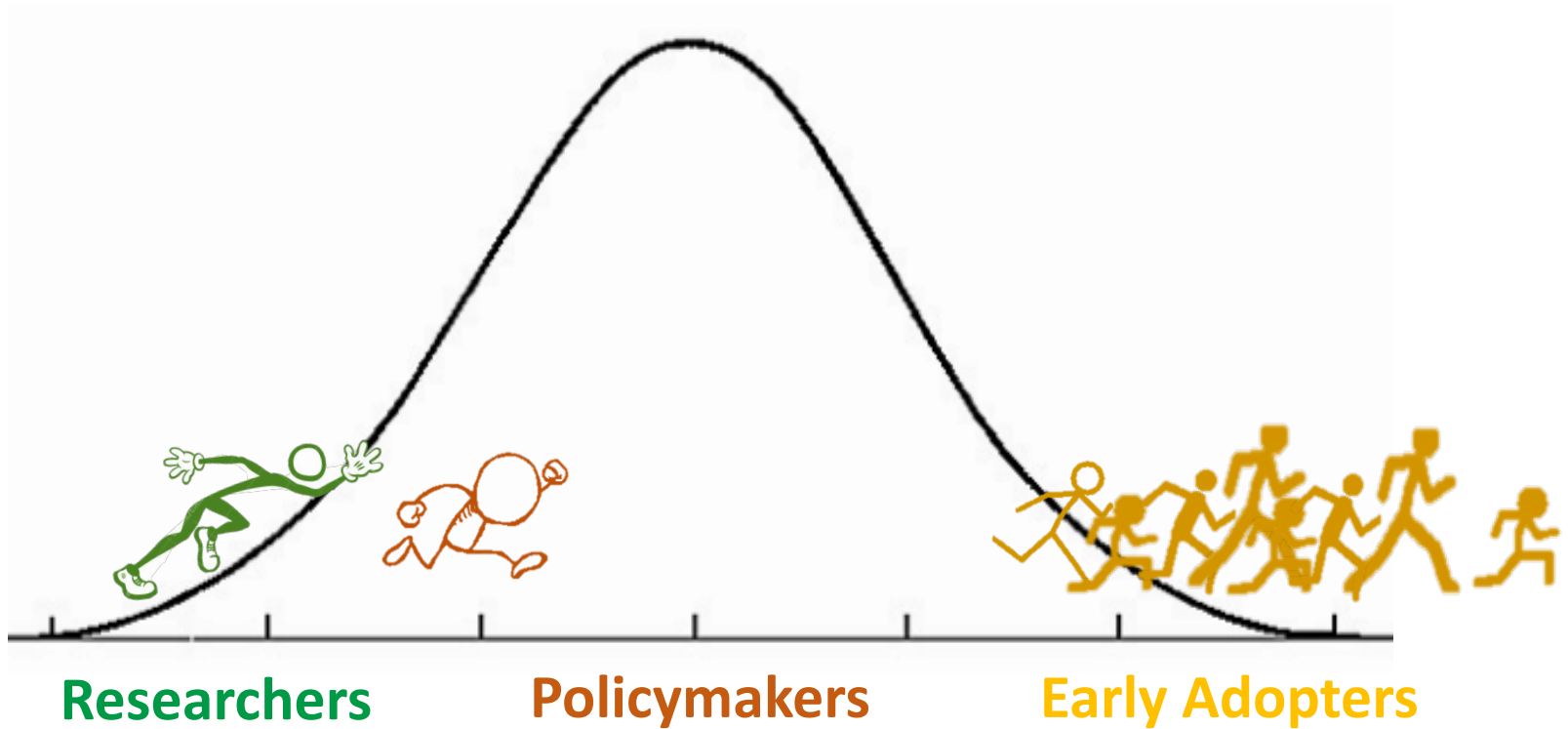
- ***Panelist Introductions and Presentations (20 mins)***
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- ***Discussion (25 mins)***

Introduction: The Bell Curve of Social Care Integration



Introduction: The Bell Curve of Social Care Integration



Introduction: Social Care Policymaking



Policymakers



Today's Panelists



Emily Carrier, MD
Senior Advisor
Manatt Health



Taressa Frazee, 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

Agency/Org (program)	NCQA (HEDIS)	Details
Description	Social Need Screening and Intervention	<ul style="list-style-type: none"> • % 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	<ul style="list-style-type: none"> • All members continuously enrolled during the measurement period, excluding members in hospice, I-SNPs or long-term care.
Setting	Health plans	<ul style="list-style-type: none"> • Medicare, Medicaid and commercial plans
Domains	Food, housing, & transportation security	<ul style="list-style-type: none"> • Housing encompasses housing instability, homelessness or housing adequacy.
Intervention	Intervention by 30 days post screening	<ul style="list-style-type: none"> • Intervention may include assistance, assessment, coordination, counseling, education, evaluation of eligibility, provision or referral.
Instruments	Pre-specified list of instruments	<ul style="list-style-type: none"> • Gravity Project-identified instruments, with terminology available.

Overview: CMS Programs

Agency/Org (program)	CMS Programs	Details
Description	% of patients screened for 5 HRSN; some programs also include % of screened who screen positive for each risk	Measures are based on approach used in Accountable Health Communities intervention
Population	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	Participants are expected to report data for their entire adult population, not only Medicare-enrolled individuals
Setting	MIPS: Eligible outpatient providers (voluntary) IQR: Hospitals (voluntary for 2023, mandatory for 2024)	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.

Overview: CMS Programs Continued

Agency/Org (program)	CMS Programs	Details
Domains	Food, housing, transportation, & utilities security and interpersonal violence	Because different screening programs may use varying instruments, type/degree of need captured by positive screen may vary as well
Intervention	None required	<ul style="list-style-type: none">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
Instruments	None specified	

Overview: Oregon Health Authority (OHA)

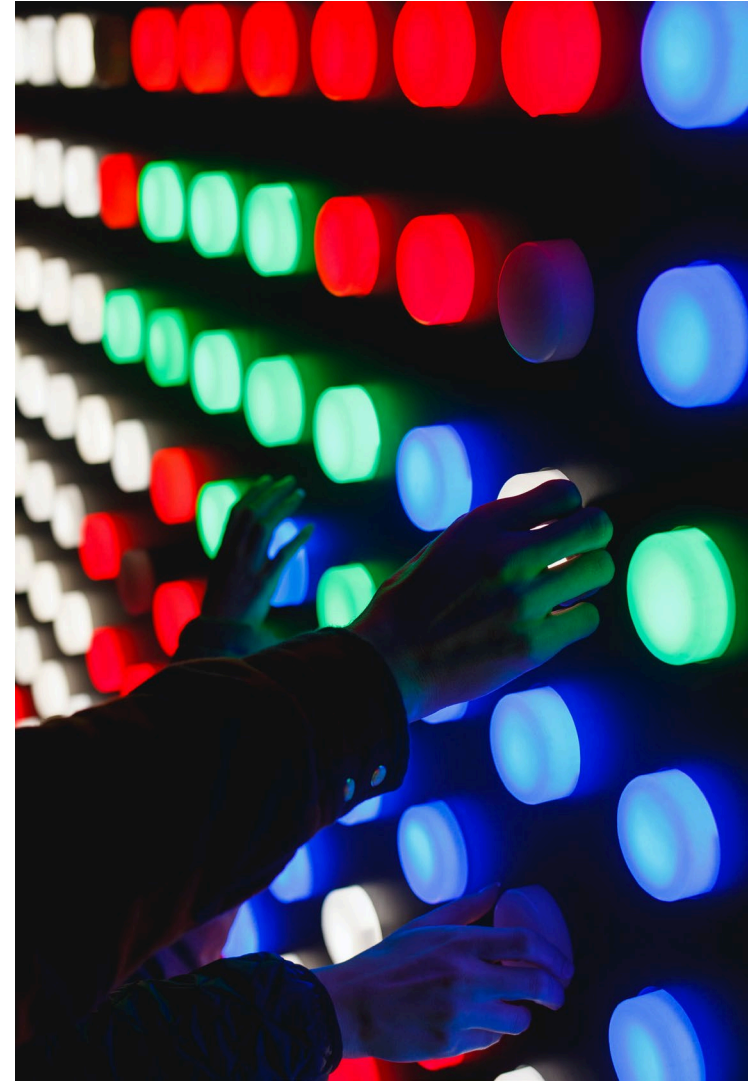
Agency/Org (program)	OHA	Details
Description	Coordinated care organization (CCO) self-attestation: screening, referrals, data collection; % screened, % positive, % positive who received a referral	<ul style="list-style-type: none"> Multi-year build-up to full population data collection. CCO self-attestation 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).
Population	All ages	<ul style="list-style-type: none"> Member with a CCO for 180 days or more
Setting	Health plans	<ul style="list-style-type: none"> CCO: Oregon's Managed Medicaid Organizations
Domains	Food, housing, and transportation	<ul style="list-style-type: none"> Screening required for the three domains
Intervention	Referral	<ul style="list-style-type: none"> Does not require closed-loop referral
Instruments	Pre-specified list of screening instruments	<ul style="list-style-type: none"> Approved screenings by domain and age group

Overview: Three Quality Measure Sets

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

Getting Started

- Be pragmatic
- What can you leverage?
- Where are your touch-points?



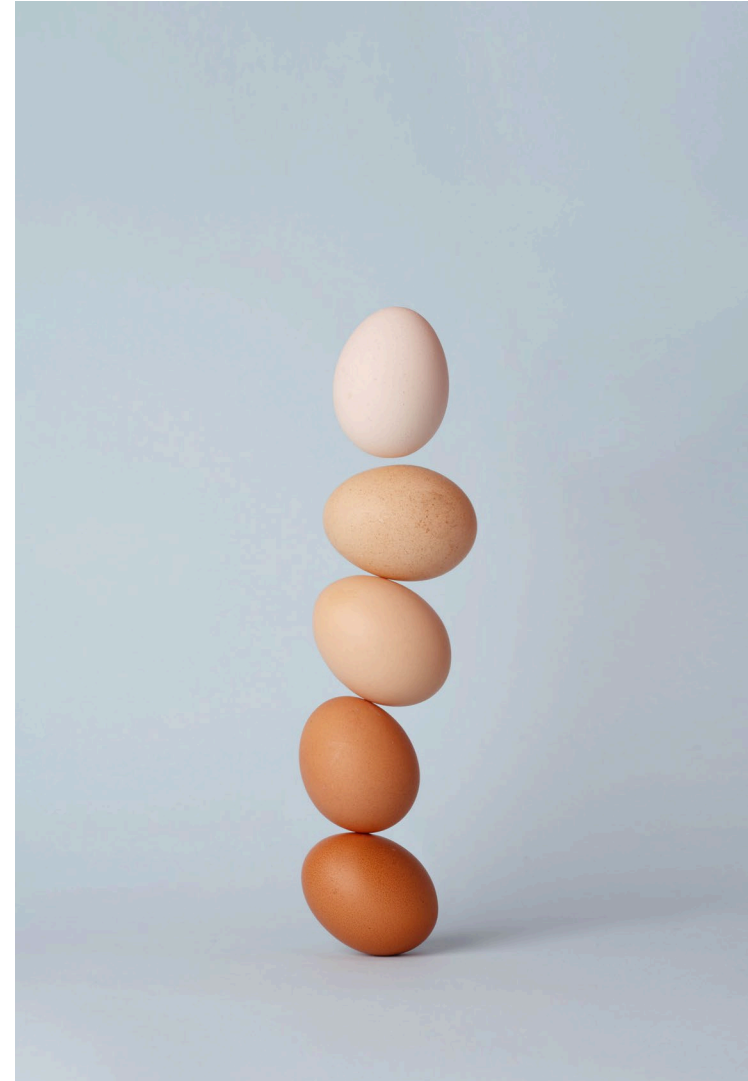


Scaffolding

--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://sirennetwork.ucsf.edu/> after the webinar.



Thank You

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