OHA SDOH Measurement Workgroup
DRAFT Social Needs Measure Concepts for Consideration

DOMAINS & TOOLS ACROSS MEASURES

Each measure concept (numbered 1-4 below) shares this same approach to domains and tools:

- **Domains screened:** Food & housing required, other domains optional.
- **Tools/Questions:** Tool-neutral, but may require specific questions (To be determined by subcommittee)

MEASURE CONCEPT 1: Rate of social needs screening in the total member population using any qualifying data source

Description: This concept would incentivize screening of all CCO members, which would promote equity and ensure that no members with social needs are missed. CCOs could report whether members have been screened in multiple settings and via multiple data collection strategies, allowing for flexibility and alignment with current systems and practices in place at the local level. CCOs will submit a plan during the first year to identify their approach, including the codes they will use and how they will collect the data.

Denominator: Total CCO membership during the measurement year (continuous enrollment period and exclusion criteria may be defined later in measurement specifications, as done in other states)	**Data source:** Enrollment data (OHA-supplied sample in initial year[s]; full enrollment data in future with collection method/system to be determined).
Numerator: CCO members who received screening using approved tool/questions, including any required domains, during the measurement year	**Data source:** Any qualifying data source that meets OHA-defined criteria (e.g. CCO care management system and/or community information exchange; provider-reported data [e.g. EHR]). Initial years screening to be reported for OHA-provided sample; full population screening data in subsequent years with collection method/system to be determined). OHA will provide a menu of qualifying codes, including the CPT/HCPCS/ICD diagnosis Z-codes/SNOMED/LOINC and other standard codes as identified by the Gravity Project and others.

Measure 1 Policy & Data Considerations

EQUITY

- All members are screened (not just those with a clinic visit), ensuring no one is missed due to lack of contact with the health care system
- Screenings conducted outside of health care settings could be counted, provided CCO is able to capture and report data (for example, through a Community Information Exchange, or CIE). This could also facilitate coordination and reduce rescreening among partners, and lead to referrals more quickly
- No guarantee that screening outcome data is available to prevent rescreening and to be actionable at the point of care, unless there is a system in place to share data with clinics

ALIGNMENT

- Allows integration with current systems and data collection practices (e.g., Community Information Exchange, Health Risk Screening, clinic-based screening practices, etc.), which may mean lower burden on CCOs and providers to build new systems
- Potential for integration of screenings done by all parties, including community-based organizations and clinics
- Potential to move systems towards desired future state of integrated medical and social care
- Could align with other measure development processes given that measure is not prescriptive, for example Integrated Care for Kids project

FEASIBILITY

- Flexible approach to data collection and sharing could allow for use of current systems (e.g. case management system) and multiple avenues to receiving credit for screening
- Depending on current data sharing processes, CCOs and clinics may need to amend existing data agreements
- Administrative challenges for CCOs, clinics, and OHA in matching and combining data across multiple data sources. This challenge may be addressed in the future by Community Information Exchange (CIE) or other systems that support cross-sector data sharing, but these systems are still nascent

Measure 1: Potential glide path

	Year 1	Year 2	Year 3	Year 4	Year 5+

Structure: Self-attestation survey & Data collection plan
 	
• Implement screening in an equitable and trauma-informed way, including:
    o required domains and approved tool;
    o using REALD data to inform culturally responsive and accessible screening practices;
    o patient/member engagement and preferences (e.g. asking patients which need they would like addressed); and
    o Plans for workflows and data sharing to prevent unnecessary rescreening.
• CCOs submit environmental scan and data collection plan:
    o Assess available data systems (claims/EHR/CIE) used by the provider network and community-based organizations in the service area, that contain qualifying codes identified by OHA and can be systemically extracted
    o Assess population covered by data systems with OHA identified qualifying codes
    o Identify and propose additional non-standard data systems with information aligns with the required SDOH screening domains
    o Propose data integration and information exchange plan					

	Year 1	Year 2	Year 3	Year 4	Year 5+
Reporting (SAMPLE) • OHA provides **sample list** of members to CCO (considering any population exclusions) • CCO reports data in required format utilizing qualifying and/or approved list of codes to OHA (i.e. excel spreadsheet) o Member-level flags for (a) screening completion and (b) positive needs by domain • OHA to calculate rates based on CCO's member-level data submission: (a) screening rate; (b) of those screened, % with need					

Outcome/Performance (SAMPLE)
 	
• CCO reports data in required format (i.e. excel spreadsheet) to OHA
    o Member-level flags for (a) screening completion, (b) positive needs by domain and (c) referral based on identified needs
• OHA to calculate rates (a) screening rate; (b) of those screened, % with need; (c) of those with a need, % with a referral made
    o Benchmark / to meet measure:
        ▪ Report (a), (b), (c)
        ▪ Meet target on (a) - % screened*
 	
Note: Metrics & Scoring to determine whether pay-for-performance begins in year 3 or 4.					

Goal: Outcome/Performance (FULL POPULATION) • Logistical elements (e.g. data submission/system to capture data) still to be determined					

MEASURE CONCEPT 2: Rate of social needs screening in target population (children 0-21) using any qualifying data source

Description: This measure concept would incentivize CCOs to focus efforts on a target population, in this case children 0-21, but would still incentivize screening across the full population of the target group (as opposed to just those in the target group with a clinic visit). CCOs would be responsible for ensuring screening is conducted and for reporting on this target population. CCOs could report whether members have been screened through multiple methods, allowing for flexibility and alignment with current systems and practices in place at the local level. CCOs will submit a plan during the first year to identity their approach, including the codes they will use and how they will collect the data.

Important note: Measure concept 2 is focused on a target population, which is a subset of the total population. This measure concept could be moved forward either as a stand-alone option that stays focused on a target population, or as a stepping stone to Measure concept 1 with a longer glide path.

Denominator: Total CCO members ages 0-21 (continuous enrollment and exclusion criteria may be defined later in measurement specifications, as done in other states) *	**Data source:** Enrollment data (OHA-supplied sample in initial year[s]; full enrollment data in subsequent years with collection method/system to be determined)
Numerator: CCO members ages 0-21 who received screening using approved tool*	**Data source**: Any qualifying data source that meets OHA-defined criteria (e.g. CCO care management system and/or community information exchange; provider-reported data [e.g. EHR]). Initial years screening to be reported for OHA-provided sample; full population screening data in subsequent years with collection method/system to be determined) OHA will provide a menu of qualifying codes, including the CPT/HCPCS/ICD diagnosis Z codes/SNOMED/LOINC and other standard codes as identified by the Gravity Project and others.

* Other target populations are possible, but each would have to be considered in terms of the data sources available, the settings in which the screening could occur, or both.

Measure 2 Policy & Data Considerations

EQUITY

- Targeted approach has potential to have a greater impact on equity for priority groups, yet members outside of the priority population would not be counted in the measure
- A focus on children would direct resources upstream, which could prevent future health and social risks and health care costs
- Screenings conducted outside of health care settings could be counted, provided CCO is able to capture and report data (for example, through a Community Information Exchange, or CIE). This could also facilitate coordination and reduce rescreening among partners, and lead to referrals more quickly.
- No guarantee that screening outcome data is available to prevent rescreening and to be actionable at the point of care, unless there is a system in place to share data with clinics
- Would not allow statewide tracking of social needs over time for the full population (but would for sub-population)

ALIGNMENT

- Allows integration with current systems and data collection practices (e.g., Community Information Exchange, Health Risk Screening, clinic-based screening practices, etc.), which may mean lower burden on CCOs and providers
- Potential for integration of screenings done by all parties, including community-based organizations and clinics
- Potential to move systems towards desired future state of integrated medical and social care
- Could align with other measure development processes given that measure is not prescriptive and the target population aligns with the state's Integrated Care for Kids project

FEASIBILITY

- Flexible approach to data collection and sharing could allow for use of current systems (e.g. case management system) and multiple avenues to receiving credit for screening
- Depending on current data sharing processes, CCOs and clinics may need to amend existing data agreements
- Administrative challenges for CCOs, clinics, and OHA in matching and combining data across multiple data sources. This challenge may be addressed in the future by Community Information Exchange (CIE) or other systems that support cross-sector data sharing, but these systems are still nascent

Measure 2: Potential Glide Path**

	Year 1	Year 2	Year 3	Year 4	Year 5+

Structure: Self-attestation survey and Data collection plan
 	
• Implement screening in an equitable and trauma-informed way, including:
   o required domains and approved tool;
   o using REALD data to inform culturally responsive and accessible screening practices;
   o patient/member engagement and preferences (e.g. asking patients which need they would like addressed)
   o Plans for workflows and data sharing to prevent unnecessary rescreening
• CCOs submit environmental scan and data collection plan, focused on the target population:
   o Assess available data systems (claims/EHR/CIE) used by the provider network and community-based organizations in the service area, that contain qualifying codes identified by OHA and can be systemically extracted
   o Assess population covered by data systems with OHA identified qualifying codes
   o Identify and propose additional non-standard data systems with information aligns with the required SDOH screening domains.
   o Propose data integration and information exchange plan					

	Year 1	Year 2	Year 3	Year 4	Year 5+
Reporting (SAMPLE) • OHA provides **sample list** of members to CCO (considering any population exclusions) • CCO reports data in required format (i.e. excel spreadsheet) to OHA utilizing qualifying and/or approved list of codes ○ Member-level flags for (a) screening completion and (b) positive needs by domain • OHA to calculate rates based on CCO's member-level data submission: (a) screening rate; (b) of those screened, % with need					

Outcome/Performance (SAMPLE)
 	
• CCO reports data in required format (i.e. excel spreadsheet) to OHA
    ○ Member-level flags for (a) screening completion, (b) positive needs by domain and (c) referral based on identified needs
• OHA to calculate rates (a) screening rate; (b) of those screened, % with need; (c) of those with a need, % with a referral made
    ○ Benchmark / to meet measure:
        ▪ Report (a), (b), (c)
        ▪ Meet target on (a) - % screened*
 	
Note: Metrics & Scoring to determine whether pay-for-performance begins in year 3 or 4					

Goal: Outcome/Performance (FULL TARGET POPULATION) • Logistical elements (e.g. data submission/system to capture data) still to be determined					

**Please note: Glide path will be scaled to match the population size. For example, if a larger target population (such as all CCO members age 0-21) is chosen, the glide path may more closely resemble the glide path for Measure 1, which reports on sample data in years 1-4 and the full population (in this case full target population) in Year 5.

MEASURE CONCEPT 3: Rate of social needs screening in the total member population by any Medicaid billing provider using claims data

Description: This concept would incentivize screening of all CCO members, including those with any type of healthcare visit and those for whom a CCO-employed nurse care manager or other provider conducts the screening. A key difference in this measure is that information would be collected using claims data (i.e. customized modifier codes, ICD diagnosis z-codes and HCPCS/CPT codes) and not other sources, which would limit collection to clinical settings of any type, CCO clinical staff, and/or community-based setting with the capacity to bill for Medicaid services (e.g. through the use of Traditional Health Workers). An advantage of claims data is that it offers a standard set of diagnosis codes (i.e. z-codes) that may be used to identify positive screening results and specific social needs identified. On the other hand, if the screening does not result in needs being identified, the positive diagnosis z-codes cannot be used in claims. Therefore, a different method needs to be explored for capturing social needs screening when a person has no identified social needs. Currently, the most feasible way it to define a customized modifier code (or a set of modifier codes).

Because claims offers a standard set of codes to identify social needs, this measure begins with two numerators. The first rate (Numerator A) would be incentivized to improve screening rates, and the second rate (Numerator B) would provide us a standardized way to better understand social needs statewide.

Denominator A: Total CCO membership during the measurement year (continuous enrollment and exclusion criteria may be defined later in measurement specifications, as done in other states)	**Data source:** Enrollment data
Numerator A: CCO members who received screening using approved tool in a healthcare visit during the measurement year or conducted by a CCO-employed nurse care manager or other provider	**Data source**: Claims (including a combination of a CPT/HCPCS + unique modifiers for all qualifying screening)
Denominator B: CCO members who received screening using approved tool in a healthcare visit or conducted by a CCO-employed nurse care manager or other provider	**Data source:** Claims (including a combination of a CPT/HCPCS + unique modifiers for all qualifying screening)
Numerator B (subset of numerator A): Members who received screening in a healthcare visit during the measurement year <u>and</u> are identified as having social need in required domain(s)	**Data source:** Claims (i.e. CPT/HCPCS + unique modifiers + appropriate ICD diagnosis z-code)

Measure 3 Policy & Data Considerations

EQUITY

- All members are considered for screening (that is, the population to be measured is not limited to those with a clinic visit), ensuring no one is left out of the measure. Screenings that occur outside a healthcare setting or outside a qualified healthcare professional employed by a CCO or Medicaid-billing community-based organization, however, cannot be captured for numerator credit.
- ICD Z-codes don't currently cover all social needs that may be present, which may create gaps in care or ability to identify, track and address certain needs.

ALIGNMENT

- Offers promise of universal system of coding for social needs
- Some large health systems use this approach already
- Alignment with statewide pilot to test out approach (OPCA) & national project to align social needs data use in clinical settings (the Gravity Project)

FEASIBILITY

- ICD diagnosis Z-codes not widely used at present, so implementation would be burdensome for OHA, CCOs and clinics
- Captures social need, but z-codes do not capture whether *screening* was conducted, which would necessitate using a combination of procedure (CPT/HCPCS) and modifier codes. This may be complex for clinics and require additional outreach and technical assistance by the state.
- Would need to standardize how z-codes are linked to screening tools, including provider education.
- Potentially more upfront burden in terms of dropping codes that don't have clear benefit to providers (e.g. payment) and may have less specificity to be meaningful for patient services; however, likely less burden in terms of calculating the rate and reporting data than the EHR measure or other two measures.
- There is a huge range in how z-codes are applied to outbound medical claims, from semi-automatic (coded observations from clinical encounter) to completely manual (done by clinical or administrative reviewer when processing). There may be a 1:1 match between some EHR codes and ICD diagnosis z-codes, but this would only benefit data collected from clinical encounters.

Measure 3: Potential glide path

	Year 1	Year 2	Year 3+

Structure: Self-attestation survey
 	
• Process to increase use and accuracy of ICD diagnosis z-codes
• Process to define/customize unique modifier codes for identifying screening activities alone
• Implement screening in an equitable and trauma-informed way, including:
   ○ required domains and approved tool;
   ○ using REALD data to inform culturally responsive and accessible screening practices;
   ○ patient/member engagement and preferences (e.g. asking patients which need they would like addressed)
• Plans for workflows and data sharing to prevent unnecessary rescreening			

Reporting (FULL POPULATION) • OHA to calculate rates and provide data to CCOs in monthly dashboard: (a) screening rate; (b) of those screened, % with need			
GOAL: Outcome/Performance (FULL POPULATION) • OHA to calculate measure and provide data to CCOs in monthly dashboard • OHA to calculate rates (a) screening rate; (b) of those screened, % with need ○ Benchmark / to meet measure: Meet target on (a) - % screened			

MEASURE CONCEPT 4: Rate of social needs screening for members with a primary care visit using Electronic Health Records (EHR)

Description: This measure would incentivize CCOs to be responsible for ensuring screening happens at the clinic level, specifically as a part of a primary care. While this may seem like a less attractive option because not all members are screened, there are some benefits to centering screening in clinics, including coordination among the care team and better assurance that screening information will be available at point of care. This could build on existing efforts in primary care, such as in FQHCs (e.g. PRAPARE) and Patient-Centered Primary Care Homes (for example, the PCPCH program recently adopted a new social needs screening standard).

Note: To date, OHA's EHR data collection has focused on collecting data from primary care. We would need to address significant barriers in certain clinical settings (e.g. limited/varied EHR use in behavioral health) and unknowns in other settings (e.g. emergency departments) to be able to feasibly collect from these settings.

Denominator A: CCO members with primary care visit* during the measurement year (exclusion criteria may be defined later in measurement specifications, as done in other states) *Note: One option would be to borrow the denominator definition from the existing depression screening/SBIRT metrics in the Quality Incentive Program. This would create consistency with these other existing EHR-based metrics; however, this would limit the denominator to members ages 12 and over.*	**Data source:** EHR + Enrollment data
Numerator A: CCO members who received screening using approved tool during the measurement year	**Data source**: EHR
Denominator B: CCO members who received screening using approved tool during the measurement year	**Data source**: EHR
Numerator B: CCO members who received screening using approved tool during the measurement year **and** had an identified social need	**Data source**: EHR

Measure 4 Policy & Data Considerations

EQUITY

- Not all members screened, only those seen in clinics. Members who don't have a clinic visit aren't considered in the measure/ counted in the denominator.
- Results from the screening available at point of care
- Promotes coordination among member care team in clinic
- Focusing on a single type of care setting (e.g., primary care) may make it easier to standardize tools and questions, and train staff in trauma-informed approaches
- Doesn't account for screenings that occur outside the clinic (e.g., in CCOs or CBOs or even in clinics outside of primary care) so increases potential for rescreening in other clinical and non-clinical settings

ALIGNMENT

- Potential to build on existing efforts in FQHCs, PCPCHs (e.g. align with new PCPCH standard)
- Does not account for or capture existing CCO or CBO screening efforts

FEASIBILITY

- Huge diversity in EHR systems and capabilities, including uncertainty about screening/referral tracking capabilities
- Currently, members who are seen at multiple clinics can't be deduplicated in reporting. At present, each clinic or organization/ health system would generate a report from its EHR. There is no method to match up the data, so the member would be independently counted by each clinic or organization.
- Increased burden on both clinic staff and CCO (for data collection and aggregation)
- Depending on current data sharing processes, CCOs and clinics may have or perceive a need to amend existing data agreements.
- Some Electronic Health Records (EHRs) may already link specific observations to LOINC and/or SNOMED codes, which are the preferred standards for capturing clinical observations, but these codes are usually hidden from the user and often difficult to extract.

Measure 4: Potential glide path

	Year 1	Year 2	Year 3+

Structure: Self-attestation survey
 	
• Report on CCOs' plans to work with clinics to ensure data elements are captured and can be reported
• Implement screening in an equitable and trauma-informed way, including:
   o required domains and approved tool;
   o using REALD data to inform culturally responsive and accessible screening practices;
   o patient/member engagement and preferences (e.g. asking patients which need they would like addressed)
   o Plans for workflows and data sharing to prevent unnecessary rescreening			

Reporting • CCO must report data from primary care clinics where 25% of the CCO's members are assigned.			

GOAL: Outcome/Performance
 	
• Benchmark / to meet measure:
   ▪ Report (a) and (b)
   ▪ Meet target on (a) - % screened
• Use year 2 performance to inform benchmarks and to set improvement targets
• Population threshold for reporting increases over time, with goal to reach reporting from clinics where 75% of CCO members are assigned			