# Social Determinants of Health Measure Concepts Summary

SDOH Measurement Workgroup, October 2020

| MEASURE CONCEPTS | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| | Rate of social needs screening in the total member population -- any data source | Rate of social needs screening in children 0-21* -- any data source | Rate of social needs screening by any Medicaid billing provider -- Z-codes | Rate of social needs screening for members with a primary care visit --Electronic Health Records (EHRs) |
| **Denominator** | Total CCO membership | Total CCO members ages 0-21 | Total CCO membership | CCO members with a primary care visit |
| **Numerator** | CCO members screened | CCO members ages 0-21 screened~ | CCO members screened | CCO members screened |
| **Data Source (Numerator)** | Any qualifying source (Data must be reported in required excel format. OHA to provide list of qualifying codes) | Any qualifying source (Data must be reported in required excel format. OHA to provide list of qualifying codes) | Claims data: Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Technology (CPT) code + Z-codes and customized modifier | EHRs |
| **Data Source (Denominator)** | Enrollment data | Enrollment data | Enrollment data | EHR + Enrollment data |
| **Availability of data to support member care, avoid unnecessary rescreening, and support referrals (e.g. outcome data is available at point of care and/or sharable across multiple settings)** | Depends on workflows & data sharing. Most, but not all, CCOs are using or planning to use Community Information Exchanges or a similar system to support social needs data sharing. Referral data may be available, but not standardized | Depends on workflows & data sharing. Most, but not all, CCOs are using or planning to use Community Information Exchanges or a similar system to support social needs data sharing. Referral data may be available, but not standardized | Use of standard z-codes could facilitate data sharing across clinic sites that participate, but would require chart review and/or Health Information Exchange. No codes to capture closed loop referrals. | Available at point of care in primary care offices; coordination with CCO and non-clinical partners depends on workflows & data sharing, including use of Community Information Exchange (CIE), Health Information Exchange (HIE) or other system. No codes to capture closed loop referrals |

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| **Allows for population-wide tracking of social needs at state or local level to inform community health improvements** | Yes, captures data from full population. Aggregation depends on standard domains, questions, and coding, via sample in initial years. | Partially, includes a subset of the full population with/without a health care visit, yet standard, domains, tools and coding could support widespread implementation. | Partially, includes only those with a health care visit, yet standard, domains, tools and coding could support widespread implementation. | Partially, but only for those with a primary care visit, yet standard, domains, tools and coding could support widespread implementation. |
| **Screening outside the clinical setting "counts"** | Yes, provided CCOs collect data from partners | Yes, provided CCOs collect data from partners | Yes, but only from those who can bill Medicaid | No, and only screening in primary care settings counts |
| **Potential burden on CCOs, clinics and OHA for full implementation** | Lower burden, due to ability to use current systems & practices. Higher burden to build systems to aggregate and share data. | Lower burden, due to ability to use current systems & practices, and smaller total population. Higher burden to build systems to aggregate share data | Higher burden for implementation of multiple codes and workflows; Lower burden for data reporting | Possible increase burden on clinical staff to conduct screen; Higher burden for EHR integration; depending on level of standardization, lower burden for reporting once systems built |
| **Potential to align with other emerging & existing efforts, like CIEs** | High, "no wrong door" approach to data collection allows alignment with existing efforts. | High, "no wrong door" approach to data collection allows alignment with existing efforts; proposed population aligns with state goals and programs | Medium, some pilots tests underway, but generally low use of z-codes | Medium, alignment limited to clinical efforts, but clinics could certainly use CIE to access closed loop referrals and share 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.*

*~ 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.*