NCQA
Measuring quality. Improving health care.

Charting New Territory: The Early Lessons in Integrating Social Determinant of Health (SDOH) Measurement into Practice

Adrianna Nava, PhD[1], Kristen Bishop[1], Polina Lissin, MPH[1]

Background

Social determinants of health (SDOH), including food insecurity, inaccessible transportation, housing instability, and social isolation are non-clinical factors which are associated with worse overall health outcomes and access to care. Health plans, medical providers, social service providers, and community-based organizations can help address these determinant to improve patient care and outcomes. [1,2]

The National Committee for Quality Assurance (NCQA) developed two measures to capture health plan activity and performance in assessing and addressing the social needs of their member populations.

- Social Need Screening and Intervention (SNS-E): % of members screened for unmet food, housing and transportation needs, and if screened positive, received a corresponding intervention within 30 days. *(published in HEDIS®3 for Measurement Year 2023)*
- Social Connection Screening and Intervention (SCS-E):% of Medicare members aged 65+ who were screened for social isolation, loneliness, or inadequate social support and, if screened positive, received a corresponding intervention within 30 days *(currently under development)*

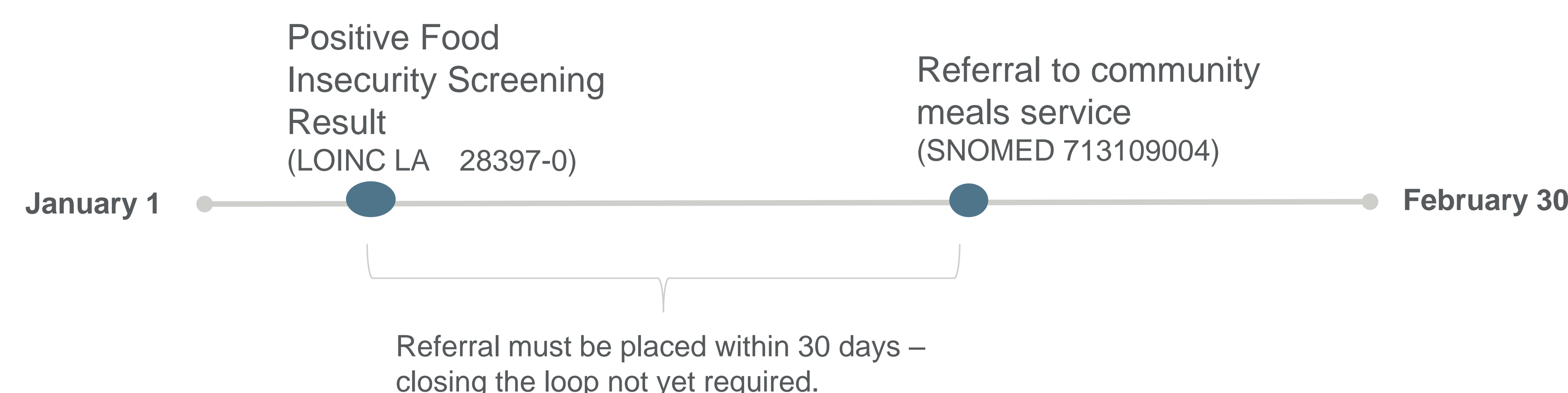

Figure 1. Example of Food Insecurity Indicator within the Social Needs Screening and Intervention (SNS-E) Measure

PURPOSE: To summarize qualitative findings from testing efforts while developing the SCS-E measure and considering the addition of a utility insecurity domain for the existing SNS-E measure. We discuss challenges and opportunities for improvement in capturing and addressing social needs in the current practice environment.

Study Design

RECRUITMENT AND METHODS

- Purposive outreach to NCQA customers with selection of testing partners based on experience with quality reporting and feasibility of delivering testing outputs. (**Table 1**)
- One-hour semi-structured interviews addressing challenges and facilitators for reporting requested data elements including how plans define positive screen, mapping positive screen to interventions, and availability of data on interventions.

Study Population	
Health plan attributes	**Interviewee attributes**
• 8 health plan organizations • Geographically diverse regions (including South, Midwest, West, Mid-Atlantic) • Serving Medicare, Medicaid, and commercial product lines • Membership populations averaged 13 million members	• 2-5 employees representing each health plan • Represented roles: director of quality, director of population health data & strategy, director of HEDIS® 3 operations, accreditation and quality improvement manager, healthcare analyst

Table 1. Study Population Attributes

Results

Measure development teams organized qualitative data findings into tables and categorized information into three themes (1) Health Plan Coding Practices; (2) Health Plan Data Storage, Extraction and Mapping; (3) System-wide Opportunities for Future Improvement (**Figure 2**).

Primary difficulties for reporting data elements: non-standardized coding practices, resource intensive processes for mapping information to codes, and the lack of specificity of information captured.

Facilitators for improvement: implementation of standardized screening tools, expanding eligible codes for reporting, financial incentives tied to standardizing SDOH data collection, and policy-level industry alignment.

Participants noted that the challenges and facilitators for improvements could be addressed through larger policy efforts in standardization, interoperability and implementation (**Figure 3**).

Interview Themes		
Health Plan Coding Practices	**Data Storage, Extraction, and Mapping**	**System-Wide Opportunities for Improvement**
Most health plans able to pull SNOMED, CPT, and LOINC codes. Capturing of z-codes was provider dependent.	Multiple health plans mapping SDOH data manually from free-text fields.	Effort existing to follow industry standards in interoperability and Gravity Project value sets.
Social connection data more likely to be captured by z-codes.	Case management systems tended to demand greater IT resources for querying, mapping, and reporting data. Case management systems associated with more limitations when extracting LOINC codes or EHR data.	Increasing specificity of intervention definitions may facilitate mapping to positive screens.
Reporting utility insecurity via LOINC is feasible.	Difficulty matching positive screens to appropriate intervention. Data may be stored across different databases.	Screening tool standardization to facilitate implementation and coding practices.
Financial incentives tied to standardization of SDOH data would help facilitate changing coding practices.	Lack of timestamp associated with codes. Difficulty in determining if interventions delivered within follow-up period.	Alignment in policy requirements and measurement tools will streamline the process of modifying workflows and data systems.
	Implementing further domains or measures reliant on SDOH data will be straightforward given similarities to current social need measure data needs.	

Figure 2. Table of Overall Findings and Themes

Implications for Policy

Improving SDOH data collection and exchange will require a concerted effort throughout the industry. **Figure 3** provides examples of regulatory policies, the role of standardization efforts, and contextualizes measurement work.

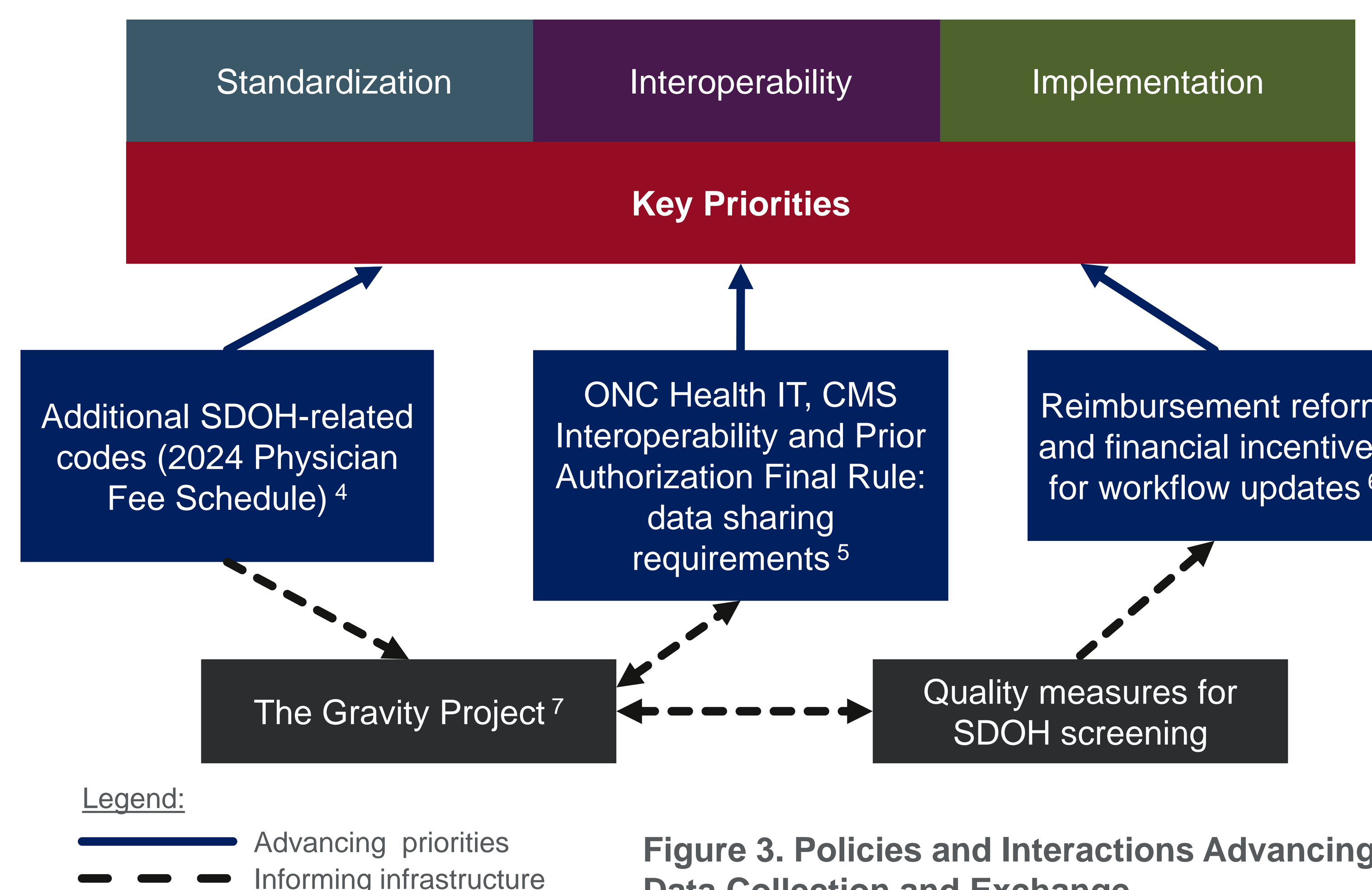

Figure 3. Policies and Interactions Advancing SDOH Data Collection and Exchange

Conclusion

Capturing SDOH data is possible, barriers in coding practices, data storage, extraction and mapping impede better collection and reporting. Continued efforts from policy makers to standardize this data, IT advancements to make the data interoperable, and entities from the provider to payer level willing to address SDOH needs with their populations will drive better outcomes for all.

References

1. American Medical Association (AMA). How to Improve Screening for Social Determinants of Health. AMA. 2019. Accessed 2024 Mar 28. https://www.ama-assn.org/delivering-care/patient-support-advocacy/how-improve-screening-social-determinants-health

2. American Academy of Family Physician (AAFP). Social Determinants of Health- Guide to Social Needs Screening. AAFP. 2019. Accessed 2024 Mar 28. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

3. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

4. Centers for Medicare and Medicaid Services (CMS). Physician Fee Schedule. CMS. 2024. Accessed 2024 Mar 28. https://www.cms.gov/medicare/payment/fee-schedules/physician

5. Centers for Medicare and Medicaid Services (CMS). CMS Interoperability and prior authorization final rule CMS-0057-F. CMS. 2024. Accessed 2024 Mar 28. https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

6. Campbell, E., Dyer, M. B., & Taylor, E. Addressing Health-Related Social Needs Through Medicaid Managed Care. State Health and Value Strategies. 2023. https://www.shvs.org/wp-content/uploads/2023/12/Addressing-HRSN-Through-Medicaid-Managed-Care_December-2023.pdf

7. Gravity Project. Introducing the Gravity Project. [Publisher unknown]. [Date unknown]. Accessed 2024 Mar 28. https://thegravityproject.net/

Acknowledgements

The analyses upon which this information is based were performed under CMS Task Order Number GS-10F-0012Y/75FCMC21F0094, entitled, “Performance Measurement for the Medicare Advantage Program“.

Author Affiliations: 1. National Committee for Quality Assurance, Washington, DC
For questions, contact Adrianna Nava at anava@ncqa.org