Addressing Social Needs Electronic Clinical Quality Measure Summary of Technical Expert Panel (TEP) Evaluation of Measures

October 2024

Prepared by:

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This material was prepared by CORE under contracts to the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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Background

The Centers for Medicare & Medicaid Services (CMS) contracted with Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (Yale CORE) to re-design a measure of screening for social needs (food insecurity, housing insecurity, transportation insecurity, utility insecurity). The re-designed measure is an electronic clinical quality measure (eCQM) evaluating hospitals addressing social needs. The contract name is Measure & Instrument Development and Support (MIDS): Development, Reevaluation, and Implementation of Outcome/Efficiency Measures for Hospital and Eligible Clinicians, Option Period 4. The contract number is HHSM-75FCMC18D0042.

As part of this project, CORE assembled a national Technical Expert Panel (TEP) of stakeholders including experts and consumer advocates who contributed to obtain their input through the measure re-design process. The purpose of this TEP was to assemble a group with diverse perspectives and expertise to advise on conceptual, technical, and implementation considerations of the measure under development. A schedule of TEP meetings can be found in Appendix A.

This report summarizes the feedback and recommendations received from the TEP during the project's fourth TEP meeting held in July 2024. During this TEP meeting, CORE presented an overview of measure specifications in development for the Hospital Inpatient Quality Reporting HIQR) program and the Merit-based Incentive Payment System (MIPS), reviewed measure testing results, and solicited face validity votes. A supplemental TEP 4 Meeting Packet was provided to TEP members in advance of the meeting to provide more in-depth background on the project, goals of the meeting, testing results, and listed key questions to be discussed during the meeting. A copy of the full meeting minutes can be found in Appendix B. A detailed list of TEP members can be found in Appendix C.

Measure Development Team

The CORE Measure Development Team provides a range of expertise in outcome measure development, health services research, clinical medicine, statistics, and measurement methodology. See Appendix D for the full list of members for the CORE Measure Development Team.

In alignment with the CMS Measures Management System (MMS), Yale CORE held a 30-day public call for nominations and convened a TEP for the development of a re-designed measure evaluating hospitals addressing social needs. CORE solicited nominations for TEP members via a posting on CMS's website and emails to individuals and organizations identified by the CORE Measure Development Team, and through email notifications sent to CMS physician and hospital email listservs. After reviewing the TEP nominations, CORE confirmed a TEP of 20 members (see Table 1 for members). The appointment term for the TEP is from November 2022 to January 2025.

CORE hosted the fourth meeting for the project on July 26,2024, via Zoom webinar/teleconference. Majority of TEP members (18 of 19) attended the meeting. See

Appendix C for the full list of TEP members. The TEP meetings follow a structured format consisting of the presentation of key issues identified during measure development, as well as CORE's proposed approaches to addressing the issues, followed by an open discussion of these issues by the TEP members.

Specific Responsibilities of the TEP Members

The role of the TEP is to provide feedback and recommendations on key methodological and clinical decisions. TEP members are required to:

- Complete and submit all nomination materials, including the TEP Nomination Form, statement of interest, and curriculum vitae
- Review background materials provided by CORE prior to each TEP meeting
- Attend and actively participate in TEP conference calls
- Provide input on key clinical, methodological, and other decisions
- Provide feedback on key policy or other non-technical issues
- Review the TEP summary report prior to public release
- Be available to discuss recommendations and perspectives following TEP meetings and public release of the TEP Summary Report to CMS
- Provide formal assessment on measure importance

TEP Members Present for Fourth Meeting

Table 1. TEP Member Name, Affiliation, and Location

Name, Credentials, Professional Role*	Organizational Affiliation, City, State*	Consumer/ Patient/ Family/ Caregiver Perspective*	Health Information Technology	Care Management/ Social Services	Health Equity
Rosie Bartel	Chilton, Wisconsin	X	-	-	-
Nabil Chehade, MD, MSBS, Executive Vice President, Chief Population and Digital Health Office, MetroHealth	Broadview Heights, Ohio	-	X	X	X
Terrisca Des Jardins, MHSA, Plan President, Molina Healthcare of Michigan	Troy, Michigan	-	X	X	X
Gail Grant, MD, MPH, MBA, Director, Clinical Quality Information Services	Cedars-Sinai Medical Center, Los Angeles, California	-	X	-	X

Name, Credentials, Professional Role*	Organizational Affiliation, City, State*	Consumer/ Patient/ Family/ Caregiver Perspective*	Health Information Technology	Care Management/ Social Services	Health Equity
Karen S. Johnson, PhD, Vice President, Practice Advancement	American Academy of Family Physicians, Leawood, Kansas	-	X	-	X
Barbara Kivowitz, MSW, PFA	Sutter Health, Los Angeles, CA	X	-	-	-
Roger Lacoy	PFCCpartners, ATW Health Solutions, Des Moines, Iowa	X	-	-	-
Ned Mossman, MPH, Director of Social and Community Health	OCHIN, Portland, Oregon	-	X	X	X
Juan Na?ez, RN, BSN, Director of Programs	PHIX - Paso Del Norte Health Information Exchange, El Paso, Texas	-	X	-	X
Karthik Sivashanker, MD, MPH, CPPS; Quality, Safety and Equity Professional; Psychiatrist	Justice Resource Institute, Boston, MA	-	-	-	X
Nālani Tarrant, MPH PMP, Director, Social Drivers of Health	National Associations of Community Health Centers, Bethesda, Maryland	-	-	-	X
Kevin Wake	Kansas City, Missouri	X	-	-	-

Fourth TEP Meeting

CORE held the project's fourth TEP meeting on July 26, 2024, to further discuss development of the ASN eCQM, which will measure how hospitals address the social needs of their patients. The purpose of the TEP is to provide feedback to CORE on proposed methodologies.

TEP Meeting Overview

Prior to the meeting, CORE provided TEP members a copy of the PowerPoint slides and background document for review. During the TEP meeting, CORE solicited feedback from the panel on testing results and face validity of the measure. The TEP meeting presenters were Leianna Dolce, Sarah DeSilvey, Nicole Voll, and Mariel Thottam. Following the meeting, CORE provided TEP members unable to join the teleconference with a copy of the meeting recording and opportunity to provide written feedback with an invitation to complete the Qualtrics survey on measure face validity.

The following bullets represent a high-level summary of what was presented and discussed during the TEP meeting. We also included meeting minutes with unique identifiers removed in Appendix B.

Background and Approach

- CORE started the meeting by reviewing confidentiality, funding sources, discussion decorum, an overview of the meeting agenda, and the goals of the meeting Speakers introduced themselves.
- Measure grounding was provided for the Addressing Social Needs (ASN) Electronic Clinical Quality Measure (eCQM), beginning by reviewing the April 2024 TEP meeting and progress of the measure since. Next, an overview was provided of the programs for which the measure is being developed:
    - Inpatient Quality Reporting (IQR) program[1], and
    - Merit-based Incentive Payment System (MIPS) for clinicians and clinician groups
- CORE re-visited the measure mission, to calculate a score based on patients receiving a social needs assessment and, if positive, have their needs addressed through a goal-oriented action and goal, to assess all patients and if positive, provide a follow-up, as well as a reminder of specifications across programs and specific to programs, including measure scoring.
- Next, the approach to testing was reviewed beginning with a reminder that the measure is aspirational in nature with standardizing screening for social determinants of health (SDOH) across the ecosystem and with its data requirements using standard terminologies. However, CORE emphasized that these requirements align with both United States Core Data for Interoperability (USCDI) and the Gravity Project. Additionally, CORE reviewed additional drivers towards use of the data standards through the Office of the National Coordinator (ONC) Regulation HTI-1 certified health record requirements beginning in 2026 and alignment with the National Center for Quality Assurance (NCQA) Social Needs Screening and Intervention measure.
- CORE provided details on the need for data approximation for testing given the current ecosystem. CORE noted that despite many facilities rapidly implementing the needed

[1] Note: This measure is also being developed for the Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program and Medicare Promoting Interoperability Program. All IQR specifications and testing results discussed reflect these programs as well.

Logical Observation Identifiers Names and Codes (LOINC) encoded screening questionnaires and Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) encoded follow-up options, these standards are unavailable in testing partner data at this time. Testing was conducted based on exact data matches as determined by subject matter experts. Additional approximation was utilized in testing the MIPS measure as Tax Identifier Number (TIN)/National Provider Identifier (NPI) were unavailable, however provider IDs were. Secondarily, data included patient office visits and outpatient visits, which would be included in the specifications, but the specific admin codes are not available.

- Measure testing was reviewed beginning with main takeaways including:
    - There was limited social needs screening in the data set used for testing (2022 to 2023). Testing partners reported, however, that some of their facilities have begun systematically screening and collecting social needs data on more patients beginning in 2024;
    - Follow-up interventions were not being documented in structured fields by these testing partners.
    - Standard coding terminology is not currently being used when screening for social needs, and;
    - Implementation standards required by this measure are rapidly evolving and we expect more data to be captured in 2024.
- Two data sources were reviewed (A and B), one utilized for MIPS testing, and both used for inpatient testing, including the limitations of the structured fields available in the data.
- Results were reviewed for z-codes indicating positive social need assessment, narrative measure rates for each program and dataset, and the distribution of domain-specific summary scores. Takeaways included: 1) a low frequency of the Z codes to identify social needs, consistent with literature; 2) summary scores for Dataset A Inpatient and Dataset A MIPS are too small to derive meaningful results and will require more robust screening; and 3) for Dataset B Inpatient, the housing domain had 50% of encounters with documented screening, which provided large enough numbers to note variability in scores between providers.
- CORE reviewed that signal-to-noise reliability testing was conducted and produced high mean and median reliability for all measured entities, higher than the recommended 0.6. CORE also noted that reliability estimates were highly variable due to low frequencies of screenings.

Summary of TEP Input (including both teleconference and written responses)

- When asked about testing results, TEP members offered feedback including a lack of surprise about the low rates of assessment and follow-up currently, contrasting with a note that some facilities are assessing and following-up at higher rates than shown. Concern was shown that an unintended consequence of the measure may include

patient "cherry-picking" to increase a population already assessing negative for social needs. Another member emphasized that when building a measure, it is meant to measure what is happening as opposed to incentivizing things one way or another.

- A member noted support for screening on every admission for IQR, however, they would have liked more frequent screening required for MIPS due to the changing nature of social needs. Additionally, this member noted there may be important differences in how facilities view follow-up being completed, whether a patient is directly connected with a specific organization or is more generally referred, making it difficult to receive help.
- When asked about face validity of the measure CORE utilized the following two questions; whether the ASN eCQM is easy to understand and useful for decision-making, and whether it could differentiate good from poor quality care among providers or accountable entities. Members generally agreed that the measure is easy to understand, however members had concerns with the wording of the second question. A discussion on the wording of the second question was held and during the meeting it was revised to "The ASN eCQM can differentiate good from poor quality of care, defined as hospital or provider performance on capturing screening rates and interventions for those patients who had a social need." An increased number of members agreed with this statement representing a narrower definition of quality of care. After the meeting the statement was further revised to: whether "the ASN eCQM identifies the adoption of processes related to social needs screening and intervention that have the potential to differentiate good from poor quality of care among providers (or accountable entities)." Additionally, members noted an interest in measuring the effectiveness of the interventions provided and a concern that there may be an unintended consequence of health systems changing policies to eliminate access for patients who have more social needs need care the most to improve scores.
- TEP members provided additional valuable input throughout the meeting including concern of possible unintended consequences of patient cherry-picking, usefulness of peer grouping for measure reporting, and concern for including patients who decline in the denominator of the domain level summary score.

Next Steps

Ongoing Measure Development

CORE will continue to solicit feedback from TEP members and other relevant stakeholders during the measure development process.

Conclusion

The TEP provided valuable feedback on elements of measure development, testing results, need for peer grouping for equitable comparison, and measure importance. During the meeting, TEP members reviewed testing results that indicated limited coded screening data sites and lack of coded intervention data at test sites. Following the meeting, all TEP members

were asked to complete a survey on measure importance; asking them to rate their level of agreement with the following statements:

- "The INPATIENT Addressing Social Needs Electronic Clinical Quality Measure is easy to understand and useful for decision making."
    - The TEP members responded: 5 strongly agree, 11 agree, 2 disagree, 0 strongly disagree.
- "The INPATIENT Addressing Social Needs Electronic Clinical Quality Measure identifies the adoption of processes related to social needs screening and intervention that have the potential to differentiate good from poor quality of care among providers (or accountable entities)."
    - The TEP members responded: 3 strongly agree, 9 agree, 4 disagree, 2 strongly disagree.
- "The MIPS Addressing Social Needs Electronic Clinical Quality Measure is easy to understand and useful for decision making,"
    - The TEP members responded: 5 strongly agree, 11 agree, 2 disagree, 0 strongly disagree.
- "The MIPS Addressing Social Needs Electronic Clinical Quality Measure identifies the adoption of processes related to social needs screening and intervention that have the potential to differentiate good from poor quality of care among providers (or accountable entities)."
    - The TEP members responded: 4 strongly agree, 7 agree, 6 disagree, 1 strongly disagree.

CORE will take the feedback from this TEP meeting into consideration in ongoing measure development activities.

Appendix A. TEP Call Schedule

A list of TEP meetings scheduled.

TEP Meeting #1
Tuesday, November 29, 2022 – 2:00-4:00PM EST (Zoom Teleconference)

TEP Meeting #2
Thursday, March 2, 2023 – 1:00-3:00PM EST (Zoom Teleconference)

TEP Meeting #3
Thursday, February 29, 2024 – 1:30-3:30PM EST (Zoom Teleconference)

TEP Meeting #4
Friday, July 26, 2024 – 2:00–4:00 PM EST (Zoom Teleconference)

Appendix B. Detailed Summary of HBP TEP Meeting #4

Addressing Social Needs eCQM Technical Expert Panel (TEP) Meeting #4 Minutes
Date: Friday, July 26, 2023, 2:00–4:00 PM EST

Participants:

- **Technical Expert Panel (TEP) Members:** Terrisca Des Jardins, Nabil Chehade, Nalani Tarrant, Gail Grant, Juan Nanez, Karen Johnson, Karthik Sivashanker, Ned Mossman, Rosie Bartel (PFE), Barbara Kivowitz, Roger Lacoy, Kevin Wake
- **Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (CORE):** Sarah DeSilvey, Leianna Dolce, Roisin Healy, Floraine Evardo**,** Katherine O'Hare, Mariel Thottam, Elizabeth Triche, Nicole Voll, Ariel Williams, Lisa Suter, Jin Cho, Faseeha Altaf
- **Centers for Medicare & Medicaid Services (CMS):** none
- **Centers for Medicare and Medicaid Innovation (CMMI):** none

Welcome/Administrative Items

- Ms. Mariel Thottam introduced herself and welcomed participants to the Technical Expert Panel (TEP), stating their feedback is crucial to the development of the Addressing Social Needs (ASN) electronic clinical quality measure (eCQM), but noting the ultimate decisions will be made by the Centers for Medicare & Medicaid Services (CMS).
- Ms. Thottam encouraged participants to use the virtual meeting controls (chat and raise hand feature) as needed, provided information on confidentiality, funding sources, discussion decorum and provided an overview of the meeting agenda:
    - Settling in;
    - Administrative items;
    - Reintroductions;
    - Measure Grounding;
    - Approach to testing;
    - Measure Testing results;
    - Face validity discussion; and
    - Next steps.
- Ms. Thottam reviewed the goals for the meeting:
    - Bring TEP members up to date on measure testing; and
    - Discuss face validity.

Re-Introductions

- Dr. Sarah DeSilvey thanked the TEP for joining the call and introduced herself as the ASN eCQM project co-lead. Ms. DeSilvey added that she is the Director of Terminology for the Gravity project and works within policy leadership at the Department of Human and Health Services (HHS).
- Ms. Leianna Dolce introduced herself as the project co-lead for the ASN eCQM team.

- Ms. Nicole Voll noted that she is a project lead for Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation (CORE) but specifically for the ASN eCQM team she is the Measure Testing lead.
- Ms. Thottam acknowledged the additional members of CORE's ASN eCQM team who were in attendance.
- Ms. Thottam acknowledged the TEP members (listed in the presentation slides) and stated they would forego introductions since the TEP members met previously.
- Ms. Thottam reviewed the TEP member responsibilities and the role of the TEP, including the meeting purpose of gaining stakeholder input from a range of perspectives to inform measure development, and promoting public transparency in measurement.
    - TEP members were asked to disclose any updated conflicts of interest in the meeting chat (none were disclosed).

Measure Grounding

- Ms. Dolce summarized April's TEP meeting and shared the progress of the measure development since then.
    - In April, the group reviewed the results of public comment, reviewed updated measure specifications, scoring, and instrument, reviewed alpha and beta testing results, and discussed measure importance and possible peer grouping for implementation.
    - Ms. Dolce added that since the last TEP, the team has finalized measure specifications, submitted the measure to the 2024 Measure Under Consideration (MUC) List, and completed testing.
- Ms. Dolce gave an overview of the measure programs for which the measure is being developed.
    - In the Hospital Inpatient Quality Reporting (IQR) program, the measurement is at the encounter level, meaning if a patient is admitted more than once a year, they will be included in the measure more than once. If the patient is assessed positively, they must be provided intervention each time.
    - In the Merit-based Incentive Payment System (MIPS) program for clinicians the assessment of needs and provision of follow-up are required once a year. Measurement is at the patient level.
- Ms. Dolce reviewed the measure's mission and goal:
    - Mission: Calculate a score based on patients receiving a social needs assessment and, if positive, have their needs addressed through a goal-oriented action or intervention.
    - Goal(s): Assess all patients and, if positive, provide a follow-up.
- Ms. Dolce reviewed the differences between the measure specifications found in each program.

    - In the IQR program's denominator, encounters for patients of all ages who are discharged from an acute hospital or critical access hospital (CAHs) during the measurement period. The following are excluded:
        - Discharged against medical advice;
        - Dies prior to discharge; or
        - Transferred to another acute care hospital.
    - In the MIPS program's denominator, patients of all ages who had at least one eligible visit type based on Current Procedural Terminology (CPT) and The Health and Care Professions Council (HCPC) codes (no exclusions).
- Ms. Dolce provided a refresher on the measure scoring. Ms. Dolce noted that the narrative reporting includes five numerators and a measure summary score for each of 4 domains. The goal of the numerators is to give hospitals detailed information regarding assessment and interventions. Each numerator and measure summary score are calculated for each domain. The summary score is composed of patients or encounters who screen negative in addition to those who screen positive and are provided intervention divided by patients or encounters.
- A TEP participant questioned why the language "disparity" is used in the numerator description instead of "social need".
    - Dr. DeSilvey clarified that CMS made the final decision to use the language "disparity" to align with disparity work across their ecosystem.
- A TEP participant asked if patients who decline screening are included in the measure summary score.
    - Dr. DeSilvey confirmed that patients who decline screenings are excluded from the measure summary score. Dr. DeSilvey noted that the measure would like to highlight the number of patients who are negative or positive and those who received help over time.
    - The TEP participant inquired if it is possible to exclude patients that decline in the summary denominator instead of excluding the whole group.
    - Dr. DeSilvey noted that the measure team discussed declinations with CMS, who decided that excluding declinations from the summary score was the best choice.
    - A TEP member noted it may be valuable to know the amount and type of individuals declining evaluation.
    - Dr. DeSilvey stated that the number of declinations per domain is included as one of the detailed measure score rates.
- A TEP participant asked if the measure is evaluating if the patients use interventions or resources provided to them.
    - Dr. DeSilvey noted that intervention includes education on the resources, CMS is still evaluating ways to assess the effectiveness of the interventions and highlighted that the ASN eCQM is a process measure.

Approach to Testing

- Dr. DeSilvey elaborated on the current ecosystem drivers. She described the aspirational nature of the measure in terms of standardizing screening for social determinants of health (SDOH) across the ecosystem with aligned data requirements. She added that it is important to note there are additional drivers that are assisting in accomplishing that aim.
- Dr. DeSilvey explained that the testing findings that will be presented over the following slides align with the United States Core Data for Interoperability (USCDI) Gravity Project data standards supporting the ASN eCQM.
- She noted that given a set of national regulations and drivers, the ecosystem is rapidly advancing to implement ASN aligned data standards.
    - The Office of the National Coordinator (ONC) Regulation HTI-1 verified that by January 2026, any certified healthcare record must be able to represent the core data of the ASN eCQM measure.
    - Additionally, the National Center for Quality Assurance (NCQA) Social Needs Screening and Intervention measure is directly aligned with the data standards that underlie the ASN eCQM measure.
- Dr. DeSilvey added that incoming CMS regulations for instrument guidance point to the same value sets and recommendations that we have in our measure including the Special Needs Plans, Social Determinants of Health Risk Assessment HCPCs.
- Dr. DeSilvey elaborated on the need for standardized data approximation, an approach that provides the data needed for testing in the shifting and evolving ecosystem noted on the prior slide.
    - She noted that the measure specifications reference USCDI aligned terminologies with Logical Observation Identifiers Names and Codes (LOINC) encoded screening questionnaires and Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) encoded follow up options.
    - Although settings appear to be rapidly implementing the standardized terminology, these standards are unavailable in testing partner data at this time. Therefore, subject matter experts were recruited to analyze the testing partners' structured data to establish exact matches to incoming aligned standard terminologies. The team conducted approximation testing based on these matches.
- Dr. DeSilvey provided data approximation examples and solutions.
    - She noted that when looking at screening data across testing partners, most entities were using an instrument that matched measure specifications in 2024, largely driven by SDOH 1 and 2 measures. In this case, LOINC codes were applied in testing to match the exact requirements of the measure to the instrument.
    - Dr. DeSilvey noted that when thinking about implementation, the simple solution is LOINC encoding the existing instrument and directly supporting the

data specifications of the measure; the complex solution is changing screening instruments to align with TEP specified measure requirements.
    - She explained for intervention, if entities had a qualifying intervention that exactly matched specifications, the matching SNOMED CT code was applied in testing to meet the requirements of the measure. Examples of this included social work and care management referrals. There were exact codes for each in the standard data set. The simple solution is for a measured entity to start encoding with SNOMED CT codes behind the two common referrals.
    - Dr. DeSilvey emphasized that exact match approximation testing was done due to the common absence of those structured data standards to support the eCQM aims of the measure.
- Dr. DeSilvey elaborated on MIPS data.
    - The MIPS ASN measure is reported at the provider/provider group level Tax Identifier Number (TIN)/National Provider Identifier (NPI). Due to the unavailability of these data fields, testing was conducted with provider IDs for approximation.
    - The measure specification for MIPS also utilizes a set of qualified outpatient visits to include patients in the denominator. All patient visits provided for this setting via the testing partner are noted as office visits and outpatient visits, which would be included in the specifications, but the specific admin codes are not available.
- Dr. DeSilvey paused for any questions. There were none.

Measure Testing Results

- Ms. Voll described the main takeaways. They are as follows:
    - 1) She noted there was limited social needs screening in the data set used, (2022 to 2023) and noted that testing partners have reportedly begun systematically screening and collecting social needs data on more patients beginning in 2024;
    - 2) Follow up interventions were not being documented in structured fields;
    - 3) Standard coding terminology is not being used when screening for social needs and;
    - 4) Implementation standards required by this measure are rapidly evolving and we expect more data to be captured in 2024.
- Ms. Voll described the data sources:
    - Dataset A Inpatient and Dataset B Inpatient tested the inpatient version of the measure. Dataset A Inpatient had 12 hospitals with over 137,000 inpatient encounters and Dataset B Inpatient had 3 hospitals with over 275,000 encounters.
    - Dataset A MIPS tested the MIPS version of the measure, with almost 14,000 providers seeing 101.5 million patients.

- Ms. Voll described the limitations of each data set noted in the last column of slide #27, but noted that in the big picture, in both inpatient data sets, no follow up interventions were documented in structured fields for those encounters with a social need. The MIPS data set did have some interventions documented, although very few.
    - With Dataset B Inpatient, there was no indicator for the setting, so while most encounters in the data set were for the inpatient setting, there were a minority of encounters that were from hospital-based outpatient departments. She noted, however, the team feels comfortable naming this as an inpatient data set and ultimately due to the lack of intervention data, it did not dramatically impact any measure results.
- Ms. Voll noted that the main takeaway is that at the inpatient and outpatient settings, there was very limited screening being documented in 2022 and 2023 with few follow up interventions captured in structured fields. She added that this is a rapidly evolving field and data in 2024 should be more robust and therefore we expect to see improvement in measure scores going forward.
- Ms. Voll provided an overall testing methods description.
    - She noted that the systems in Dataset A Inpatient and Dataset A MIPS did not use LOINC to identify SDOH screens or follow up interventions. A manual search identified the information through structured flow sheet data- which is accurate data, but not identified using standard terms.
    - Ms. Voll noted that not all domains were being screened systematically prior to 2024 and that interventions were identified by keyword search of structured EHR fields, limited to referral codes.
    - She described the table on slide #28 which shows the percent of encounters in each data set that were assessed for social needs, either through a screening or documentation of an ICD-10 Z code, noting that the MIPS measure is patient based and not encounter based.
    - Ms. Voll noted that all domains are not being systematically screened, but housing as the most robust. Providers in the outpatient setting were screening in about 2% to 5% of patients.
    - She noted there are two reasons for this slide. The first is that the measure results are being called “approximate measure scores” as the data was not identified using the actual electronic specifications, but rather manual extraction. Despite this, the data was equally valid. Second, the results from testing data largely reflect what was expected. This data aligns with what other public reports have shown in the literature: that systematic social needs screening is currently minimal or is not being documented in structured fields if screening is taking place.
    - Ms. Voll emphasized that this creates a case for the ASN eCQM and why it is needed to push the field forward in identifying social needs for patients.
- Ms. Voll presented the results slide of Z-codes Indicating Positive Social Need Assessment on slide #29.
    - She describes the table which depicts a percentage of encounters, or patients for the MIPS version, with documented ICD-10 Z codes. She noted that the ASN

eCQM measure includes the flexibility for providers to either screen the patient during the encounter or if the social need is previously known or identified during the encounter in another way (for example, through conversation) to document the need with an ICD-10 Z code.
    - The main takeaway is that there is very low use of the Z codes to identify social needs, which is consistent with literature.
- Ms. Voll presented the results slide of the Narrative Measure Rates for Dataset A Inpatient on slide #30.
    - She reminded the group that each row is mutually exclusive. Each column is a domain, and the columns total the number of encounters (or patients for MIPS) listed at the top of the slide.
    - In Dataset A Inpatient, the top row has the largest percentage, which are those encounters not screened, with percentages ranging from 98% to 100%.
    - For the housing domain, about 1.6% of encounters screened positive for housing instability or homelessness, but overall rates for all domains were very low.
    - Ms. Voll noted that there were no interventions documented in structured fields, however, included the table to show the output of what it would look like for a hospital that did not conduct any systematic screening.
- Ms. Voll presented the results slide of the Narrative Measure Rates for Dataset B Inpatient on slide #31.
    - She noted that for the three hospitals in this dataset, 50% of encounters were being screened for the housing domain only. Overall, there was a very high rate of assessment for housing instability and homelessness, but there were no documented interventions for positive assessments.
- Ms. Voll presented the results slide of the Narrative Measure Rates for Dataset A MIPS on slide #32.
    - Overall, there is a high percentage of patients not being assessed with documentation, and some evidence of patients declining screening. While the documented screening rates are low, the rates of those being screened negative are similar across domains indicating providers are likely conducting screening across three or four domains at the same time on patients.
- Ms. Voll presented the results slide of the Distribution of Domain-Specific Summary Scores on slide #33.
    - As previously noted, each domain has a summary score which is calculated as (the number of encounters screened negative plus the number of encounters positive with a follow up) divided by all encounters.
    - Due to the lack of intervention data, the summary score here is skewed towards those being screened negative.
    - Takeaway: summary scores for Dataset A Inpatient and Dataset A MIPS are too small to derive meaningful results and will require more robust screening.
    - For Dataset B Inpatient, the housing domain had 50% of encounters with documented screening, which provided large enough numbers to note variability in scores between providers.

    - Ms. Voll noted that what we are looking for here and moving forward is the wide range of those measure scores, which would indicate a difference between the quality of care at different hospitals and therefore highlight room for quality improvement. While Dataset B is small, this can be compared to Dataset A Inpatient who did little screening.
    - She noted that ultimately, the team expects a wide range of measure scores as this measure is implemented. Documentation of social needs screening and intervention is a newer area for hospitals; even if we consider the other SDOH measures in use, the ASN eCQM measure also requires documentation of follow up intervention.
- Ms. Voll described testing methods reliability on slide #34.
    - She explained that one of the biggest analytic tests is measure score reliability where a signal-to-noise calculation is used, which is the proportion of quality signal to noise or error in the measure. The score itself is a range from zero to one, with scores closer to one indicating more of a quality signal than noise or error in the measure.
    - The Partnership for Quality Measurement, an external certification body, advises having a 0.6 signal to noise reliability statistic for endorsement of a quality measure for use across programs.
- Ms. Voll presented the results slide of the Distribution to Measure Score Reliability, Signal-to-Noise on slide #35.
    - Ms. Voll noted that the mean and median reliability is high for all measured entities, higher than the recommended 0.6. She noted that this is a good sign stating that the noise, or "error", in the measure is small. What is shown are the true number of the encounters in the numerator, however, to get a reliable score, the hospital has to be at least screening for social need. The wide range in reliability and scores in Dataset A Inpatient was because they had very few encounters that screened negative.
    - Overall, the measure is operating as intended.
- Ms. Thottam reviewed the major takeaways from the results section:
    - 1) There was limited screening during the retrospective data testing, but rates show improvement in screen in screening current data and;
    - 2) Standardized terminology for both screening and interventions are evolving to be more consistent based on the ecosystem drivers.
- Ms. Thottam asked the group if there were any questions or comments on the results presented.
- A TEP member noted that the results showing that most facilities were not screening patients, let alone not documenting any interventions for those that screen positive, should not be surprising, but they wondered for the signal-to-noise ratio, if there is a minimum sample size of those screened needed to calculate reliability. The numbers of patients that were actually screened were small, which can affect reliability.
    - Ms. Voll noted that we are seeing the floor in terms of measure reliability. The more data present, the more clearly you are able to see the reliability signal.

However, this is not a risk adjusted outcome measure where quality is being projected or predicted; because this is a process measure, you are capturing closer to what is observed. Nevertheless, with more data, the reliability signal would likely be even stronger.

- A TEP member had a follow up question. They asked if this would be the only testing done.
    - Ms. Voll stated that the team is in the process of trying to obtain another data set for the inpatient space. The goal is to identify a data source with more robust testing, which is something the team will follow up with stakeholders.
- A TEP member noted that they have heard there is more screening happening than we are able to document and measure through this mechanism due to the low use of the standardized codes. They added that it may not be accurate to conclude that organizations are not screening at this stage in the development and deployment of the right codes- but rather that organizations are screening, but it is not being documented in structured fields in the EHR data. The TEP member emphasized that a narrative the ASN eCQM team should lean into is to be able to document and measure this in order to give organizations credit for the work they are doing, while identifying opportunities for improvement in ways that can support organizations that are doing screening. The TEP member noted that focusing on the adoption and implementation of those codes will be telling the true tale of what is happening.
    - Dr. DeSilvey stated this is a good point and noted that from her work in the Gravity Project, she is aware of entities that have been screening for a long time, but noted that from the data, some facilities have just started. She added that there are two stories- one of SDOH 1 and 2 creating a process where many measured entities are just starting what many have been doing for a long time and a second story that everyone has the heft of getting the data standards to support the measure- which she noted are both true.
- A TEP member made a comment about “cherry picking” regarding the summary score. They asked what are health systems incentivized to do right now? Are they incentivized to spend a lot of money and resources to invest in a patient or patients to essentially lift them out of poverty or to fill in those critical gaps and social needs to essentially take them from screening positive with an intervention to eventually screening negative? Or should they throw up ads in more affluent neighborhoods and attract more patients who already screen negative, boosting the numerator? Or maybe they just build their new clinic, like many are doing, in that affluent neighborhood. They noted that it may be easier to game the system and to increase your score by just changing the demographics of the patients and changing the communities that you're serving over time. The TEP member asked what does it actually takes to get a patient from screening positive to screening negative and what does that mean? The TEP member provided an example of Westwood, MA, with average home prices in the millions. A person screening negative

there means a very different thing than a person who's screening negative where they are probably just barely getting by and surviving, who are also getting services that technically allow them to check those boxes and screen negative. How effectively are they translating to actual better health and outcome? They ask if the goal is ultimately to actually help people and communities achieve their maximum health potential, or is it just to keep those who are most oppressed and disadvantaged just from sinking to the bottom, which is currently what it is? They added that there is the need for investment in infrastructure and communities to lift people and communities out of poverty and right now, the system is just not incentivized for that and acts like a band-aid. How are we ensuring that facilities are not just shifting their patient population?
    - Dr. DeSilvey thanked the TEP member for the important equity minded question. She noted these are types of critical questions which inform the approach the team is working on with CMS regarding peer grouping. She noted that if peer grouping is not done, then the mission of the measure is not met. She added that the team is leaning in with CMS to try to figure out how appropriate peer grouping can help us address just that risk.
    - Ms. Dolce added that SDOH 1 and 2 helped build the capacity to begin screening in many facilities; these measures focus on screening rate for social needs and for the screen positive rate. The ASN measure will obtain more detailed information on not just the screening and screen positive but also on whether there is something being done (intervention) to try and help patients – which intersects many of the comments previously made. She noted that part of this measure aims to be a gentle glide path to moving towards possibility of counting more intense interventions more heavily than informational interventions. Ms. Dolce added that future versions of the measure may try to close the loop on whether the screening and intervention actually helped patients. For example, a different version of the measure may look back over some period of time (for example, a year) to determine whether patients' social needs improved based on the screening and intervening. There are many places CMS could go, but noted CMS is aware of all of the feedback and are discussing it.
- A TEP member built onto the previous point. They noted that measure development does not happen in a vacuum, it has a bias towards accountability, one way or another. When building a measure, it is meant to measure what is happening as opposed to the intent to be incentivizing things one way or another- it is CMS's job to incentivize. The way to build a pathway for accountability and judgement about whether an organization is meeting their responsibilities is with the output of the measure, with the ability to look at subgroups, and the way they process and understand the output of this measure. They noted that ultimately, it is building a measurement cascade that illustrates what is happening. Are patients who are arriving in a variety of care settings, are they being screened for these social needs? Those who have a social need, are they being connected or are they being referred- is action being taken? They added that it is

important to put this in the context of a measurement cascade and think about balancing the burden on organizations with understanding a clear picture of what is happening with their patients. The TEP member noted that they do not feel as though measures should be incentivizing something one way or another but should be measuring it so that CMS and others can build those incentives in the right way.
    - Ms. Dolce thanked the TEP member for their input.
- A TEP member asked how many times a patient will be asked about their social drivers of health needs? They noted that it is not something that is static- one instance you may be well housed, but then your landlord can sell your building, and you may end up homeless – and this could happen in the course of a month. Is there a way to build and see how frequently patients are being measured?
    - Ms. Dolce responded that this is a good question and hits on the fact that social needs change often, which is why we are recommending screening at every inpatient admission for the IQR measure. She added that there was a pushback on this for MIPS in the outpatient setting due to provider burden and even patient burden, so this was reduced to once a year.
    - The TEP member noted that they would push back on the pushback. They added that during their outpatient visits, their supplements, smoking history and alcohol consumption history are reviewed and stated that social drivers of health are equivalent to all those other health indicators.
    - The TEP member also noted that there are many facilities, particularly large, urban, academic healthcare centers that exist in a bubble. For these facilities, intervening may mean just tossing the patient out into the world of community-based organizations. Other hospitals already have connections with community-based organizations, maybe supporting them monetarily. As an example, during the early days of COVID in San Francisco, the data showed that the Latinx population was being severely underrepresented in terms of vaccination. One approach could have been to send a message in a community newspaper encouraging vaccination, but what UCSF and Sutter Health did was go into the Mission District in San Francisco and connected with local organizations who already had connections with the people who needed vaccinations. These facilities worked through and with them and supported their approaches to rousing community members to get vaccinated and the results were tremendous. They asked if, down the road, a future state version of the measure could be about to what extent are healthcare organizations already linked up with community-based organizations because it will be where social driver needs exist and where they are going to be met.
- Ms. Thottam thanked all of the TEP members for sharing excellent feedback about potential future iterations of the measure down the line. She noted that it is really helpful and will be summarized, collected, and shared with CMS as the measure

continues to move through the different phases. She moved forward to the next agenda topic.

Face Validity

- Ms. Dolce moved to discussing face validity which focused on the measure concept itself and emphasized the importance of considering both the measure specifications and testing results. She started with an overview of the measure specifications to reorient the meeting attendees with how the measure is built, including its description, domains, type, adjustments, and raters.
    - The ASN ECQM is designed to measure gold standard practices and coding early in their implementation. Electronic measures often require extended time after implementation for facilities to report effectively, and CMS has adjusted the timeline to accommodate this.
    - The goal of the measure is to share important and actionable information with entities and the public, and the potential for peer grouping based on like populations.
    - Ms. Dolce reminded participants to consider the measure in the context of its reporting readiness and the ecosystem's ability to utilize the required data standards, aligning with the measure's mission to screen patients for social needs and ensure necessary interventions.
    - She encouraged participants to think about the measure's ease of understanding and its ability to differentiate good care from poor quality care.
- Ms. Dolce shared that a survey would be sent out after the meeting to collect final votes and rationales, with responses due by the 6th.
    - The survey questions would be asked separately for each program and encouraged participants to reach out if they experienced any technical difficulties accessing the survey.
    - The survey results would be shared as anonymous summary percentages once collected.
- Dr. DeSilvey emphasized the importance of considering peer grouping as a key factor in analyzing quality and noted that it will be an incoming element.
- Ms. Thottam initiated a round-robin call on each TEP member. During their turn, she asked members to share any questions on either version of the ASN eCQM measure (IQR and MIPS versions) and provide initial thoughts or feedback on two statements: whether the Addressing Social Needs eCQM is easy to understand and useful for decision-making, and whether it could differentiate good from poor quality care among providers or accountable entities.
    - A TEP member stated that while the measure is easy to understand, it does not differentiate good from poor quality care because intervention does not always equate to receiving appropriate services.

- A different TEP member agreed that the measure is easy to understand and appreciated the change to narrative percentages and component breakdowns, but they concurred with the first TEP member that it does not differentiate good from poor quality care because it only indicates whether a patient was screened and an intervention attempted, without measuring the effectiveness of the intervention, which they suggested could be improved in future iterations.
- A different TEP member agreed that the measures are easy to understand but, like the previous two TEP members, expressed doubts about their ability to differentiate good from poor quality care, particularly highlighting issues with access to resources, facility connections for referrals, and the ability to coordinate and close the loop on resource access.
- Another TEP member agreed with the consensus that the measure is easy to understand but noted that its usefulness for decision-making depends on the specific question being asked. They agreed that the measure does not differentiate good from poor quality care but can help understand the extent of screenings and documentation. They highlighted the importance of measures in prompting organizational changes and suggested that additional analysis could explore the effects of screening and intervention, potentially using reliable data points around social determinants to better understand the quality of care.
- Dr. DeSilvey clarified that the measure in discussion is intended to assess whether an entity intervened in the presence of a positive need, similar to the depression screen and intervene measure, rather than measuring the effectiveness of the intervention. She emphasized that the measure will likely remain focused on screening and intervention, with possible changes only to the types of qualifying interventions. She highlighted the importance of understanding this distinction, as it aligns with existing measures and the literature on social needs.
- Ms. Dolce clarified that the primary goal of this specific measure is to ensure that a patient was assessed for all social needs domains and received intervention(s) for each identified need, if necessary. She acknowledged the importance of the effectiveness of interventions for overall quality but emphasized that assessing intervention effectiveness would either be covered by another measure or fall within the general scope of the patient's visit.
- A TEP member shared that while the measure is easy to understand, they have concerns about its long-term utility. They are worried that health systems might change policies to eliminate access for patients who need care the most, potentially misinterpreting improvements as progress. Their main concern is the lack of a balancing measure to ensure continued access for all patients, despite the peer groups.
- Another TEP member agreed that the measure is easy to understand. Initially, they thought the measure did not differentiate good care from poor quality care,

but with the clarification that it focuses on intervening and providing resources to patients, they acknowledged that it does represent good care as measured by this question.

- A different TEP member acknowledged agreement with the general consensus that the measure is easy to understand and appreciated the emphasis provided by Dr. DeSilvey. However, they expressed difficulty with the question as a clinician, noting that clinical quality outcomes should be measured by efficiency and impact on health. They found the question misleading because it asked about good quality care without addressing the ultimate health outcomes, which made it hard for them to simply answer yes or no.
- A TEP member believed both questions should be answered "yes" within the narrow scope of what is being asked. They acknowledged the concerns about differentiating good from poor quality care but emphasized that this measure is specifically designed to determine if patients with identified needs are being referred or if their needs are being addressed. They urged others to view this measure within its intended purpose, not as a comprehensive solution, but as a step in ensuring that referrals and needs are being managed appropriately.
- A TEP member agreed that the measure is understandable but shared mixed feelings about addressing social needs. They noted that while it is a component of good quality care, it is not comprehensive enough to fully differentiate quality. Thus, they felt it was both a yes and a no and emphasized that poor performance in one area doesn't negate excellence in others.
- Another TEP member agreed that the measure is easy to understand and useful for decision-making. They concurred with the previous TEP member, emphasizing that this performance measure evaluates whether actions are being carried out and that failing to intervene or offer support indicates poor quality. Drawing from their experience with rural hospitals, the TEP member highlighted the importance of addressing social needs to reduce readmissions and improve quality care. They acknowledged that while this measure is a step in the right direction, further measures will eventually be needed to evaluate the effectiveness of interventions.
- A TEP member noted that the measure is easy to understand and useful for decision-making. They referred to the World Health Organization's definition of quality of care, emphasizing that it should increase the likelihood of desired health outcomes. They agreed that the measure could differentiate good from poor quality in a narrow sense but expressed concerns about implementing it before other measures are fully developed and feared it might break patient trust if needs cannot be met. A TEP member suggested a phased rollout in states with dedicated investments in social services, such as those addressing food insecurity, to mitigate unintended consequences and ensure resources are available to meet increased demands.

- Dr. DeSilvey acknowledged the overall agreement amongst TEP members regarding the responses to the two questions about the measure's ease of understanding and its ability to differentiate between poor and good quality care.
    - She emphasized that while the standard questions are part of the measure development process, providing additional context could help align everyone's understanding.
    - Ms. Voll acknowledged the challenge of using the term "quality of care" in the measure's standard phrasing and the need for clarity to prevent confusion. She suggested expanding the definition of quality of care within the measure to encompass performance metrics like screening rates and interventions for social needs. Ms. Voll confirmed that while the quality of care aspect cannot be removed, it can be operationally defined to align with the measure's intent. She emphasized that this is a process measure, not an outcome measure, and its narrow scope should be kept in mind.
- Ms. Thottam asked the group if the new wording would change how members would vote on the question, considering it is a process measure rather than an outcome measure. The reworded version stated: "The addressing social needs electronic clinical quality measure could differentiate good from poor quality of care, defined as hospital or provider performance on capturing screening rates and interventions for those patients who had a social need."
    - A TEP member expressed that while the reworded question captures the concept, it might need slight adjustment for clarity. They suggested it should differentiate capturing screening rates for all patients and interventions specifically for those with a social need. However, they stated that this rewording does not change her opinion about the measure. They still believe that the gap between simply recording an intervention and providing effective, targeted care is too wide. Capturing an intervention does not indicate anything about the quality or impact of the care provided.
    - A different TEP member acknowledged that the reworded question does not fully address their concerns but recognized the need to start somewhere. They indicated that while this rewording might not be ideal, it is a first step that makes him feel more comfortable with the measure.
    - A TEP member suggested that the measure could differentiate care processes related to social needs screening and intervention that contribute to differentiating good from poor quality of care. While agreeing with the other TEP member’s point, they emphasized the necessity of starting somewhere. The TEP member proposed reframing the measure to indicate that it identifies the adoption of processes that have the potential to contribute to or differentiate care quality. They appreciated the effort in rewording but felt the original phrasing still did not fully capture the group's intent.

- Another TEP member emphasized the importance of building and maintaining trust with patients and expressed concern that without timely follow-up measures to assess the quality and effectiveness of interventions, patient trust could be eroded. They stressed that CMS needs to understand the urgency of developing the next measure to ensure interventions create better outcomes for patients.

Next Steps

- Ms. Thottam outlined the next steps, stating that the feedback from the discussion will be summarized and returned to CMS for consideration as the ASN measure moves through the measure lifecycle, including evaluation and implementation.
    - Both versions of the ASN eCQM measure for IP and MIPS are going through the Measures Under Consideration (MUC) process, and there will be opportunities for public comment as they advance. The team will keep all TEP members informed of these opportunities via email.
    - Additionally, a TEP summary report will be sent out for formal review in the coming weeks.
    - Ms. Thottam reminded everyone to complete the test facility survey by the August 6th deadline. The two extensively discussed questions will be included in the survey, which will be sent out soon, possibly by Monday morning, after considering the feedback on the question framing.

Appendix C. List of all TEP Members and Information

Table 2. TEP Member Name, Affiliation and Location

Name	Title, Organization	Location
Rosie Bartel	Consumer/Patient/Family Caregiver	Chilton, Wisconsin
Nabil Chehade, MD, MSBS	Executive Vice President, Chief Population and Digital Health Officer, MetroHealth	Broadview Heights, Ohio
Terrisca Des Jardins, MHSA	Plan President, Molina Healthcare of Michigan	Troy, Michigan
Gail Grant, MD, MPH, MBA	Director, Clinical Quality Information Services, Cedars-Sinai Medical Center	Los Angeles, California
Karen S. Johnson, PhD	Vice President, Practice Advancement, American Academy of Family Physicians	Leawood, Kansas
Barbara Kivowitz, MSW, PFA	Consumer/Patient/Family Caregiver	Los Angeles, California
Roger Lacoy	Consumer/Patient/Family Caregiver	Des Moines, Iowa
Nikolas Matthes, MD, Ph.D, MPH, MSc,	Assistant Vice President, State Healthcare Assessment	Lake Success, New York
Ned Mossman, MPH	Director of Social and Community Health, OCHIN	Portland, Oregon
Juan Na?ez, RN, BSN	Director of Programs, PHIX-Paso Del Norte Health Information Exchange	El Paso, Texas
Anand Shah, MD, MS	Vice President, Social Health, Kaiser Permanente	Moraga, California
Shannon Simms, MD, Ph.D, FAMIA	Senior Vice President, Emerging Markets, Vizient Inc.	Chicago, Illinois
Karthik Sivashanker, MD, MPH, CPPS	Quality, Safety and Equity Professional; Psychiatrist, Justice Resource Institute	Boston, MA
Megan V. Smith, DrPH, MPH	Senior Director, Community Health Transformation	The Connecticut Hospital Association, Wallingford, CT
Tressa Springmann, CHCIO, CPHIMSS	Senior Vice President and Chief Information and Digital Officer, LifeBridge Health Systems	Baltimore, Maryland

Name	Title, Organization	Location
Walter G. Suarez, MD, MPH, FHIMSS	Executive Director, Health IT Strategy and Policy (KP-HITSP), Kaiser Permanente	Washington, DC
Nālani Tarrant, MPH PMP	Director, Social Drivers if Health, National Association of Community Health Centers	Bethesda, Maryland
Kevin Wake	Consumer/Patient/Family Caregiver	Kansas City, Missouri
Janelle White, MD, MHCM, FAAP	System Medical Director of Community Health, Atrium Health	Charlotte, North Carolina

Appendix D. List of CORE Team Members.

Table 3. Center for Outcomes Research and Evaluation (CORE) Team Members

Name	Role & Team	Team
Faseeha Altaf, MPH	Division Lead	Testing
Kojo Danquah-Duah, MPH	Project Manager	Project & Testing
Sarah DeSilvey, DNP, FNP-C	Project Co-Lead	Project
Leianna Dolce, BS	Project Co-Lead	Project
Floraine Evardo, MPH	Research Support	Project
Patricia Faraone Nogelo, PhD, LCSW	Division Lead	Project
Katherine O'Hare, MSW	Project Coordinator	Project
Elizabeth Triche, PhD	Director of Digital, Health Equity & Innovation Division	Project & Testing
Brooke Villarreal, DNP, MSN	Associate Director of Digital Product Development	Testing
Nicole Voll, MPH, PMP	Testing Lead	Testing
Nicole Walton, BS	Project Coordinator	Testing