Summary of Technical Expert Panel (TEP) Meetings
Addressing Social Needs Electronic Clinical Quality Measure (eCQM)

March 2023

Prepared by:

Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (YNHHSC/CORE)

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.

Table of Contents

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 (e.g., housing status, food insecurity, transportation). The re-designed measure will be 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 3. The contract number is HHSM-75FCMC18D0042.

As part of this project, CORE assembled a national Technical Expert Panel (TEP) of stakeholders, 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 second TEP meeting held in March 2023. During the second meeting, CORE presented and solicited TEP input on how to deal with declined screening, the results of applying instrument criteria utilizing the approach recommended from the first TEP meeting, as well as began a conversation around follow up. The full meeting minutes can be found in Appendix B and 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.

The TEP

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 September 2022 to December 2023.

CORE hosted the second meeting for the project on March 2, 2023, via webinar/teleconference. Most TEP members (15 of 20) attended the meeting on March 2, 2023. C. See Appendix C for a full list of the twenty TEP members. 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.

TEP Members Present for Second Meeting

Table 1. 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
Barbara Kivowitz	Consumer/Patient/Family Caregiver	Los Angeles, California
Nikolas Matthes, MD, Ph.D, MPH, MSc,	Measure Developer, IPRO	Lake Success, New York
Ned Mossman, MPH	Director of Social and Community Health, OCHIN	Portland, Oregon
Juan Nanez, RN, BSN	Manager of Informatics and Operations, PHIX-Paso Del Norte Health Information Exchange	El Paso, Texas
Marilyn Parenzan, MBA, RHIA, CPHQ	Project Director, The Joint Commission	Oakbrook Terrace, Illinois
Anand Shah, MD, MS	Vice President, Social Health, Kaiser Permanente	Moraga, California

Name	Title, Organization	Location
Shannon Simms, MD, Ph.D	Senior Vice President, Data Operations, Vizient Inc.	Chicago, Illinois
Karthik Sivashanker, MD, MPH, CPPS	Vice President- Equitable Health Systems; Medical Director for Quality, Safety, and Equity, American Medical Association; Brigham Health	Norwood, Massachusetts
Megan V. Smith, Dr.PH, 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
Nalani Tarrant, MPH PMP	Deputy 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

Second TEP Meeting

CORE held the project's second TEP meeting on March 2, 2023, to further discuss the development of an 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 TEP meeting, CORE provided TEP members with a background packet providing the meeting agenda, an overview of feedback provided from a recent patient, family, and caregiver working group meeting, and a description of the proposed discussions with relevant background material. During the TEP meeting, CORE solicited feedback from the panel on defining the measure parameter (inclusion and exclusion), application of screening instrument criteria, and accountability for follow-up care. As the TEP functions in an advisory-only capacity, no motions to vote or approve concepts were undertaken. The TEP meeting presenters were Leianna Dolce, Elizabeth Triche, Alon Peltz, Sarah DeSilvey, and Laura Gottlieb (CORE and CORE consultants). The TEP meeting was facilitated by HealthCare Dynamics International (HCDI). Following the meeting, CORE provided the TEP member who was unable to join the TEP teleconference with the meeting recording and the opportunity to provide written feedback. The following bullets represent a high-level summary of what was presented and discussed during the TEP meeting, as well as the written responses of the TEP member unable to join the meeting. For full transparency, we provide meeting minutes with unique identifiers removed. For this, please see Appendix B.

Background and Approach

- CORE presented the background and overview of the Addressing Social Needs (ASN) Electronic Clinical Quality Measure (eCQM), reviewed the current measure development timeline, and outlined potential next steps.
- CORE shared that as part of the measure development, a patient, family, and caregiver workgroup was hosted to provide input on the screening portion of the measure. The workgroup highlighted that it is important to consider when the screening takes place, that discharge can be a busy and confusing time for screening, the experience of screening depends on how the screening is conducted, having an identified caregiver is an important requirement; and including the in the conversation/screening is essential, and understanding individual requirements around follow-up.
- CORE reviewed that the ASN eCQM will initially focus on the acute hospital setting and prioritize four social need domains that CMS has considered high priority: Food Insecurity, Housing Insecurity, Transportation Insecurity, and Utility Insecurity.
- CORE presented the Domain Roadmap and explained there would ideally be additional public input to identify candidate social domains for inclusion in future versions of the ASN eCQM in measure re-evaluation.

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

- When asked about how the measure should consider people declining screenings and/or follow up, the TEP generally agreed that there are many reasons as to why patients decline, and that it is important to track patients who decline participation in the measure. There was not consensus about how these declinations should be handled in measure calculation. Several TEP member noted that the requirements of individuals with cognitive limitations should be uniquely considered in this measure.
- When asked about the application of screening instrument criteria, the TEP generally agreed with the application of both the gold standard and face valid approaches. However, TEP members cautioned that having too many instruments can become a barrier in the screening process. Furthermore, the TEP recommended ensuring that equity regarding patient race and ethnicity should be considered when thinking of a gold standard and equitable measurement.
- When asked about accountability for follow-up care, the TEP generally agreed that it is not just what follow-up is delivered, but how the follow-up is done that is relevant to both patient trust and outcomes. It would be ideal to track the timeline of interventions and any receipt of services in a specific timeframe, but TEP members recognized that the timeline would differ for different needs and interventions. TEP members noted that a specified timeline for outcomes might fail to account for the influence of shared patient-provider decision making about appropriate follow up.

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 the different approaches to screening, instrument selection, and follow-up. The TEP was in favor of having the declined screenings be tracked and measured and suggested better understanding the different reasons why a patient may decline may be helpful. The TEP approved of the outcomes of the screening instrument criteria but cautioned that the number of screening tools used could increase complexity and stated that it was important to ensure eligible instruments were valid and relevant to all populations when possible. TEP members also agree that to increase patient trust, screenings should be done with respect to different populations' needs and backgrounds, that they were timely, and that there was some intervention. 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
To be determined based on Yale CORE need and TEP availability

TEP Meeting #4
To be determined based on Yale CORE need and TEP availability

Appendix B. Detailed Summary of OP3 TEP Meeting #2
Addressing Social Needs eCQM Technical Expert Panel (TEP) Meeting: Meeting #2 Meeting Minutes

Meeting Information:
Date:
Thursday, March 2, 2023, 1:00-3:00 PM ET

Participants:

- **Technical Expert Panel (TEP) Members:** Barbara Kivowitz, Karthik Sivashanker, Kevin Wake, Juna Nanez, Ned Mossman, Nabil Chehade, Janelle White, Megan Smith, Anand Shah, Tressa Springman, Shannon Sims, Nalani Tarrant, Nikolas Matthes, Rosie Bartel, Marilyn Parenzan
- **Yale New Have Health Services Corporation – Center for Outcomes Research and Evaluation (CORE):** Rachelle Zribi-Williams, Lear Burton, Elizabeth Triche, Faseeha Altaf, Brooke Villareal, Ariel Williams, Karen Dorsey, Sarah DeSilvey, Laura Gottlieb, Alton Peltz, Leianna Dolce, Nicole Walton
- **The Center for Medicare & Medicaid Services (CMS):** Melissa Hager, Michelle Schreiber, Raquel Myers, Stephanie Clark, Ron Kline, Ngozi Uzokwe, Vinitha Meyyur, Lisa Marie Gomez, Gigi Crane, Jessica Lee, Virginia Raney, Aditi Mallick, Liz Clark, Gigi Raney, Sarah Downer
- The Office of the National Coordinator for Health Information Technology (ONC): Alexander Baker
- HealthCare Dynamics International (HCDI): Achaia Logan, Stefani Brown

Welcome

- Dr. Beth Triche welcomed participants and introduced herself as providing director-level oversight. She welcomed feedback from the TEP and stated their feedback is crucial to the development process but remembering the ultimate decisions will be made by CMS.
- Ms. Dolce welcomed all participants and provided information on confidentiality and funding sources, she provided a CORE overview and the meeting agenda.

Introductions

- Ms. Logan introduced herself as the facilitator and outlined the discussion decorum expectations of appreciating diverse perspectives, communicating respectfully, being attentive of time parameters, using first/preferred names to address others and sharing pronouns if comfortable, and use of the Zoom platform to raise your hand for a comment.
- Ms. Dolce briefly introduced the CORE team and TEP Role.
- The TEP members introduced themselves (Barbara Kivowitz, Karthik Sivashanker, Keven Wake, Juna Nanez, Ned Mossman, Nabil Chehade, Janelle White, Megan Smith, Anand Shah, Tressa Springman, Shannon Sims, Nalani Tarrant, Nikolas Matthes, Rosie Bartel, Marilyn Parenzan).

Background

- Ms. Dolce provided a background and overview of the project; explaining that the yellow star in the graph represents specification. The steps in the yellow box are potential steps to include, CBE Submission, Rulemaking, Implementation Planning and National Reporting.
- Ms. Dolce introduced that as part of measure development, a patient, family, and caregiver workgroup was hosted to provide input on the screening portion of the measure. She explained the workgroup highlighted that it is important to consider when the screening takes place, discharge can be a busy and confusing time, the experience of screening depends on how the screening is conducted, having an identified caregiver is an important requirement; and including the in the conversation/screening is essential, and understanding individual requirements around follow-up.
- Ms. Dolce presented and explained the decision regarding social needs, the initial measure will focus on 4 core domains with a plan for expansion through public input to identify next domains. Also, regarding screening instruments, the decision has been made to start with Approach #2 (apply criteria but allow flexibility if not meeting the gold standard); work towards Approach #3 (only gold standard instruments).
- Ms. Dolce presented and explained The ASN eCQM will initially focus on the four high priority domains (Food Insecurity, Housing Insecurity, Transportation Insecurity, and Utility Insecurity).
- Ms. Dolce presented the Domain Roadmap and explained there will be public input to identify candidate social domains for inclusion in future versions of the ASN eCQM in measure re-evaluation. Ms. Dolce reviewed the principles of such a process that would include ideally a review scientific evidence of benefits and harms and assemble expert panel to assess readiness for measurement; once approved, incremental phasing in of new social needs domains in v2.0 of the ASN eCQM.
- Ms. Dolce presented goals for today's TEP is to solicit feedback on declined screening and follow-up, list of permitted instruments for each domain/sub-domain, and conceptual approach for determining follow-up actions.

Topic #1: How to Approach Declined Screening and Follow-Up

Background

- Dr. Peltz introduced the first topic discussion, “How to approach declined screening and follow-up".
- Dr. Peltz highlighted that the goal is to identify guiding principles and measurement implications as we think about how to make the measure person-centered, and effective.
- Dr. Peltz reiterated that the measure focuses on the four domains (Food Insecurity, Housing Insecurity, Transportation Insecurity, and Utility Insecurity) as this measure builds on the social drivers of health.
- A TEP member stated that screening vs wanting help are two different things. They asked if they are being included together or separate?
- Dr. Peltz responded that both are under consideration, but the expectation is for the measure to drive behavior that promotes both recognition and follow-up.
- Dr. Peltz presented the “Inclusion and Exclusion Criteria” and explained that the inclusion criteria start at 18 years of age or above. He continued to explain the idea for this inclusion is to count every eligible discharge, regardless of a prior discharge, screening, and known social need.
- Dr. Peltz explained the exclusion criteria is aimed at focusing on episode of care such as, death prior to discharge, discharged against medical advice, transfers to acute care hospital or long-term care facility. In regard to the two final criteria, Dr. Peltz explained that the goal is to prioritize screening to take place before the patient is transitioning to a community-based setting where needs such as, food, housing, utilities, and transportation needs would be immediately addressed by the patient or caregiver.
- Dr. Peltz stated that today’s focus is on the acute hospital measure. He explained that as measurement advances into other settings, it will build a chain of continuity to looks at areas where the current measure does not include screening requirement but the next care setting that receives the patient would have a requirement for screening. The challenge is promoting timely, but not redundant, screening approaches.
- Dr. Peltz presented the “Measure Score” and explained each approach (Domain, Activity, and Rolling). He explained the first approach is required to complete BOTH screening and follow-up for each domain and the final score is a weighted combination of 4 individual domains rates; second approach it’s required to complete screening (or follow-up) for all domains and the final score is a weighted combination of a screening and a follow-up rate; the final approach, is to complete BOTH screening and follow-up for ALL four domains and the final score is one rate calculated using a rolling denominator.
- Dr. Peltz stated that there will be future opportunities for the TEP to provide feedback on the measure scoring and this is still in development but included now for context to the next conversation.
- Dr. Peltz discussed several considerations regarding how to best classify those who decline participation. He stated that we want to reduce the risk that people will feel pressured to participate in screening or follow-up activities as well as potential

differences in this across populations, and allow people to be able to prioritize needs, and limit potential for undesired clinician behavior.

- Dr. Peltz continued to explain that the team anticipates there to be a technical capability to measure which individuals decline the screening (or follow-up), and it remains unclear how those individuals should be counted in the measure score.
- Dr. Peltz presented the first discussion topic.

TEP Discussion: How Should the Measure Consider People Declining Screening and/or Follow-Up?

- A TEP member commented in the chat that she has two additional measures for the future wish list- household violence, climate instability (e.g., drought, fire, flooding, etc.)
- A second TEP member asked a question in the chat, why exclude transfers to long term care facilities? Understood transfer to acute hospital (where screening should take place) but why LTC?
- A TEP member agreed that it's important to include and be able to track if a patient declines participation in the screening or the follow-up.
- A TEP member expressed a thought of making the data fair by including the decline in the denominator at most 10% and if a patient decline screening, then they're out of the denominator of how the measure works. If you have more than 10% of patients declining screening, then a penalty can be assessed, this is because providers are trying to score themselves too.
- A TEP member commented in the chat that they appreciate the rationale re: inclusion criteria, but not sure that they agree with "regardless of prior discharge/screening/known social need."
- A TEP member asked a question in the chat, why not include patients of all ages? Should hospice or comfort measures only be excluded?
- A TEP member expressed additional ideas on why a patient would decline screening and stated that if a patient declined screening, it's a call for help and a warning sign, and that follow up needs to be done. The TEP member also expressed that the more patients become acclimated to the screenings as the normative part of their health assessment, the declining ratio will go down, but declining needs to be measured, captured, and followed up on. The TEP member also noted if patient declined screening, it doesn't mean that the family or social network isn't suffering from the lack of those needs, so there may be a need to include the caregiver in the screening.
- A TEP member asked a question in the chat, "why not include patients of all ages? Should hospice or comfort measures only be excluded"?
- A TEP member commented in the chat, "depending on the patient, that could introduce a lot of redundancy and inefficiency; that's not necessarily helpful to the patient either."
- A TEP member commented in the chat, "even when the patient dies the family social needs don't go away - in fact, they are likely to worsen. Why not screen family for social needs post patient death?"
- A TEP member responded in the chat agreeing that this information may also be helpful for pediatric/adolescent populations.
- A TEP member commented in the chat agreeing that many patients will not have this change from encounter to encounter. However, those experiencing things like housing

insecurity (who would most benefit intervention) can have changes from encounter to encounter. Additionally, with all quality measures, it does introduce a burden and that burden must be balanced against benefit.

- A TEP member asked a question in the chat, “why not a simple question to the patient asking if anything has changed in their circumstances since their last visit?”
- A TEP member stated that if the exclusion criteria had an option for cognitive impaired, patients would be unable to respond to screening questions. The TEP member also wanted the group to consider the frequency of required screening, as this may cause burden on an already burdened healthcare provider organization.
- A TEP member responded in the chat, “there may be a way to involve Patient Family Advisors or volunteers to help have these conversations and record responses to alleviate some of the burden on the provider”.
- A TEP member commented that if there is cognitive impairment or inability to answer screening questions, it will be important to look at the caregiver or family member for those questions.
- A TEP member responded in the chat that they agree with a minimum frequency, like once a year or two years for full screening.
- Dr. DeSilvey responded, we are also working on ways of utilizing application of critical ICD-10-CM codes for identified social risks as a screening equivalent. Thus, there is no need to screen again if known prior concern and this is re-identified and coded as such. This would reduce burden and redundancy but also allow for the patient to get follow-up for long-standing concerns.
- A TEP member commented in the chat that it’s important to track if the patient declined participation and it will be important to capture that in the measure.

Open Discussion

- A TEP member shared a link in the chat https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01423
- A TEP member asked, "Is this something that should be excluded from the denominator or included in the numerator?" The TEP member shared that a patient may have a valid reason for declining screening question, especially if they’ve experienced trauma.
- A TEP member asked a question in the chat, is the screening followed by referrals to appropriate resources (with tracking)? Without the offer of help, the questions might just heighten vulnerability and make the patient reluctant to answer the questions the next time.
- A TEP member highlighted from an article on the reason a patient may decline screening questions.

Topic #2: Application of Screening Instrument Criteria

Background

- Dr. DeSilvey presented the next topic of discussion, “Application of Screening Instruments Criteria.”
- Dr. DeSilvey explained that during the last TEP meeting three basic conceptual approaches were presented to help the team guide instrument selection for the social

domains and it was decided that option 2 was the best selection due to scientific criteria to screening tools to assess validity; it also required high-grade tools for domains with sufficient high-grade options.

- Dr. DeSilvey stated that the presence of a Gold Standard Instrument- an instrument recognized as the most accurate to encompass the dimensions of the social risk domain. Serves as the benchmark for psychometric testing of other social risk domain-level screening instruments. She also stated the consideration of pragmatics- a brief practical instruments with domain-level social risk identification.
- Dr. DeSilvey presented the 'Social Risk Domain-Level Screening Instrument Selection with a Gold Standard' slide. She explained that step one is encoded, face validity; step two would be to assess if there is a gold standard instrument; step three would evaluate if there are pragmatic instruments tested against the gold standard. Both steps two and three would default to face validity.
- Dr. DeSilvey explained that step four would identify if domain-level instruments meet 70% sensitivity and 70% specificity thresholds which are common scientific conventions.
- Dr. DeSilvey reiterated that one domain: Food Insecurity has a long-standing gold standard methodology that is supported by USDA 18-item Food Security Module, whereas the other domains do not have a gold standard instrument. She explained the Housing of Urban Development is working on a housing insecurity module that will mirror the USDA module.
- Dr. DeSilvey discussed that there is valid brief instruments pragmatic for clinical applications and domain-levels are scorable.
- Dr. DeSilvey discussed the steps for when there is no gold standard. She stated that step one would be to gather LOINC encoded, face valid instruments; step two assesses if there is a gold standard instrument and if not default to face validity; and third step is to consider instrument pragmatism.
- Dr. DeSilvey presented that the Gravity Project recently assessed social risk domain instruments for face validity and maintained domain and sub-domain level VSAC (Value Set Authority Center) value sets with instruments that meet face validity and are encoded in US terminologies (in line with USCDI). She explained that CORE has further assessed domain-level instruments by whether they have the capacity for domain-level scoring resulting in a final set applicable to the ASN measure.
- Dr. DeSilvey discussed the overall approach and that each instrument is analyzed according to how individual domain is met.
- Dr. DeSilvey presented the next slide outlining the instruments that have been identified through this criteria for each of the domains.
- Dr. DeSilvey presented the second discussion question and asked the TEP if they agreed with the application of the criteria. Is there anything we have not considered?

TEP Discussion: Do you agree with our application of the criteria to the identified screening instruments for each domain? Is there anything we have not considered?

- A TEP member commented in the chat regarding validity and asked the question, were the validation studies current with emerging standards as it relates to equity and racial equity? TEP member also shared the following

https://www.healthaffairs.org/do/10.1377/forefront.20200630.939347/full/ and https://jamanetwork.com/journals/jama/fullarticle/2783090

- Another TEP member commented in the chat that they agree with what is being said- that the instruments work for other population is important.
- A TEP member left a link in the chat https://www.healthaffairs.org/do/10.1377/forefront.20210415.305480/full/ and stated that they do think interrogating some of these base assumptions is part of the work of this group (and all researchers, policy makers, etc.).
- Another TEP member responded in the chat agreeing that it is important to think about predictive validity in the future and the links to outcomes.
- A TEP member commented that the items are focused not on homelessness but the fear of homelessness within the next two months. TEP member asked if the gravity project looked at face validity regarding actual homelessness versus the worry of homelessness?
- Dr. DeSilvey commented that worry of homelessness would fall in the category of housing instability as opposed to actual homelessness.
- A TEP member commented in the chat they need to be cautious on having too many instruments.
- A TEP member questioned, when were these studies done? How explicit and intentional were they in thinking about inclusion of social factors (race, ethnicity etc.). TEP member continued to explain the "gold standard" has been effectively known as the "white standard" because it's been for studied on white populations, whereas populations of color and other marginalized populations aren't considered or included in meaningful ways.
- Dr. DeSilvey acknowledged the TEP member's concerns, the need to consistently consider equity, and the cited literature. She furthermore stated that the only gold standard of reference is the all-population USDA Food Security Module which is psychometrically tested to ensure it adequately represents diverse respondents.
- A TEP member commented, as you consider different instruments 'gold standard' or 'face validity' the goal of this measurement is to tie assessments to outcomes, or to improve experiences for patients. TEP members continued to state, when you analyze this data and assess its impact on outcomes, having more instruments becomes a barrier if they're all not collecting the same data.

Topic #3: Accountability For Follow-Up Care

Background

- Dr. Gottlieb provided an overview of the quality measure and stated it should promote follow-up care when a social risk is disclosed, but then posed an overarching question to guide the discussion: what is meaningful follow-up care and how can measures reflect it?
- Dr. Gottlieb continued to state that there's no nationally accepted definitions and classifications for social care interventions; no meaningful follow-up care appropriately varies based on social risk; and little empirical evidence assesses or compares impacts of different interventions.

- Dr. Gottlieb presented and discussed Social Care Interventions Models: NASEM (National Academies of Science, Engineering and Medicine).
- Dr. Gottlieb continued to discuss person-level interventions (adjustment, assistance) and explained the definitions for each of them. She also discussed system-level interventions (alignment, advocacy) and what those interventions mean.
- Dr. Gottlieb discussed the Gravity Project data/value sets build off the NASEM report by expanding person-level "intervention" activities (Adjustment and Assistance) to develop intervention sub-types.
- Dr. Gottlieb presented key considerations regarding interventions and proposed three questions for the TEP to consider: What counts as follow-up? Can intervention be documented using USCDI standards? What is prescribed follow-up timeline?

TEP Discussion: Follow-up after a positive screening.

- A TEP responded in the chat we chose to specify connection to a community resource specifically to avoid creating incentives for a "referral to nowhere."
- A TEP commented in the chat that the patient needs to choose the intervention details.
- A TEP member commented in the chat, it's important to capture system-level interventions but perhaps not as part of these measures. Part of the challenge with a wide range of interventions meeting the numerator requirement is comparing the measure across providers.
- A TEP member commented in the chat, that the member's fear is that "intervention" will devolve to giving the patient a list or a phone number. The point-to-point tracking of the string of connections that needs to be completed for the patient to receive what they need - this is what needs to be documented.
- A TEP member responded in the chat agreeing on specifying a single platform or approach -- but standards like the Gravity FHIR IG are crucial to be able to approach as eCQMs.
- A TEP member commented in the chat they have an intervention that a EHR was thinking about using for the need for financial help with their bill. How it was going to be asked would have destroyed any trust a patient might have had in the system. It is an example of how we ask and how we engage the patient. It shows how one poor question can destroy a patient's trust.
- A TEP member stated that the documentation does need to be specific and regarding the timeline some things do need to be addressed immediately.
- A TEP member commented that there should be a follow up and a timeframe.
- A TEP member commented that follow-up should be included as an intervention and explained that means- was the initial screening adequate in identifying the need, was the person connected to the appropriate resource, and what timeframe was those social needs delivered.
- A TEP member agreed that there needs to be shared decision-making, it doesn't matter what the intervention, frequency, and time.

Open Discussion

- A TEP member commented that they would not worry about the administrative piece if you're trying to track what the care teams do; but if you try to close the loop there may be a lot of expenses incurred.
- A TEP member stated that it's impossible to have an electronic platform close the loop and to be cautious about any standard that would imply one using a technology platform over another due to cost. TEP members commented that special populations like, perinatal would require a different timeframe on follow-up.
- A TEP member responded in the chat that Health Information Exchanges could be core to collecting regional data from various hospitals by flexing their current infrastructure and connections (multiple EHR connections).
- A TEP member commented in the chat that shared problem solving discussions/outcomes should be documented so that the next provider can see the context and follow up.
- Dr. Gottlieb restated the concerns of the TEP regarding referrals to social services, and that patients should define what counts as follow-up. She continued to propose another question to the TEP and asked, if a provider is not being able to ensure that a patient will get housing and other social needs, but had a conversation with the patient regarding this, should it be in the follow-up list?
- A TEP member commented that there should be services to assist the provider in caring for patient's social needs, the provider should not be the centerpiece.
- A TEP member commented that they would be open to other types of activities that health systems can do to remove harm or provide more contextualized, supportive care for the individual.
- A TEP member expressed that they like the idea of a supported, patient-reported outcome until data is collected to close the loop.

Concluding Remarks and Next Steps

- Ms. Dolce thanked everyone and explained the next steps that feedback will be utilized as Yale CORE continues to develop the ASN eCQM measure.
- Ms. Dolce provided a preview of the next meeting and what it will discuss.
- Ms. Dolce also encouraged all TEP members to reach out with any additional feedback or questions via email at: cmsdisparitymethods@yale.edu.

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	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, Ph.D	Vice President, Practice Advancement, American Academy of Family Physicians	Leawood, Kansas
Barbara Kivowitz	Consumer/Patient/Family Caregiver	Los Angeles, California
Roger Lacoy	Consumer/Patient/Family Caregiver	Des Moines, Iowa
Nikolas Matthes, MD, Ph.D, MPH, MSc,	Measure Developer, IPRO	Lake Success, New York
Ned Mossman, MPH	Director of Social and Community Health, OCHIN	Portland, Oregon
Juan Nanez, RN, BSN	Manager of Informatics and Operations, PHIX-Paso Del Norte Health Information Exchange	El Paso, Texas
Marilyn Parenzan, MBA, RHIA, CPHQ	Project Director, The Joint Commission	Oakbrook Terrace, Illinois
Anand Shah, MD, MS	Vice President, Social Health, Kaiser Permanente	Moraga, California
Shannon Simms, MD, Ph.D	Senior Vice President, Data Operations, Vizient Inc.	Chicago, Illinois
Karthik Sivashanker, MD, MPH, CPPS	Vice President- Equitable Health Systems; Medical Director for Quality, Safety, and Equity, American Medical Association; Brigham Health	Norwood, Massachusetts

Name	Title, Organization	Location
Megan V. Smith, Dr.PH, 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
Walter G. Suarez, MD, MPH, FHIMSS	Executive Director, Health IT Strategy and Policy (KP-HITSP), Kaiser Permanente	Washington, DC
Nalani Tarrant, MPH PMP	Deputy 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
Karen Dorsey-Sheares, MD, MHS	Project Director
Amena Keshawarz, PhD	Project Support
Alon Peltz, MD MBA MHS	Consultant, Project Lead
Sarah DeSilvey, DNP, FNP-C	Project Consultant
Elizabeth Triche, Ph.D	Associate Director
Nicole Walton, BS	Research Associate
Faseeha Altaf, MPH	Division Lead
Kojo Danquah-Duah, MPH	Project Manager
Leianna Dolce, BS	Project Coordinator
Stafani Brown	HCDI Consultant
Achaia Logan	HCDI Consultant