

## Measure Applications Partnership (MAP)

Currently selected 2022 MAP Measures Under Consideration (MUC)

Comments submitted re: MUC2022-053, MUC2022-050, MUC2022-098, and MUC2022-111

On behalf of Children's HealthWatch, we applaud the National Quality Forum (NQF) for its work to advance integration of social drivers of health. We are grateful for this opportunity to submit comments for Measures Under Consideration (MUC). We support the MUCs: Screening for Social Drivers of Health (MUC2022-053); Screen Positive Rate for Social Drivers of Health (MUC2022-055); Connection to Community Service Provider (MUC2022-098); and Resolution of At Least 1 Health-Related Social Need (MUC2022-111) – especially given HHS's stated commitment to health equity and CMS's identification of a key measurement gap focused on "measures that reflect social and economic determinants." We note that no other patient-level SDOH measures or equity measures for hospital or clinician programs are under consideration in this measurement cycle.

Children's HealthWatch seeks to achieve health equity for young children and their families by advancing research to transform policy, including through dismantling systems of institutionalized discrimination and inequity at the root of these economic hardships. Our work begins with research through interviewing caregivers of young children on the frontlines of pediatric care, in urban emergency departments and primary care clinics in five cities: Boston, Minneapolis, Little Rock, Baltimore, and Philadelphia. Since 1998, we have interviewed over 75,000 caregivers of children under four years of age and analyzed the data to determine the impact of Health-related Social Needs (individual-level adverse social determinants of health) and public policies designed to address those social risk factors on the health and development of young children and the well-being of their families. Specifically, our research focuses on the following: nutrition, housing, health care, child care, utilities, income and wealth, employment, Adverse Childhood Experiences and Experiences of Discrimination. Our research – in addition to that of others – shows that lack of access to basic needs is associated with poor child health and development, poor parental physical and mental health, higher child hospitalization rates, and learning and behavioral/emotional impairments. Health consequences are often compounded, as they are frequently experienced simultaneously, as a result of limited income and resources.

### ***Regarding MUC2022-053, and MUC2022-050***

Based on decades of our research, and the research of others, we stress the importance and value of measuring social risk factors to identify and address unmet social needs (social needs differ from social risks insofar as they convey the patient's preferences and priorities regarding the social risk) and enable policymakers and agencies such as CMS and other payers to incorporate them in value-based payment models. The measures under consideration (MUC2022-053, and MUC2022-050) also offer a valuable opportunity to provide a foundation for comparable measures for the Medicaid Adult and Child Core Measure Set and guidance for states in their efforts to standardize these data.

The measures have been implemented and tested in the CMS Accountable Health Communities model over five years across 2M+ beneficiaries in 644 clinical sites, including hospital inpatient psychiatric settings. The SDOH screening instrument used in that program has been formally

validated. In the AHC model, screening, navigation, referral, and resource connection are part of the same workflow – to mirror how patients experience the care process in real-time. Thousands of clinical practices across the country are already conducting SDOH screening to identify patients’ unmet social needs (including via [nearly half of CMS’s Innovation Center models](#)) – but have done so to date without the benefit of any formal quality measures, guidance, or tools from CMS.

To minimize the burden on providers and patients – especially those most clinically vulnerable – CMS must enact the same SDOH screening and screen positive measures across federal healthcare payment/quality programs. The benefits of measuring social risk factors far outweigh the burden of data collection and reporting. Numerous studies have shown relatively high acceptability of social needs screening and referral among both patients and providers (<https://bit.ly/3rSik2v>, <https://bit.ly/3rOPIN5>). Initial evaluation of the Accountable Health Communities (AHC) Model found that among navigation-eligible beneficiaries who reported unmet social needs, 41% had one unmet social need and nearly 60% reported having multiple unmet social needs. While research and implementation of social needs screening and intervention has grown substantially over the past decade, providers and health systems struggle with heterogeneous screening tools and interventions. This contributes to absence of consideration of unmet social needs in federal health care policymaking. The prospect of these two measures being utilized would be beneficial because they would both elevate the importance of these issues for health at the federal level and shed much needed light on social risk factors in a standardized way that allows for accurate comparison of data across settings and communities. Furthermore, if these measures are stratified by race and ethnicity, by nativity, and by age, policymakers and agencies will be prepared to effectively target resources and actions that advance health equity and address long-standing disparities in health outcomes.

We urge the MAP to recommend screening and screen-positive rate measures – to act on CMS’s commitment to tackling equity, closing its stated “social and economic determinants” measurement gap, and enacting meaningful measures for patients and providers. Rewarding screening – but not reporting the screen-positive rate – would mask disparities.

***Regarding MUC2022-098, MUC2022-111***

Children’s HealthWatch, alongside other stakeholders, called on CMS to enact SDOH navigation and resource referral measures alongside the SDOH screening measures during the public comment for last year’s NQF MAP process and in responding to CMS’s proposed rules, including the screening measures. The navigation and referral measures data are crucial for highlighting where investment is required in community resources, including healthy food systems, affordable housing, etc.

As we suggested then, we continue to recommend and support creating a paired measure of improvement over time in the specific social risk factors dimensions as a better measure than simply a one-time measure of proportion, again stratified by race and ethnicity, nativity, and age. This improvement measure is similar to what the NQF Measure Incubator project has developed for its food insecurity measures (<https://bit.ly/3pGLZt0>). Further, also aligned with the NQF Measure Incubator project’s insecurity measures, we suggest a paired measure on appropriate interventions that have occurred due to identifying unmet social needs on screening. Interventions need the flexibility to adapt to the local context, resources, and community needs, however, certain core principles and best practices can still be standardized.

Without an intervention-focused measure, we miss opportunities to understand the landscape of programs and interventions that serve the needs of families and coordinate strategies that target or improve interventions.

Any model of care that seeks to measure outcomes should focus measurement and evaluation on providers' and institutions' ability to effectively 1) measure and 2) address Health-Related Social Needs or concerns (e.g., food insecurity, housing instability, and transportation). A report from the National Committee for Quality Assurance (NCQA) describes healthcare organizations' use of both process (i.e., the number of patients screened or referred) and outcome (i.e., an improvement from a baseline, meeting quality targets, impact on health care utilization) measures to evaluate the impact of their overall strategy and specific interventions. This report also notes that the field focuses more on process measures for specific social needs rather than health outcomes and healthcare utilization outcomes. A broad set of outcome measures beyond process measures is an area for further exploration, in which CMS can lead.

It is essential that we not allow the perfect to be the enemy of the good as we move towards equity. Thousands of clinicians -- particularly in underserved communities—are undertaking the hard work of SDOH navigation and referral. These measures will recognize and incentivize these efforts to drive better quality and equitable care.