2023 Medicaid Quality Incentive Measure

Measure 6 **Contact Person**	**Abigail Berube, (206) 216-2544**
Measure Name:	SDOH Screening and Consultation
Measure eligibility:	All hospitals who wish to participate in MQI are eligible to complete this metric. Critical Access Hospitals (CAH) are not eligible to receive the incentive payment.
Why?	2023 is the fourth year that MQI has included a measure pertaining to SDOH screening. Overall, uptake by hospitals of screening for at least 3 core health related social needs has been high and major EHR vendors have released enhancements that make documenting social needs much faster and easier. Previous SDOH measures have been primarily structural, uploading policies and screening questions. Beginning in 2023, this measure will now focus on the process, hospitals will enter the number of patients screened. Future measures may set targets for screening rates, with the goal of working towards universal screening. Last year (2022), hospitals were incentivized to share policies for the "action" or referral outlined in a policy or procedure. Similar to screening, this component has shifted from a structural measure (attestation) to a process measure (count of patients screened positive who received consultation). Additional points will be awarded to hospitals who are able to respond to at least 80% of patients who screen positive. The purpose of this point attribution is to incentivize the thoughtful rollout of screening, to ensure that patients who are screened can also be appropriately supported with staff and resources. While universal screening is the long-term goal, we recognize it takes time and creativity to design and implement effective workflows and community partnerships for addressing patient health related social needs.
Clinical Rationale:	Screening patients is the first step in addressing social needs, a key driver of health. Social drivers of health (SDOH) account for at least 80% of health outcomes. This SDOH metric promotes screening and identification of five core health-related social needs: housing instability, food insecurity, transportation, utilities and interpersonal violence. The goal should be for hospitals to universally screen all patients including patients of all races, ethnicities and patients speaking languages other than English for SDOH needs. As many hospitals are still in the process of scaling up screening efforts, the 2023 measure scoring is not dependent on the percent screened this year. Points are awarded for reporting the proportion of patients screened stratified by race, ethnicity and language; there is no threshold or target this year. In addition, this measure requires that appropriate action be taken when patients screen positive for a health-related social need, such as consultation with case management or social work. The highest number of points will be awarded to hospitals who are able to respond to at least 80% of patients who screen positive. Again, we urge hospitals to thoughtfully scale up screening efforts to be able to respond in a timely meaningful way to needs that are identified.

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	This measure builds on the SDOH MQI measures from previous years by moving away from structural measures requiring attestation and policy evidence to process measures on screening and action. **Selected References:** 1. AHA Screening for Social Needs: Guiding Care Teams to Engage Patients 2. Health Leads Screening Toolkit 3. Core Determinants of Health Screening Tool, aka the "Core 5" 4. CMS Accountable Health Communities Health-Related Social Needs Screening Tool 5. Collaborative Screening: a person-centered approach to gathering information and following up with referrals in health and social service settings 6. Bree Collaborative: Social Determinants of Health and Health Equity Recommendations, 2021 7. CMS Inpatient Quality Reporting (IQR) program, SDOH measure rationale and specifications, 2023
Definition:	SDOH Screening and Consultation measure is comprised of two parts: 1.) Report the number of inpatients screened upon admission or prior to discharge for all of the following core SDOH needs (housing instability, food insecurity, transportation, utilities and interpersonal violence), stratified by race, ethnicity and language. Do not include ED patients who are not admitted. Note: This measure is specific to screening for SDOH in an inpatient setting. For hospitals who are screening in ambulatory settings, if your clinical team is able to review recent SDOH screening results with a patient, the screening may instead be a review and confirmation of current data. 2.) For patients who "screen positive" for a SDOH, report number of patients with documentation showing that action was taken to address the need(s). This may consist of a consultation with case management, social work or a navigator for example. A referral without documentation of whether the referral took place will not be accepted. Hospitals do not need evidence of closed loop communication because access to community information exchanges (CIEs) are not yet widely available. Note: This measure is specific to screening for SDOH in an inpatient setting. For hospitals who are screening in ambulatory settings, if your clinical team is able to review recent SDOH care plan with a patient, the "action" may instead be a review and confirmation of current care plan or making adjustments or updates taking into consideration any new complications.
Included Populations: **Exclusions:**	Pediatrics, adult patients and specialty patients. Exclude patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during

	their inpatient stay. This exclusion pertains to patients who pass away prior to discharge or are transferred out of the hospital.
Fields to be reported:	1.) Report the number of patients screened for all of the following core SDOH needs (housing instability, food insecurity, transportation, utilities and interpersonal violence) prior to discharge over the 6-month reporting period; admitted July 1st to Dec 31st 2023. **Numerator:** The numerator consists of the number of patients admitted to an inpatient hospital and are screened for all of the following five SDOH: Housing instability, food insecurity, transportation needs, utility difficulties, and interpersonal violence during their hospital inpatient stay. **Denominator**: The denominator consists of the number of patients who are admitted to a hospital inpatient stay between July 1st to Dec 31st 2023. **Exclusion**: The following patients will be excluded from the denominator: (1) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay, (2) patients who pass away prior to discharge or are transferred out of the hospital. **Report** the number of patients who "opted-out" of screening and include this data in stratification by race, ethnicity and language (REaL stratification). **Stratification**: Stratify counts by race, ethnicity and language. In QBS, manually enter in the numerator and denominator and count of screening "Opt-outs." Upload an Excel file with the screening rate and opt-outs stratified by race, ethnicity and language. 2.) For patients who "screen positive" for a SDOH, report on number of patients with documentation showing that action was taken to address the need(s). This may consist of a consultation with case management, social work or a navigator for example. Note, an order or referral is not sufficient to count as "action taken." Note, if hospital stay is very brief, the action can take place immediately post-discharge. **Option 1:** Run report for patients who screen positive for SDOH and look for referral triggered. Validate through query of the notes if the consult took place or if follow-up happened with a community service provider. **Option 2:** Audit a random sample of 60 charts for patients who screened positive between July 1, 2023 and December 31, 2023 and review to note who received consults or warm handoffs to community service providers. In QBS, manually enter the **numerator** of patients who screened positive and received a consult or warm handoff and **denominator** of patients who screened positive for SDOH. Include **upload** of excel file with stratification by race, ethnicity and language.
Data Collection period:	July 1, 2023 - December 31, 2023
Reporting deadline:	30 days after the close of the performance period or by January 31, 2024

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Audits and validation: Do not change	Data are subject to audit by the state. WSHA will not audit but will complete a few basic validity checks.
Submission Frequency:	Once during the performance period from July 1, 2023 to December 31, 2023. Submit between January 1st 2024 and January 31, 2024. *May lock the ability for early submissions prior to Jan 1 *Potentially give until Feb 15th to submit (signoff needed from WSHA)
Data collection system:	Washington State Hospital Association Quality Benchmarking System, QBS.
Data Scoring:	To receive all 10 points: • Count of patients screened (numerator), count of inpatients (denominator), count of opt-outs and upload of stratification by REaL: 4 points Note: There is no screening threshold. Points this year are awarded for submitting this data, not for the percent screened. • Count of patients screened positive with action (numerator), count of patients screened positive (denominator) and upload of stratification by REaL: 4 points • If at least 80% of patients screened positive have received action: 2 points

Thresholds	Count of patients screened (numerator), count of inpatients (denominator), count of opt-outs and Upload of stratification by REaL:	Count of patients screened positive with action (numerator), count of patients screened positive (denominator) and Upload of stratification by REaL	If at least 80% of patients screened positive have received action
Point Awards 2023	4 points	4 points	2 points