

SUMMARY OF NATIONAL ACTIVITY ON IDENTIFYING
AND ADDRESSING HEALTH-RELATED SOCIAL NEEDS

OVERVIEW

This issue brief reviews the current national landscape of activity related to collecting data from patients about health-related social needs. It is a companion brief to new MN Community Measurement (MNCM) issue briefs summarizing results from a recent survey of medical groups in Minnesota about their [current activities and priorities](#) for data on social risk factors and [lessons learned](#) from MNCM's collection of data on race, ethnicity, language, and country of origin.

In part due to the COVID-19 pandemic and increased attention to disparities in health outcomes that are influenced by disparities in economic and social circumstances, there is currently high interest in identifying and addressing health-related social needs, both in Minnesota and nationally. Minnesota has been recognized as a national leader in its data that identify disparities in health outcomes by race, ethnicity, language, and country of origin, and much of this success has been due to convening stakeholders to agree on common definitions and best practices. Minnesota is well positioned to be successful in a similar way with collection and aggregation of data on health-related social needs but must undertake this work with understanding of the national context in order to align with emerging national priorities and standards where possible.

This issue brief summarizes current national activity related to common approaches to identifying and addressing health-related social needs. It also discusses some of the key gaps in evidence and where future research is needed to add to the evidence base about identifying and addressing health-related social needs.

There is a substantial amount of activity on health-related social needs at the national level, on a variety of fronts

The current national landscape of activity encompasses work around screening patients for health-related social needs, common ways of coding and exchanging data, and emerging expectations for accountability through quality measurement and reporting. Each of these is described briefly below:



Standardized ways of asking patients about risk factors

One way of aligning data collection practices on social risk factors is through standardized patient surveys that to ensure comparability of the topics that are asked about and the way in which questions are asked. There are a number of standardized questionnaires in wide use, such as the PRAPARE¹ and Accountable Health Communities Health-Related Social Needs Screening Tool.² The Social Interventions Research and Evaluation Network (SIREN) at the University of California San Francisco has developed a comparison tool of social needs screening tools, which includes information on the topics included, specific questions asked, languages the survey tool is available in, cost to use the survey (most are free), and other information.³

Agreement on common definitions of key concepts



To successfully harmonize data about health-related social needs from different sources, it is not necessarily the case that everyone would need to collect the exact same information from patients in the exact same way. Efforts are under way nationally to create common definitions of what constitutes a social need, such as food insecurity, by creating crosswalks of commonly used survey tools. Gravity Project⁴ is a nationwide collaborative effort to develop consensus standards for coding data related to social determinants of health in EHR systems. Its scope of work includes not just developing common definitions of what constitutes social need based on patient screening, but also common ways of coding goals, interventions, and outcomes.⁵

Initial priorities for the Gravity Project focused on food security, housing stability and quality, and transportation access. Recent milestones in this effort include 1) the addition of SDOH assessments, goals, problems/concerns, and interventions (e.g., education and referrals) to the Version 2 of the US Core Data for Interoperability in July 2021,⁶ and 2) the addition of ICD-10-CM codes for education, food insecurity, and housing effective October 2021.



Medicare policies and programs

As a major payer for health care in the U.S., Medicare's policies about payment, data collection, and measurement have a significant impact throughout the health care system. In October 2021, the Centers for Medicare and Medicaid Innovation published a white paper⁷ on its updated strategic priorities. As part of CMMI's aim of embedding health equity in every aspect of its payment models, the white paper stated that all new CMMI payment models will require participants to "collect and report the demographic data of their beneficiaries and, as appropriate, data on social needs and social determinants of health."

In December 2021, CMS published its annual list of "Measures Under Consideration" for Medicare's quality reporting and payment programs.⁸ Publication of this list is part of a pre-rulemaking process that informs CMS decisions about which measures to include in its programs through formal rulemaking. Notably, for hospitals and clinicians the list of measures under consideration includes measures of the percentage of patients screened for social drivers of health and the percentage of patients screening positive for social drivers of health. These two measures are currently in use in CMMI's Accountable Health Communities model, and their scope includes food insecurity, housing instability, transportation, utility assistance, and interpersonal violence.

Health plan accreditation and accountability



Other national programs and standards for measurement and evaluation of health plan performance also have the potential to have a significant impact on measurement of health equity and health-related social needs. The National Committee for Quality Assurance (NCQA) is the home of the widely used Healthcare Effectiveness Data and Information Set, or HEDIS. In 2021, NCQA announced plans to first tackle the issue of completeness of data on race and ethnicity in national data sets, beginning with a requirement that health plans stratify five quality measures by race and ethnicity in 2022. Currently, health plans may do so using either direct patient self-reported data or “indirect data” that may be imputed from other sources but must transition over the next few years to direct patient-reported information. On the topic of social needs, a June 2021 issue brief notes that NCQA sees this as an opportunity for future expansion in the scope of HEDIS quality measurement.⁹

Despite high interest and a clear need for action, much is still unknown about the best screening tools, screening strategies, and interventions

While there is little disagreement that social needs contribute to disparities in health outcomes, there are important limitations to the current state of knowledge about social risk factor screening and interventions. For example:

- A recent systematic review¹⁰ of standardized social risk screening tools found that evidence for the validity and reliability of current commonly used tools is generally lacking, indicating the need for additional research in this area.
- The U.S. Preventive Services Task Force has recently noted the need for more evidence about whether screening for, identifying, and addressing social risk factors improves health outcomes.¹¹

Despite these limitations, improving health equity by addressing “upstream” factors that contribute to health disparities is a clear priority for health care stakeholders both in Minnesota and nationally. This information about the current national landscape, in combination with results from MNMCM’s medical group survey, provides a guide for future discussion on how stakeholders in Minnesota can make progress together.

This work was supported in part by a grant from the University of Minnesota School of Medicine.



ENDNOTES

- 1 PRAPARE stands for Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences, and was developed by the National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Association. <https://www.nachc.org/research-and-data/prapare/>
- 2 This tool was developed by CMS for use in its Accountable Health Communities payment model. <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>
- 3 <https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison>
- 4 <https://thegravityproject.net/>
- 5 Much of this work is happening through forums focused on interoperability of health care data. A major milestone was publication of the SDOH Clinical Care Implementation Guide first published in August 2021 by HL7 International and the Gravity Project, available at <http://build.fhir.org/ig/HL7/fhir-sdoh-clinicalcare/>
- 6 <https://www.healthit.gov/isa/sites/isa/files/2021-07/USCDI-Version-2-July-2021-Final.pdf>
- 7 Centers for Medicare and Medicaid Innovation. Innovation Center Strategy Refresh. 2021. Retrieved from <https://innovation.cms.gov/strategic-direction-whitepaper>
- 8 Centers for Medicare and Medicaid Services. List of Measures Under Consideration for December 2021. 2021. Retrieved from <https://www.cms.gov/files/document/measures-under-consideration-list-2021-report.pdf>
- 9 National Committee for Quality Assurance. Health Equity and Social Determinants of Health in HEDIS: Data for Measurement. 2021. Retrieved from <https://www.ncqa.org/about-ncqa/health-equity/health-equity-and-social-determinants-of-health-in-hedis-data-for-measurement/>
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