Contents

Introduction:

This measurement strategy document outlines the framework for evaluating the effectiveness of the Social Determinants of Health (SDOH) Learning Collaborative (SDOHLC) for participating acute care hospitals in New Jersey. The intended strategy is to build upon the existing QIP-NJ pay-for-reporting measures of the Use of a Standardized Screening Tool for Social Determinants of Health for both Behavioral/Maternal Health Patients (BH11/M009) and accelerate improvement in creating effective referral pathways with service providers. SDOHLC planners have defined a set of process-oriented and outcome measures to serve in the SDOH LC measurement strategy that will support hospitals through a continuous quality improvement process.

These measures should allow teams to identify if the practice changes they test have the desired outcome to improve SDOH screening or connection to services. Therefore, attention has been paid to selecting measures that are impactful with suggestions for feasible, small scale data collection that can be reported monthly to reflect the impact of changes tested in real-time. The measures defined below are a strategic sample of measures and do not represent all measures that teams might decide to track to show impact of their work. Hospital teams are encouraged to identify additional measures unique to their systems to enable them to track the impact of their changes on the ground. These measures are intended for learning, not participating in health systems' judgement. Therefore, teams are encouraged to adapt the measures to their systems in ways that allow them to gather useful insight into the impact of their improvements.

This measurement strategy document details the required measures that all participating teams will be expected to report on and the frequency of collection/reporting, throughout the SDOHLC. More frequent data collection will accelerate your improvement and help your team get the most benefit from the SDOHLC but is not tied to funds earned in the pay-for-performance QIP-NJ program. You can find an operational definition and guidance for data collection and reporting for each measure. The measures selected for inclusion in the SDOHLC measurement strategy were based on the literature, recommendations from an interprofessional panel of experts convened in Spring 2024, and the results of a feasibility assessment performed by two participating hospitals. As more teams begin to collect data, the SDOHLC faculty will continue to revise the guidance around data collection to spread best practices and ameliorate challenges. Any revisions, suggestions or best practice recommendations that lead to a new version of this document will be communicated to hospital teams.

AIM

By May 2025, NJ acute care hospitals participating in QIP-NJ will ensure that at least 50% of patients with an identified social need subsequently initiated services to address that need within 30 days of discharge, ensuring that patients received a trauma-informed and culturally humble care experience at all stages of care.

Hospitals will choose to focus their efforts on at least one of the following domains based on the greatest need at your hospital:

- Housing Supports
- Meal Supports
- Transportation support

How can a team define what level of services would adequately address a patient's needs in each domain?

Teams should strive to have patients themselves define what level of services they need in each domain to meaningfully address their own needs. Program planners have provided the following suggestions to help teams envision and plan to provide a meaningful level of support in our key domains of focus.

Housing Supports:
A patient is connected to either permanent, transitional or emergency housing services which can include an actual shelter, rental assistance or eviction assistance. Connections ideally take place with a warm handoff. Consider establishing connections for patients with Continuum of Care (CoC) housing agencies who have capacity. Note that each agency has varied eligibility criteria and the eligibility criteria of the organization you attempt to establish a relationship with during the Collaborative may impact how you collect data and which sub-populations you focus on in your improvement efforts to establish more successful connections to services. For instance, if an organization focuses on veterans this may be the population you focus your tests of change and data collection on in this short-term Collaborative.

Meal Supports:
This could include medically supported meals, healthy meal delivery and connection to food benefits like SNAP and WIC. Hospital teams should be prepared to provide emergency meals and vouchers to patients and families, in addition to connecting patients to long term support through programs like SNAP / WIC. For patients not eligible for SNAP / WIC, teams should consider identifying additional community-based resources that provide meal and food support.

Transportation Supports:
Transportation services should consider access to general care providers like taxi/Uber/Lyft in addition to wheelchair, ambulance and other accessible modes of transport. Transport should be arranged for all scheduled or planned appointments. If a patient takes public transportation, clear instructions in the patient's preferred language must be provided and the care team should inform the patient of the cost of travel and assure that the patient can afford that cost of travel, providing vouchers or other options if the cost is not affordable.

SDOHLC Tasks and Relationship Building Roadmap

*Adapted from Oaks Integrated Care "Building Effective Relationships with Community Partners- Key Steps From the Field" presentation from the QIP-NJ Behavioral Health Learning Collaborative in 2021 (Session Recording Available for SDOH LC Participants Upon Request).

July 2024

Pre-work Tasks:

- ❑ Form a Team
- ❑ Hold First Team Meeting *(Pre-work Handbook Appendix C)*
- ❑ Begin to identify the domain(s) your team will focus on and identify potential community partners
- ❑ Perform System Review *(Pre-work Handbook Appendix B)*
- ❑ 7/31 Attend Data Collection and Measurement Strategy Guidance Webinar

Aug 2024

Pre-work Tasks:

- ❑ Collect Baseline Data *(See Measurement Strategy)*
- ❑ Conduct stakeholder experience *interviews (Pre-work Handbook Appendix D)*
- ❑ Review and plan Change Package strategies with team

Sept 2024

Learning Session 1!

Pre-work Tasks:

- ❑ Register team members for Learning Session 1 (LS1)
- ❑ Complete and submit Storyboard for LS1
- ❑ Conduct stakeholder interviews *(Pre-work Handbook Appendix D)*
- ❑ Submit Baseline Data

Oct 2024

Tasks:

- ❑ Submit monthly data
- ❑ PDSA cycles on Change Package strategies

Milestones:

- ❑ Reach out to CBO partner(s) to establish relationship
- ❑ Identify key CBO contacts, schedule initial meeting, define roles
- ❑ Establish shared vision and goals with CBO

Nov 2024

Tasks:

- ❑ Submit monthly data
- ❑ PDSA cycles on Change Package strategies

Milestones:

- ❑ Establish and test Referral Workflows with CBO
- ❑ Consider sustainable data tracking methods with CBO partner

Dec 2024

Learning Session 2!

Tasks:

- ❑ Submit monthly data
- ❑ PDSA cycles on Change Package strategies

Milestones:

- ❑ Improve Referral Workflows with CBO with eye towards sustainability
- ❑ Consistent communication and meetings with CBO partner

Jan 2025

Tasks:

- ❑ Submit monthly data
- ❑ PDSA cycles on Change Package strategies

Milestones:

- ❑ Improve Referral Workflows with CBO with eye towards sustainability
- ❑ Consistent communication and meetings with CBO partner
- ❑ Begin plan for data sharing agreement or MOU

Feb 2025

Tasks:

- ❑ Participate in final outcomes event

Milestones:

- ❑ Ensure and further plan for sustainability of progress!

Measures and Definitions- Social Determinants of Health Learning Collaborative

We strive to find alignment and leverage the value of existing data collection requirements to support the SDOHLC. There are a total of four measures in the SDOHLC to help us evaluate progress to our aim. In the SDOHLC, the measures are split into two categories Quantitative & Qualitative Measures. Ideally, all teams will report on each of our quantitative and qualitative measures in the SDOHLC every month.

Quantitative Measures: These measures involve collecting data expressed in numerical terms. They focus on objective and measurable outcomes that can be easily compared and analyzed statistically.

Qualitative Measures: These measures capture non-numeric data, such as descriptions, experiences, milestones accomplished or opinions. They provide a deeper understanding of the "why" behind the numbers in the quantitative measures.

Legend: **Quantitative Measures** | **Qualitative Measures**

Quantitative Measures

	Measure	Measure Definition	Measure Type	Suggested Data Collection Strategies
1	Completion Rate for Follow-Up Services after SDOH screening	Denominator: Number of patients who had an identified social need from a (positive) screening, who accepted help, and were subsequently referred to the appropriate services. Numerator: Number of referred patients who attended scheduled follow up appointments or began receiving services after an SDOH screening identified social needs within 30 days of discharge from the ED or in-patient settings (general and/or OB). **Allowable Exclusion: Patients who did not accept help with services**: It is acknowledged that there may be patients who screen positive but choose not to accept help. If this constitutes a large percentage of your population, it is recommended that your team reviews and understands the underlying reasons. This could be a target area for patient experience data collection.	Process, Monthly reporting	Source: SDOH screening data, EHR, Patient Follow up surveys, Provider reports, collaboration with Community Organizations. **Step 1: Identify patients for denominator.** Option 1: Sample 20-30 patient charts from the EHR who meet the denominator criteria. Option 2: Analyst produced roster of all patients screening positive with a referral. **Step 2: Identify a strategy to access numerator data.** Option 1: Partner with a Community Based Organization (CBO) to establish a feedback loop for gathering data. Option 2: Implement a shared data platform to track population success towards the measure. Option 3: Incorporate targeted questions into existing post-discharge patient outreach practices to collect patient reported outcomes. **As a collaborative we encourage teams to stratify data by payer, housing status, race, ethnicity, sexual orientation etc. whenever possible, as noted in the Change Package)*
2	Patient Experience	Teams will report the number of individuals they received patient experience feedback from. (so, no numerator and denominator, just the total who responded to your patient experience mechanism). *Teams should seek patient experience feedback from those who are screened for SDOH needs. Teams can learn unique and useful information from individuals representing each category: 1. Patient who accepted help. 2. Patient screened positive but did not accept help or referrals. 3. Patient who was referred to services. **Suggested Goal:** The target is to engage with 5 patients per month, from whom you will report concise anecdotal insights gathered during patient discussions. ****Please see appendix D of the Prework Handbook for more information on guiding questions for conversations with patients.**	Outcome, Monthly Reporting	**Option 1**: Asking a targeted set of patients who were screened from the denominator for Measure 1, who were referred to services (perhaps through established outreach phone calls) **Option 2**: Organization (perhaps a CBO) who you've built a relationship with, asking patient experience questions. **Option 3**: Circulated survey If Option 1-3 is not possible, the fallback option is to use: The hospital-level sum of the CTM-3 scores for all eligible sampled individuals. Hospitals may submit results from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and/or Experience of Care and Health Outcomes (ECHO) surveys in lieu of administering an independent survey. *This refers to the pay-for-reporting* QIP-NJ Measure *(BH11/M009). *If selecting this option, discuss with your team about how this generalized patient experience data source will impact your month-to-month practice change process in this Collaborative, recognizing that this data does not specify those who were screened or connected to services for SDOH needs.*

Qualitative Measures

	Measure	Measure Definition	Measure Type	Suggested Data Collection Strategies
3	Establish Relationship with Community Organization who Provides Most Needed Services	Establish a relationship with at least one CBO that provides services in 1 of the 3 domains. Teams will work together to identify characteristics of an effective and strategic relationship to denote that the milestone was achieved (i.e., key contacts established, goals defined, workflows defined, MOU/BAA signed, data sharing agreement). An established relationship, we are defining as: an organization that is able to meet the needs of your patients based on your identified domain of interest, where clear and consistent communication is maintained between the hospital and CBO. Please review the Change Package section 3 "3. Establishing Referral Protocols with Networks of Strategic Partners." Sample question that we will ask on monthly data collection form: {Yes/No} Did you have a meeting with key stakeholders/key contacts from your community organization in the past month?	Qualitative reporting on process measures	Source: Maintain database to track contacted organizations, monitor services provided and usage rates with key contacts.
4	SDOH Training for Staff	Establish and complete training for 100% of staff engaged in SDOH screening and connection to services including all front-line staff. This would be a training highlighting adherence to best practices/policies/protocols that also include a trauma- informed approach and teaches cultural humility. See additional guidance in the Change Package section 4: "Staffing and Coordination."	Process, Milestone	Source: Attendance records, pre post training assessments, database of training schedules and completion statuses.

Appendix

Supplemental Measures: The supplemental measures are meant to be additional data points that complement and further support your ability to track progress in the Collaborative aim and in QIP-NJ larger portfolio of pay-for-performance measures. These measures are not required for reporting in the Collaborative but provide an opportunity for teams to track progress, further align with QIP-NJ P4P measure improvement, identify areas of success that may help gain leadership buy-in or demonstrate ROI, and make targeted interventions where necessary.

	Measure	**Measure Definition**	**Measure Type**	**Data Collection Strategies** **(this is where we can consider guidance on sources to pull data elements, sampling strategies, analysis strategies like universal analysis, hot-spotting by zip code, group based risk IDs like by a diagnosis etc).**
5	Use of a Standardized Screening Tool for Social Determinants of Health	Behavioral Health: For the BH population served, the percent of individuals 18 to 64 years of age who have received a screening using a validated tool including SDOH domains identified by the State. Maternal Health: Of the birthing individuals who delivered at the hospital during the measurement period, the percent of individuals who have received a screening using a validated tool including the five SDOH domains identified by the State: Housing, Food Security, Transportation, Social Supports, and Domestic Violence.	Process, Monthly reporting	This is a required pay-for-reporting QIP-NJ Measure **Option 1:** Sample 20-30 patient charts from the EHR, regardless of domain. **Option 2:** Report specifically on the number and % of individuals screened in your chosen domain(s).
6	30- Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization	Denominator: Of the hospital's attributed behavioral health population, eligible index admissions with a principal diagnosis of a psychiatric disorder (Table BH01_00). Numerator: A readmission is defined as any "unplanned" admission to an ACH. Hence, the numerator is defined by filtering out "always planned" and "potentially planned" diagnoses and procedures. It must occur within 3 to 30 days after the index discharge date from the eligible index admission date that had the principal discharge diagnosis of a psychiatric disorder QIP-NJ pay-for-performance measure BH01: Databook_v3_2 REDLINE_FOR_POSTING.pdf (nj.gov)	Outcome, Milestone-based	This is a required pay-for-reporting claims -based QIP-NJ Measure Source: EHR **Option 1:** Focus on subset of individuals who were screened (denominator) vs screened positive (numerator)
7	Follow-Up After Emergency Department (ED) Visit for Substance Use or Mental Illness (30-day)	Denominator: An ED visit (BH03_DetailOID->ED Value Set) with a principal diagnosis of SUD (BH03_DetailOID-> AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the MY where the individual was 18 years of age through 64 years of age on the date of the visit.	Outcome, Milestone based	This is a required pay-for-reporting claims -based QIP-NJ Measure For all options presented, teams can either perform a chart audit on a small sample of 20 patients or build a

		Numerator: An SUD use treatment follow-up visit (AOD Treatment Service Follow-up CPT/HCPCS Value Set) with any provider, within 30 days (31 total days) after emergency department discharge with a principal diagnosis of SUD. Include visits that occur on the date of the ED visit. Claims must have the appropriate modifiers to indicate substance use treatment services, as identified in the AOD Treatment Value Set. QIP-NJ pay-for-performance measures BH03 and BH04: Databook_v3_2 REDLINE_FOR_POSTING.pdf (nj.gov)		report from the EMR to capture more patient records if possible. **Option 1**: Accessing Data from an Available Health Information Exchange (HIE) **Option 2:** Report Data from Hospital Based or System Based Clinic **Option 3:** Using Deidentified Aggregate Data from Community Partner(s)
8	Postpartum Care (PPC)	Denominator: Individuals who delivered a live birth on or before October 7th of the MY. Include birthing individuals who delivered in any setting except hospice. Numerator: Individuals who had a postpartum visit on or between 7 and 84 days after delivery. QIP-NJ Pay-for-performance measure M004: Databook_v3_2 REDLINE_FOR_POSTING.pdf (nj.gov)		This is a required pay-for-reporting claims -based QIP-NJ Measure For all options presented, teams can either perform a chart audit on a small sample of 20 patients or build a report from the EMR to capture more patient records if possible. **Option 1**: Accessing Data from an Available Health Information Exchange (HIE) **Option 2:** Report Data from Hospital Based or System Based Clinic **Option 3:** Using Deidentified Aggregate Data from Community Partner(s)

Selection of Sources Used During Development:

2024-specs-(SDOH)-2023.12.29.pdf (oregon.gov)

Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care | ACOG

A qualitative assessment of barriers and facilitators associated with addressing social determinants of health among members of a health collaborative in the rural Midwest | BMC Health Services Research (springer.com)

Social Needs and Social Determinants: The Role of the Centers for Disease Control and Prevention and Public Health - Karen Hacker, Debra Houry, 2022 (sagepub.com)

20201009_SDOH-Resource_Guide.pdf (ncqa.org)