



# Screening for Social Risk Factors Part 2: Developing a Screening Measure

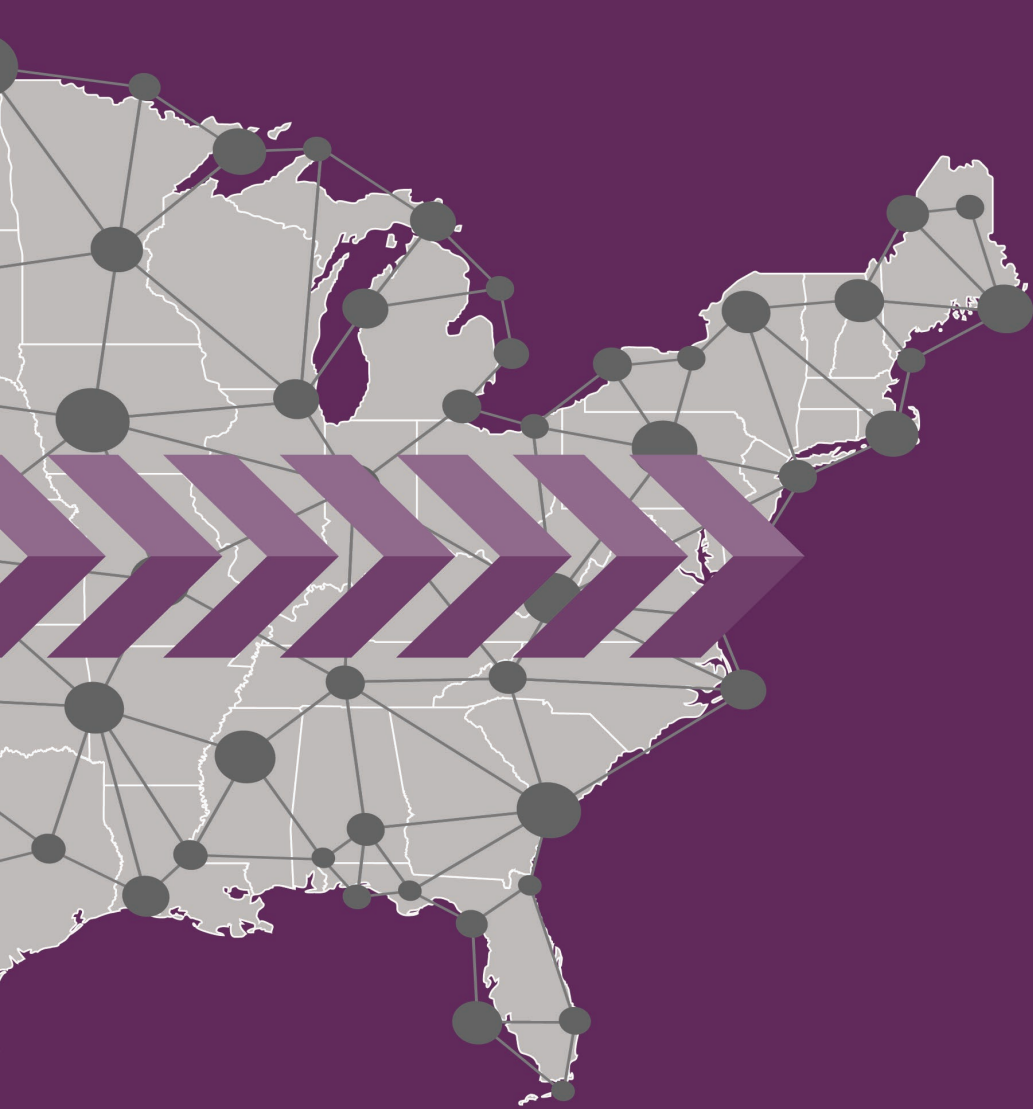
November 16, 2020 3:00 – 4:00 PM EST

*Please stand by, this webinar will begin shortly*

**STATE**  
Health & Value  
**STRATEGIES**

*Driving Innovation  
Across States*

*A grantee of the Robert Wood Johnson Foundation*



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Bailit Health

November 16, 2020

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# About State Health and Value Strategies

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State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at [www.shvs.org](http://www.shvs.org).

**Questions?** Email Heather Howard at [heatherh@Princeton.edu](mailto:heatherh@Princeton.edu).

*Support for this webinar was provided by the Robert Wood Johnson Foundation.  
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# Welcome

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All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **[www.shvs.org](http://www.shvs.org)**.

# Webinar Presenters

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**Michael Bailit**

**President  
Bailit Health**



**Clara Filice, MD**

**Deputy Chief Medical Officer  
MassHealth**



# Companion Briefs

- *Social Risk Factor Screening in Medicaid Managed Care*
  - An introduction to screening Medicaid managed care members for social risk factors
- *Developing a Social Risk Factor Screening Measure*
  - The focus of today's webinar



# Agenda

What are Social Risk Factors & Why Screen for Them?

Selecting a Social Risk Factor Screening Measure

Key Considerations in Selecting or Designing the Measure

Measure Evolution

Conversation with Clara Filice



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# What are Social Risk Factors (SRF)?

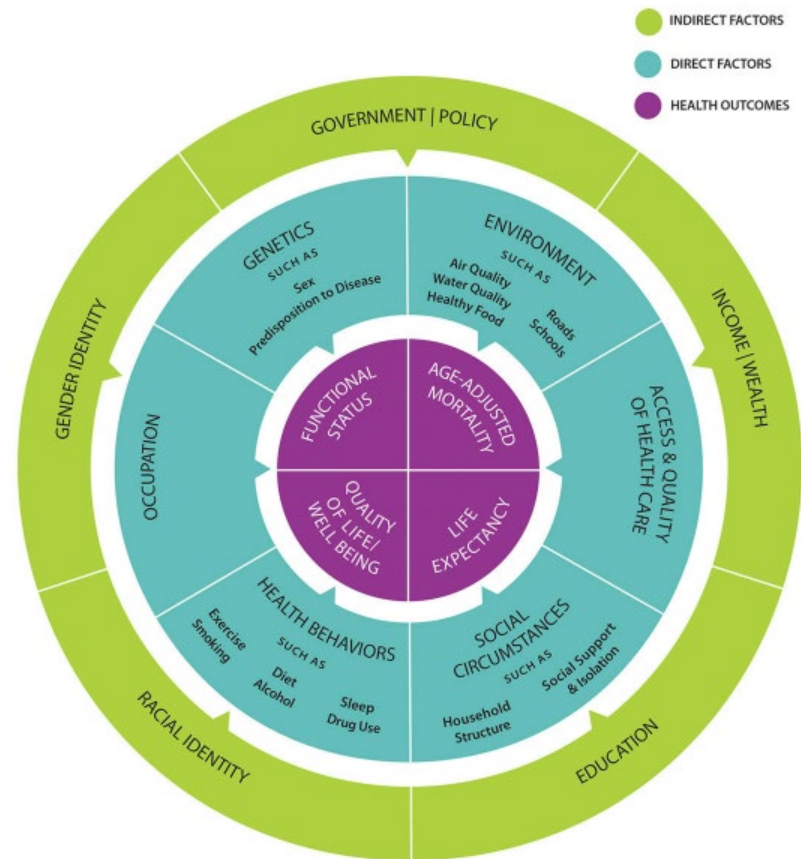
- State Medicaid agencies are increasingly recognizing the impact that non-medical factors, such as social needs, have on health.
- SDOH, or “conditions under which people are born, grow, live, work, and age,” impact populations. SDOH can be positive or negative.
  - Examples include housing and food
- SRFs are the harmful impacts that individuals experience.
  - Examples include homelessness and food insecurity



# Why Screen for SRFs in Medicaid Managed Care?

- Certain groups, like low-income individuals and Black, Indigenous and People of Color, disproportionately experience SRFs, leading to health inequities and increased health care costs.
- **Screening is a first step to identifying SRF.**
- By intervening on SRFs, we potentially can improve health, reduce health inequities, and decrease health care costs.

- Health is influenced by:



# Why Measure Social Risk Factor Screening?

- State Medicaid agency interest in the impact of social determinants of health on the health status of Medicaid beneficiaries has surged in recent years.
- This heightened interest has led states to stipulate performance requirements of their contracted managed care organizations (MCOs) and accountable care organizations (ACOs) to identify and mitigate social risk factors affecting individual members/patients.



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# Four States Engaged in Screening Measure Development

State	Measure Name	Purpose
MA	Health-Related Social Needs Screening	The measure was first implemented in 2018 as part of the Medicaid ACO quality measure slate, with performance implications for payment beginning in 2020.
NC	Screening for Social Determinants of Health	Will be used in the state's Medicaid managed care program contract after it becomes effective in July 2021.
OR		To be used in the state's coordinated care organization contracts. Currently under active development.
RI	Social Determinants of Health Screening	Used in the state's accountable entities (AE) program for Medicaid members. Initially used for calendar year (CY) 2017 reporting. Modified measure for CY 2020 will moving from pay-for-reporting to pay-for-performance status in CY 2021.

# Selecting a Social Risk Factor Screening Measure: Make, Borrow or Adapt?

- As of now, those looking to use a social risk factor screening measure can:
  1. Borrow from MA, NC, or RI
  2. Modify one of their measures
  3. Develop your own measure





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# Key Considerations in Selecting or Designing the Measure

- There are nine key questions states may wish to consider in selecting or designing their measure.
- Some decisions states make initially may change over time as best practices are identified. As of yet, there are no established best practices.

# Selecting or Designing the Measure: Nine Key Considerations

## 1. How should the measure denominator be defined?

- Total population, with or without limited exceptions (*used by NC, MA, and RI*)
- Only enrollees with an outpatient visit, with or without limited exceptions
- Only enrollees with a primary care visit, with or without limited exceptions (*used by RI beginning in 2020*)

## 2. Should states specify the use of one tool or allow use of any state-approved tool?

- Specify a tool (*used by NC; allows for supplemental questions*)
- Approve use of a tool (*used by MA and RI*)
- Require that a tool includes specific questions and allow for supplemental questions

# Selecting or Designing the Measure: Nine Key Considerations

- 3. For which social risk factor domains should MCO/ACOs be required to screen (if a single tool is not specified)?**
- Require that the tool only include questions for specific domains
  - Require inclusion of some domains and provide an option for including others (*used by MA, NC, and RI*)
  - Require the selection of a set number of domains from a list of options (menu approach)
  - Do not have any requirements with regards to domains

The most commonly used screening tools include the following domains: 1) food, 2) housing, 3) safety/ interpersonal violence, 4) transportation, 5) utilities.

# Selecting or Designing the Measure: Nine Key Considerations

## 4. Should the MCO/ACO screen by individual or by household?

- The individual enrollee (*used by MA, NC, and RI*)
- The household within which the enrollee resides
- A combination: for example, if the enrollee is a young child, then the screening entity can complete a household screen (*used by RI beginning 2020*)

## 5. Where should the screen be performed?

- Primary care physician's (PCP) office
- PCP office and other clinical settings
- Clinical and non-clinical settings (*used by MA, NC and RI*)
- Non-clinical settings

# Selecting or Designing the Measure: Nine Key Considerations

## **6. What should be the source of the data to calculate the measure?**

- Administrative data
- Clinical data (*used by MA and RI*)
- Care management data, collected by an MCO or delegated entity (*used by NC*)

## **7. How should data for the measure be collected?**

- A sample (*used by MA and RI*)
- The full population (*used by NC; used by RI beginning 2020*)

# Selecting or Designing the Measure: Nine Key Considerations

## 8. Who should calculate the measure?

- ACO
- MCO (*used by RI*)
- State/vendor (*used by MA and NC*)

## 9. How should screen completion be captured in the electronic health record?

- Require documentation of screening in a care management platform or health record with no specific requirement that data be included in the EHR (*used by MA and NC*)
- Complete screen (Yes/No indicator)
- Complete screen (Yes/No) plus attachment of full results (*used by RI*)
- Complete screen (Yes/No) plus embedded full results (*used by RI*)
- Complete screen (Yes/No) plus notation of any flagged screen items in EHR



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# Measure Evolution

- The implementation of a screening process measure facilitates the development of the screening infrastructure that, in turn, makes it possible for ACOs and MCOs to identify and address enrollees' social risk factors.
- States may have additional goals, that would require moving beyond the process of screening:
  - Informing efforts to prioritize resources/initiatives to address social risk factors
  - Gathering member-level data to inform risk adjustment based on social risk factors for ACOs and MCOs
  - Connecting more members with resources to address social risk factors

# Other Potential Social Risk Factor-Related Measure Development Areas

Area	Potential Measures
Documenting screening results	<ul style="list-style-type: none"><li>•% of complete screening results submitted to the state (denominator: total population OR of screens conducted)</li><li>•% of individuals that had a positive screen for a domain (e.g., homelessness) (denominator: the population screened for that domain)</li></ul>
Responding to screening results – process measures	<ul style="list-style-type: none"><li>•% of members with a positive screen that received a referral to a community-based organization (CBO) (denominator: those with a positive screen)</li><li>•% of members with a positive screen that received community services (denominator: those with a positive screen)</li></ul>

# Other Potential Social Risk Factor-related Measure Development Areas

Area	Potential Measures
<b>Responding to screening results – outcome measures</b>	<ul style="list-style-type: none"><li>•% of members who no longer have a positive screen or have a reduced risk at a defined follow-up time [e.g., one, two or five year(s)] after receiving an initial positive screen (denominator: those with a positive screen)</li> <li>•% of members with improved health measures at a defined follow-up time [e.g., one, two or five year(s)] after baseline screen (denominator: those with a positive screen)</li> <li>•% of members with lower health care costs measured at defined follow-up time [e.g., one, two or five year(s)] after baseline screen (denominator: those with a positive screen)</li></ul>



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# Discussion

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# Thank You

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