Developing a Social Risk Factor Screening Measure

Authored by Bailit Health

STATE Health & Value STRATEGIES
Driving Innovation Across States
A grantee of the Robert Wood Johnson Foundation

October 2020

Introduction

State Medicaid agency interest in the impact of social determinants of health on the health status of Medicaid enrollees has surged in recent years. Social determinants of health (SDOH) are defined as "the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[1] SDOH can be positive or negative—for example, increased education is associated with better health outcomes while limited education is associated with lower earning potential and poor health outcomes.[2] Social risk factors have a narrower meaning. They are defined as "specific adverse social conditions that are associated with poor health, like social isolation, lack of transportation access, utility insecurity, or housing instability."[3]

States have begun 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.[4,5] To aid the identification process, some states have begun to recommend—and sometimes require—their contractors perform social risk factor screens. MCOs and ACOs can elect to perform the screening or assign that task to a contracted entity or entities. To ensure enrollees are being screened, states are looking to assess compliance with the screening requirement, regardless of which entity performs the screen. There are no nationally established measures to assess screening rates at the present time, however. This has led a few states to design their own measures.

This brief is designed as a resource for states looking to adopt a measure to assess social risk factor screening rates. It is the result of a series of convenings that the authors facilitated with three states—Massachusetts, Oregon, and Rhode Island—which helped them consider, discuss, and share perspectives related to the development of their own social risk factor screening process measures. We look at the progress these states and North Carolina have made in developing their own social risk factor screening measures and highlight considerations for other states either planning to adopt an existing or develop a new screening measure.

We summarize the various state approaches, examine differences in methodologies and walk through key questions that states may want to consider, including:

1. How should the measure denominator be defined, i.e., who should be screened?
2. Should states specify the use of one tool or allow use of any state-approved tool?
3. For which social risk factor domains should MCOs/ACOs be required to screen (if a single tool is not specified)?
4. Should the MCO/ACO screen by individual or by household?
5. Where should the screen be performed?
6. How should screen completion be captured in the electronic health record?
7. What should be the source of the data to calculate the measure?
8. How should data for the measure be collected?
9. Who should calculate the measure?

The scope of these convenings was narrowly focused on decisions related to the development and implementation of screening process measures (i.e., measures that assess screening rates).

At the outset of the convenings, the states and the authors discussed the goals that can be realistically achieved through the implementation of a screening process such as:

- Encouraging MCOs and/or providers to conduct social risk factor screenings
- Enabling the state to assess compliance with screening requirements
- Encouraging other provider actions, such as incorporating awareness of social risk factor needs into care planning and making referrals to social service organizations to address social risk factor needs

All three states expressed significant interest in moving beyond these initial screening measures in the future in order to achieve broader goals such as:

- Informing efforts to prioritize resources/initiatives to address social risk factors
- Gathering member-level data to inform risk adjustment for ACOs and MCOs based on social risk factors
- Evaluating program impact

The last section of this brief, Measures Evolution, considers additional screening-related measures that could be used to encourage and facilitate achievement of these higher-level goals.

Experience of Four States Engaged in Screening Measure Development: This brief draws upon work initially performed for, and information gathered during, three virtual convenings in 2019 facilitated by Bailit Health on behalf of the State Health and Value Strategies program. The convenings provided a forum for peer learning related to the design and implementation of a social risk factor screening process measure. Three states participated: Massachusetts, Oregon, and Rhode Island. They were selected because all three had previously been identified by the authors as planning to develop, or in the process of developing, screening measures. Following the convenings, the authors learned that North Carolina had also developed a social risk factor screening measure. As a result, some information about its measure design was incorporated into this brief.

Massachusetts, North Carolina, and Rhode Island have all developed measures to assess social risk factor screening by their contracted ACOs (MA, RI) and MCOs (NC). Oregon is in the process of developing a measure for its coordinated care organizations (CCOs). Below are descriptions of the measures used in these four states.

Massachusetts

- **Measure name:** *Health-Related Social Needs Screening*
- **Purpose:** Used in the state's 2018 Medicaid ACO contracts. The measure was first implemented as part of the Medicaid ACO quality measure slate, with performance implications for payment beginning in 2020.
- **Development process:** Developed with input from the State's Delivery System Reform Incentive Payment (DSRIP) Quality Subcommittee of the Quality Alignment Taskforce, the Centers for Medicare & Medicaid Services (CMS), and other stakeholders.

North Carolina[7,8]

- **Measure name:** *Healthy Opportunities Screening*
- **Purpose:** Will be used in the state's Medicaid managed care program contract.
- **Development process:** From 2017 to 2018 a technical advisory group recommended a set of standardized screening questions. To develop its screening questions, North Carolina drew from validated tools, released its draft health screening questions for public comment in April 2018, and field-tested the screening questions at 18 clinical sites. North Carolina's screening questions can be found in **Appendix A**. In time, the state hopes to continue measure development to look at results of the questions and some measure of improvement across domains.

Oregon

- **Measure name:** *Measure not yet developed*
- **Purpose:** To be used in the state's CCO contracts.
- **Development process:** The state's Health Plan Quality Metrics Committee and the Metrics and Scoring Committee prioritized the development of a measure for Medicaid members. A public work group is meeting in 2020 to develop its recommended measure(s).

Rhode Island

- **Measure name:** *Social Determinants of Health Screening*
- **Purpose:** Used in the state's accountable entities (AE) program for Medicaid members. Initially used for calendar year (CY) 2017 reporting, with the measure moving from pay-for-reporting to pay-for-performance status in CY 2021.
- **Development process:** The initial measure was developed by the state. During CY 2019 the state refined the measure's specifications with input from the Department of Health, contracted AEs, and managed care organizations for CY 2020 implementation.

Current versions of the Massachusetts, North Carolina, and Rhode Island screening measures can be found in **Appendix B**.

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

As of the publication of this brief, a state can borrow a measure from Massachusetts, North Carolina, or Rhode Island, modify one of these measures, or develop its own.[9] Adopting an existing measure is surely a less resource-intensive path, but the lack of testing on the existing measures could justify a state creating its own. Regardless of the path selected, it is important for any state seeking to implement a social risk factor screening measure to consider a range of factors when selecting or designing a screening measure. Several of these considerations relate directly to the underlying program requirements. For example, should all enrollees, those who have completed a primary care visit, or those served by an intensive care management program be screened?

Some decisions states make initially may change over time as best practices are developed in this area. As of yet, there are no established best practices. The next section of this brief reviews key measure design considerations.

Selecting or Designing the Measure: Nine Key Considerations

As noted above, we describe nine key design considerations when evaluating or designing a social risk factor screening measure. For each design choice, this brief identifies potential options and describes the decisions made by the states involved in this analysis. **Appendix C** provides additional information about each design choice, including a comparison of advantages and disadvantages.

Design Choice #1: Defining the Denominator – Who Should Be Screened?

The denominator of the measure is the total number of people who meet the criteria for being screened. One state may elect to screen its entire Medicaid population, while another state may identify a subpopulation of its Medicaid members to screen. The following is a list of the populations selected for screening by the four states as well as other options for defining the screened population:

1) Total population *(used by NC)*
2) Total population, with limited exceptions *(used by MA with an exception for enrollees receiving hospice care)*
3) Only enrollees with an outpatient visit
4) Only enrollees with an outpatient visit, with limited exceptions
5) Only enrollees with a primary care visit
6) Only enrollees with a primary care visit, with limited exceptions *(used by RI with exceptions for hospice and patient refusals)*

When contemplating these options, a state should consider whether it wants to capture the state or program's full population, or just those members who have received care (any care or primary care). The answer will depend upon whom the state is holding accountable (e.g., MCO, ACO, or PCP), for what they are being held accountable, and whether the state is using other measures (e.g., patient engagement) to supplement the screening measure.

Massachusetts elected to recommend screening for all ACO-attributed members given the state's program emphasis on outreach and engagement. Conversely, Rhode Island included only those with a primary care visit and is in the process of creating a separate patient engagement measure so as not to conflate patient engagement in primary care with provision of the screen.

Design Choice #2: Specify Use of One Tool or Allow Use of Any State-Approved Tool?

For the purpose of this brief, a tool is an externally developed or state-developed set of structured questions and responses used to screen for social risk factors. (The Social Interventions Research and Evaluation Network's Screening Tools Comparison compares features of several widely used screening tools.[10]) There are four options when establishing requirements for which screening tool to use:

1) Specify a tool
2) Specify a tool and allow for supplemental questions *(used by NC)*
3) Do not specify a tool but require approval of a tool *(used by MA and RI)*
4) Require screening but do not specify a tool

For states, the key consideration is whether to require the use of a specific screening tool, which facilitates the aggregation of screening results across populations, or to allow providers/payers to either continue using existing tools for which they have already established an infrastructure or select their own tool. A compromise solution could be to require specific questions related to some priority social domains, which would facilitate aggregation of those data, but permit more variability in questions used on other topics.

Massachusetts and Rhode Island both elected to allow providers/payers to select the tool contingent on the state's review and approval, since some providers in their states were already conducting social risk factor screenings across their populations using a variety of tools. The states noted that providers tended to use a few common tools, including:

- CMS Accountable Health Communities Health-Related Social Needs (HRSN) Screening Tool[11]
- Health Leads Social Needs Screening Tool[12]
- The National Association of Community Health Centers Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)[13]

These tools all vary in terms of the questions they ask and the response options within individual domains, making it difficult to aggregate data across tools. If a state is interested in collecting screening results information, this process is much easier if the state specifies the screening tool. Review of standard screening tools has shown that they tend to have strong pragmatic properties as the tools are low-cost and easy to use and understand, but weak psychometric properties with limited evidence of validity or reliability.[14]

In addition to the commonly used tools noted above, providers also use homegrown as well as other recognized tools. Massachusetts and Rhode Island reported that they do not see a single predominant tool in their Medicaid ACOs.

In contrast to Massachusetts and Rhode Island, North Carolina opted to create its own social risk factor screening tool. With input from its technical advisory committee, North Carolina developed a list of required questions for a state-developed screening tool, examining research and selecting questions from existing tools. North Carolina permits its MCOs to supplement the standard screening questions with questions about risk factors not included in the tool. A drawback of creating a tool by drawing from elements of one or more tools deemed reliable is that the newly created tool may not be reliable or valid. Since there is not yet sufficient research evidence demonstrating that the currently available SRF screening tools accurately and precisely measure social risk domains, it is important to be mindful of the limitations of these tools and the implications for the quality of the data collected through these tools.

Design Choice #3: Which Social Risk Factor Domains to Require?

Social risk factors are grouped into "domains," including, for example, housing, food, transportation, and social isolation. Should the state decide not to specify a particular screening tool, there are four options states can consider to specify screening of specific domains:

1) Require that the tool only include questions for specific domains
2) Require inclusion of some domains and provide an option for including others *(used by MA, NC, and RI)*
3) Require the selection of a set number of domains from a list of options *(menu approach)*
4) Do not have any requirements with regards to domains

For this design decision, states need to determine whether they want contracted organizations to focus on specific domains or provide organizations with the flexibility to tailor their screening to domains of interest or greatest need. Massachusetts, North Carolina, and Rhode Island have all elected a compromise position and require that screening tools include specific domains while also allowing organizations to include additional domains of interest.

The most commonly used social risk factor screening tools include the following five domains:[15]

a. Food
b. Housing
c. Safety/Interpersonal Violence
d. Transportation
e. Utilities

Table 1. The domains included in the most commonly used social risk factor screening tools compared to those domains required by Massachusetts, North Carolina, and Rhode Island

Domains included in the most commonly used screening tools[16]	MA	NC	RI
Food	*Yes*	*Yes*	*Yes*
Housing	*Yes*	*Yes*	*Yes*
Safety/Interpersonal Violence	*No*	*Yes*	*Yes*
Transportation	*Yes*	*Yes*	*No*
Utilities	*Yes*	*Yes*	*Yes*

Massachusetts, North Carolina, and Rhode Island reported reviewing the research literature to identify the domains with the greatest evidence of impact on improved health outcomes to inform their domain selection process.

Design Choice #4: Screen by Individual or Household?

States have three options to consider when selecting the unit of measurement for screenings:

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

Screens are generally designed to be completed by or on behalf of a specific individual patient or enrollee. That means that a parent or guardian with multiple children would need to complete a screen for each child, even though the social risk factors in most screenings are primarily experienced at the household level. Since this may be considered unduly burdensome, states must weigh reducing the administrative burden versus capturing the specific needs of individuals within a household. For example, if a child is in school, the child may not experience food insecurity due to school food programs, while a preschool-aged child in the same household may experience food insecurity.

In addition, different domains may warrant different levels of screening. For example, housing insecurity is likely to be accurately measured at a household level, but food insecurity, as described above, may vary by individual.

Rhode Island's specifications state that screens should be performed at the individual level for adults and adolescents. For children 12 and under, one screen may be performed for all such children in a household. In contrast, Massachusetts requires screening at the individual level.

Finally, it is worth noting that lack of access to screening results across family and household members and providers may pose barriers to developing a comprehensive picture of a household's social conditions. For example, even if immediate members are part of the same ACO, it can be difficult for a pediatrics provider to view the patient's mother's screening results. In fact, a child's provider may not be authorized to look up the mother's record unless the mother is also a patient of the same provider.

Design Choice #5: Where Should the Screen Be Performed?

Options for the setting of the screening include:

1) Primary care physician's (PCP) office
2) PCP office and other clinical settings
3) All clinical and nonclinical settings *(used by MA, NC, and RI)*
4) Nonclinical setting

The central consideration for this decision is who should be held accountable for screening—the provider or MCO—and if a provider, which provider(s)? Holding the provider accountable facilitates integration of screening information into the medical record and care planning. However, some states may prefer to hold their MCOs accountable for screening given it requires less state supervision.

Massachusetts and Rhode Island each elected to allow screenings in any setting to be counted as a completed screen and included in the numerator. The state's choice was motivated by minimizing the duplication of screenings and, as a result, minimizing question fatigue on the part of members. However, encouraging screening at multiple sites will only reduce duplication of effort if there is good communication and data-sharing infrastructure across entities and if sites share data with one another. Because both states have implemented their measures in ACO programs, they expect most screening will occur in a clinical setting.

In North Carolina, Medicaid health plans are held accountable for completing screening within 90 days of a member's enrollment and thereafter annually.[17] The Medicaid health plans can elect to delegate responsibility to their Tier 3 Advanced Medical Homes, local health departments, or care management entities, but thus far health plans have indicated their preference to conduct the screenings themselves and then share results with the primary care providers and Advanced Medical Homes. The 90-day requirement is consistent with the CMS requirement for MCOs to complete new member needs assessments in that time period. It is North Carolina's intent that health plans will consider unmet social needs when developing care management strategies for all members.

Finally, COVID-19 has resulted in a large-scale expansion of telehealth. For example, Rhode Island decided to add telehealth codes to its measure specifications for 2020. Therefore, when we reference "office" and "other clinical settings," telehealth visits should be included as well.

Design Choice #6: How Should the Screen Be Captured in the Electronic Health Record?

Options for how screening results should be documented in the electronic health record (EHR) include:

1) 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)*
2) Complete screen (Yes/No indicator)
3) Complete screen (Yes/No) plus attachment of full results *(used by RI)*
4) Complete screen (Yes/No) plus embedded full results *(used by RI)*
5) Complete screen (Yes/No) plus notation of any flagged screen items in the EHR

This design decision weighs the interest in making screening results easily accessible to providers against the administrative burden associated with inputting the results into the EHR. It also anticipates building infrastructure for potential future social risk factor-related measurement. For example, some states are considering adding a measure that looks at the prevalence of different social risk factors within the population, which necessitates the capture of individual risk factor screen results in the health record or another location.

Massachusetts requires documentation of screening results in a member's health record, which could include care management software, registries, an EHR, etc. The state offered additional flexibility in the definition of a health record in recognition that member-level data may originate and/or reside in multiple data systems.

North Carolina requires that social risk factors are assessed as part of the care needs screening that will be conducted by the health plans (or their delegated entities) at the time of enrollment and then shared with members' primary care providers within seven days of screening or PCP assignment, whichever is sooner, for documentation. The transmittal format has yet to be determined but will likely be a file containing "yes/no" indicators for each social risk factor question.

Rhode Island requires that the EHR contains the documentation of the completion of a screen, as well as results of the screen. Specifications allow for full results to either be embedded or scanned (e.g., as a PDF attachment) into the record.

Design Choice #7: What Should Be the Source of the Data to Calculate the Measure?

With Design Choice #7 the focus pivots away from defining the screening requirement to constructing a complementary measure to assess screening completion. There are at least three options for the data source:

1) Administrative data
2) Clinical data *(used by MA and RI)*
3) Care management data,[18] collected by an MCO or delegated entity *(used by NC)*

For this design decision, states should consider the documentation of relevant data elements for the population of interest. There are currently challenges to administrative data collection by providers due to the limited utilization of procedure codes. The Gravity Project[19] is exploring the use LOINC and SNOMED codes to document completion of a screen.

Both Massachusetts and Rhode Island rely on clinical data. Such data can be housed in provider-accessible locations, such as the EHR, and can be collected and accessed at the point of care. One complication is that both of these states also permit screenings to be conducted outside of health care provider organizations, for example, by community partners. To be credited for screening completion, non-health care organizations would need to be able to transmit the data back to partnering health systems.

North Carolina will collect its screening data as part of its care management data collection, a process by which all MCO enrollees are screened and assessed for multiple needs, including those related to social risk factors. This process allows for the collection of data for all enrollees, not just those who access care. While North Carolina has allowed MCOs to delegate this process to certain entities, the state reports that all MCOs are currently planning to collect these data themselves.

Design Choice #8: How Should Data Be Collected?

There are two options for the data collection method:

1) A sample *(used by MA)*
2) The full population *(used by NC and RI)*

There are a few considerations when evaluating the options for data collection: a) the burden of data collection, b) the completeness of the data capture, and c) the timeline for implementation. Sampling a subset of the population requires less data capture and reporting infrastructure and can typically be implemented immediately. However, by definition, it does not capture the entire population and it places a significant ongoing administrative burden as the state or plan must identify and collect an appropriate, ideally representative, sample each year in perpetuity.

Collection of data for the whole population carries a significant but different administrative burden. If data are collected at the provider level, providers need to either manually input data into a reporting form or electronically transmit data from their EHR, population health management system, or other clinical repository. The former is laborious, while the latter is technically infeasible for many health systems.

Due primarily to the upfront electronic infrastructure requirements of collecting data on its full population, Massachusetts is currently collecting sample data from its ACOs. In 2020, Rhode Island began to transition from a sample methodology to collecting data for its entire population as the state's MCOs and contracted ACOs implement clinical data exchange capabilities. Once this capability is fully established, Rhode Island will be able to collect screening data by electronically extracting it from provider EHRs. This approach requires significant up-front costs and effort to create the capabilities, but once it is established, it is likely to be far less burdensome on an ongoing basis and more complete than sampling.

Full population data can also be gathered through MCOs. In North Carolina, data may be collected by Medicaid health plans or by plan-delegated entities for the full population. When data are collected by the health plan, plans will have all of the screening data in-house. Should a plan elect to delegate these responsibilities to another entity, additional workflows may need to be set up to ensure consistent collection methods or file formats across entities to reduce administrative burden on the plan to aggregate data.

Design Choice #9: Who Should Calculate Performance on the Measure?

Options for which entity calculates performance on the screening measures include:

1) ACO
2) MCO (used by RI)
3) State or vendor *(used by MA and NC)*

This design choice requires considering which entity is most suited to the calculation of the screening measure. The answer depends, in part, on the data collection method selected, the extent to which the state wishes to delegate responsibility, and whether the state is interested in creating an aggregate provider performance measurement across MCOs.

At the time of publication, of the states profiled, only Massachusetts has collected performance data on its screening measure. Massachusetts used a vendor to generate a random sample of ACOs, similar to the way HEDIS measures are calculated from a sample of participating providers. Massachusetts has not yet made performance data public.

Other Key Considerations

In addition to the measure design considerations outlined above, states should also consider the impact of screening on members and on providers. Screening activities can have impact on members before the results are even considered by a provider or health plan. For example, the screen may create an expectation that the provider or plan will mitigate the social risk factor. It may also be experienced as inappropriate or intrusive by the patient. Data on patient perceptions are mixed. Additional information can be found in *Part I: A Quantitative Study of Social Risk Screening Acceptability in Patients and Caregivers*[20] and *It's About Trust: How Pediatricians Can Screen Children for Social Factors*.[21]

Screening also impacts provider or health plan workflow. In the case of primary care practices that are often asked to perform the screening, assessment, and referral process, the screen creates another administrative requirement when busy care teams may already feel overburdened. Screening will also require screening primary care practices to expend additional resources, making it harder for them to contain costs.[22]

In addition, some clinicians are uncomfortable asking about social risk factors that they have no ability to address. While clinicians may be unable to intervene directly on some of the risk factors identified, there may nonetheless be opportunities to ensure screening results inform care delivery. For example, if a patient screens positive for food insecurity, a clinician could consider prescribing medications that can be taken without food in addition to improving food access. This kind of adjustment that modifies medical care on the basis of social data is sometimes referred to as social needs-informed care.[23,24]

As states consider the implications of social risk factor screening on members, providers, and health plans, they should be aware of the resources provided by the Social Interventions Research and Evaluation Network, which includes an evidence library of resources related to identifying and intervening on social risk factors in health care settings.

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 addressenrollees" social risk factors. While implementing a screening process measure is an essential first step, it is important to recognize the limitations of such a measure. The states profiled in this brief expressed hope for related goals that can only be achieved by moving beyond the process of screening. These next-level goals include:

- 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

Table 2 below identifies potential areas for future social risk factor-related measure development.

Table 2: Other potential Social Risk Factor-related measure development areas

Area	Potential Measures
Documenting screening results	› **Percentage of complete screening results submitted to the state** *(denominator: total population OR screens conducted)* › **Percentage of individuals that had a positive screen for a domain** *(e.g., homelessness) (denominator: the population screened for that domain)*
Responding to screening results – process measures	› **Percentage of members with a positive screen that received a referral to a community-based organization** *(denominator: those with a positive screen)* › **Percentage of members with a positive screen that received community services** *(denominator: those with a positive screen)*
Responding to screening results – outcome measures	› **Percentage 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)* › **Percentage 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)* › **Percentage 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)*

Additional information on the requirements, advantages, and disadvantages of using these measures can be found in **Appendix D**.

Ultimately states, ACOs and MCOs, whether through outcome measures and/or through formal evaluation, will need to assess whether these identification and mitigation strategies are yielding desired results.

Support for this brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation or of the states that participated in the convenings.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.

ABOUT STATE HEALTH AND VALUE STRATEGIES—PRINCETON UNIVERSITY WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

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'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*.

ABOUT BAILIT HEALTH

This brief was prepared by Justine Zayhowski, Kate Reinhalter Bazinsky, and Michael Bailit. Bailit Health is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see *www.bailit-health.com*.

ACKNOWLEDGMENTS

The authors thank Laura Gottlieb, Sally Mabon, and Tara Oakman for reviewing and offering insightful feedback on this brief.

Endnotes

1. "Social Determinants of Health." Social Determinants of Health | Healthy People 2020, www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
2. Alderwick, Hugh, and Laura M. Gottlieb. (2019) "Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems." *The Milbank Quarterly*, vol. 97, no. 2, pp. 407–419., doi:10.1111/1468-0009.12390.
3. Alderwick, Hugh, and Laura M. Gottlieb. (2019). "Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems." *The Milbank Quarterly*, vol. 97, no. 2, , pp. 407–419., doi:10.1111/1468-0009.12390.
4. Manatt Health. (2019, April). Addressing Social Factors That Affect Health: Emerging Trends and Leading Edge Practices in Medicaid. State Health and Value Strategies. Retrieved May 28, 2019 from Manatt website: www.manatt.com/Manatt/media/Documents/Articles/Social-Factors-That-Affect-Health_Final.pdf.
5. Crumley, D., Lloyd, J., Pucciarello, M., & Stapelfeld, B. (2018, December). Addressing Social Determinants of Health via Medicaid Managed Care Contracts and Section 1115 Demonstrations. Association of Community Affiliated Plans and Center for Health Strategies, Inc. Retrieved May 28, 2019 from Center for Health Strategies, Inc. website: www.chcs.org/resource/addressing-social-determinants-of-health-via-medicaid-managed-care-contracts-and-section-1115-demonstrations/.
6. Social risk factor screening results are not always captured in electronic health records.
7. Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina. (2018, April). North Carolina Department of Health and Human Services. Retrieved April 25, 2019, from the state of North Carolina website: https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf.
8. Wilkins, J., Van Vleet, A., & Thompson, S. (2019, May 10). [Telephone interview by the author].
9. It is quite possible that the National Committee for Quality Assurance (NCQA) will develop a social risk factor screening measure for health plans, CMS will develop such a measure for physicians, or the National Quality Forum will endorse a social risk factor screening measure in the future.
10. Cartier Y., Fichtenberg C., Gottlieb L. (2018). Screening Tool Comparison. Retrieved on June 22, 2020 from Social Interventions Research and Evaluation Network website: https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison.
11. The Accountable Health Communities Health-Related Social Needs Screening Tool. (n.d.). Retrieved April 23, 2019, from Centers for Medicare and Medicaid Services website: https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf.
12. The Social Needs Screening Toolkit. (2018, September 17). Retrieved April 23, 2019, from Health Leads USA website: https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/.
13. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE/ (2016, September 2). Retrieved April 23, 2019, from the National Association of Community Health Centers website: www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf.
14. Henrikson, N. B., Blasi, P. R., Dorsey, C. N., Mettert, K. D., Nguyen, M. B., Walsh-Bailey, C., ... & Lewis, C. C. (2019). Psychometric and pragmatic properties of social risk screening tools: a systematic review. American Journal of Preventive Medicine, 57(6), S13-S24.
15. Accountable Health Communities core questions, Health Leads, and Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE).
16. Accountable Health Communities core questions, Health Leads, and Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE).
17. North Carolina Department of Health and Human Services. (n.d.). RFP 30-190029-DHB V. Scope of Services [PDF]. Retrieved from https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf.
18. North Carolina uses the term "care management" to include a screening and assessment process performed with all MCO enrollees, not just with those identified as high-risk patients.
19. Additional information on the Gravity Project can be found here: https://www.hl7.org/gravity/.
20. De Marchis, E. H., Hessler, D., Fichtenberg, C., Adler, N., Byhoff, E., Cohen, A. J., ... & Lindau, S. T. (2019). Part I: A quantitative study of social risk screening acceptability in patients and caregivers. American journal of preventive medicine, 57(6), S25-S37.

21. Public Agenda (2019, June 24). It's About Trust: Low-Income Parents' Perspectives on How Pediatricians Can Screen for Social Determinants of Health. Retrieved from Public Agenda website: https://www.publicagenda.org/reports/its-about-trust-low-income-parents-perspectives-on-how-pediatricians-can-screen-for-social-determinants-of-health/.

22. Breslin, E. Lambertino, A., Heaphy, D., & Dreyfus, T. (2017). Medicaid and social determinants of health: Adjusting payment and measuring health outcomes. Retrieved from https://www.shvs.org/wp-content/uploads/2017/07/SHVS_SocialDeterminants_HMA_July2017.pdf.

23. Alderwick, H., & Gottlieb, L. M. (2019). Meanings and misunderstandings: a social determinants of health lexicon for health care systems. *The Milbank Quarterly*, 97(2), 407.

24. Further reading on how health care can incorporate information on social needs include: Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health, Social Determinants of Health: What's a Healthcare System to Do? and Bringing Social Context into Diabetes Care: Intervening on Social Risks versus Providing Contextualized Care.