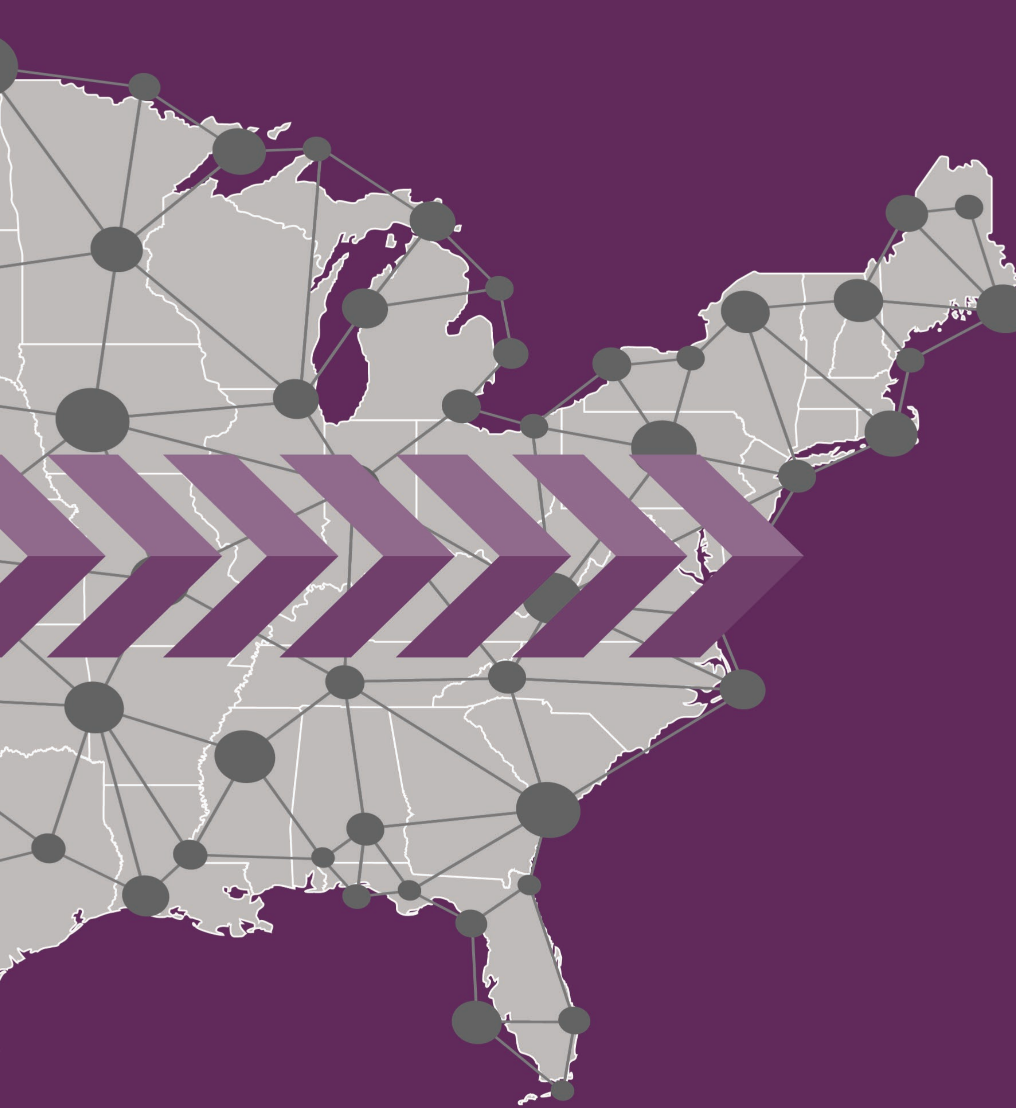

Screening for Social Risk Factors Part I: Working with Medicaid Managed Care Plans to Design Screening Requirements

Bailit Health

October 26, 2020

STATE Health & Value STRATEGIES

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Questions? Email Heather Howard at heatherh@Princeton.edu.

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Welcome

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**.

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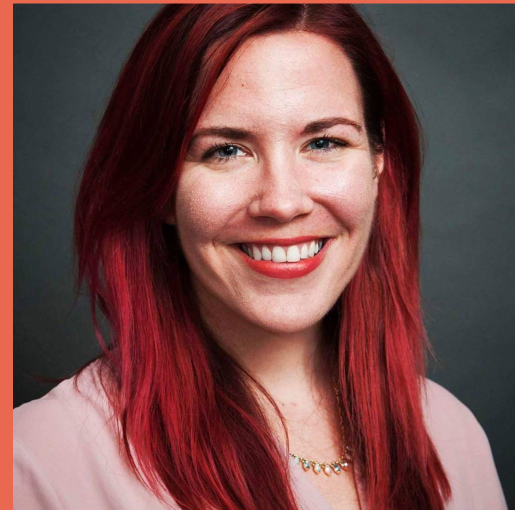

Companion Briefs

- *Social Risk Factor Screening in Medicaid Managed Care*
  - The focus of today's webinar
- *Developing a Social Risk Factor Screening Measure*
  - A resource for states looking to adopt a measure to assess social risk factor screening rates
  - This webinar is scheduled for November 16 at 3:00 p.m. ET

Agenda

- What are social risk factors (SRFs)?
  Why should we screen for them?
- Design Decisions for SRF Screening Requirements
- SRF Screening Tools
- Learn from Virginia's Department of Medical Assistance Services
- Q&A

Agenda

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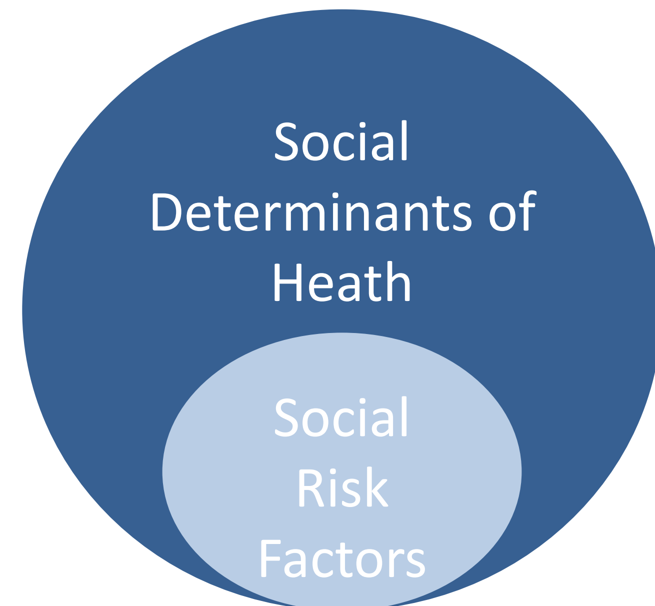
What are Social Risk Factors (SRF)?

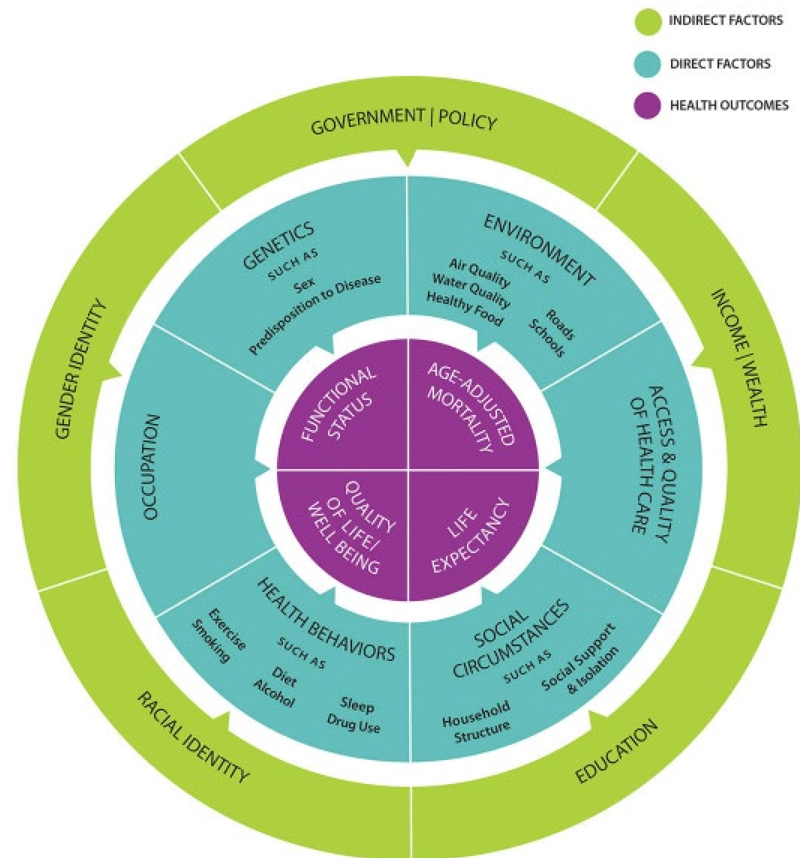
- State Medicaid agencies are increasingly recognizing the impact that non-medical factors, such as social needs, have on health.
- SDOH, or "conditions under which people are born, grow, live, work, and age," impact populations. SDOH can be positive or negative.
  - Examples include housing and food
- 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 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 SRF, we potentially can improve health, reduce health inequities, and decrease health care costs.

- Health is influenced by:



How Can MCOs Support Member SRF Screening?

MCOs can support the SRF screening process through:

1. Screening members, or directing/incentivizing their network providers to screen
2. Implementing interventions, such as:
   i. Care Coordination
   ii. Care Management
   iii. MCO/social service agency partnerships
   iv. Implementing a Community-Based Referral Platform
   v. Providing additional plan services, and/or
   vi. Performance incentives in value-based payment arrangements.

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Design Decisions for Screening Requirements

1. Should screening be required or optional?
2. Who will be screened?
   i. All members
   ii. Specific high-cost / high-needs members
3. Who is responsible for screening?
   i. MCOs (who can be allowed to delegate this responsibility)
   ii. Providers

In **New York** and **North Carolina**, MCOs are encouraged but not required to screen.

In **Massachusetts,** screening is required for all ACO-attributed members.

Design Decisions for Screening Requirements

4. Where should the screen occur?
   i. Clinical setting
   ii. Any setting or modality, which could include telehealth or community-based settings
5. Should the screen be conducted for individuals or for households?

Massachusetts, **Rhode Island**, and **North Carolina** allow screening to occur in any setting.

In **Rhode Island**, screening is completed for households if the beneficiary is a young child.

Design Decisions for Screening Requirements

6. At what frequency should the screen occur?
   i. Upon enrollment
   ii. Annually
7. Should the screen stand alone, or be included within another assessment?

In **Rhode Island**, screens must be completed annually.

California will require that MCOs conduct Individual Risk Assessments to assess health status and SRFs including lack of transportation, social isolation, and housing needs.

Design Decisions for Screening Requirements

8. Should there be a standardized screening tool and/or domains?
   i. States could standardize the screening tool and/or domains
   ii. States could allow the screening entity to select their screening tool and/or domains

Once managed care is implemented, **North Carolina** will conduct SRF screening using a standardized tool.

Massachusetts and **Rhode Island** have specified the domains for which screening must occur and require approval of the screening tool.

Design Decisions for Screening Requirements

9. How to document, aggregate, analyze, and share screening results?
   i. How screening occurs will determine whether and how it can be shared between MCOs, providers, and the state.
   ii. If MCOs conduct screens, new data sharing mechanisms should be implemented to enable screening results to be shared with providers for use within clinical decision making and EHR documentation.
   iii. States may require that MCOs aggregate and report on screening data to calculate statewide SRF prevalence, track trends, and analyze screening-related performance.

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Common Screening Tools: AHC HRSN, PRAPARE, and Health Leads

	AHC HRSN	PRAPARE	Health Leads
Developed by	CMS CMMI for Medicare and Medicaid enrollees	National Association of Community Health Centers (CHC) for CHC patients	Health Leads
# of core questions	10	17	10
# of optional questions	16	4	6
Reading Level	7th grade	7th grade	6th grade
Additional Languages	10	26	1
Cost	Free	Free	Free

Example of SRFs Included in Screening Tools

SRF	AHC HRSN	PRAPARE	Health Leads
Education	Optional	Core	Optional
Employment	Optional	Core	Optional
Financial strain	Core & Optional	Core	Core
Food Insecurity	Core	Core	Core
Housing Instability	Core	Core	Core
Homelessness	Core	Core	Not included
Incarceration	Not included	Optional	Not included

More information is available in SIREN's Social Needs Screening Tool Comparison Table

Psychometric and Pragmatic Properties of SRF Screening Tools

- **Psychometric properties** enable screening tools to accurately identify SRFs (e.g., reliability and validity).
- **Pragmatic properties** assess the appropriateness of the tool and the ease of administration (e.g., cost, language, training to administer, and length).
- Many screening tools have strong pragmatic properties yet minimal psychometric assessment, limiting their ability to accurately and precisely measure SRFs.
- Reliability and validity further decrease if individual screening questions are "mixed and matched" between screening tools, or if the wording of questions is altered.

Patient Perceptions of Screening

- Research suggests that patients who are screened for SRFs by providers believe screening is important.
  - Screening can help them feel "cared for" by their care teams, particularly when screening is conducted in a patient centered way.
- To date, no studies have assessed patient acceptability of SRF screening conducted by MCOs.
- If MCOs conduct the screening, strengthening data sharing and communication mechanisms can allow providers to utilize these results.

Final Considerations for SRF Screening

- After screening is conducted, MCOs/providers can identify how best to address members' SRF(s), in order to improve health equity and reduce health care costs.
- As the evidence base is still developing, it is important to build in opportunities for evaluation and quality improvement.
- Using a screening rate measure can allow states to assess MCO performance on the delivery of SRF screens.
  - This topic will be explored during our next SRF screening webinar on November 16 at 2:00 p.m. ET.

Agenda

What are social risk factors (SRFs)?
Why should we screen for them?

Design Decisions for SRF Screening Requirements

Common SRF Screening Tools

Learn from Virginia’s Department of Medical Assistance Services

Q&A

SDOH ASSESSMENT & OPPORTUNITIES FOR HEALTH EQUITY

Virginia's Experience 2017 - Present

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Beginnings: SDOH Contract Requirements

The Contractor shall collaborate with the Department to continually develop programs and/or establish partnerships to address social factors that affect health outcomes, also called social determinants of health (SDOH), which contribute significantly to the cost of care and the member's health care experience. **The Contractor shall provide care coordination efforts that identify and address member employment, food, housing, education, social, health and health care, and/or environmental needs identified by the member**.

- On an annual basis, the Contractor shall submit:
  - 1) Policies and procedures related to identifying, addressing, and tracking member housing, food, and employment needs;
  - 2) Policies and procedures related to SDOH programs and partnerships;
  - 3) SDOH care coordination training materials for Expansion and non-expansion populations.
- The Department encourages the Contractor to focus SDOH programs on the following priority populations:
  - Members transitioning from hospitals, nursing facilities, or incarceration
  - High risk members and high ER utilizers
  - SUD/OUD members

2018: Medicaid Expansion Opportunities

Virginia's screener (MMHS) catalyzed in 2018 as a result of Medicaid Expansion implementation planning:

- Needed a solution to assess medical complexity as well as determine member risk (inclusive of social/environmental needs) to inform program assignment and stratify levels of care
- 10 triage questions modeled from the PRAPARE tool and conducted by MCO staff to get baseline information on newly eligible members.

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MMHS Assessment Development

Social Risk Factors Screened:

- Housing and food security
- Ability to afford necessities like utilities and childcare
- Access to transportation
- Caregiver status
- Level of education
- Employment status and satisfaction
- Interpersonal relationships

SDOH and HRA Assessment Triage Questions

QUESTION 1: What is your housing situation today?

	I have housing		
	Yes	No	I am worried about losing my housing
	I do not have housing (**check all that apply**)		
			Staying with others
			Living in a hotel
			Living in a shelter
			Living outside (on the street, on a beach, in a car, or in a park)
	I choose not to answer this question		

QUESTION 2(a): In the past **3 months**, did you worry whether your food would run out before you got money to buy more?

QUESTION 2(b): In the past **30 days**, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? **Check all that apply.**

Yes	No	Prescription Drugs or Medicine
Yes	No	Utilities
Yes	No	Clothing
Yes	No	Child Care
Yes	No	Phone
Yes	No	Health Care (doctor appointment, mental health services, addiction treatment)
		I choose not to answer this question

QUESTION 3: How many times have you been in the Emergency Room or a hospital in the last 90 days for one of the conditions you listed earlier?

QUESTION 4: How many times have you had a fall in the last 90 days and needed to visit a doctor, Emergency Room, or hospital because of the fall?

SDOH and HRA Assessment Triage Questions

QUESTION 5: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? **Check all that apply.**

	Yes it has kept me from medical appointment or from getting my medications
	Yes it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

QUESTION 6: Caregiver Status **(Adult Population Question)**

Yes	No	Do you live with at least one child under the age of 19, AND are you the main person taking care of this child?
Yes	No	Do you live with and are you the primary caretaker of an adult who requires assistance with bathing, dressing, walking, eating, or using the bathroom?

QUESTION 7: What is the highest level of school that you have finished? **(Adult Population Question)**

	Some high school but no diploma
	High school diploma or equivalency (GED)
	Some college but no degree
	Workforce Credential or Industry Certification after High School
	Associate's Degree
	Bachelor's Degree or higher
	I choose not to answer this question

SDOH and HRA Assessment Triage Questions

QUESTION 8: Do you have a job? **(Adult Population Question)**

	I have a part-time or temporary job
	I have a full time job
	I do not have a job and am looking for one
	I do not have a job and I am not looking for one
	I choose not to answer this question

QUESTION 9: Do you like your current job? **(Adult Population Question)**

Yes	No	Yes, I like my job
Yes	No	I must work more than one job because I can't find a full time job
Yes	No	I work more than 40 hours per week at two or more part time jobs
Yes	No	I have been looking for a job for more than 3 months and I have not been offered a job
Yes	No	I would like help finding a job that I like more or pays more money

QUESTION 10: In the past year have you been afraid of your partner, ex-partner, family member, or caregiver (paid or unpaid)?

	Yes
	No
	Unsure
	I choose not to answer this question

DMAS

MMHS Assessment Requirements

- **MCOs initially held accountable for using MMHS to screen all new Expansion members within 120 days of plan enrollment (to accommodate volume), now within 90 days of plan enrollment:**
  - MCOs must make 3 good-faith attempts to contact member, including at least 2 modes of communication (in-person, phone, or mailing).
    - Between 2019 and 2020 we reduced members unable to be contacted by 50% (currently ~84,000 members out of 448,000)
  - Members can refuse to answer the assessment, but our data shows us this is infrequent (~3,500 members).
- **Currently, only medically complex members are required to be re-assessed on an annual basis.**

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MCO MMHS Data Snapshot

We sent a data request to our plans, and highlights of their individual experience with MMHS shows prevalence of social needs (though data incomplete):

- Between 33% and 37% of members across the state have reported an Economic Stability SDOH need (food, employment, or housing)
- 23% of respondents reported at least one unmet need (of these, 21% food and 10% housing)
- Highest needs since 2019 include food (6,589 members), employment (5,669 members), and housing (4,280 members)

Virginia Next Steps

Following nearly two years of using our MMHS screener, Virginia is now working to:

- Continue to partner with statewide initiative developing a standardized SDOH assessment and connected referral platform, have these incorporated into clinical workflows for expanded, longitudinal dataset.
- Develop data analytics tools, and data-sharing partnerships, to more thoroughly understand and track member SDOH needs and trends to use for budget requests, policy proposals, and MCO accountability mechanisms
- Enhance our assessment and data collection practices through health and racial equity lenses, and use what we know about assessed social needs to inform health equity priorities and initiatives.

SDOH & Health Equity Opportunities

How addressing SDOH helps VA promote health equity:

1. Assessing for SDOH provides an avenue for member feedback and engagement on non-clinical issues impacting health and access to needed services.
2. Provides a mechanism to view member health, circumstances, and needs more holistically and to better understand the prevalence and impact of systemic barriers our members face.
3. Enables Virginia to develop informed policy proposals and interventions addressing documented needs.

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Implementation Lessons Learned

1. **Internal Champion:** SDOH champion left DMAS early in the implementation process, creating a leadership void.
2. **Outreach:** Weekly MCO leadership check-ins provided a venue for feedback and troubleshooting, especially surrounding bad member contact info that created initial assessment delays.
3. **Funding:** Lack of funding and support from General Assembly has stalled next-steps.
4. **Role Clarification:** Still refining DMAS SDOH role (independent state agency from social services and department of health) and MCO expectations, outcomes, and accountability mechanisms
5. **Data:** DMAS has off-loaded monitoring and analysis of assessment data to MCOs, only now working to develop internal dashboards.

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Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

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Next Webinar in the Series

- *Screening for Social Risk Factors Part II: Developing a Screening Measure*
- Monday, November 16 from 3:00 to 4:00 p.m. ET
- Webinar will feature findings from *Developing a Social Risk Factor Screening Measure*
- Register for webinar at following link: https://rwjfevents.webex.com/rwjfevents/onstage/g.php?MTID=ea645b90962e67d3073063349a5355be3

Appendix

Social Determinants of Health and Corresponding Social Risk Factors

SDOH	Corresponding Social Risk Factor		
Housing	Homelessness	Housing Insecurity	Poor quality housing
Employment	Unemployment	Underemployment	
Education	Low educational attainment	Low literacy or health literacy	
Economic Security	Financial strain	Inability to pay for utilities	
Food	Food insecurity	Low quality nutrition	
Incarceration	History of incarceration		
Safety	Interpersonal violence	Neighborhood safety	
Social Support	Social isolation	Loneliness	
Transportation	Lack of transportation (medical or non-medical)		

State Screening Approaches

Massachusetts

- Screening is required for **housing, utilities, transportation, and food**
- In addition to the required domains, at least one optional domain must be included. Optional domains include **employment, training or education; experience of violence; and social supports**
- ACOs can select their own screening tool, which must be approved by the state

North Carolina

- Screening is strongly encouraged but is not required
- Screening is conducted through a standardized, NC-specific screening tool that focuses on four priority domains:
  - **Food insecurity**
  - **Housing instability**
  - **Lack of transportation**
  - **Interpersonal violence**
- MCO may add supplemental questions

State Screening Approaches

New York

- Screening is strongly recommended before members are connected to an intervention
- Interventions must align with the domains of:
  - **Economic stability**
  - **Education**
  - **Health & health care**
  - **Neighborhood & environment,**
  - **Social, family, and community context**
- MCOs choose their screening tool
- MCOs in risk arrangements with providers are required to implement an intervention that addresses one of the priority domains

Rhode Island

- SRF screening is required
- Screening must include the domains of:
  - **Food**
  - **Housing**
  - **Safety**
  - **Transportation**
  - **Utilities**
- MCOs are responsible for completing the screen, with approval of their tool required

Three State Examples: Domains Required in Screening Tools

Domain	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