Developing a Social Risk Factor Screening Measure: Appendix

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STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Appendix A: North Carolina's Healthy Opportunities Screening Questions

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

Appendix B: Social Risk Factor Screening Measures

This appendix contains the current specifications for screening measures used in Massachusetts, North Carolina, and Rhode Island.

Massachusetts

Measure Name: Health-Related Social Needs Screening
Steward: Massachusetts EOHHS
NQF #: -

Description

The Health-Related Social Needs Screening (HRSN) is conducted to identify members who would benefit from receiving community services to address health-related social needs that include but are not limited to housing stabilization services, housing search and placement, utility assistance, transportation, and food insecurity.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	ACO-attributed members 0 to 64 years of age as of December 31st of the measurement year
Continuous enrollment	The measurement year
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year
Anchor date	December 31st of the measurement year
Lookback period	12 months
Event/diagnosis	None
Exclusions	Members in hospice (Hospice Value Set)

Specifications

The percentage of ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.

Data Source	Clinical data
Data Collection Method	Sample
Denominator	A systematic sample drawn from the eligible population
Numerator	ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.
Unit of Measurement	Individual
Setting of the Screen	Clinical and nonclinical settings

Documentation requirements	To satisfy the measure requirements a member must have received one Health-Related Social Needs Screening during the measurement year. Results from an HRSN screening tool must be present in the member's health record in the measurement year and be readily accessible to the primary care provider. The screen may be completed by any member of the ACO care team. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS. The numerator is met if the member's health record (as defined above) contains a completed Health-Related Social Needs screening tool which includes: a. All four (4) core domains, and b. At least 1 supplemental domain The following information must be reported to EOHHS for the purpose of measure performance calculation: Was an HRSN screening completed (including 4 core domains and 1 supplemental domain) (Y/N) Name of Screening Tool Source of Information (Mail, Phone, Email, In-person, Other) Was a need identified for each of the following domains? (Y/N/Unclear)
Approved Screening Tools	EOHHS must approve the screening tool. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS.
Required Domains	**Core Domains:** The following domains must be completed and *results must be reported to EOHHS* in order to satisfy the measure: 1. Food 2. Housing 3. Transportation 4. Utility **Supplemental Domains:** At least one of the following domains must be completed: 5. Employment, training, or education 6. Experience of Violence 7. Social Supports

North Carolina

Measure Name: Screening for Social Determinants of Health
Steward: North Carolina DHHS
NQF #: -

Description

The percentage of Medicaid managed care enrollees who received a screening for social determinants of health.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	All
Continuous enrollment	None
Allowable gap	None
Anchor date	Date of enrollment
Lookback period	90 days of enrollment
Event/diagnosis	None
Exclusions	None

Specifications

The percentage of enrollees who received a screening for social determinants of health.

Data Source	Care management data, collected by an MCO or a delegated entity
Data Collection Method	Full population
Denominator	All managed care enrollees
Numerator	All managed care enrollees for whom the Prepaid Health Plan (PHP) completed a social determinants of health screening within 90 days of enrollment.
Unit of Measurement	Individual
Setting of the Screen	Nonclinical setting, completed by PHP
Documentation requirements	Completed screenings are those screenings for which all questions have been addressed. Staff administering the screenings will have an option to indicate that a question was asked, but the enrollee chose not to answer.
Approved Screening Tools	The North Carolina Standardized SDOH Screening Questions: https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf
Required Domains	1. Food Insecurity 2. Housing Instability 3. Transportation 4. Interpersonal Violence

Rhode Island[1]

Measure Name: Social Determinants of Health (SDOH) Screening
Steward: RI EOHHS
NQF #: -

Description

Social determinants of health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[2]

The percentage of attributed patients who were screened for social determinants of health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than one month.
Anchor date	December 31st of the measurement year.
Lookback period	12 months

Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel. • Follow the below to determine a primary care visit: o The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381-99387; 99391-99397; 99490; 99495-99496 o The following are the eligible telephone visit, e-visit, or virtual check-in codes for determining a primary care visit: ▯ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▯ Any of the above CPT/HCPCS office visit codes for determining a primary care visit *with* the following POS codes: 02 • Any of the above CPT/HCPCS office visit codes for determining a primary care visit *with* the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Appendix A) • Refused to participate

Electronic Data Specifications

The percentage of attributed patients who were screened for social determinants of health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

Data Source	Clinical data
Data Collection Method	Full population
Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for social determinants of health once per measurement year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously (i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator). • Screens rendered during a telephone visit, e-visit, or virtual check-in meet numerator criteria.
Unit of Measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Setting of the Screen	All clinical and nonclinical settings
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer, or a community partner. The screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR (i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results). Results for at least one question per required domain must be included for a screen to be considered numerator compliant.

Approved Screening Tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.
Required Domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit, or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Rhode Island Social Determinants of Health (SDOH) Screening Measure Specifications Appendix A

The following codes should be utilized to identify patients in hospice care:

Code System	Code		Code System	Code
UBREV	0115		CPT	99377
UBREV	0125		CPT	99378
UBREV	0135		HCPCS	G0182
UBREV	0145		HCPCS	G9473
UBREV	0155		HCPCS	G9474
UBREV	0235		HCPCS	G9475
UBREV	0650		HCPCS	G9476
UBREV	0651		HCPCS	G9477
UBREV	0652		HCPCS	G9478
UBREV	0655		HCPCS	G9479
UBREV	0656		HCPCS	Q5003
UBREV	0657		HCPCS	Q5004
UBREV	0658		HCPCS	Q5005
UBREV	0659		HCPCS	Q5006
SNOMED CT US EDITION	170935008		HCPCS	Q5007
SNOMED CT US EDITION	170936009		HCPCS	Q5008
SNOMED CT US EDITION	183919006		HCPCS	Q5010
SNOMED CT US EDITION	183920000		HCPCS	S9126
SNOMED CT US EDITION	183921001		HCPCS	T2042
SNOMED CT US EDITION	305336008		HCPCS	T2043
SNOMED CT US EDITION	305911006		HCPCS	T2044
SNOMED CT US EDITION	385763009		HCPCS	T2045
			HCPCS	T2046

1. Rhode Island developed a new SDOH Infrastructure Development measure for use by its Medicaid Accountable Entities for 2020. This is a reporting-only measure intended to help Accountable Entities be prepared to report on the SDOH Screening measure for 2021. The SDOH Infrastructure Development measure assesses the percentage of members for which an Accountable Entity can report whether a screen was performed or not.
2. Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on March 18, 2019.

Appendix C: Advantages and Disadvantages of Key Social Determinants of Health Design Considerations

The tables below provide additional detail on potential advantages and disadvantages to selecting individual design options for a social risk factor screening measure.

Table 1. Denominator Definition

Options	Advantages	Disadvantages	State Use?
Total population	› Motivates outreach to every enrolled/attributed household and/or individual › If collect results, provides complete picture of risk factor burden	› Increases burden on plans and providers to conduct outreach and complete screenings › May require screening in nonclinical settings to capture total population	NC
Total population, with limited exceptions	› Removes populations for whom screening expectation may not be reasonable	› Requires an administrative means to reliably document exceptions	MA: hospice
Those with an outpatient visit	› Easier for providers to focus on those actively engaged in care › May feel fairer to ACO/AE/MCO	› Sanctions exclusion of people who may benefit from screening › If collecting results, provides incomplete picture of social risk factor burden	
Those with an outpatient visit, with limited exceptions	› Removes populations for whom screening expectation may not be reasonable	› Requires an administrative means to reliably document exceptions	
Those with a primary care visit	› Easier for providers to focus on those actively engaged in care › May feel fairer to ACO/AE/MCO	› Sanctions exclusion of people who may benefit from screening › If collecting results, provides incomplete picture of social risk factor burden	
Those with a primary care visit, with limited exceptions	› Removes populations for whom screening expectation may not be reasonable	› Requires an administrative means to reliably document exceptions	RI: hospice and refusals

Table 2. Specify or Approve Tools

Options	Advantages	Disadvantages	State Use?
Specify	› Ensures that screening tool includes state priorities › State has control over validity and reliability of the screening tool › Facilitates aggregation of results (if that is a future goal)	› Will increase implementation burden if organizations are currently using different tools or are required to use a specific tool for another purpose (e.g., FQHCs and PRAPARE)	NC
Specify, and allow for supplemental questions	› Ensures that screening tool includes state priorities › State has control over validity and reliability of the screening tool › Facilitates aggregation of results (if that is a future goal) › Allows for customization to perceived local needs	› Will increase implementation burden if organizations are currently using different tools or are required to use a specific tool for another purpose (e.g., FQHCs and PRAPARE)	
Approve	› Offers flexibility › Allows for customization to perceived local needs › Recognizes and accepts current diversity of approach	› Requires work at state level to review and approve tools › Does not facilitate the aggregation of results (if that is a future goal)	MA RI
Require screening but do not specify a specific tool	› Allows for customization to perceived local needs	› Does not allow for aggregation of results (if that is a future goal)	

Table 3. Domain Requirements

Options	Advantages	Disadvantages	State Use?
Require that the tool only include questions from specific domains	› Focuses on state priorities and/or domains with greatest impact on health status or spending › Could focus on domains for which services/resources are available › Supports analysis across entities	› May miss domains of importance to certain populations › May miss unanticipated needs	
Require inclusion of some domains and provide an option for use of others	› Ensures inclusion of state priorities › Allows for some provider flexibility and customization to local needs	› May miss domains of importance to certain populations › May miss unanticipated needs	MA NC RI
Require the selection of a set number of domains from a list of options (menu approach)	› Allows for greater provider flexibility and customization	› May not focus on state priorities › Doesn't support analysis across entities	
Do not have any requirements with regard to domain	› Allows for greatest provider flexibility and customization to local needs	› May not include state priorities › Doesn't support analysis across entities	

Table 4. Screen by Individual or Household

Options	Advantages	Disadvantages	State Use?
Individual	› Needs could differ or have perceived difference among family members	› Increases burden of screening among providers › Screening of individual family members may not yield additional information, particularly if parents are responding for their children's needs	MA NC
Household	› Needs are likely similar among members of a household › Reduced burden for providers	› Needs could differ or have perceived difference among family members › EHRs will have difficulty recording information by household	
Combination – allow household screen for young children	› Allows for differential treatment of adolescents/adults and children	› Could be more complicated to administer	RI

Table 5. Setting of the Screening

Options	Advantages	Disadvantages	State Use?
PCP office	› If the goal is to increase PCP awareness of social risk factors, requiring it to occur in the practice increases likelihood that the PCP will see/consider the results	› Will miss members who do not visit PCP › Places greater burden on PCP › Passes up opportunity for screening in alternative settings	
PCP office and other clinical settings	› Increases likelihood that the screen is conducted (compared to PCP-only) › Captures members who do not visit PCP › Potentially raises awareness of social risk factors with other clinical providers	› May not share results with PCP › Even if results are transmitted to PCP, provider may not see or consider them	
All clinical and nonclinical settings	› Increases likelihood that the screen is conducted (compared to clinical-only) › May capture individuals that are not engaged in care	› May not share results with PCP and other providers › Even if results are transmitted, providers may not see or consider them	MA NC RI
Nonclinical setting	› May capture individuals that are not engaged in care › Does not increase physician burden for data collection	› May not share results with PCP and other providers unless there is a contractual obligation to do so (NC has included such a requirement) › Even if results are transmitted, providers may not see or consider them	

Table 6. Electronic Health Record Documentation

Options	Advantages	Disadvantages	State Use?
Require Documentation of Screening in a Care Management Platform or Health Record with no Specific Requirement that Data be in the EHR	› Administratively easy › Allows clinicians and other data collectors to use existing workflows	› Accessibility of care management platforms may vary by organization, resulting in inconsistent accessibility to actionable data	MA, NC
Complete Screen (Y/N)	› Simplest version of inclusion in the EHR › Administratively very easy	› Does not provide the clinician with any actionable information/documentation of the results	
Complete Screen (Y/N) plus attachment of full results	› Relatively simple from an administrative perspective	› As the number of steps it takes for a clinician to access the data increases, the likelihood that the clinician will see the data decreases	RI
Complete Screen (Y/N) plus embedded full results	› All information is readily available for clinician review and potential response	› Requires significant EHR modification	RI
Complete Screen (Y/N) plus attachment of full results	› Increases likelihood that clinician will see the relevant information and potentially respond	› Requires significant EHR modification if automated, and skilled reviewer time if not	

Table 7. Data Source

Options	Advantages	Disadvantages	State Use?
Administrative data	› Once claim system is established, low administrative/financial burden going forward › Does not require EHR infrastructure	› Significant increased provider administrative burden to add information to claims › May be unable to find a unique z code for each social risk factors domain	
Clinical data	› Providers can access data at the point of care	› Administrative burden at practice and plan levels › Requires providers to document screen in their EHRs	MA RI
Care management data, collected by an MCO or a delegated entity	› Once incorporated into routine data collection, low administrative/financial burden going forward › Does not require EHR infrastructure › Provides information on complete denominator population › Captures members not engaged in care	› Increased administration burden at the plan level › Would require additional workflows to ensure that providers can access data	NC

Table 8. Data Collection Method

Options	Advantages	Disadvantages	State Use?
Sample	› Eliminates need for EHR entry and clinical data extract	› Increased administrative burden at plan and/or provider level › Expense associated with ongoing record review	MA
Full population	› Provides information on complete denominator population	› Administrative burden to set up infrastructure for full data collection and transmission › Requires valid processes for the data	NC RI

Table 9. Calculation of the Rate

Options	Advantages	Disadvantages	State Use?
ACO	› If ACOs are using different screening tools and/or EHR systems, this allows them to collect the data in a way that make sense for them › ACOs could have the information more readily available throughout the year in order to act on it	› Different payers may require the ACO to submit information in different formats › No external validation of data	
MCO or delegated entity	› MCOs routinely collect and analyze quality measure data › Likely to have greater administrative and financial resources to collect the data (compared to the ACOs)	› No external validation of data	RI
State/Vendor	› Eliminates need for EHR entry and clinical data extract	› May disincentivize ACO/MCO development of their own data infrastructure	MA NC

Appendix D: Alternative Social Determinants of Health Measures for Consideration

Below are alternative measures states could consider for use in MCO programs

Option	Measure	Requirements	Advantages	Disadvantages
Documenting screening results				
Require submission of all screen results and allow the state to analyze the data	Process measure: percentage of complete screening results submitted to the state (of total population OR of screens conducted)	› Use of a standardized tool, or at least information that can be aggregated › A system for submitting the results information	› Encourages the submission of results data › State gets access to all of the raw data to run any number of analyses › The raw data received by the state could be used to inform risk adjustment for plans	› Potentially significant administrative burden on the clinician (that varies depending on the mechanism for submission) › Burden on the state to do the analysis
Require the screener to indicate the presence of a positive screen within a particular domain	Outcome measure: percentage of individuals that had a positive screen for a domain (e.g., homelessness) of the population screened for that domain	› Requires the clinic to identify individuals with positive screen results › A system for indicating whether a positive screen has been made	› Forces the clinician to identify individuals with positive screen results › Could be done without a standardized tool › Could be used to inform risk adjustment	› Would require submission of a different measure for each domain, resulting in significant measures proliferation › Significant EHR configuration to report › If there isn't a standardized tool, it will be hard for the state to interpret the results, beyond generally identifying a domain that needs attention (would likely not provide sufficient detail to indicate an appropriate intervention)
Responding to screening results – process measures				
Referral by clinician to community resources	Process measure: percentage of members with a positive screen that received a referral	› A system to identify those with a positive screen › A (preferably electronic) system to track referrals	› Forces the clinician to identify those with positive screen results and act upon that information › Could be done without a standardized tool	› Potentially significant administrative burden on the clinician › -Does not demonstrate that the individual actually received services
Receipt of community services	Process measure: percentage of members with a positive screen that received community services	› A system to identify those with a positive screen › A (preferably electronic) system to track referrals › A system to collect information from the community-based organization (CBO) about provision of services	› Forces the clinician to identify those with positive screen results and act upon that information › Measures whether the system for referrals works › Could be done without a standardized tool	› Potentially significant administrative burden on the clinician › Measures things that are beyond the scope of control of the clinician (e.g., CBO capacity, patient engagement with CBO)

Responding to screening results – outcome measures				
Mitigation of SDOH issue	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)	› A system to identify those with a positive screen › Conduct social risk factors survey every year › Collection and analysis of screening results	› -Demonstrates whether the system that the clinician/plans have created to address social risk factors actually works › Allows flexibility to the clinician/program to respond to results as they see fit › Could be done without a standardized tool (as long as the clinicians do not change the tools over time) › Less administratively burdensome than other measure options (once a system for results collection is in place)	› The results may be unrelated to action taken on the part of the clinician/measures things that are beyond the scope of control of the clinician
Improved health outcomes	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)	› A system to identify those with a positive screen on a multi-part scale › Identification of specific health outcomes that are linked to social risk factors › Potentially requires the implementation of a new tool to assess health at baseline and follow-up	› Measures what is arguably the ultimate goal of focusing on SDOH: improvement of patient health › Allows flexibility to the clinician/program to respond to results as they see fit	› Potentially significant administrative burden on the clinician › Could lead the clinician to focus on making changes that have nothing to do with social risk factors in order to impact the measure › Measures things that are beyond the scope of control of the clinician (e.g., CBO capacity, patient engagement with CBO)
Reduced health care costs	Percentage of members with lower health care costs measured at a defined follow-up time [e.g., one, two, or five year(s)] after baseline screen (denominator: those with a positive screen)	› A system to identify those with a positive screen › Ability to link individual patient clinical data with individual cost data	› Measures an outcome of interest to many stakeholders › Assesses the financial value of social risk factors programs	› Administratively very complicated and burdensome at multiple levels › Could lead the clinician to focus on making changes that have nothing to do with social risk factors in order to impact the measure