PCMH Health Measure TIPS (To Improve Performance Sheet): Addressing Social Determinants of Health in HUSKY Health Members to Improve Health Outcomes

Importance of the Quality Measure

The World Health Organization defines Social Determinants of Health (SDOH) as the "conditions in which people are born, grow, live, work and age."[1]

Did you know?

- In 2020, 10.5% of U.S. households were food insecure (lacking reliable access to sufficient quantity of affordable, nutritious food)[2]
- 7.77 million renter households were classified as having worst-case housing needs or as having experienced housing instability in 2019, according to the U.S. Department of Housing and Urban Development (HUD)[3]
- According to a study published in the Annals of Emergency Medicine, housing instability is known to adversely affect health. This population was shown to have frequent emergency department use, and the findings suggest that patients may benefit from efforts to identify housing instability[4]

SDOH can affect the health and quality of life of your patients. By identifying and addressing these barriers, either directly or through timely referrals, you can help improve health outcomes for your patients.

This quality metric is recognized by a number of national quality improvement measure stewards, and supports an objective of the *Healthy People 2030* initiative developed by the U.S. Department of Health and Human Services and the Office of Disease Prevention and Health Promotion.

A PCMH recognized practice must collect data on social determinants of health and use the information to continuously enhance care systems and community connections to systematically address needs. Below you will find the NCQA PCMH (Version 7) criteria related to SDOH that must be met.

KM 02 (CORE) COMPREHENSIVE HEALTH ASSESSMENT	KM 21 (CORE) COMMUNITY RESOURCE NEED
G. Practice collects information on social determinants of health—conditions in a patient's environment that affect a wide range of health, functioning and quality-of-life outcomes and risks.	The practice identifies needed resources by assessing collected population information. Practice may assess social determinants, predominate conditions, emergency department usage, and other health concerns to prioritize community resources (e.g. food banks, support groups) that support the patient population.

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Help Available to You and Your Patients

*SDOH Codes

Ensuring that the proper ICD-10 codes are captured on a claim will allow individuals who may need assistance, to be identified and connected to the appropriate community resources.

DESCRIPTION	ICD-10 CODES
FOOD INSECURITY	Z59.4, Z59.41
OTHER SPECIFIED LACK OF ADEQUATE FOOD	Z59.48
INADEQUATE DRINKING WATER SUPPLY	Z58.6
HOUSING INSTABILITY	Z59.0
HOMELESSNESS UNSPECIFIED	Z59.00
SHELTERED HOMELESSNESS	Z59.01
UNSHELTERED HOMELESSNESS	Z59.02
HOUSING INSTABILITY, HOUSED, WITH RISK OF HOMELESSNESS	Z59.811
HOUSING INSTABILITY, HOUSED, HOMELESSNESS IN PAST 12 MONTHS	Z59.812
HOUSING INSTABILITY, HOUSED UNSPECIFIED	Z59.819
OTHER PROBLEMS RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES	Z59.89
DOMESTIC VIOLENCE RISK	Z63.0
PROBLEMS RELATED TO SOCIAL ENVIRONMENT	Z60.0, Z60.2, Z60.3, Z60.4, Z60.5, Z60.8, Z60.9
PROBLEMS IN PRIMARY SUPPORT GROUP INCLUDING FAMILY CIRCUMSTANCES	Z63.0, Z63.1, Z63.31, Z63.32, Z63.4, Z63.5, Z63.6, Z63.71, Z63.72, Z63.79, Z63.8, Z63.9
PROBLEMS RELATED TO PSYCHOSOCIAL CIRCUMSTANCES	Z64.0, Z64.1, Z64.4, Z65.0, Z65.1, Z65.2, Z65.3, Z65.4, Z65.5, Z65.8, Z65.9
PROBLEMS RELATED TO EDUCATION AND LITERACY	Z55.0, Z55.01, Z55.2, Z55.3, Z55.4, Z55.8, Z55.9
LESS THAN A HIGH SCHOOL DIPLOMA	Z55.5
PROBLEMS RELATED TO EMPLOYMENT AND UNEMPLOYMENT	Z56.0, Z56.1, Z56.2, Z56.3, Z56.4, Z56.5, Z56.6, Z56.81, Z56.82, Z56.89, Z56.9
OCCUPATIONAL EXPOSURE RISK	Z57.0, Z57.1, Z57.2, Z57.31, Z57.39, Z57.4, Z57.5, Z57.6, Z57.7, Z57.8, Z57.9
ECONOMIC BARRIERS	Z59.1, Z59.2, Z59.3, Z59.5, Z59.6, Z59.7, Z59.8, Z59.9
PROBLEMS RELATED TO UPBRINGING (ADVERSE CHILDHOOD EXPERIENCES [ACE])	Z62.0, Z62.1, Z62.21, Z62.22, Z62.29, Z62.3, Z62.6, Z62.810, Z62.811, Z62.812, Z62.819, Z62.820, Z62.821, Z62.822, Z62.890, Z62.891, Z62.898, Z62.9, Z04.81, Z04.82, Z62.813, Z91.42

Quality Improvement Opportunities

- Evaluate all patients for SDOH needs
- Document and code claims appropriately
- Make referrals when appropriate, to 2-1-1 or the CHNCT ICM program

Tools & Resources for Healthcare Professionals

- Community Health Network of Connecticut (CHNCT) Intensive Care Management (ICM) is a program that helps patients who have SDOH needs. An ICM care manager will coordinate referrals to ensure that your patient is connected to the appropriate resources to meet their needs. To refer your HUSKY Health patients to ICM, download the referral form at https://portal.ct.gov/husky, click "***Information for Providers***," then the "***Reports & Resources***" menu item, then "***Provider Forms,***" then select "***ICM Referral Form***."

Resources for Patients and Families

- Connecticut 2-1-1 is a one-stop service that can help people find the local resources they need. Dial 2-1-1 or visit www.211ct.org.

Additional Information on HUSKY Health

For information on quality improvement, quality measures, or the programs and services made available through the HUSKY Health program:

- Visit: https://portal.ct.gov/husky, click "**Information for Providers**," and then select "**Health Measures**" under the "**Reports & Resources**" menu item
- Email: Quality@chnct.org
- Call: 1.866.317.3301

References

[1]World Health Organization. Social Determinants of Health. (2021) Retrieved from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3

[2]U.S. Department of Agriculture. Food Security in the U.S. Key Statistics & Graphics. September 8, 2021. Retrieved from https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#foodsecure

[3]U.S. Department of Housing and Urban Development. Office of Policy Development and Research. Worst Case Housing Needs 2021 Report to Congress. July 2021. Retrieved from https://www.huduser.gov/portal/sites/default/files/pdf/Worst-Case-Housing-Needs-2021.pdf

[4]Doran, K., et al. Homeless Shelter Entry in the Year After an Emergency Department Visit: Results From a Linked Data Analysis. Health Policy/Brief Research Report. Volume 76, Issue 4, P462-467. October 1, 2020. Annals of Emergency Medicine. Retrieved from https://www.annemergmed.com/article/S0196-0644(20)30180-3/fulltext

**Code sets are routinely updated. Please reference the current year's manuals when billing for services. Not all codes listed above are reimbursable. For a list of codes reimbursed by DSS, please refer to the Physician Office and Outpatient Services Fee Schedule on the Connecticut Medical Assistance Program website: www.ctdssmap.com.*