Addressing Social Determinant Needs in Primary Care

December 13, 2023

HUSKY HEALTH CONNECTICUT

Connecticut Person-Centered Medical Home

Learning Objectives

- Describe the components of social determinant needs
- Learn how to incorporate assessment of social determinant needs into your practice
- Explain National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) core criteria associated with social determinant needs
- Understand the new HEDIS® measure Social Need Screening and Intervention (SNS-E)
- Review billing and coding for specific social determinant needs
- Discuss community and CHNCT resources

What are Social Determinant Needs?

Social Determinants of Health

- Social determinants of health (SDOH) are:
  - Nonmedical factors that influence health outcomes.
  - Conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping daily life.
    - These forces and systems include, but are not limited to: economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.
    - The family environment in childhood is particularly important and can have far-reaching consequences on physical and mental health, as well as mortality.

https://www.cdc.gov/chronicdisease/healthequity/social-determinants-of-health-and-chronic-disease.html

https://health.gov/healthypeople/priority-areas/social-determinants-health

Housing Security

- Having safe, quality, affordable housing; spending no more than 30% of monthly income on rent.
- Households are considered to be cost burdened if they spend more than 30% of their income on housing, and severely cost burdened if they spend more than 50% of their income on housing.
- Cost-burdened households have little left over each month to spend on other necessities such as food, clothing, utilities, and healthcare.
- Black and Hispanic households are almost twice as likely as White households to be cost burdened.

https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability

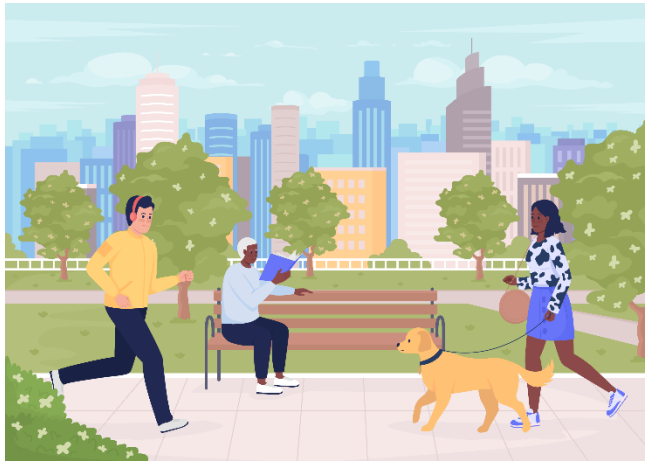
Food & Nutrition Security

- Having reliable access to enough high-quality food to avoid hunger and stay healthy.
- Improving access to nutritious food supports overall health, reduces chronic diseases, and helps people avoid unnecessary healthcare.
- “Food deserts” are an issue in many urban areas.
- Limited transportation also disrupts access to healthy food choices.

https://www.cdc.gov/chronicdisease/healthequity/sdoh-and-chronic-disease/nccdphp-and-social-determinants-of-health/food-and-nutrition-security.htm

Neighborhood & Built Environment

- Human-made surroundings that influence overall community health and people's behaviors that drive health.
  - e.g., communities with parks and walking paths make it easier for people to be active.
- A person's built environment can determine whether they exercise safely, buy healthy food, or drink clean water.



https://www.cdc.gov/chronicdisease/healthequity/sdoh-and-chronic-disease/nccdphp-and-social-determinants-of-health/built-environment.htm

Community-Clinical Linkages

- Connections made between healthcare, public health, and community organizations to improve population health:
  - Can reduce health disparities by bridging the gap between clinical care, community care, or self-care within the public health infrastructure.
- Organizations often use Community Health Workers (CHWs) to make these connections for patients.

https://www.cdc.gov/chronicdisease/healthequity/sdoh-and-chronic-disease/nccdphp-and-social-determinants-of-health/community-clinical-linkages.htm

Social Connectedness

- When people or groups have relationships in which they feel cared for, valued, and supported.
- When people are socially connected, they are more likely to make healthy choices and are better able to cope with stress, trauma, adversity, anxiety, and depression.

https://www.cdc.gov/chronicdisease/healthequity/sdoh-and-chronic-disease/nccdphp-and-social-determinants-of-health/social-connectedness.htm

Addressing Social Determinant Needs

Why Assess for SDOH?

- Ensuring access to healthy foods and providing supportive housing for people facing homelessness have been found to lower healthcare utilization and costs.
- Screening for, and attempting to address unmet needs within a primary care setting, can improve patient health.
- Primary care practices and health systems are increasingly integrating formal screening for social determinant needs into clinical care services.

https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/social-needs-tool.pdf

Implementation - Education

- Educate staff about the significance of SDOH assessment through conversation to gather support and feedback.
- Educate patients about why the practice wants to “have the conversation” with them about their social needs as part of their healthcare:
- Reassure patients that your practice wants to better understand them as a person and anything they may require other than just their health needs.

Implementation - Process

- Determine how the SDOH assessment will fit into existing practice workflows:
  - The healthcare team can collaborate to decide best practice.
- Provide training for staff on the chosen assessment tool, workflow, data evaluation, and referral process.
- Compile a list of local community resources for your most frequent population needs. Engage staff in developing a “Community Resource Guide” as they may be knowledgeable about resources available in the community.

Workflow Integration

- First, assess your practice's readiness to implement SDOH screening. Determine how to incorporate SDOH screening into your practice's workflows. Create implementation timelines.
- Choose a screening tool. Make it part of the health risk assessment that patients complete prior to an annual well visit. Patients can complete the questions while in the waiting room.
- Medical assistants can complete SDOH screening with patients as part of the rooming in process.
- The process starts with screening, then conversation, and finally, referral to and help accessing local support services.

Implementation - Screening

- Empathic inquiry:
  - Suggested when discussing an SDOH assessment with a patient.
  - Purpose is to authentically connect with patients to understand their needs and priorities.
  - Asking for information with the intention of understanding the patient's experiences, concerns, and perspectives.
  - Motivational interviewing and compassionately communicating understanding creates human connection and trust between patients and professionals.

Strategies for Empathetic Inquiry

- Have the conversation in a private area.
- Reflectively listen and affirm the individual's responses.
- Ask the patient, "Is it ok to review this screening with you?" "You can stop at any time, just let me know." This respects the autonomy of the person.
- Use familiar wording, not medical or advanced vocabulary. Consider the person's education and literacy.
- Convey that other people may experience similar needs.
- Connect the individual to needed resources when they are available.

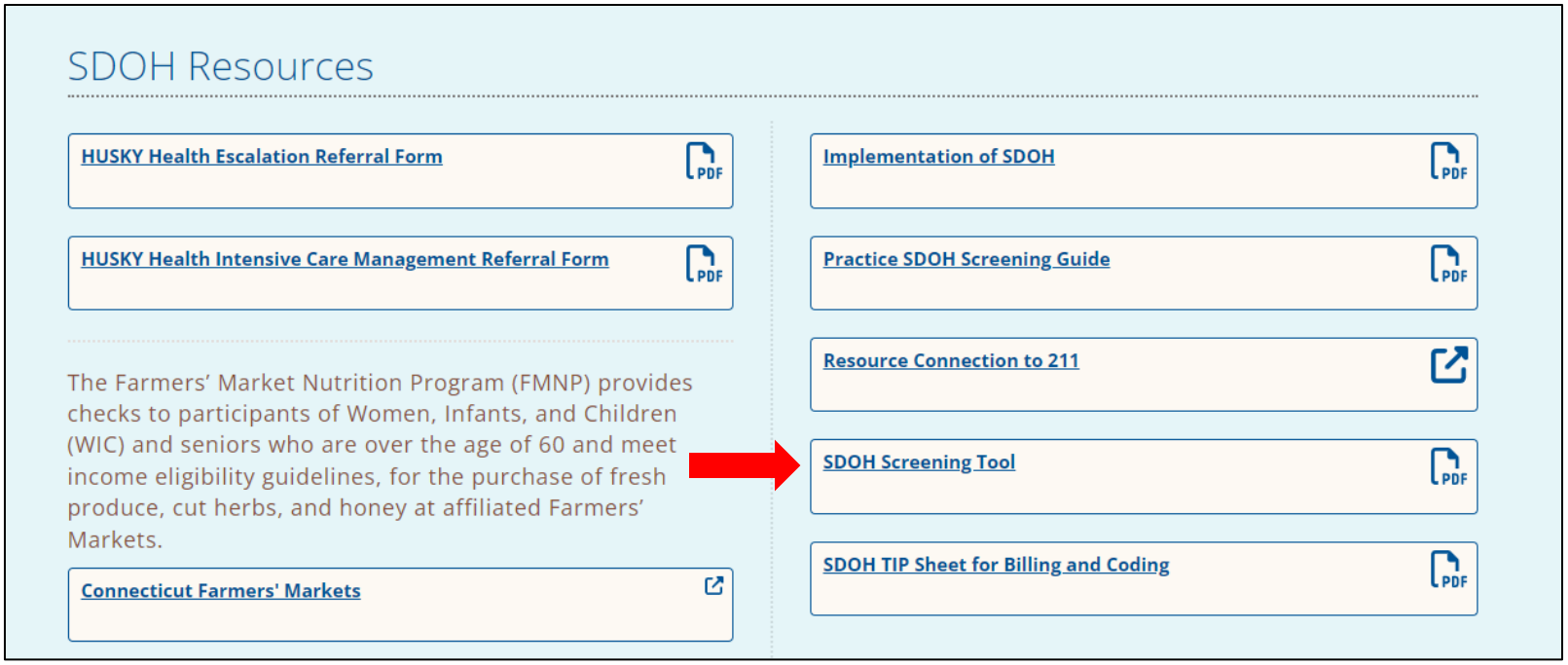
Assessment Tools

- The Agency for Healthcare Research and Quality (AHRQ) is involved in assisting health systems and clinicians to improve healthcare through a better understanding of SDOH in communities and the social needs of patients.
- Information on many aspects of social needs screening, from education to process can be found on their website including resources from the Department of Health and Human Services (HHS).
- A list of recommended screening tools is also available.

https://www.ahrq.gov/sdoh/practice-improvement.html

Assessment Tool

- A social needs screening tool is available on the SDOH Resources page of the HUSKY Health provider website. The tool is 15 questions and can be completed before a patient's annual visit or after their vitals are taken in the exam room:
  - https://www.huskyhealthct.org/providers/sdoh_resources.html



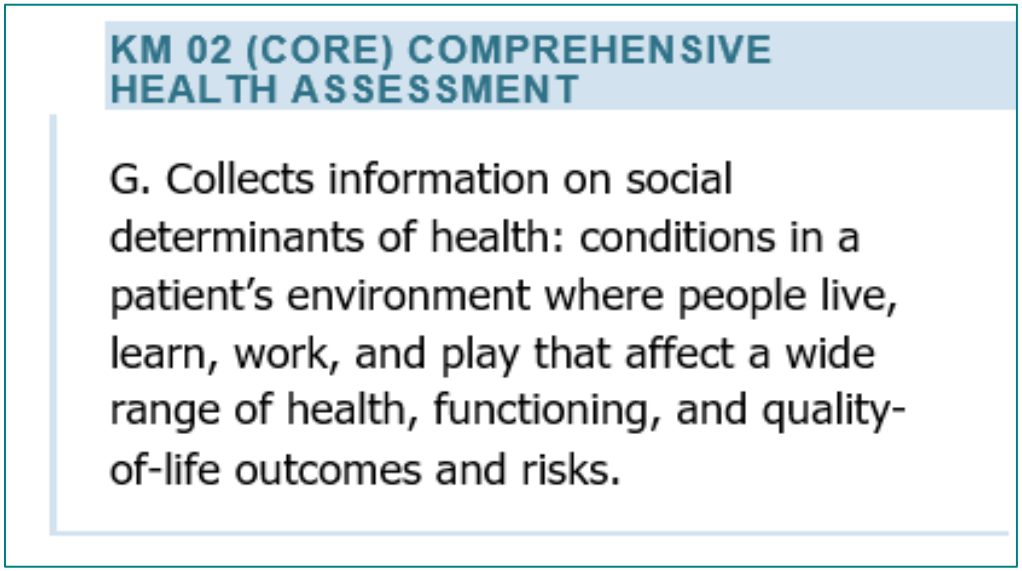
PRAPARE™ Assessment Tool

- PRAPARE™ is both a standardized patient risk assessment tool and a process and collection of resources to identify and act on the SDOH.
- The toolkit helps providers understand the project and strategies for implementation.
- The assessment tool is available for EHR implementation: https://prapare.org/prapare-toolkit/

NCQA Criteria Addressing Social Determinants of Health

NCQA Core Criteria

- NCQA PCMH recognized practices must collect data on SDOH and use the information to continuously enhance care systems and community connections to systematically address needs.
- There are two core criteria related to SDOH. The first is:



https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

KM 02 (Core)
Comprehensive Health Assessment

- Family/social/cultural: Social and cultural needs, preferences, strengths, and limitations (e.g., family/household structure, support systems). Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support).
- Social functioning: The patient's ability to interact with people in everyday social tasks and maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, and social interactions.
- Information on SDOH: Conditions in a patient's environment where people live, learn, work, and play that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

KM 21 (Core)
Community Resources Needed

- The practice identifies needed resources by assessing collected population information.
- It may assess SDOH, predominant conditions, emergency department usage, and other health concerns to prioritize community resources (e.g., food banks, support groups) that support the patient population.
- Practices identifying and referring to community organizations with resources for their patient population are part of community-clinical linkages.

https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

Social Need Screening and Intervention (SNS-E) Measure

- The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.
- This is a new electronic measure captured via claims.
- Social needs cited as considerably impacting health inequity include inadequate access to nutritious food, transportation barriers, and insecure or unstable housing.
- Consider that social needs often intersect and compound an individual's health risks.

Billing & Coding SDOH

Billing 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.
- Use of the Z codes allows SDOH needs to be tracked and reported so that funding can be allocated to areas of greatest need.
- It is also important to include the Z codes when coding for SDOH assessment in order to obtain accurate rates for the SNS-E measure.

ICD-10 Codes

- Utilize the ICD-10 Z codes with the CPT codes for SDOH assessment. This is crucial to capture rates for the measure
- Clinical Practice Transformation Specialist (CPTS) staff can provide an SDOH TIP sheet with all the codes
- Listed are some of the most common SDOH needs with the codes

Description	ICD-10 Codes	CPT Codes	HCPCS Codes
Food Insecurity	Z59.4, Z59.41	96156, 96160, 96161, 97802, 97803, 97804	S5170, S9470
Housing Instability	Z59.0, Z59.81		
Homelessness Unspecified	Z59.0, Z59.00	96156, 96160, 96161	
Transportation Insecurity	Z59.82	96156, 96160, 96161	

SDOH TIP Sheet

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Quality Improvement

HEDIS® MY 2023 TIPS (To Improve Performance Sheet): Social Need Screening and Intervention (SNS-E)

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]

Quality Measure Description

The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive.

Codes for Screening Instruments: Food Insecurity

Food insecurity instruments

Eligible screening instruments with thresholds for positive findings include:

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel®[1]	95251-5	LA33-6
Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)®[1]	95400-8	LA33-6
	95399-2	LA33-6

Codes for Screening Instruments: Food Insecurity (cont.)

Food Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Codes for Screening Instruments: Housing Insecurity

Housing instability, homelessness and housing inadequacy screening instruments

Eligible screening instruments with thresholds for positive findings include:

Housing Instability and Homelessness Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 LA31995-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
Children's Health Watch Housing Stability Vital Signs™1	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
Health Leads Screening Panel®1	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93033-9	LA33-6
	71802-3	LA30190-5
We Care Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Codes for Screening Instrument: Housing Insecurity (cont.)

Housing Inadequacy Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2

Codes for Screening Instruments: Transportation Insecurity

Transportation insecurity screening instruments

Eligible screening instruments with thresholds for positive findings include:

Transportation Insecurity Instruments	Screening Item LOINC Codes	Positive Finding LOINC Codes
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®1	99553-0	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93030-5	LA30133-5 LA30134-3
PROMIS®1	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93671-6	LA33-6

[1]Proprietary; may be cost or licensing requirement associated with use.

Data Analysis

- The method of reviewing data with the purpose of finding useful information, proposing conclusions, and reinforcing decision-making:
  - Run descriptive analysis on all data to observe trends.
  - Use Excel or other data analysis software.
  - Can you validate the results?
  - Communicate what you have found with staff. Were results consistent with expectations?
  - Compare your results to current baseline data.

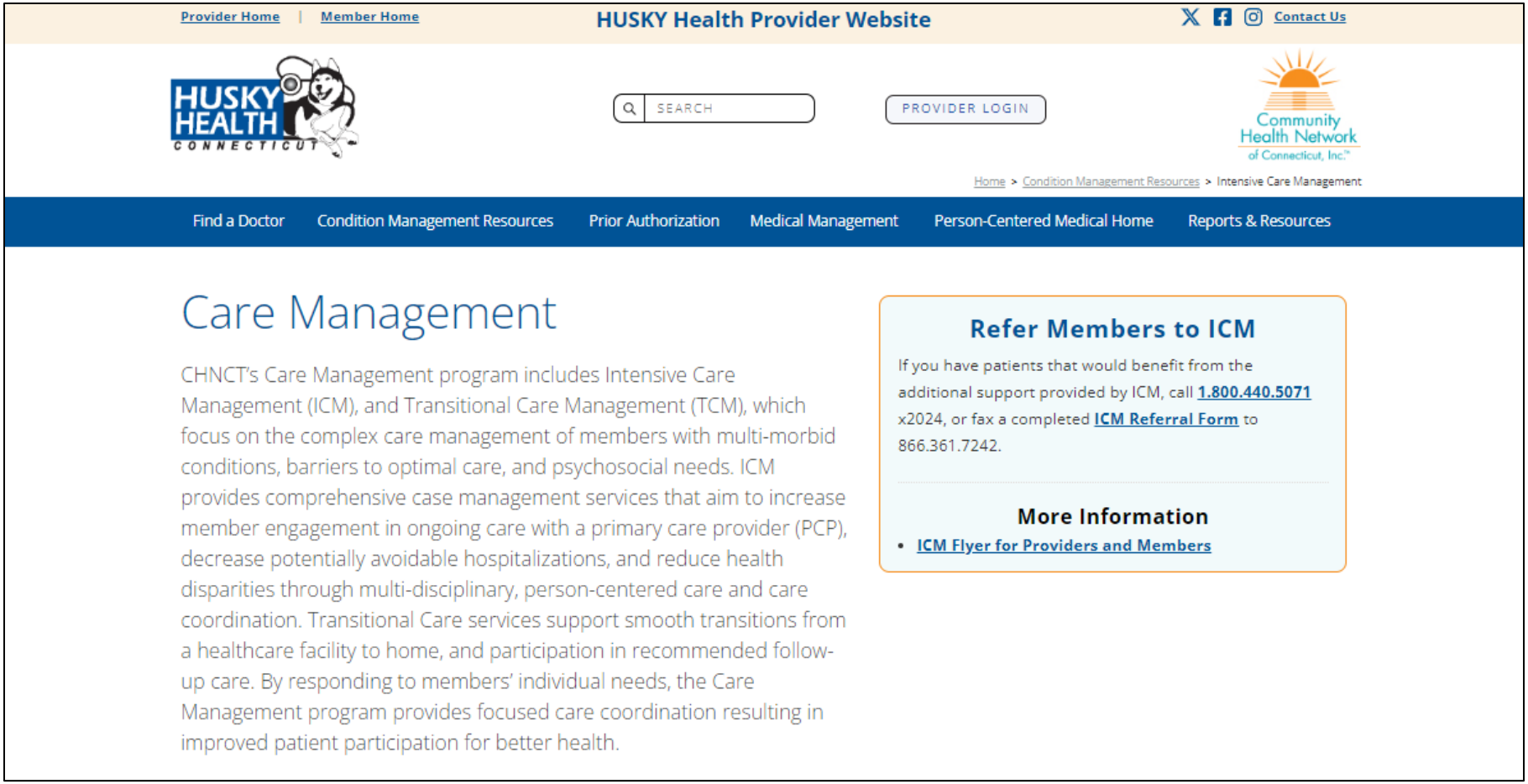
Community Resources

Connecting Patients

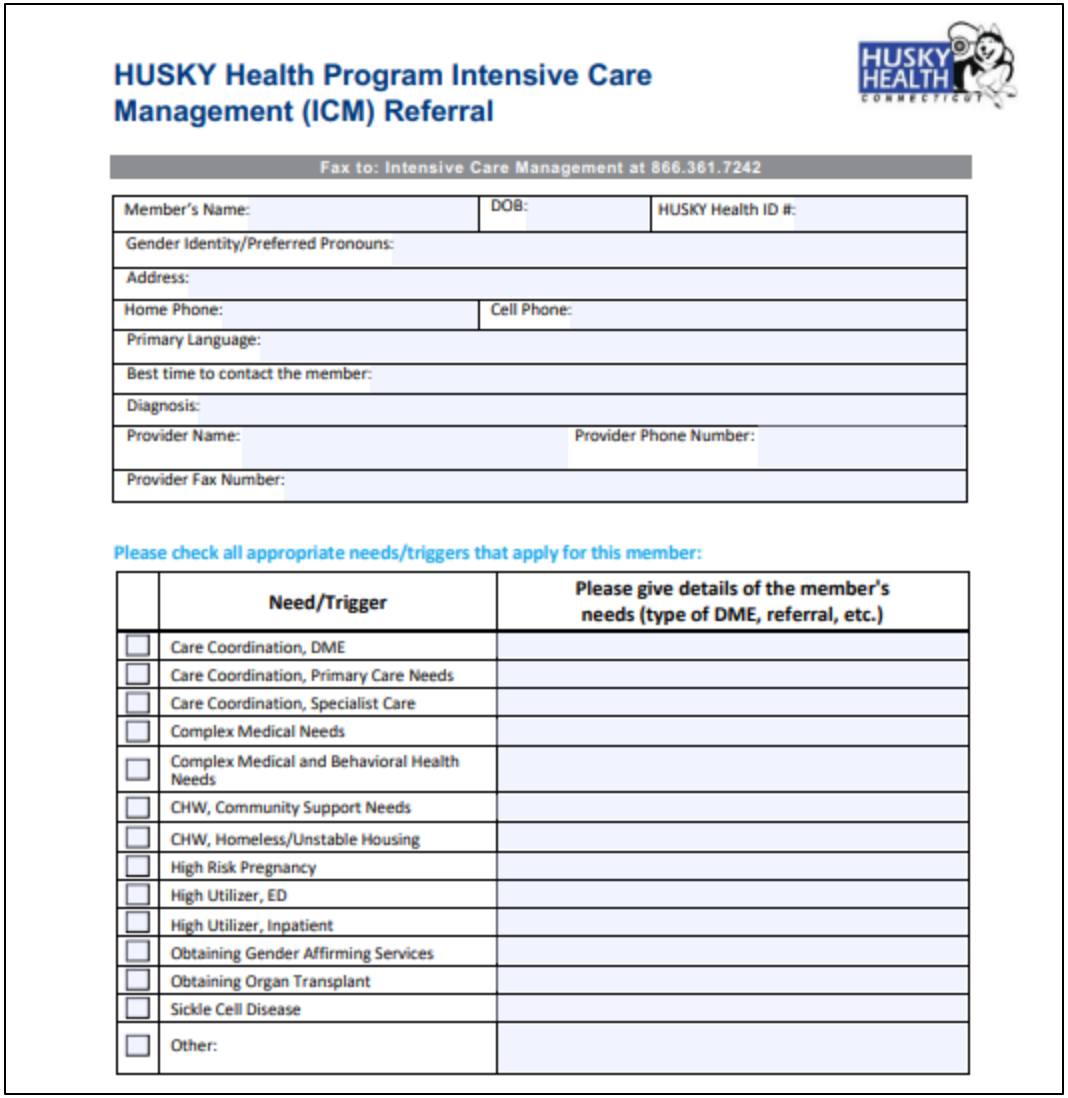
Referring Patients

- Even when a patient screens positive for a social determinant need, they may not want or need help at that time.
- Practices can create a list of community resources in their area to share with their patients. Update the list regularly.
- Connecticut 2-1-1 is a one-stop service that can help people find the local resources they need. You or your patients can dial 2-1-1 or visit www.211ct.org.
- Transportation to and from healthcare appointments for HUSKY Health is available at https://www.mtm-inc.net/connecticut/ or by calling 1.855.478.7350.

ICM Referrals



Referral Form



HUSKY Health Program Intensive Care Management (ICM) Referral

Fax to: Intensive Care Management at 866.361.7242

Member's Name:	DOB:	HUSKY Health ID #:
Gender Identity/Preferred Pronouns:		
Address:		
Home Phone:	Cell Phone:	
Primary Language:		
Best time to contact the member:		
Diagnosis:		
Provider Name:	Provider Phone Number:	
Provider Fax Number:		

Please check all appropriate needs/triggers that apply for this member:

	Need/Trigger	Please give details of the member's needs (type of DME, referral, etc.)
☐	Care Coordination, DME	
☐	Care Coordination, Primary Care Needs	
☐	Care Coordination, Specialist Care	
☐	Complex Medical Needs	
☐	Complex Medical and Behavioral Health Needs	
☐	CHW, Community Support Needs	
☐	CHW, Homeless/Unstable Housing	
☐	High Risk Pregnancy	
☐	High Utilizer, ED	
☐	High Utilizer, Inpatient	
☐	Obtaining Gender Affirming Services	
☐	Obtaining Organ Transplant	
☐	Sickle Cell Disease	
☐	Other:	

Community Health Workers (CHWs)

- CHWs provide community-based outreach, advocacy, culturally based education, health promotion, and social services referrals.
- CHWs develop positive, supportive relationships with HUSKY Health members through ongoing contact via phone and face-to-face visits.
- These relationships guide members toward the adoption of healthy behaviors, improved self-management, and increased independence, which contributes to improved health outcomes.

Community Health Workers (cont.)

- CHWs also work with a member's care manager, primary care team (or other medical provider), and other agencies, to address the member's needs.
- CHWs are knowledgeable about statewide services available to HUSKY Health members.
- CHWs assist members to access resources to address their SDOH needs and aim to reduce barriers to maintaining a healthy lifestyle by offering primary care provider (PCP) appointment assistance and help with transportation and benefits.

Questions/Comments

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