Addressing Social Determinants of Health

Million Hearts Grantee Technical Assistance Recorded Webinar

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ADDRESSING BARRIERS TO CARE SERIES

- Addressing Social Determinants of Health
  Recorded Webinar (September 2021)

- Virtual Care: Best Practices for Patient Engagement
  Recorded Webinar (September 2021)

- Addressing Behavioral Health Issues
  Recorded Webinar (Fall 2021)
Social Determinants of Health

The conditions in the environments where 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.

• 5 domains:
  • Economic Stability
  • Education Access and Quality
  • Health Care Access and Quality
  • Neighborhood and Built Environment
  • Social and Community Context

Social Determinants of Health

Impact on care:
- Appointment show rate
- Follow-through on referrals to specialists, labs, etc.
- Self-management: diet, exercise, medication adherence
- Increased cost of later stage care settings

The top three SDOH:
- Housing
- Food
- Transportation
Universal Screening - recommended by the AAP, AAFP, & ACOG

Patient support to address needs

Follow-up to ensure needs were addressed

Code ICD-10 Z codes for payment where available

Partner with community organizations to improve health
• Providers are in a critical role
• Requires training to screen
• There are many tools available:
  o The EveryONE Project – American Academy of Family Physicians 
  o PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences [www.nachc.org/PRAPARE](http://www.nachc.org/PRAPARE)
• Organize the practice team to support patients and families during referrals and transitions.

• Referral management - logistical “referral” coordinator:
  • Tracks all referrals and transitions
  • Provides patient (and family) with information about referral
  • Addresses barriers to referrals
  • Follows up on missed appointments
  • Tracks completion of referrals

Adapted from: http://www.improvingchroniccare.org
Inform patients about logistics including what to bring & where to go.

Prepare patients by describing the reason for the referral

Empower patients to ask questions and to follow-up with the practice
• **Identify community resources** your practice can use to build confidence in responding to patient barriers.

• **Establish processes** to ensure clear accountability and minimize missed patient support opportunities.

• **Make information readily available** to reduce staff time to respond to identified patient needs.

• **Incorporate community health workers**, health outreach workers, or peer health advisors in the care team as a cost-effective strategy.

• **Connect with community-based organizations** that offer support services.

• **Explore available resources**.....
211 Answers Please!

• 24/7 Access
• Links residents with essential services and human services programs
• Calls are anonymous and confidential
• Provides access to services in 140 different languages
• Downloadable database

https://answersplease.dc.gov/
Cooperative Extension Service

- University of District of Columbia – Cooperative Extension Service (CES)
- Extension specialists use research-based education to help people gain knowledge and develop confidence in making healthy choices, manage health conditions, and create healthier environments.

https://www.udc.edu/osp/research-facilities/
http://healthextensiontoolkit.org/
CLEAR Collaboration

- Community Links Evidence to Action Research Collaboration
- Supports health care workers in taking concrete actions to make a difference by applying evidence in addressing social determinants of health
- Download the CLEAR toolkit

https://www.mcgill.ca/clear/about
Aunt Bertha

- Connects people with community-specific social service agencies
- Promotes self-service
-Strengthens medical-community linkages
- Social care network

https://company.auntbertha.com/
Explore technology supports that enable electronic communication of referrals and closed loop feedback are emerging, such as:

- Unite Us operates in DC: [https://uniteus.com/sdoh/](https://uniteus.com/sdoh/)
  - Connects health and social care through a shared technology platform
  - Enables referrals to be sent and received electronically
• Develop partnerships with local support resources and advocacy groups to raise awareness and create solutions that respond to the needs of the community.

• Implementation of the Collective Impact model with public health officials, community-based organizations, and local leaders is a promising practice.
  • Collective Impact Forum, https://www.collectiveimpactforum.org/

• There are also tools and resources available to support providers including those available through the CDC.
  • CDC Tools for Putting Social Determinants of Health into Action https://www.cdc.gov/socialdeterminants/tools/index.htm

• The PETAL Program provide a strategic approach for organizations working to address health equity.
  • The Petal Program - https://www.petalprogram.com/

These strategies can be combined by sharing ideas with community leaders and learning new ways of collaborating at the local and practice levels.
• CMS Letter to State Health Officials 1/7/21 highlighted strategies by which states can promote a value-based system fostering treatment of the whole person by addressing SDOH [https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf]

• New reimbursement models: Pathways Community HUBs identify and address risks [https://pchi-hub.com/]

• Potential grant opportunities to fund Community Health Workers [https://www.ruralhealthinfo.org/toolkits/community-health-workers/6/grant-funding]

• Supplemental ICD-10 Z codes Z-55 to Z-65, “Persons with potential health hazards related to socioeconomic and psychosocial circumstances” [https://icd.codes/icd10cm/chapter21/Z55-Z65]
  ▪ AmeriHealth Caritas DC offers an incentive payment for each claim that includes an appropriate Z-code
USING SDOH Z CODES
Can Enhance Your Quality Improvement Initiatives

Health Care Administrators
Understand how SDOH data can be gathered and tracked using Z codes.
- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:
- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team
Use a SDOH screening tool.
- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals
Follow the ICD-10-CM coding guidelines.¹
- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.²
- Coding team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code Categories
- Z55 – Problems related to education and literacy
- Z56 – Problems related to employment and unemployment
- Z57 – Occupational exposure to risk factors
- Z59 – Problems related to housing and economic circumstances
- Z60 – Problems related to social environment

This list is subject to revisions and additions to improve alignment with SDOH data elements.

¹ cms.gov/medicare/icd-10-2021-icd-10-cm
² cdc.gov/nchs/icd/ict10cm.htm

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**Patients**
- Enhanced Satisfaction
- Effective Self-management
- Improved Outcomes

**Team**
- Coordination of care
- Efficient use of health care
- Communication

**Practice**
- Reduced LOS & costs
- Reduced admissions
- Increased patient access
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