HEALTH MANAGEMENT ASSOCIATES

Addressing Social Determinants of Health

Million Hearts Grantee Technical Assistance
Recorded Webinar

DC | HEALTH

Deb Peartree, RN, MS
Senior Consultant
518-801-0008
dpeartree@healthmanagement.com

DC | HEALTH

Addressing Social Determinants of Health	Virtual Care: Best Practices for Patient Engagement	Addressing Behavioral Health Issues
Recorded Webinar (September 2021)	Recorded Webinar (September 2021)	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

https://health.gov/healthypeople/objectives-and-data/social-determinants-health

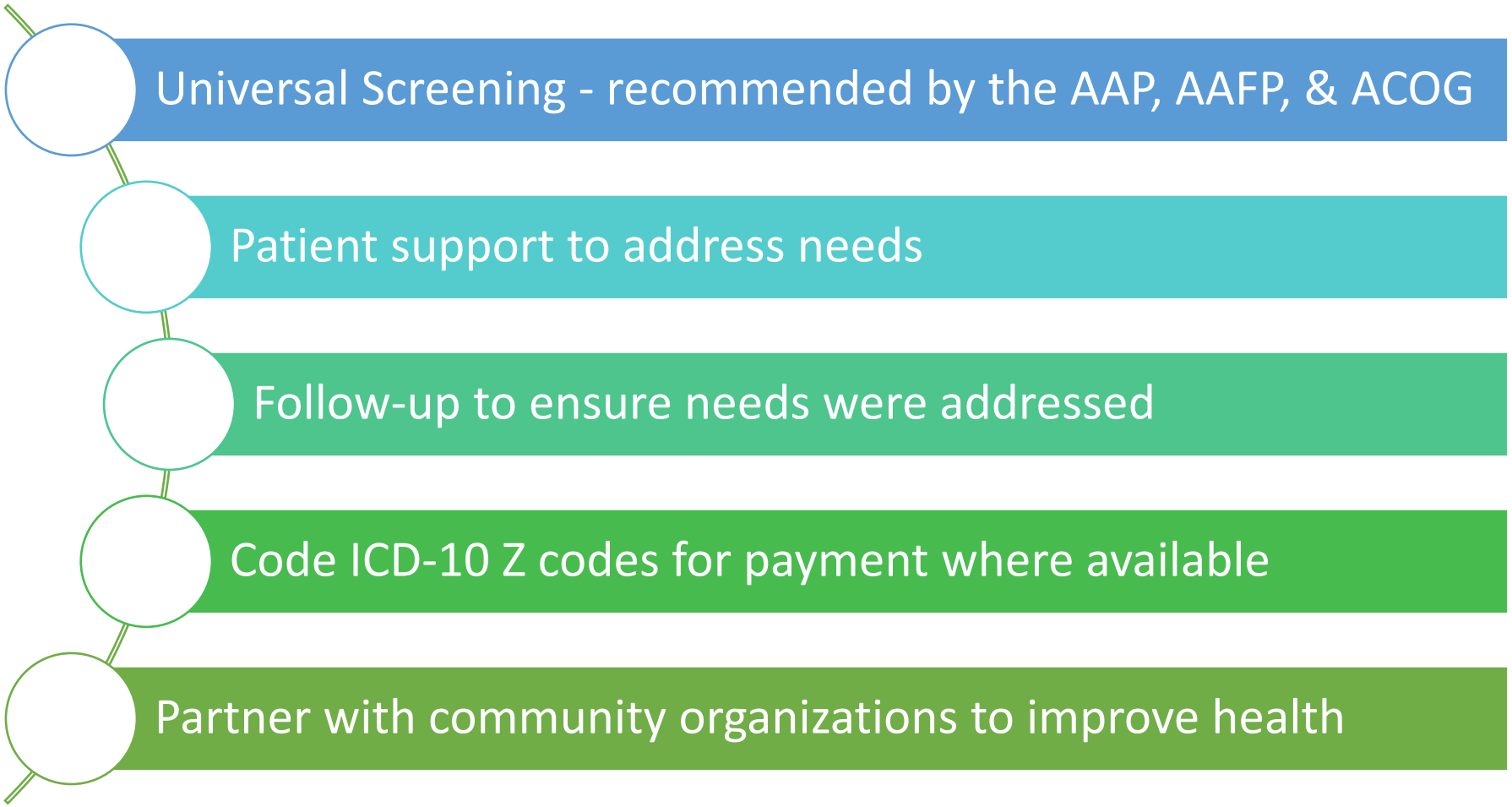
Social Determinants of Health

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



DC | HEALTH

- Providers are in a critical role
- Requires training to screen
- There are many tools available:
  - The EveryONE Project – American Academy of Family Physicians https://www.aafp.org/family-physician/patient-care/the-everyone-project.html
  - PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences www.nachc.org/PRAPARE
  - CMS Accountable Health Communities Health-Related Social Needs Screening Tool https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
  - Rural Health Information Hub: Tools to Assess and Measure Social Determinants of Health https://www.ruralhealthinfo.org/toolkits/sdoh/4/assessment-tools

- 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

DC | HEALTH HMA

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

DC | HEALTH

- **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**…..

DC | HEALTH HMA

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/

Reach out to build practice supports

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.

UNIVERSITY OF THE DISTRICT OF COLUMBIA

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

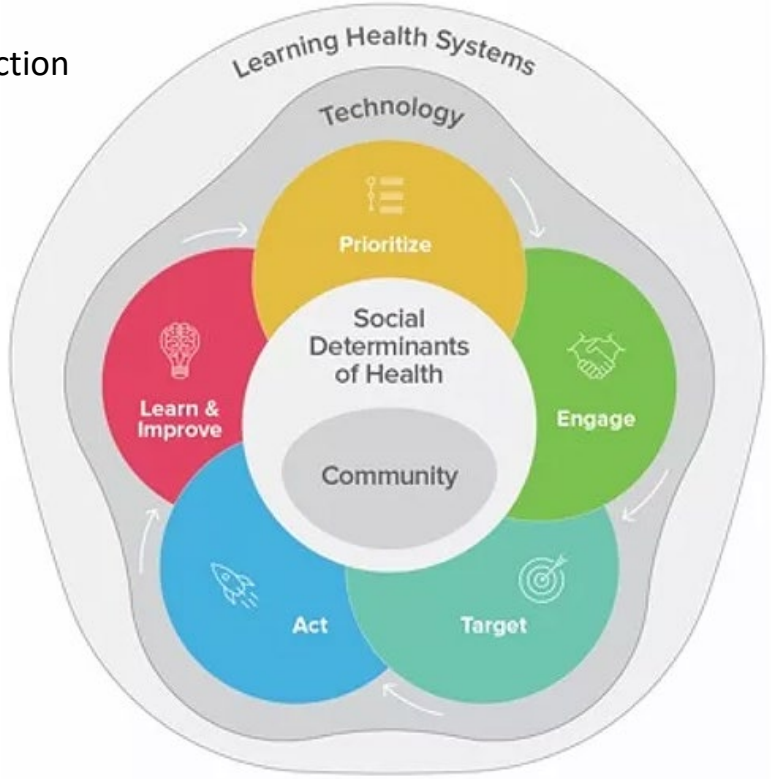
https://company.auntbertha.com/

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/
  - 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.



DC | HEALTH

- **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

DC | HEALTH HMA

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.[3]

- 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.[4]
- 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
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

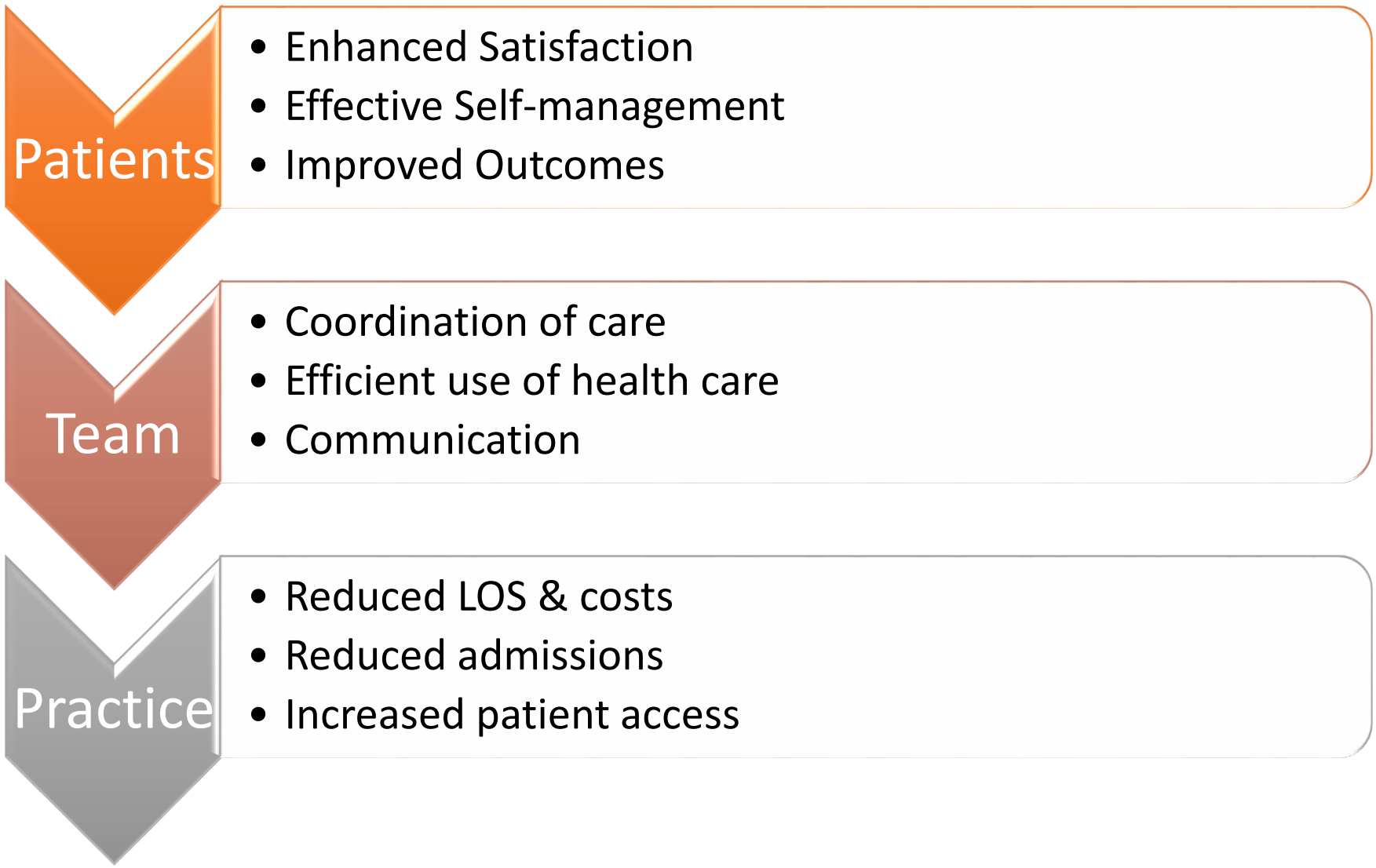
This list is subject to revisions and additions to improve alignment with SDOH data elements.

[3] cms.gov/medicare/icd-10/2021-icd-10-cm
[4] cdc.gov/nchs/icd/icd10cm.htm

Revision Date: February 2021

go.cms.gov/omh

https://www.cms.gov/files/document/zcodes-infographic.pdf



DC | HEALTH HMA

HEALTH MANAGEMENT ASSOCIATES

Deb Peartree, RN, MS
Senior Consultant
518-801-0008
dpeartree@healthmanagement.com

Contact Us

Mary Kate Brousseau, MPH
Principal
Washington, DC
mbrousseau@healthmanagement.com

Nancy Kamp, RN, CPHQ
Managing Principal
Phoenix, Az
nkamp@healthmanagement.com

Jodi M. Pekkala, MPH
Senior Consultant
New York, NY
jpekkala@healthmanagement.com

Lisa Harrison, MS, MHS, PA-C
Senior Consultant
Denver, Co
Lharrison@healthmanagement.com

Samantha Di Paola
Consultant
Washington, DC
sdipaola@healthmanagement.com

Deb Peartree
Senior Consultant
Albany, NY
dpeartree@healthmanagement.com

For full team member bios, please visit out website: https://www.healthmanagement.com/our-team/

THANKS!