Why & How Should We Address Social Determinants of Health?

Providers know firsthand that many of their patients have limited access to healthcare resources and social services to support optimal health outcomes. Medical care is insufficient to improve health outcomes. The World Health Organization defines social determinants of health (SDoH) as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[i] Unmet social needs such as food insecurity, inadequate housing and lack of transportation create barriers to timely medical care and adversely affect patient adherence to treatment and consequently, outcomes of care.

We are learning more about the influence of SDoH on the health of communities and the emerging value of integrating SDoH into health care systems. Payment approaches such as value-based payment models that reward patient outcomes over visits volume are supporting the development of new incentives to address unmet social needs to prevent health crises and reduce unnecessary health care utilization by high cost, high need patients. Innovative approaches to identify and intervene on SDoH are providing more evidence about the effectiveness in achieving the "triple aim"[ii] of better health outcomes and experience of care at lower costs.

The benefits of universal patient screening for SDoH are being recommended by the American Academy of Pediatrics, the American Academy Family Physicians, and American College of OBGYNs. It is worth taking the time to review the practice's approach to screening and the many validated SDoH screening tools that now exist.
Providers recognize the challenges of screening for SDoH including the potential that patients may ask the provider for support on issues that are outside the practice's expertise or control such as housing, the additional time screening will take from limited clinical staff activities, and the limitations that practices face in addressing identified SDoHs. Tools, community supports, and patient strategies can help address these concerns.

The process of addressing SDoH involves assessment of social and medical needs followed by support to meet self-management goals, eliminate barriers to timely care, and assisting patients to meet their needs. Implementing this process with the clinical team ensures that accountability is defined and eliminates duplication of effort. The team should identify who will perform screening, how often it will be done, where data will be stored, how results will be communicated to the team, and how follow-up will be documented.

There are several screening tools and new apps available to assess patients' lived experiences and identify SDoH. The American Academy of Family Physicians developed The EveryONE Project Toolkit[iii] that provides tools to help provider teams screen and address SDoH with community-based resources and patient action plans. The National Association of Community Health Centers worked with other organizations to develop the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Implementation and Action Toolkit[iv] to help providers use lessons learned and best practices to better understand and respond to the needs of their patients. Some DC FQHCs use the PRAPARE as a screening tool as part of an initiative to connect SDOH data and community referral resources within the regional HIE (CRISP) Community Resource Information Exchange (CoRIE) project. The Centers for Medicare & Medicaid Services developed the Accountable Health Communities Health-Related Social Needs Screening Tool[v] to determine if systematic SDoH screening will decrease healthcare costs and improve outcomes. The Pathways Community HUBS Model[vi] provides a unique approach to screening, addressing, and funding solutions to SDoH.

There are also supports available to help identify local social support resources and strengthen community networks. Aunt Bertha[vii] is a search in referral platform covering every zip code in the US. The CLEAR Toolkit[viii] helps healthcare workers address SDoH. There are also electronic software platforms that support care networks of health and social service providers such as Unite Us[ix].

Payment for practice efforts to address SDoH are emerging. Providers can include supplemental ICD-10 Z codes in the patient's diagnosis section and problem list such as ICD-10 codes Z-55 to Z-65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances[x]. These codes can help with population health, panel management, and quality improvement and may eventually be incorporated into VBP arrangements. The resulting data may help inform partnerships and collaborations. According to a CMS Letter to State Health Officials dated 1/7/21: Opportunities in Medicaid and CHIP to Address SDOH describes flexibilities States may use to address SDoH[xi], CMS highlights strategies by which states can promote a value-based system fostering treatment of the whole person by addressing SDoH. Practices and health systems should also explore potential grant opportunities to fund Community Health Workers[xii]. DCPCA requested that Z codes be added to the covered services list in DC and AmeriHealth Caritas DC offers an incentive payment for each claim that includes an appropriate Z-code. It is expected that reimbursement for Z-code related services will emerge across payers and VBP arrangements.

Practices and health systems need to address the business case for addressing SDoH by calculating the return on investment (ROI). The Commonwealth Fund supported the development of an ROI Calculator[xiii] to determine the reduction in healthcare utilization associated with the provision of social services. It was designed to help explore sustainable financial arrangements that can support social service delivery to high risk and high-cost patients. It supports decision-making around whether the practice should develop their own SDoH resource such as hiring a Community Health Worker or create partnerships or vendor relationships with existing community-based organizations to which they can refer. Practices may be able to discuss with Medicaid health plans the possibility of being paid for value-added services as a medical expense investment to be recouped from the medical cost savings they generate. Efforts to address SDoH may be documented addressing complex social issues that complicate medical decision-making and warrant appropriate coding and reimbursement for these services. The ability of these SDoH support processes to improve access and throughput should be considered in the calculation. Continued study of SDoH intervention on cost reductions will support payer funding strategies.

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[i] World Health Organization: Social Determinants of Health, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[ii] Institute for Health Care Improvement: IHI Triple Aim Initiative, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

[iii] American Academy of Family Physicians: The EveryONE Project Toolkit, https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit.html

[iv] National Association of Community Health Centers, et. al.: PRAPARE Implementation and Action Toolkit, http://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Full-Toolkit.pdf Dated 3/2019

[v] Centers for Medicare & Medicaid Services: The Accountable Health Communities Health-Related Social Needs Screening Tool, https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf Dated 9/14/20

[vi] Pathways Community Hub Institute: Pathways Community HUBs: Identifying and Addressing Risks in a Whole Person Approach, https://pchi-hub.com/

[vii] Aunt Bertha: Connected Social Care, Open Access, https://company.auntbertha.com/

[viii] McGill Department of Family Medicine: CLEAR Communication, https://www.mcgill.ca/clear/

[ix] UniteUs: We connect health and social care, https://uniteus.com/

[x] ICD.Codes: https://icd.codes/icd10cm/chapter21/Z55-Z65 Dated 2021

[xi] CMS: Letter to State Health Officials on 1/7/21, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf Accessed 2/1/21

[xii] Rural Health Information Hub: Grant Funding for Community Health Worker Programs, https://www.ruralhealthinfo.org/toolkits/community-health-workers/6/grant-funding

[xiii] The Commonwealth Fund: Welcome to the Return on Investment (ROI) Calculator for partnerships to Address the Social Determinants of Health, https://www.commonwealthfund.org/roi-calculator