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# Social Determinants of Health

## Growing Resources and Gathering Needs

Select Health Quality Provider Program | Gather & Grow Conference
May 7, 2024

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# Social Determinants of Health (SDOH)

## Growing Resources and Gathering Needs

# Overview of Presentation

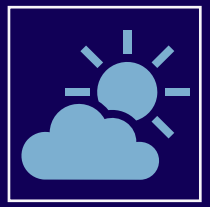
- What Are Social Determinants of Health (SDOH)?
- How Select Health Is Growing Available SDOH Resources
  - Identify SDOH Barriers in Healthcare
  - Select Health Resources that Address these Barriers
- How You Can Help Gather SDOH Need Information
  - Screening for Social Determinants of Health
  - Documentation of Health-related Social Needs
  - Referral to Select Health and Community Resources

# What Are Social Determinants of Health?

# Social Determinants of Health (SDOH)

Born & Live

Work & Play



Worship & Age


# Growing SDOH Resources

# Identified SDOH Resource Barriers

1. Resource knowledge
2. Access to resources
3. Lack of equitable resources
4. Overburdened caregivers
5. SDOH guidance/training
6. Follow-up care

# Select Health SDOH Resources

1. Caregiver roles that make an impact
   - Case Managers & Healthy Beginnings
   - Quality Provider Program
2. Equipping caregivers with relevant resources
   - Community Health Workers (Medicare/Medicaid)
   - Unite Us (Marketplace)


# Gathering SDOH Needs

# Why We Gather SDOH Data

1. Identifying community and population needs
2. Empower providers to identify and address health disparities
3. To help members live the heathiest lives possible
4. Maintain the strength of our business by supporting quality measurement:
   - NCQA Requirement
   - HEDIS & STARS Ratings
   - Health Equity Accreditation

# NCQA New HEDIS Measure

## Social Need Screening and Intervention (SNS_E):

The SNS measure looks at six indicators, one each for screening and intervention across three social needs. It measures the percentage of members who, during the measurement period, were screened via a pre-specified instrument at least once during the measurement period for unmet needs.

## Practice Requirements:

1. Screenings must include the following:
   - Food
   - Housing
   - Transportation
2. Members who screen positive receive a corresponding intervention

# Why Is This Important?

1. May require updates to clinic workflows and EMR documentation
2. Select Health is working to identify a process that includes documentation for both screening and intervention. Per Elizabeth Craig, our Medicaid Program Manager of Social Services, more information is coming later this year.

# Gathering SDOH Workflow:

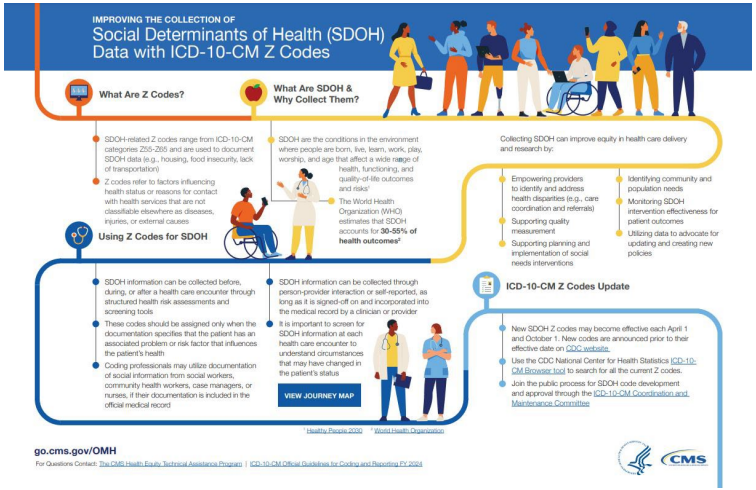
# SDOH Screening & Documentation

# SDOH Screening

1. Screen using a validated screening instrument:
   - PRAPARE
   - SEEK
   - Social Check
2. Can be collected before, during, or after a healthcare encounter
3. Person-provider interaction or self-reported

# Documentation of Social Need

## What are ICD-10-CM Z Codes?




- Used to document health-related social need
- ICD-10-CM categories Z55-Z65
- Assign when the documentation specifies an associated problem or risk factor that influences the patient's health
- Add health-related social need to the problem or diagnosis list

# SDOH Need Analysis

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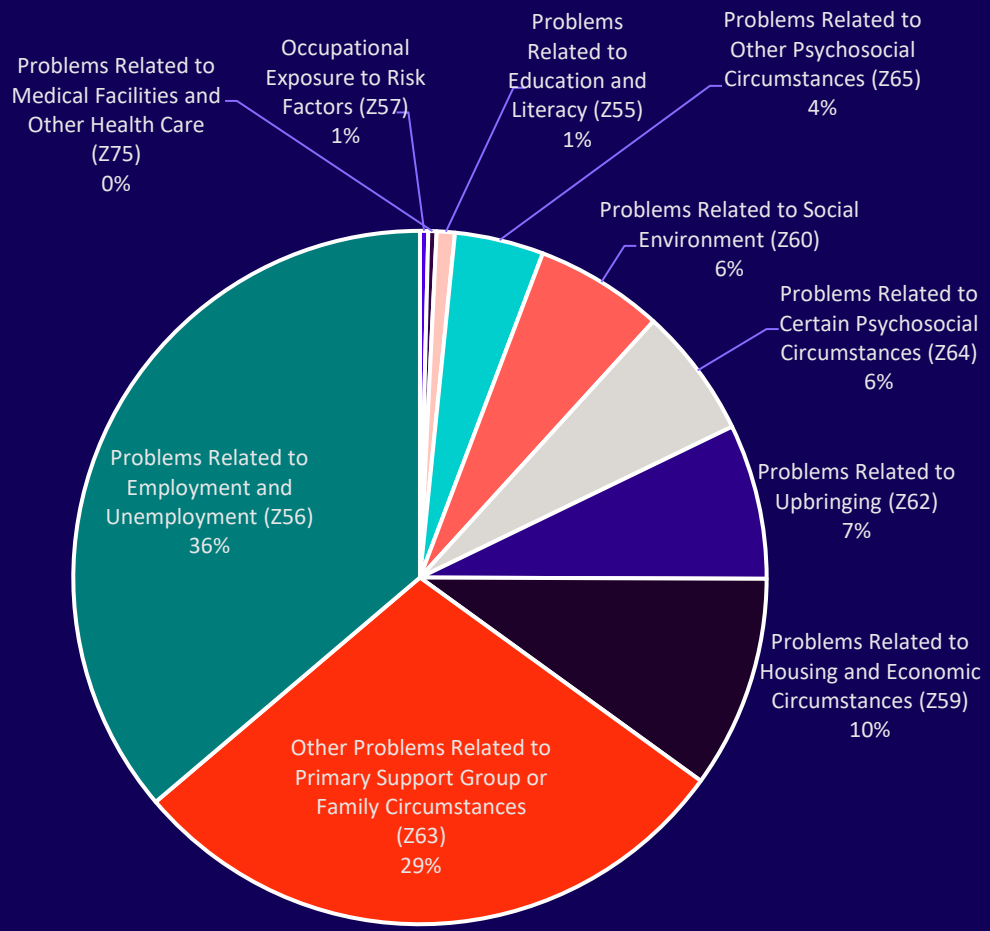
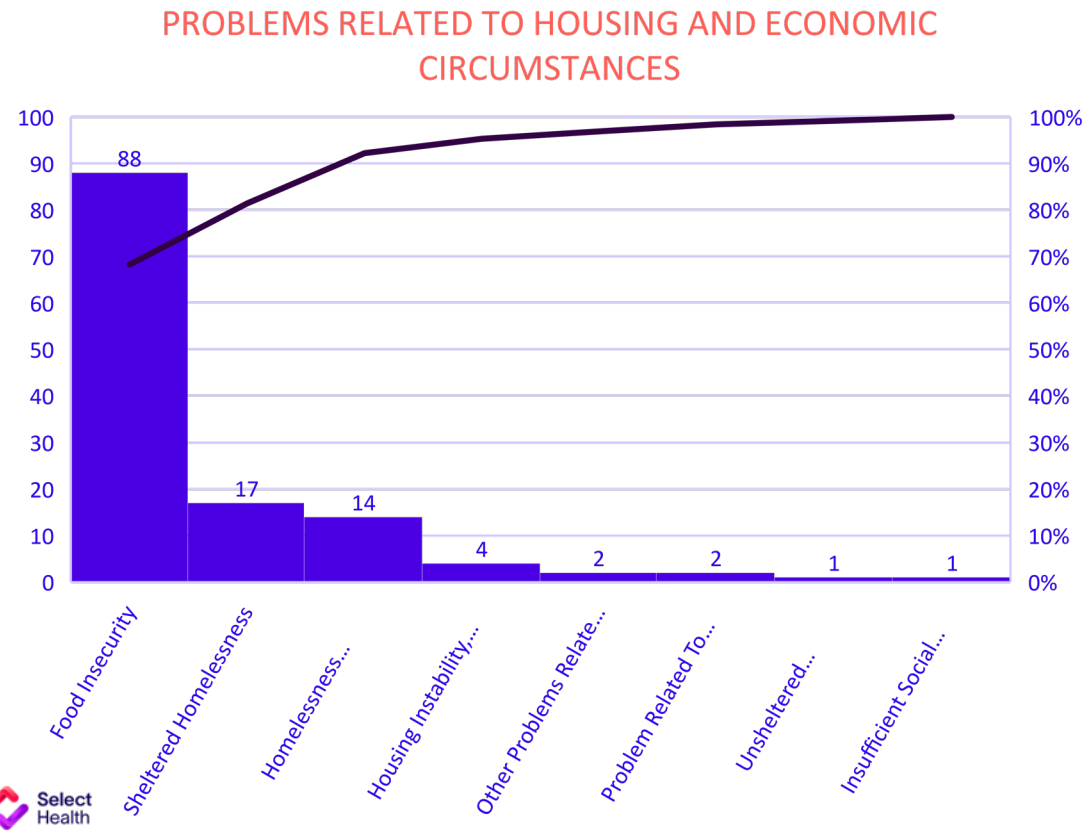
# 2023 Women's Health Quality Program SDOH Needs



# Taking a Closer Look




**Top Health Related Need:**

- Food Insecurity
- Housing/Housing Instability
- Other

# Grow SDOH Resources

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# Where Did We Focus Intervention?

## Food Insecurity & Housing:

- **Organization:**
  - Community Health Workers deliver food to member's door
  - Care Management identifies low-income housing resources
- **QPP Program:**
  - Education on simplicity of 211 website use
  - Support IPV screening implementation and housing resources
- Individual Clinic:
  - Create bulletin board with free local food & formula resources


WORKING TOGETHER TO BUILD HEALTHY COMMUNITIES

# Thank you!

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# References (AMA references in order from first usage)


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6. A quote by Fred Rogers. www.goodreads.com. Accessed May 6, 2024. https://www.goodreads.com/quotes/87819-we-live-in-a-world-in-which-we-need-to#:~:text=Quote%20by%20Fred%20Rogers%3A%20%E2%80%9CWe
7. Penman-Aguilar A, Talih M, Huang D, Moonesinghe R, Bouye K, Beckles G. Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity. Journal of Public Health Management and Practice. 2016;22(1):S33-S42. doi:https://doi.org/10.1097/phh.0000000000000373
8. The PRAPARE Screening Tool. PRAPARE. https://prapare.org/the-prapare-screening-tool/
9. SEEK Materials. SEEK - Safe Environment for Every Kid. https://seekwellbeing.org/seek-materials/

# Resources (Formatted and listed in alpha order)

- Appreciating the Impact of Social Determinants of Health (selecthealth.org)
- Care Management at Select Health (selecthealth.org)
- Health-Related Social Needs vs. The Social Determinants of Health (Oregon.gov)
- Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes (cms.gov)
- Proposed New Measure for HEDIS Measurement Year (MY) 2023: Social Need Screening and Intervention (SNS-E) (ncqa.org)
- PRAPARE Screening Tool (prapare.org)
- Quality Provider Program (selecthealth.org)
- SEEK – Safe Environment for Every Kid (seekwellbeing.org)