Select Health

Social Determinants of Health

Growing Resources and Gathering Needs

Select Health Quality Provider Program | Gather & Grow Conference
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Social Determinants of Health (SDoH)

Growing Resources and Gathering Needs

Overview of Presentation

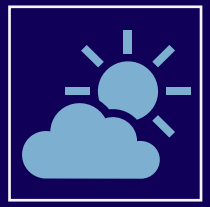
- What Are Social Determinants of Health (SDoH)?
- How does Select Health Grow Available SDoH Resources?
  - Identifying SDoH Barriers in Healthcare
  - Making Resources Available to Address Barriers
- How Can You Help Gather SDoH Needs Information?
  - Screen and Document Results for SDoH
  - Refer Patients to Select Health and Community Resources
- What are the Results of our SDoH Needs Analysis?

What Are Social Determinants of Health?

Social Determinants of Health (SDoH)

Born & Live

Work & Play



Worship & Age

The health of everyone is impacted by non-medical social factors, otherwise known as “Social Determinants of Health (SDoH).”

Social determinants are the conditions where people are born and live, work and play, and worship and age. These social conditions have either a positive or negative impact on our individual health. Learn more.

When health is impacted negatively or affects a patient’s ability to maintain health and wellness, we call this a “health-related social need.”

How is Select Health Growing Available SDoH Resources?

Identifying SDoH Barriers in Healthcare

1. **Resource knowledge** — How do we know which resources are available to our patients? How are needs appropriately defined (see examples at right)?
2. **Access to resources** — Caregivers and providers feel powerless when tangible SDoH resources are not readily accessible at the point of care.
3. **Lack of equitable resources** — Help should not be payer dependent and should address the diverse needs of our community.
4. **Overburdened caregivers** — How can we prioritize requests for more FTEs, case management, mental health integration, and simplified screening for workflow/documentation efficiency?
5. **SDoH guidance/training** — What are social determinants of health? How do they affect equity? Which are applicable to my practice?
6. **Follow-up care** — Providers feel responsible to solve the SDoH problem for every patient if the need is added to the diagnosis or problem list, which sets an unrealistic expectation that may/may not be within their scope of practice.

How do you define problems related to education and literacy"? For example:

- **"schooling unavailable"** (It's available, but they choose not to go)?
- **"unattainable"** (Does "failed school examination" fit if a child gets all Bs but fails one test?)
- **"underachievement in school"** (Should we ask patients how many Fs they get? What if smart kids don't apply themselves and gets straight Cs?)

Making Resources Available to Address Barriers

Caregiver roles/programs that make an impact:

Case Managers & Healthy Beginnings:

1. Create a plan that supports physical and mental well-being and healthy pregnancies.
2. Coordinate care for chronic illness and ensure access to needed treatment and medications.
3. Promote getting preventative care, such as immunizations and recommended screenings.
4. Support understanding of health insurance benefits.

Quality Provider Program (QPP)

1. An extended disease management and preventive care focus
2. Increased patient involvement in healthcare decisions
3. Enhanced care processes through information sharing
4. Improved quality of care and patient safety
5. Prevention of unnecessary tests and procedures

Making Resources Available, Continued

Caregivers equipped with relevant resources, such as access to:

Community Health Workers (Medicare/Medicaid)

- Frequently assess needs
- Support members with SDoH needs

Unite Us (Marketplace)

- A 211 technical organization that links members to health and social services
- A patient-centered & collaborative organization that helps:
  - Minimize barriers to care
  - Connect patients directly to a community partner or 211 specialist
  - Patients sign up in their provider's office
  - Provide closed-loop communication

How Can You Help Gather SDoH Needs Information?

Screen and Document Results for SDoH

1. Identify community and population needs.
2. Empower providers to identify and address health disparities.
3. Help members live the heathiest lives possible.
4. Maintain the strength of our business by supporting quality measurement via:
   - NCQA Requirements
   - HEDIS & STARS Ratings
   - Health Equity Accreditation
5. Incorporate new HEDIS measure (next slides) into practice workflows.

NCQA New HEDIS Measure[1]

Social Need Screening and Intervention (SNS_E):

The SNS measure:

- Looks at 6 indicators, one each for screening and intervention across three social needs
- 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

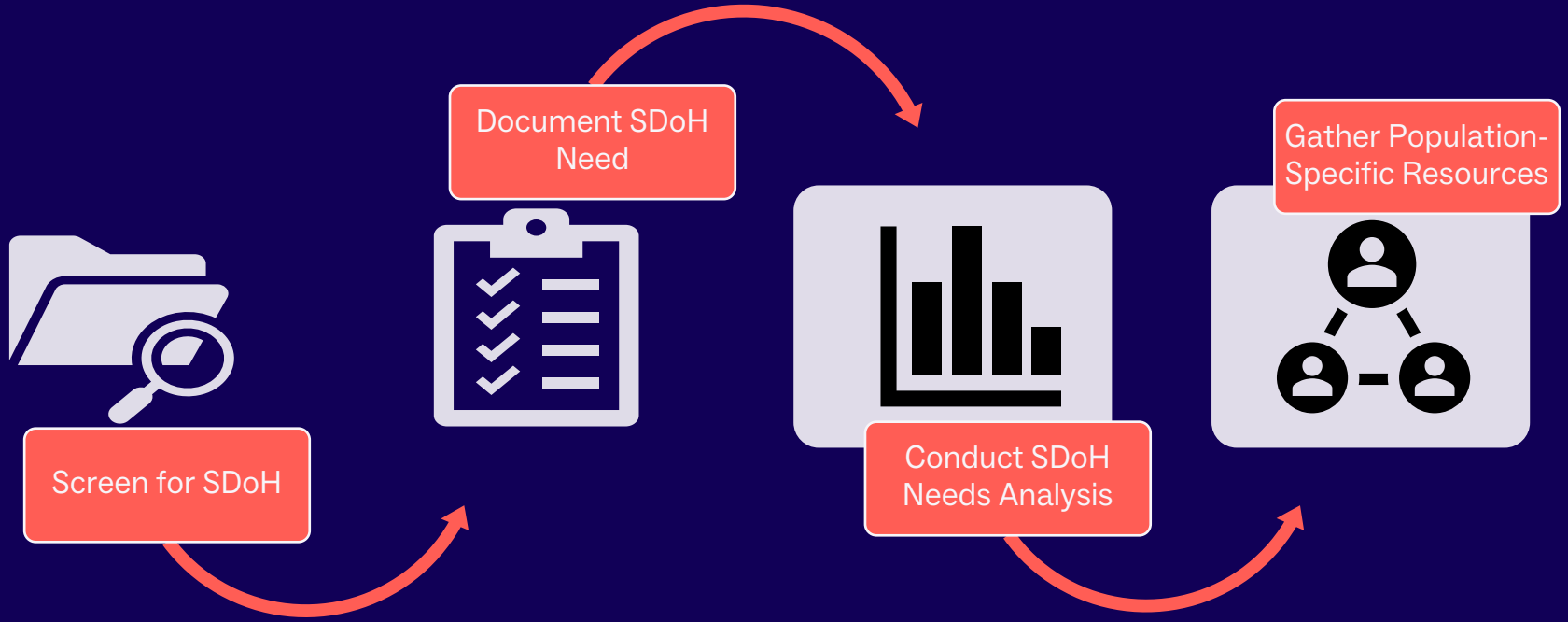
Practice Requirements:

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

Why Is This New HEDIS Measure Important?

1. Screening may require updates to clinic workflows and EMR documentation.
2. Select Health will identify a process that includes documentation for both screening and intervention later this year.
3. Begin implementing the four key elements for screening and interventions (see next slide) into your practice.

Implementing SDoH Screening and Health-related Social Need Interventions



Screen for SDoH

1. Screen using a validated screening instrument:
   - PRAPARE
   - SEEK
   - Social Check
2. Collect before, during, or after a healthcare encounter.
3. Screen as person-provider interaction or as self-reported.

Document Social Needs

To document SDoH needs:

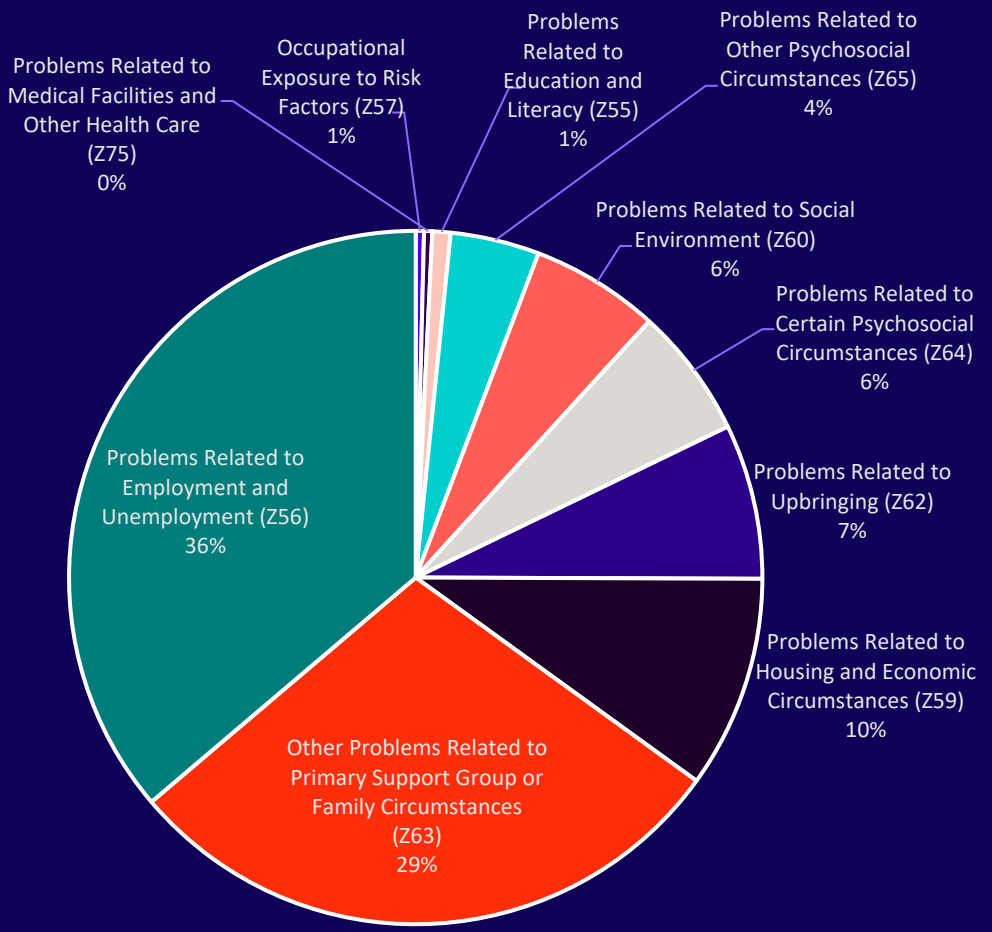
- Use ICD-10-CM Z codes to document health-related social need (ICD-10-CM categories Z55-Z65).
- Assign when documentation specifies an associated problem or risk factor that influences the patient's health.
- Add health-related social need to the problem or diagnosis list.

What are ICD-10-CM Z Codes?[2]

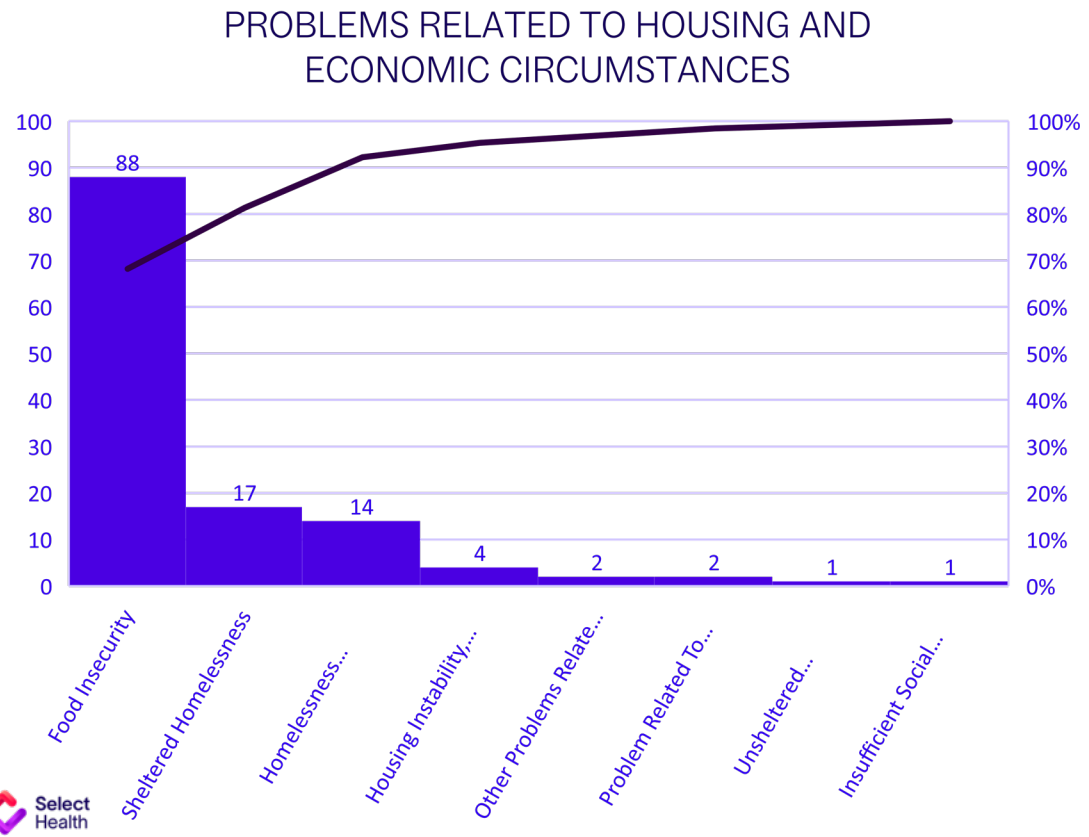
What are the Results of our SDoH Needs Analysis?*

* The Women's Health Quality Provider Program started addressing health-related social needs in 2023, and we asked our clinics to follow the workflow presented in the previous slides.

Results: 2023 Women's Health Quality Program SDoH Needs



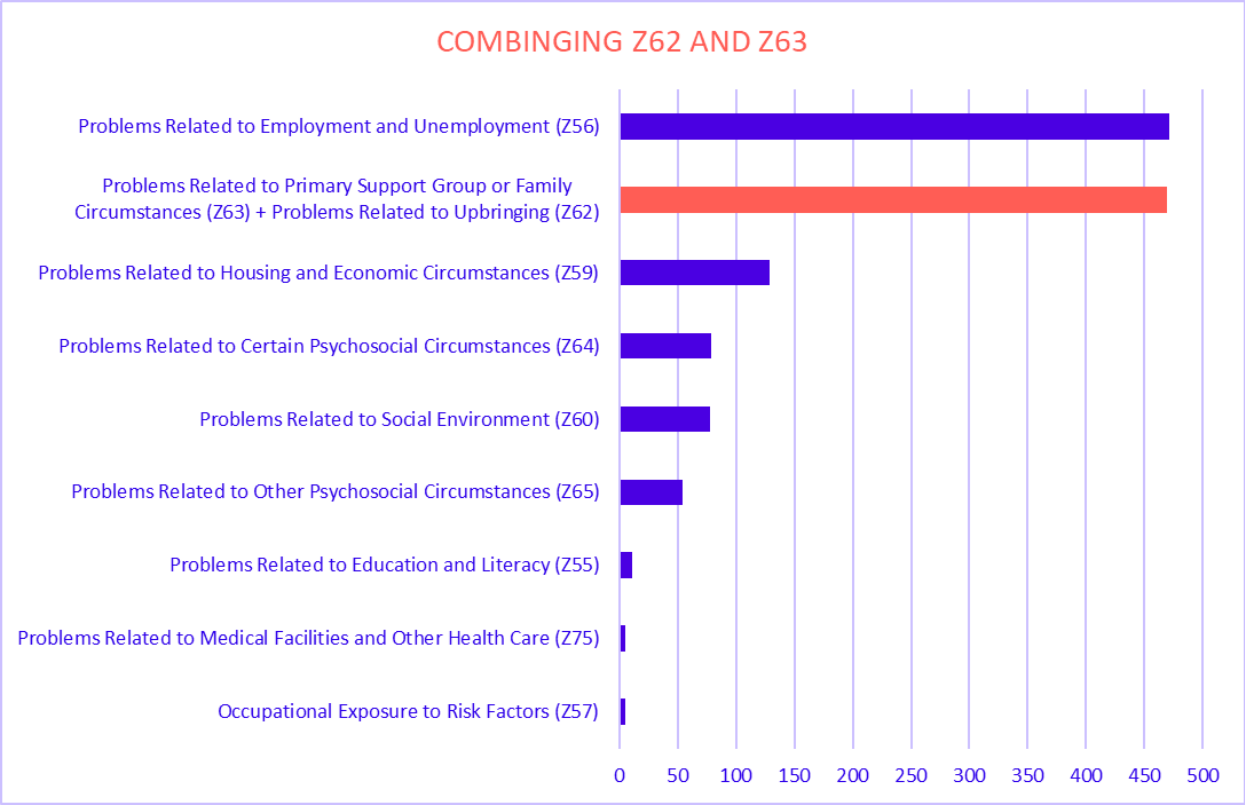
A Closer Look



Top Health-related Needs:

- Food Insecurity
- Housing/Housing Instability
- Other

A Different View



Top Health-related Needs:

- **Unemployment**
- **Primary Support & Family**
- **Housing & Economic Circumstances**

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:

- Team provides education on simplicity of 211 website use.
- Program supports IPV screening implementation and housing resources.

Individual Clinic:

Clinic can create bulletin board with free local food and formula resources.

Could We Grow Better Resources?

Problems related to primary support, family, & upbringing:

Primary Support:

- Make intimate partner violence screening a priority.
- Build a working relationship with local emergency women's shelters.

Family:

- Provide access to maternal home visitation programs.
- Use a different approach to providing care: Centering.

Upbringing:

- Ensure access to local support groups
- Have a goal of 100% PMAD screening.
- Consider ACEs and PTSD screening.

WORKING TOGETHER TO BUILD HEALTHY COMMUNITIES

Thank you!

Select Health

References

1. Reynolds, A. Social Need: *New HEDIS Measure Uses Electronic Data to Look at Screening, Intervention*. National Council for Quality Assurance (NCQA) blog. NCQA.org. https://www.ncqa.org/blog/social-need-new-hedis-measure-uses-electronic-data-to-look-at-screening-intervention/. Accessed May 8, 2024.
2. Centers for Medicare & Medicaid Services. *Improving the Collection of Social Determinants of Health (SDoH) Data with ICD-10-CM Z Codes*. CMS.gov. https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf. Accessed May 8, 2024.

Resources

- **Select Health Resources:**
  - Appreciating the Impact of Social Determinants of Health
  - Care Management at Select Health
  - Quality Provider Program

- **External Links**
  - 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)
  - Oregon Health Authority. Patient-Centered Primary Care Home Program
  - PRAPARE Screening Tool (prapare.org)
  - SEEK – Safe Environment for Every Kid (seekwellbeing.org)

- **Journal Article:** 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.