Social Determinants of Health

The Missing Link in Health Outcomes

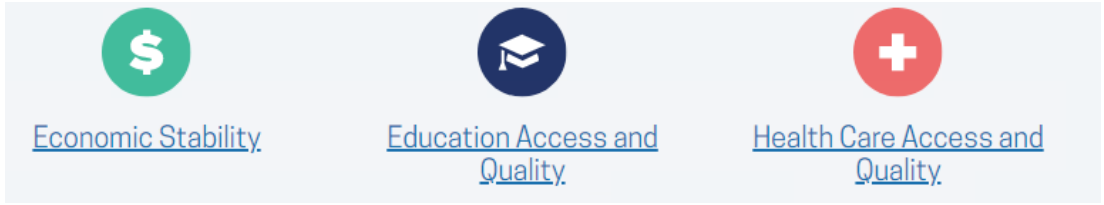
6/17/21
12 Noon – 1:00P

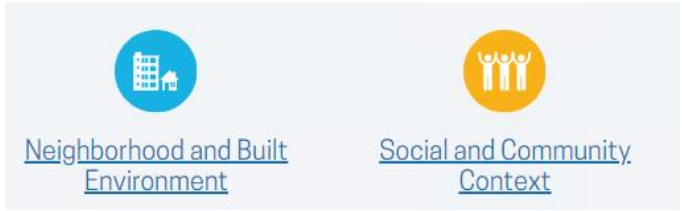
Panelist: Tammy Johnson King
RN, MSW, CCM
Clinical Specialist at CMSA-IPA

Special Guest Panelist:
Tess Lombard, M.D.
Chief Medical Officer of Stay Well Health Center

What are social determinants of health (SDOH)?

- SDOH are the conditions in the environments where people are born, live, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.





What are social determinants of health (SDOH)?

Economic Stability

- Poverty
- Employment
- Food security
- Housing stability

Education Access & Quality

- Language
- Literacy
- Early childhood Education

Healthcare Access & Quality

- Health literacy
- Primary care access
- Health insurance coverage

Neighborhood & Built Environment

- Housing
- Transportation access
- Air and water quality
- Crime and violence

Social & Community Context

- Discrimination
- Civic participation
- Incarceration

SDOH and Cigna's Efforts

- Cigna created a Social Determinants Index (SDI) derived from 6 domains that describe an individual's risk of unmet health needs.
- The SDI characterizes social determinants of health at a neighborhood level based on zip code and data from US Census Tract.
- The higher the SDI, the greater the risk of unmet needs..
  - Individuals living in HIGH or VERY HIGH risk areas are at greater risk for increased ER utilization, chronic medical conditions, under-diagnosed/managed behavior health conditions.

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CSMS-IPA's SDOH baseline data from Cigna

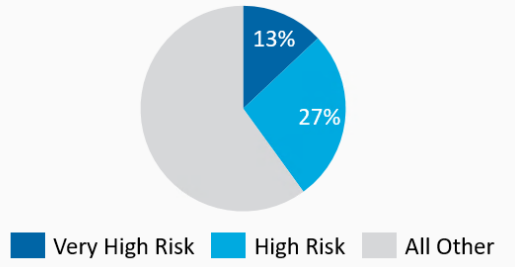
*Approx. 30k actively aligned Cigna members across the IPA network

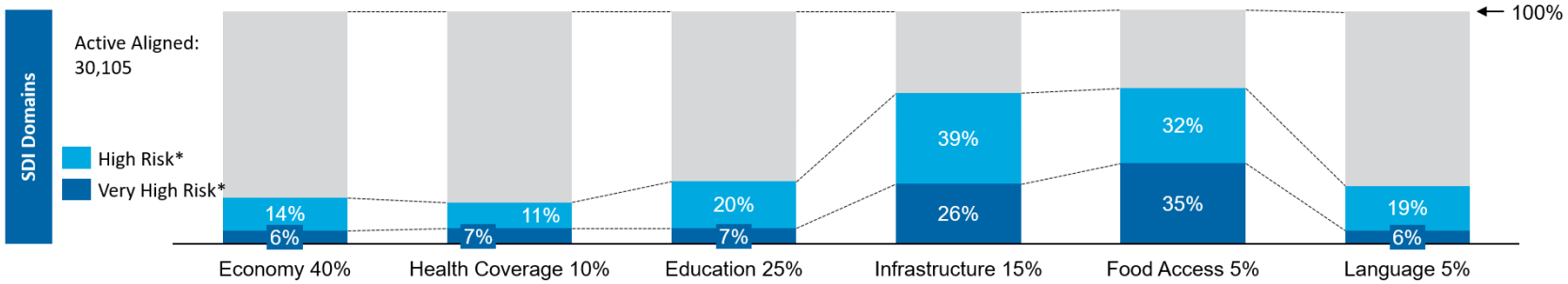
Social Determinants of Health
Active Aligned Population

Median Social Determinants Index (SDI)

57

% of Population Very High or High Risk Categories





Cigna

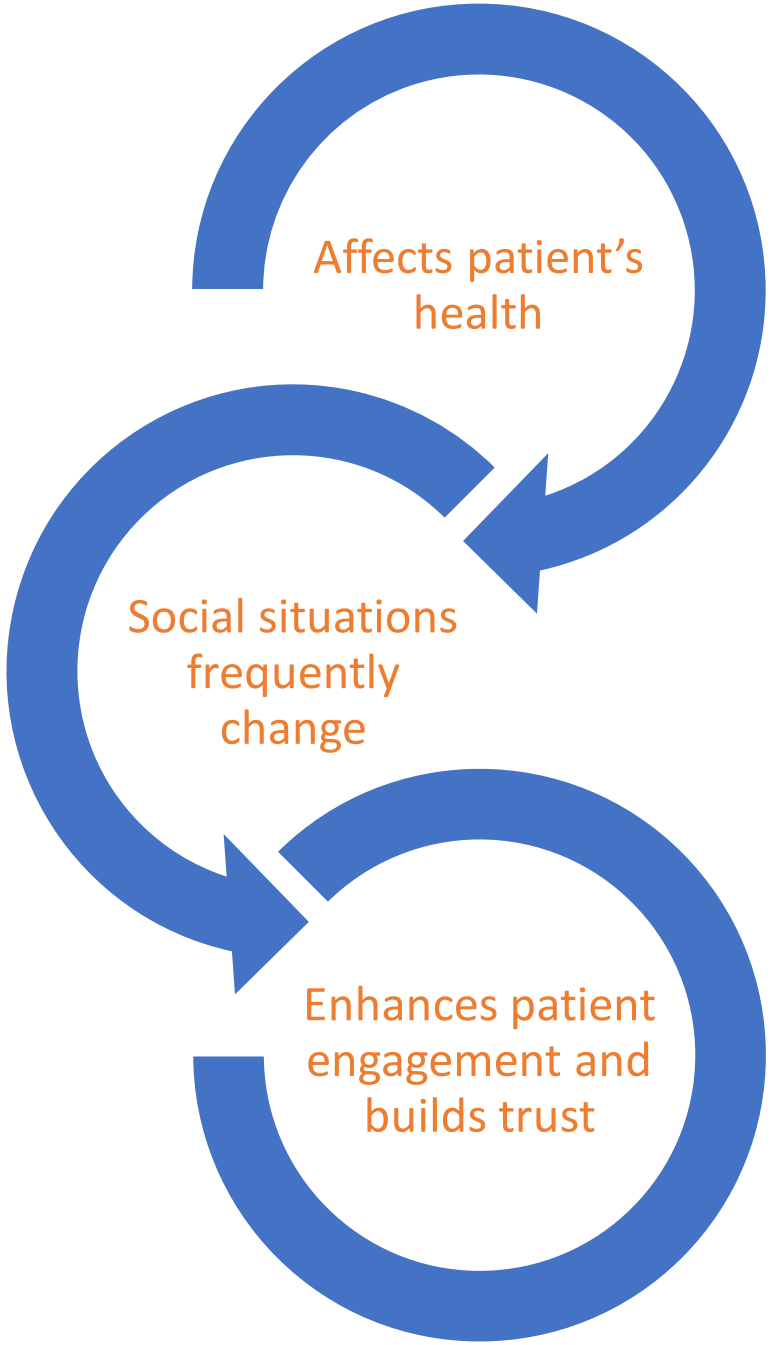
Poll Time

SDOH in Medical Practice: A Physician's Perspective

Tess Lombard, M.D.

Chief Medical Officer of Stay Well Health Center

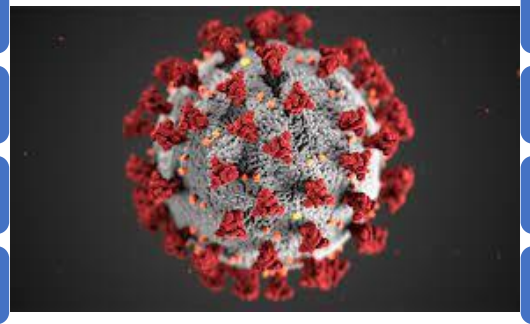
Why should I conduct a SDOH assessment?



- Affects patient health
  - Directly
  - Indirectly
- Social situations may change in between MD visits
- Enhances patient engagement
  - Anticipate their needs
  - Builds trust
  - Can have a positive impact on patient care planning

Perceived Patient + Pandemic = Actual Patient

Employed	Unemployed
Insured	Underinsured
Educated	Lack of educational resources
No sensory deficits	COVID and potentially become a “long hauler”
Stable Housing	Risk of loss of housing/eviction
Stable Daycare	Limited childcare
Strong family support	Isolation from family and supportive network
Chain grocery store	Food insecurity
Has transportation	Limited public transportation/ car repossessed
Not in any discriminatory class	Vulnerable population



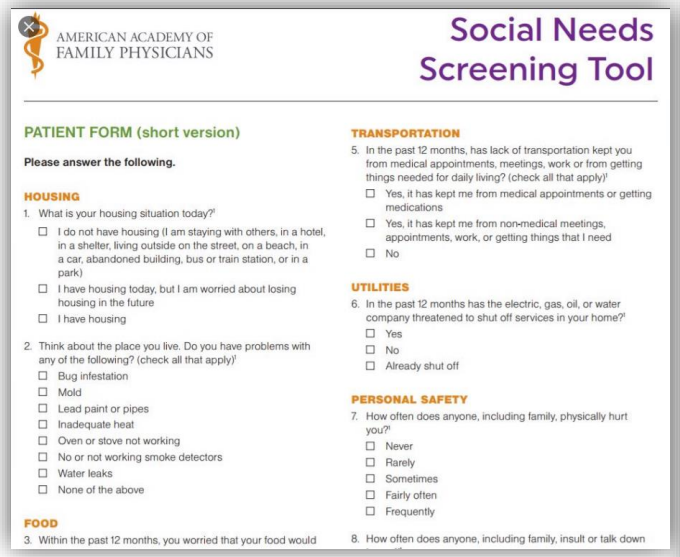
Poll Time

Health Literacy

- **Health literacy** is the degree to which individuals have the capacity to obtain, process, and understand basic **health** information needed to make appropriate **health** decisions.
- Multiple available tools
  - TOFHLA
  - NAAL
  - SAHL-S&E
  - REALM-SF
  - SIS

"How confident are you in filling out medical forms by yourself?"

READ TO SUBJECT: This information is on the back of a container of a pint of ice cream.	ANSWER CORRECT? YES	NO
QUESTIONS		
1. If you eat the entire container, how many calories will you eat? **Answer** 1,000 is the only correct answer	____	____
2. If you are allowed to eat 60 g of carbohydrates as a snack, how much ice cream could you have? **Answer** Any of the following is correct: 1 cup (or any amount up to 1 cup Half the container Note: If patient answers, "2 servings", ask "How much ice cream would that be if you were to measure it into a bowl?"	____	____
3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 g of saturated fat each day, which includes 1 serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day? **Answer** 33 is the only correct answer	____	____
4. If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving? **Answer** 10% is the only correct answer	____	____
Pretend you are allergic to the following substances: Penicillin, peanuts, latex gloves, and bee stings:		
5. Is it safe for you to eat this ice cream? **Answer** No	____	____
6. (Ask only if the patient responds "no" to question) Why not? **Answer** Because it has peanut oil.	____	____
Total Correct	_____	



AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

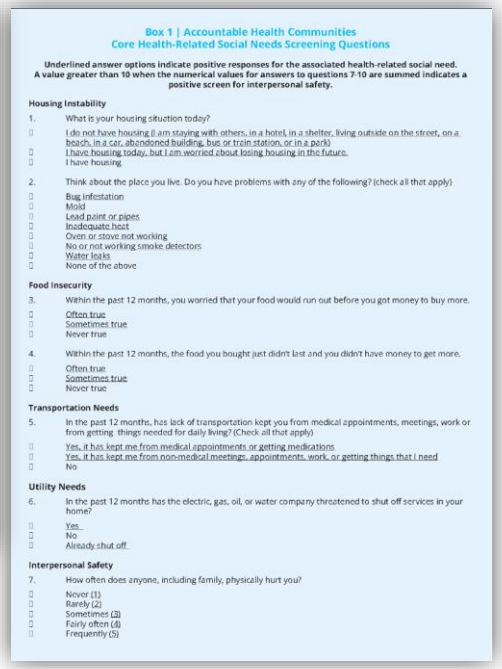
UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

8. How often does anyone, including family, insult or talk down



Box 1 | Accountable Health Communities
Core Health-Related Social Needs Screening Questions

Underlined answer options indicate positive responses for the associated health-related social need. A value greater than 10 when the numerical values for answers to questions 7-10 are summed indicates a positive screen for interpersonal safety.

Housing Instability

1. What is your housing situation today?
   - I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - I have housing today, but I am worried about losing housing in the future.
   - I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - Bug infestation
   - Mold
   - Lead paint or pipes
   - Inadequate heat
   - Oven or stove not working
   - No or not working smoke detectors
   - Water leaks
   - None of the above

Food Insecurity

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - Often true
   - Sometimes true
   - Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - Often true
   - Sometimes true
   - Never true

Transportation Needs

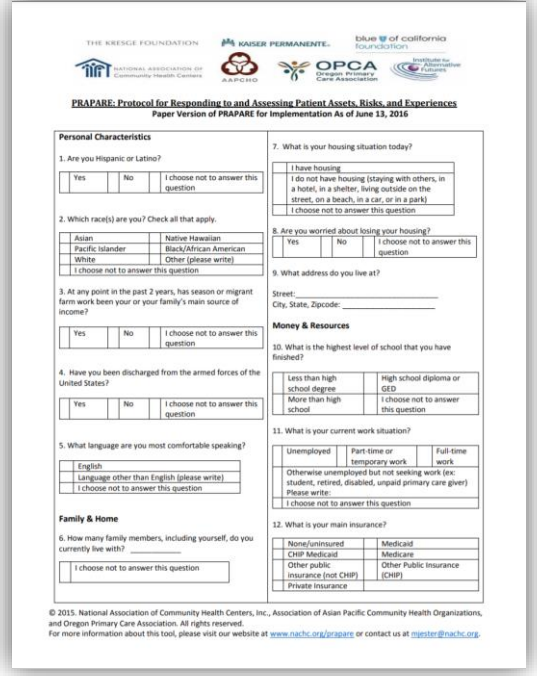
5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (Check all that apply)
   - Yes, it has kept me from medical appointments or getting medications
   - Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - No

Utility Needs

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   - Yes
   - No
   - Already shut off

Interpersonal Safety

7. How often does anyone, including family, physically hurt you?
   - Never (1)
   - Rarely (2)
   - Sometimes (3)
   - Fairly often (4)
   - Frequently (5)



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PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE for Implementation As of June 13, 2016

Personal Characteristics

1. Are you Hispanic or Latino?
   - Yes | No | I choose not to answer this question

2. Which race(s) are you? Check all that apply.
   - Asian | Native Hawaiian
   - Pacific Islander | Black/African American
   - White | Other (please write)
   - I choose not to answer this question

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
   - Yes | No | I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?
   - Yes | No | I choose not to answer this question

5. What language are you most comfortable speaking?
   - English
   - Language other than English (please write)
   - I choose not to answer this question

Family & Home

6. How many family members, including yourself, do you currently live with? _____
   - I choose not to answer this question

7. What is your housing situation today?
   - I have housing
   - I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
   - I choose not to answer this question

8. Are you worried about losing your housing?
   - Yes | No | I choose not to answer this question

9. What address do you live at?

   Street: _____
   City, State, Zipcode: _____

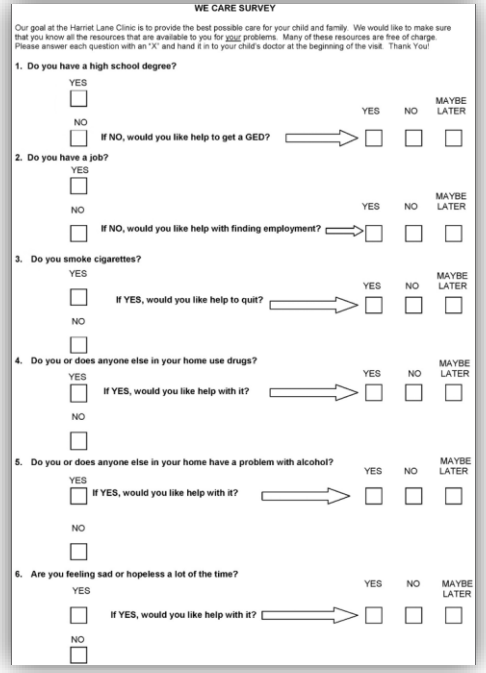
Money & Resources

10. What is the highest level of school that you have finished?
    - Less than high school degree | High school diploma or GED
    - More than high school | I choose not to answer this question

11. What is your current work situation?
    - Unemployed | Part-time or temporary work | Full-time work
    - Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:
    - I choose not to answer this question

12. What is your main insurance?
    - None/uninsured | Medicaid
    - CHIP Medicaid | Medicare
    - Other public insurance (not CHIP) | Other Public Insurance (CHIP)
    - Private Insurance

For more information about this tool, please visit our website at www.nachc.org/prapare or contact us at mjester@nachc.org.



WE CARE SURVEY

Our goal at the Harriet Lane Clinic is to provide the best possible care for your child and family. We would like to make sure that you know all the resources that are available to you for your problems. Many of these resources are free of charge. Please answer each question with an "X" and hand it in to your child's doctor at the beginning of the visit. Thank You!

1. **Do you have a high school degree?**
   YES ☐ NO ☐ — If NO, would you like help to get a GED? → YES ☐ NO ☐ MAYBE LATER ☐
2. **Do you have a job?**
   YES ☐ NO ☐ — If NO, would you like help with finding employment? → YES ☐ NO ☐ MAYBE LATER ☐
3. **Do you smoke cigarettes?**
   YES ☐ — If YES, would you like help to quit? → YES ☐ NO ☐ MAYBE LATER ☐ NO ☐
4. **Do you or does anyone else in your home use drugs?**
   YES ☐ — If YES, would you like help with it? → YES ☐ NO ☐ MAYBE LATER ☐ NO ☐
5. **Do you or does anyone else in your home have a problem with alcohol?**
   YES ☐ — If YES, would you like help with it? → YES ☐ NO ☐ MAYBE LATER ☐ NO ☐
6. **Are you feeling sad or hopeless a lot of the time?**
   YES ☐ — If YES, would you like help with it? → YES ☐ NO ☐ MAYBE LATER ☐ NO ☐

Choosing a SDOH Questionnaire

- Adult Population
  - Social Needs Screening Tool - AAFP
  - Health Related Social Needs Screening Tool– CMS
  - PRAPARE/PRAPARE Lite- NACHC
  - EMR
- Pediatric Population
  - We Care Survey – AAP
  - EMR

Suggested Workflows for Administering the SDOH Tool

- As you address SDOH in your practice setting, bring together your health care team to provide the services efficiently, and establish a process that works for your practice setting.
- Establish clear guidelines on roles and responsibilities for your team members. This will vary based on your practice size and structure.
- Allow for adequate time to review completed SDOH.
- Prepare for positive responses and need for referrals.

Receptionist/ Medical Assistants	Nurses, Health Educators	Primary Care Physicians, Advanced Practice Providers	Administrators	Community Health Workers/ Social Workers
• Provide the SDOH tool to patients upon check in • Make educational materials and resources available in waiting areas/exam rooms	• Review the completed SDOH tool and determine patient' needs • Determine available resources and complete an action plan with patient • Counsel patient during visit and assist with the necessary follow up	• Review the completed SDOH tool and action plan, incorporate action plan into visit • Refer patients to additional team members or resources as needed	• Ensure adequate resources and staffing to assist with screening • Communicate to each staff members their responsibilities • Provide training and education to current and new staff	• Determine resources available in the community • Facilitate referrals based on patient's needs • Provide ongoing care coordination as needed

“My patient has a positive response on the SDOH tool, now what?”

Communicate and build trust with your patient around the SDOH issue(s) and address unmet needs.

Develop an action plan with the patient.

Consider a referral to the patient’s health plan, specialty program, 211, local community resources

Have educational materials and pamphlets available to provide to patients at the time of the visit.

Poll Time

Case Example and Best Practices

- Remember, the SDOH assessment can be used as a tool to gain further insight into your patient and their health.
- Decide what works for your care team and practice structure.
  - Focus on a single area of opportunity, then expand
- Develop a plan to administer the SDOH screenings if you aren't currently .
- Be prepared and have a plan to respond to positive responses. Be sure to always follow up on patient action plans and referrals.
- Understand this may allow patients to feel more comfortable sharing more private information with you.

Poll Time

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StayWell Health Center
Growing a healthier community one person at a time.

Next Steps

Building Your Resources

- Identify community resources and services available within your demographic area to help address potential patient needs.
- 1 pagers and flyers are helpful
- https://www.benefitscheckup.org
- *New!* Resource Directory from the Yale COACH 4M project is now available on the Geriatrics website: https://medicine.yale.edu/intmed/geriatrics/agingresources/directory/

Cigna's SDOH Reporting Requirements

- Providers will ensure that all aligned members who are 18 years of age and older are screened for SDOH on the date of the encounter, using an appropriate tool that focuses on the 5 core domains: *housing, food, transportation, utilities, and personal safety.*
- *Starting 7/1/21 the IPA will be collecting the number of SDOH assessments conducted by the practices.*

Quality Metrics

Patient Experience	
Social Determinants of Health	Patients 18 and older are screened for social determinants of health on date of encounter (housing, food, transportation, utilities, and personal safety) through ICD-10 codes z13.9,z55-z65 or monthly report to CSMS-IPA on the number of assessments that have been completed during the measurement period

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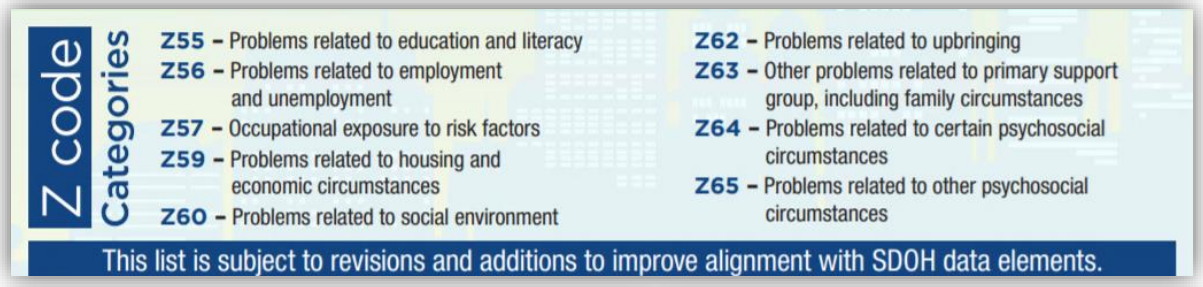
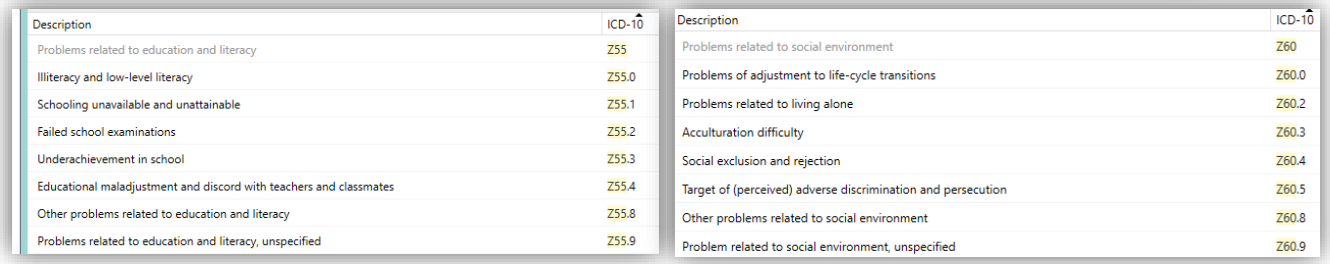
Ways to Report SDOH Screenings

- Submission of claims with ICD-10 codes
- Z13.9 for “encounter of screening, unspecified” (Cigna only)
- Z55 – Z65 (all other payers)

ICD-10	Description	Number of Sub-Codes	Frequently Used Sub-Codes and Description
Z55	Problems related to education and literacy	7	Z55.0 – Illiteracy and low-level literacy Z55.8 – Other problems related to education and literacy
Z56	Problems related to employment and unemployment	12	Z56.0 – unemployment, unspecified Z56.3 – Stressful work schedule Z56.6 – Other physical and mental strain related to work Z56.89 – Other problems related to employment
Z57	Occupational exposure to risk factors	12	Z57.8 – Occupational exposure to other risk factors
Z59	Problems related to housing and economic circumstances	10	Z59.0 – Homelessness Z59.1 – Inadequate housing Z59.4 – Lack of adequate food and safe drinking water Z59.5 – Extreme poverty Z59.6 – Low income Z59.7 – Insufficient social insurance and welfare support Z59.8 – Other problems related to housing and economic circumstances
Z60	Problems related to social environment	7	Z60.8 – Other problems related to social environment
Z62	Problems related to upbringing	24	Z62.819 – Personal history of unspecified abuse in childhood
Z63	Other problems related to primary support group, including family circumstances	14	Z63.0 – Problems in relationships with spouse or partner
Z64	Problems related to certain psychosocial circumstances	3	Z63.79 – Other stressful life events affecting family and household
Z65	Problems related to other psychosocial circumstances	8	Z65.8 – Other specified problems related to psychosocial circumstances





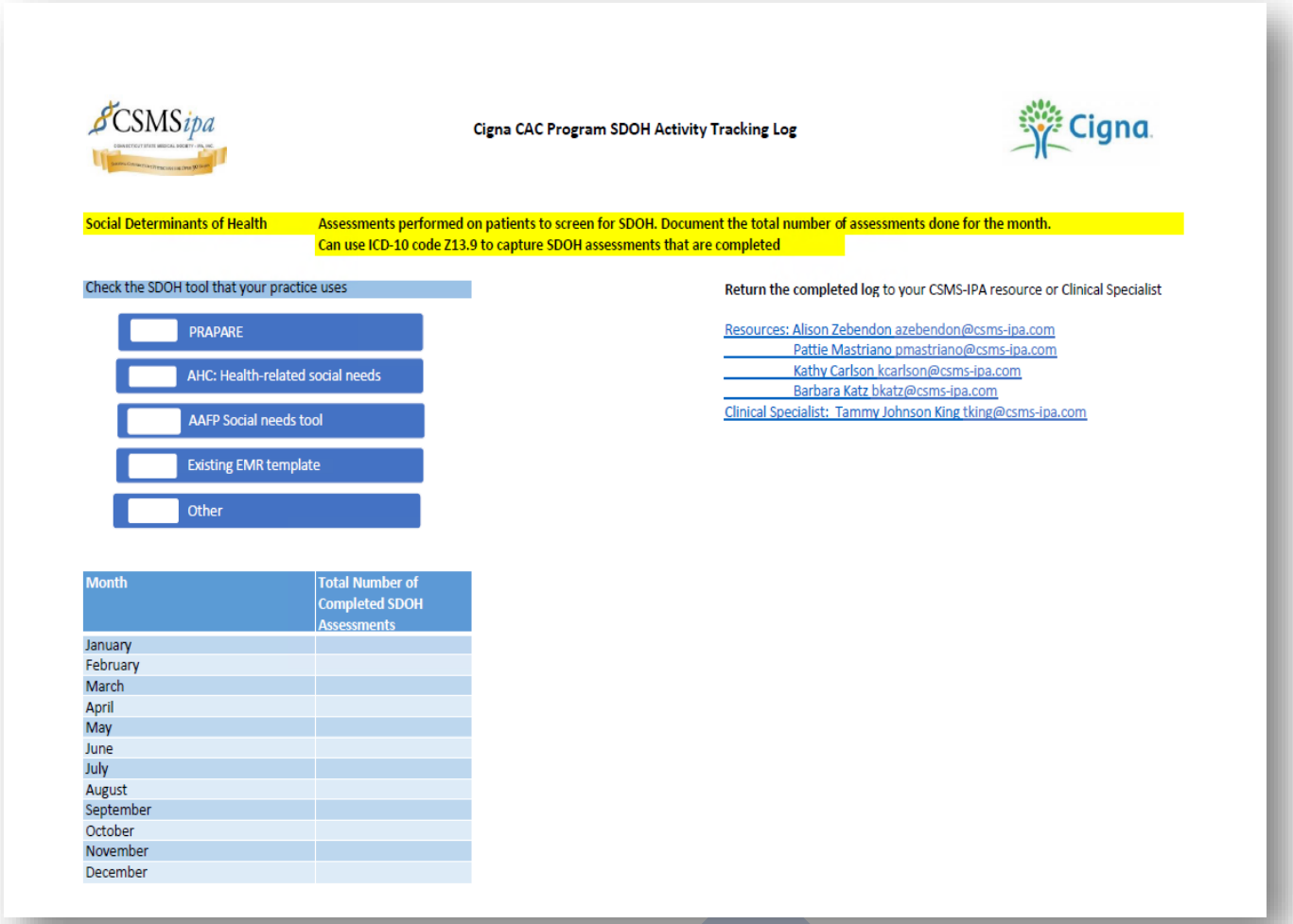
Description	ICD-10
Problems related to education and literacy	Z55
Illiteracy and low-level literacy	Z55.0
Schooling unavailable and unattainable	Z55.1
Failed school examinations	Z55.2
Underachievement in school	Z55.3
Educational maladjustment and discord with teachers and classmates	Z55.4
Other problems related to education and literacy	Z55.8
Problems related to education and literacy, unspecified	Z55.9

Description	ICD-10
Problems related to social environment	Z60
Problems of adjustment to life-cycle transitions	Z60.0
Problems related to living alone	Z60.2
Acculturation difficulty	Z60.3
Social exclusion and rejection	Z60.4
Target of (perceived) adverse discrimination and persecution	Z60.5
Other problems related to social environment	Z60.8
Problem related to social environment, unspecified	Z60.9

Example of ICD-10 subcodes

Ways to Report SDOH Screenings

- Monthly report to the IPA the number of completed SDOH screenings



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Cigna CAC Program SDOH Activity Tracking Log

Cigna

Social Determinants of Health	Assessments performed on patients to screen for SDOH. Document the total number of assessments done for the month. Can use ICD-10 code Z13.9 to capture SDOH assessments that are completed

Check the SDOH tool that your practice uses

- ☐ PRAPARE
- ☐ AHC: Health-related social needs
- ☐ AAFP Social needs tool
- ☐ Existing EMR template
- ☐ Other

Return the completed log to your CSMS-IPA resource or Clinical Specialist

Resources: Alison Zebendon azebendon@csms-ipa.com
Pattie Mastriano pmastriano@csms-ipa.com
Kathy Carlson kcarlson@csms-ipa.com
Barbara Katz bkatz@csms-ipa.com
Clinical Specialist: Tammy Johnson King tking@csms-ipa.com

Month	Total Number of Completed SDOH Assessments
January	
February	
March	
April	
May	
June	
July	
August	
September	
October	
November	
December	

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Discussion / Q&A

Resources

- https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources
- Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 6/7/21, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health
- https://www.nachc.org/research-and-data/prapare/
- https://www.nachc.org/wp-content/uploads/2020/07/Printer-Friendly-PRAPARE-COVID-FS.pdf
- https://www.aafp.org/journals/fpm/blogs/inpractice/entry/social_determinants.html
- https://pediatrics.aappublications.org/content/135/2/e296
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2324160/ (Health literacy)
- https://healthliteracy.bu.edu/all
- https://afmc.org/wp-content/uploads/2017/01/Literacy-Tools-UAMS-CHL-DHS-2017.pdf (tool
- comparison)
- https://www.cdc.gov/nchs/icd/icd10cm.htm