Social Determinants of Health

Health Partners Plans

Addressing Social Determinants of Health

Social determinants of health (SDoH) are the conditions in the environment where people are born, grow, work, live and age. They include factors such as **food security**, **housing stability**, **childcare needs**, **utility needs**, **economic stability**, **transportation needs**, **exposure to violence**, and **education needs**.

SDoH data offer rich insights into external conditions impacting health — an especially important consideration in underserved populations that may require complex care.

Benefits of Identifying SDoH for Providers

Providers should aim to improve health, quality and financial outcomes of patients by identifying and beginning to address barriers. **Patients with unaddressed SDoH needs are more likely to miss medical appointments per year.**

No-shows impact not only patient health, but present missed opportunities for provider reimbursement, contribute to lower utilization, and diminish quality measure scores.

SDoH data integration has been shown to improve readmission management, communication between patient and provider, care coordination, and overall patient experience.

The SDoH measure is included in HPP'S Quality Care Plus (QCP) program for both Medicare and Medicaid in 2021.

Medicaid sites that reach Tier 4 will earn a $1.25 PMPM bonus payment. Medicare sites that reach Tier 4 will earn a $1.50 PMPM bonus payment.

Steps to Achieving Success

1. Adopt or Develop a Screening Tool

Pull from research and needs defined at the provider level to develop a tool best for your practice.

HPP recommends that provider offices adopt a SDoH screening tool that captures the following domains: economic stability; food insecurity; housing instability; transportation; health care/medical access/affordability; childcare; employment; utilities; and clothing.

2. Define a Workflow

Determine how SDoH screening will function operationally at your practice.

Map out the process to pinpoint key decision areas and find potential problem areas before implementation. **Consider screening opportunities outside of annual/well visits, such as sick visits, vaccination clinics and pediatric visits.**

Your SDoH workflow should address the following questions:

- Which patients will be screened and during what part of the clinic encounter?
- Who is responsible for administering the screening, and who is responsible for acting on results?
- Will the screener be administered on paper or verbally?
- How will results and referrals be documented?

Screening for SDoH does not need to be administered by a physician; a screening can be performed upon check in or while rooming so that it does not disrupt the flow of the visit. The screening tool can be self-administered on paper or given via an in-person interview. Individuals may be more likely to disclose sensitive information, such as interpersonal violence, when self-administered.

3. Be Actionable

As part of your practice's SDoH process, develop actionable steps, such as referring patients with a positive screen to local resources.

Utilize an SDoH platform (your own or leverage HPP's subscription with Aunt Bertha) for referrals and connections to community organizations.

Consider creating resource guides that can be distributed to patients that may benefit from connecting with local resources and community organizations.

Prepare patient action plan templates for staff to define referral and follow-up protocols.

4. Establish Billing Procedures

Review best practices for SDoH coding and claim submission to ensure quality data sharing and maximize reimbursement (see HPP resources at the end of this document).

Staff should become familiar with diagnosis codes and the submission of both negative and positive screening claims. For assessments completed in which no barriers have been identified, submit HCPCS code G9920 only. Submit the appropriate diagnosis code(s) and HCPCS code G9919 if you complete a SDoH screening assessment and identify barriers.

5. Train and Educate Staff

Create best practices, responsibilities and FAQ resources for staff. These resources should cover general SDoH information and specific information for primary task areas.

Providers should re-examine their SDoH process annually. HPP encourages providers to develop a system for ongoing evaluation of the screening process, including recognizing and fixing barriers, which can keep the screening process efficient.

Staffing Roles & Expectations

Reception Staff, Medical Assistants and Health Educators

- Distribute or administer screening tool to patients
- Make pre-approved educational materials and resources available in waiting areas and exam rooms

Nurse Practitioners, Physician Assistants, and Physicians

- Review the completed SDoH screening tool and incorporate into the care plan
- Consider SDoH barriers when addressing care gaps
- Discuss SDOH at subsequent visits to ensure patients are accessing needed resources
- Refer patients to other care team members as needed

Social Workers, Community Health Workers, and Nurse Navigators

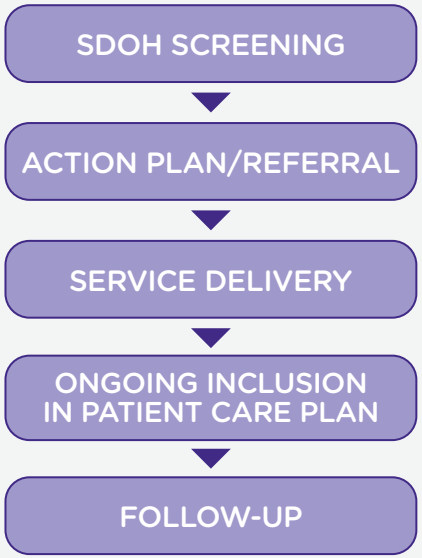
- Review the completed SDoH screening tool and determine patient needs
- Determine resources available and complete an action plan with patients
- Track referrals for patients with actionable needs

Administrators

- Ensure adequate resources and staffing
- Communicate responsibilities and expectations
- Provide ongoing training and education to staff, assuring new staff are also trained
- Continue to develop screening protocol considering updated best practices and staff/patient feedback

Tips & Best Practices

- Set a goal of screening each patient for SDoH at least once per calendar year.
- Evaluate your practice's readiness before implementing an SDoH screener. Start small if necessary; screen for one domain, such as food insecurity, that you have resources available to provide to your patients.
- If patient abrasion is a concern, consider a pre-screener or patient support survey. These tools allow patients to define only the needs that are of personal concern to them.
- Minimize administrative burden and mitigate vulnerabilities in your screening process by integrating SDoH into patients' EHR.
- Take advantage of HPP's care gap report available on NaviNet to identify member-level SDoH screening opportunities.
- Communicate expectations, accountability, and responsibility for referrals to your staff.



HPP Resources

HPP Website: Visit www.healthpartnersplans.com/providers to access resources and information for participating providers.

Aunt Bertha: Visit hpp.auntbertha.com to access our premium search platform for community resources. Aunt Bertha is free to use. Contact your Network Account Manager to request credentials so you can make and track referrals.

SDoH Diagnosis Codes: This resource provides specific screening diagnosis codes and best practices for submission.

SDoH Screening Questions by Domain: This resource provides examples of nationally recognized assessment questions by DHS domain to use when developing your practice's screener.

Other SDoH Resources

PRAPARE Toolkit: The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help providers collect the data needed to better understand and act on their patients' SDoH barriers.

The **PRAPARE** social needs screening tool is available in 25+ languages. PRAPARE EHR templates exist for EPIC, eClinicalWorks, Cerner, athenaPractice (formerly GE Centricity), NextGen and more, and are freely available to the public.

Health Leads Toolkit: The Health Leads Screening Toolkit combines a patient-centered approach to social needs screening and clinically validated guidelines for integration of SDoH into care delivery.

AAFP Screening Tool: The Social Needs Screening tool can be used by care teams to develop an action plan with patients and help them improve health outcomes.

SDoH Implementation Toolkit: This resource from the Caring Beyond Healthcare project provides action steps for developing an SDoH pilot in your practice.

"The Feasibility of Screening for Social Determinants of Health, Seven Lessons Learned": This article explores common barriers to implementation of an SDoH protocol for provider offices and shares positive results of an SDoH pilot project.

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