Maryland | Medicaid

Social determinants of health

Addressing social determinants of health in primary care

November 2022

Wellpoint

Agenda

I. Introduction to social determinants of health (SDOH)
II. Addressing SDOH in primary care
III. Team-based approach to SDOH
IV. Food Insecurity Provider Incentive Program (FIPIP) overview
V. Documenting SDOH
VI. Next steps

What are SDOH?

SDOH

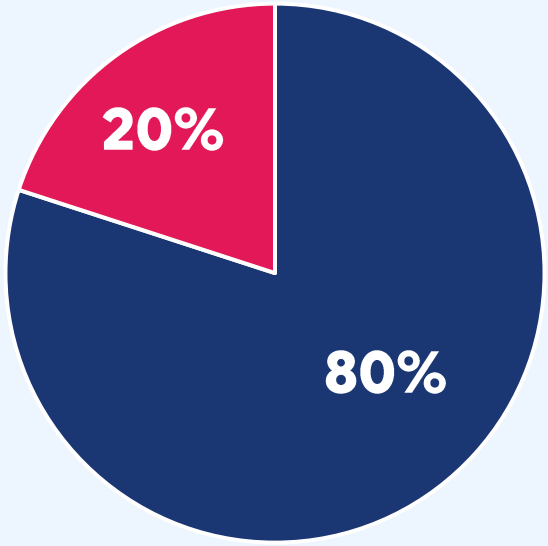
SDOH are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.

Economic stability	Education	Social/community context	Health/ health care	Neighborhood environment
• Employment • Food insecurity • Housing instability • Poverty	• Early childhood education and development • Enrollment in higher education • High school • Graduation • Language and literacy	• Civic participation • Discrimination • Incarceration • Social cohesion	• Access to healthcare • Access to primary care • Health literacy	• Access to foods that support healthy eating patterns • Crime and violence • Environmental conditions • Quality of housing

SDOH and health outcomes

Medical care: This accounts for 10 to 20% of modifiable contributors to healthy outcomes.

SDOH: 80 to 90% of healthy outcomes are impacted by health-related behaviors, socioeconomic factors, and environmental factors.



Addressing SDOH in primary care

How do you address SDOH?

Open discussion

- How does your practice currently identify and document SDOH, if at all? Whose responsibility is this?
- In what ways does your practice currently help address patients' SDOH?
  - Screen for SDOH.
  - Maintain up-to-date records of community-based resources.
  - Refer patients to community-based resources.
  - Engage patients about how to overcome their SDOH.

Open discussion (cont.)

- What systems do you have in place to ensure SDOH are addressed at patient visits?
  - Review prompts in electronic health records.
  - Identify SDOH as part of a patient's vital signs.
  - Maintain registry of patients by categories of SDOH.
  - Use flags or stickers on paper charts.

Team-based approach for addressing SDOH

- Ask patients about their SDOH.
- Identify resources in the patient's community that can help address SDOH.
- Act by connecting patients with resources that address their SDOH.

Ask patients about their SDOH

Sample patient visit	SDOH actions and considerations
Patient checks in.	Display posters in the waiting room that prompt patients to discuss their social needs.
Patient sits in waiting room.	Distribute SDOH screening tool at check-in to be completed in the waiting room.
Height and weight checked in hallway.	Nurse/medical assistant (MA) confirms social needs with patient and provides information to office clerk to cross reference social needs with available community resources.
Remaining vital signs checked in exam room.	Display posters in exam room that prompt patients to discuss their social needs.
Patient meets with clinician.	Clinician discusses social needs with patient and shares available resources and works to develop a plan to address patient's SDOH.
Patient meets with counselor.	Nurse/MA finalizes plan to address SDOH and provides referrals to community resources.
Patient stops at billing/scheduling station.	Office staff schedules follow-up appointment.
Patient leaves.	

Source: American Academy of American Physicians

Ask patients about their SDOH (cont.)

Screening tools	
Accountable Health Communities Screening Tool	• CMS developed a 10-item screening tool to identify patient needs in five domains (food security, housing, transportation, utility, and safety) • Designed to be short, accessible, consistent, and inclusive
The PRAPARE tool	• Set of national core measures • Aligns with national initiatives prioritizing SDOH (Health People 2020) • Emphasizes measures that are actionable • Templates exist for eClinicalWorks, Epic, GE Centricity, and NextGen
Health leads	• 10-item screening tool • Updated language to foster meaningful/effective dialogue between providers and patients around essential needs • Fully translated questionnaire template to remove barriers for Spanish-speaking patient populations

The Accountable Health Communities Health-Related Social Needs (AHC HRSN) screening tool

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily 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)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

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

Identify resources

Local health departments

Arundel

Baltimore City

Baltimore

Howard

Montgomery

Prince Georges

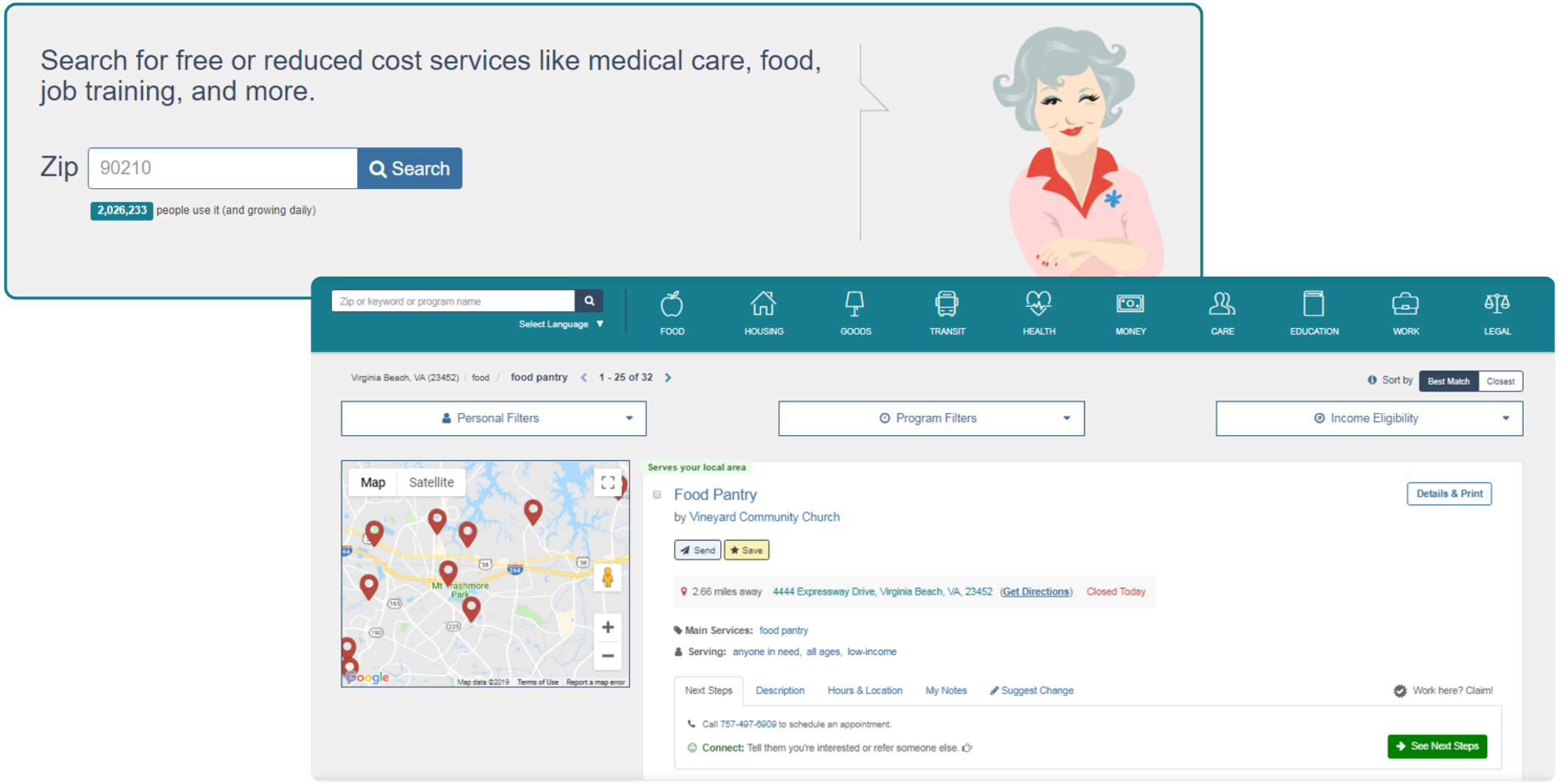
State-wide resources

Coordinating entities	• Maryland United Way 2-1-1 Helpline — information and community resources from a trusted call specialist 24 hours a day, 7 days a week (food, shelters and emergency housing, transitional housing, medical care, utility assistance, tax help, job training, eviction prevention services, family services, day care, prescription assistance, suicide prevention, crisis center services)
Food insecurity	• Moveable Feast — meal delivery for those living with HIV/AIDS, cancer and other life-threatening illnesses; prepare and deliver nutritious meals and groceries and provide nutritional counseling and other services; the only provider of medically tailored meals – free-of-charge – for people with serious illnesses
Housing	• Main Street Housing, Inc. — provides supportive housing opportunities for low-income residents of Maryland with mental illness; housing is available to individuals and families • Affordable Housing Online — has a list of affordable housing options in Maryland, as well as waitlist information for housing; the site also provides county-specific Public Housing Authority information

State-wide resources (cont.)

Jobs	• Second Chance — committed to employing the unemployed, underemployed and others facing barriers to employment; Second Chance creates living-wage, green-collar jobs and trains people to succeed in them • Living Classrooms — inspires children, youth, and adults to achieve their potential through hands-on education, workforce development, health and wellness, and violence prevention programming
Child care	• Maryland Family Network — Child Care Subsidy Program offered by the state of Maryland to help low-income families pay for childcare while parents work, attend school, or participate in job training programs
Behavioral health	• B'More Clubhouse — invites individuals living with mental illness into a community engaged in building meaningful lives, bridging the gap between patient-hood and personhood • National Alliance on Mental Illness (NAMI) Maryland — provides educational resources and events, statewide outreach, advocacy and affiliate organizational support; NAMI Maryland provides free trainings that allow NAMI affiliates to deliver NAMI programs

Aunt Bertha


Search for free or reduced cost services like medical care, food, job training, and more.
Zip
90210
Search
2,026,233 people use it (and growing daily)
Zip or keyword or program name
Select Language
FOOD
HOUSING
GOODS
TRANSIT
HEALTH
MONEY
CARE
EDUCATION
WORK
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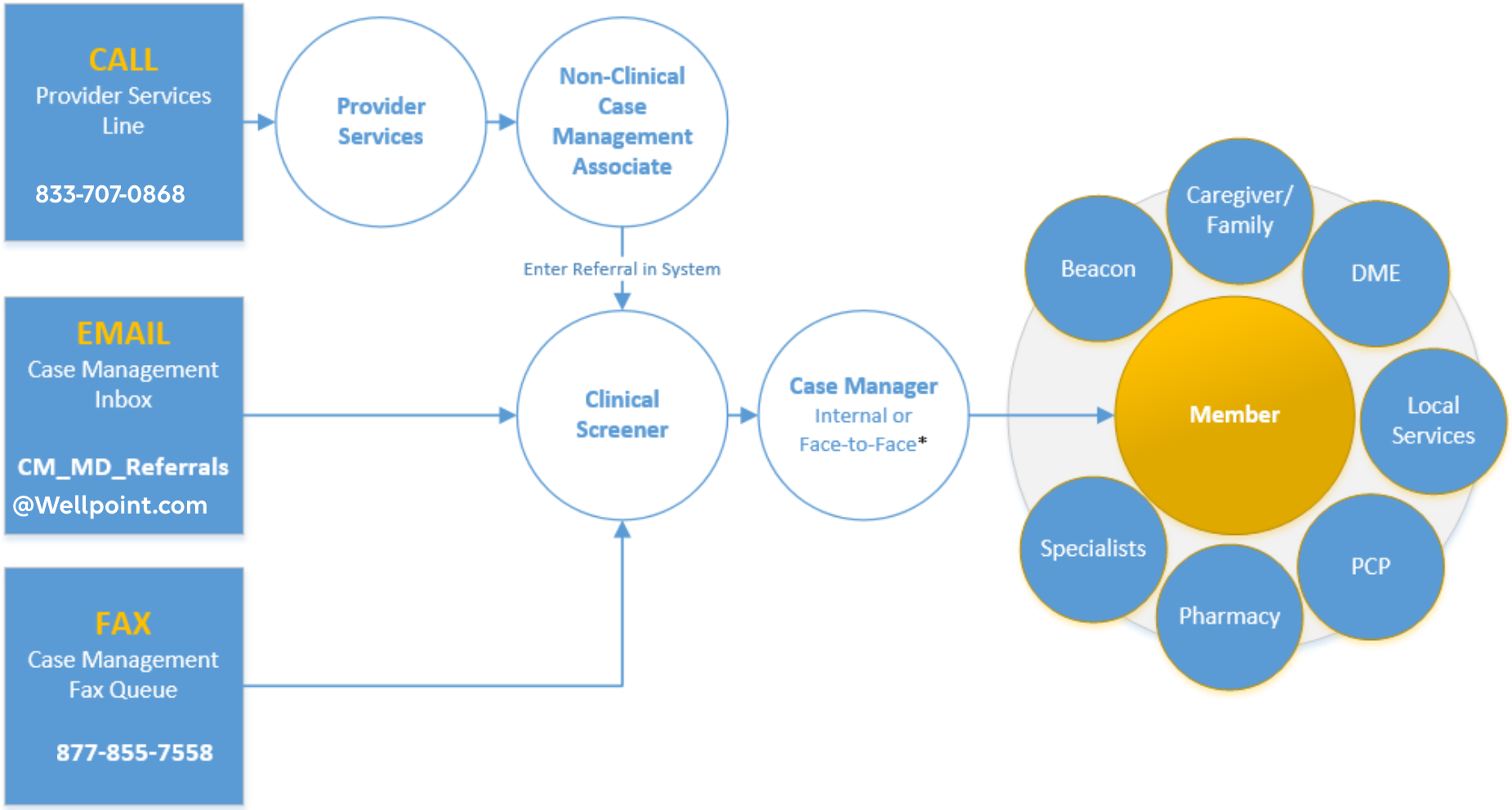
Virginia Beach, VA (23452) / food / food pantry 1 - 25 of 32
Sort by
Best Match
Closest
Personal Filters
Program Filters
Income Eligibility
Map
Satellite
Serves your local area
Food Pantry
by Vineyard Community Church
Details & Print
Send
Save
2.66 miles away
4444 Expressway Drive, Virginia Beach, VA, 23452
(Get Directions)
Closed Today
Main Services: food pantry
Serving: anyone in need, all ages, low-income
Next Steps
Description
Hours & Location
My Notes
Suggest Change
Work here? Claim!
Call 757-497-6909 to schedule an appointment.
Connect: Tell them you're interested or refer someone else.
See Next Steps

Act: connect patients with resources

- Call community resources on a patient's behalf.
- Direct member to community resource(s).
- Refer member to Wellpoint Case Management.

How to refer to Wellpoint Case Management



*Face-to-face case management is delivered through delegated partner The Coordinating Center (TCC)

Partnering with you

Food Insecurity Provider Incentive Program (FIPIP)

Food Insecurity Provider Incentive Program (FIPIP)

FIPIP will financially incentivize providers to proactively evaluate members for food insecurity and refer those in need to local food banks & community resources.

Objectives:

- Partner with providers in an effort to identify members who are food insecure.
- Assist members with food insecurity by connecting them with community resources like local food pantries.
- Help members with basic needs (like food) in an effort to improve member health outcomes.

Food Insecurity Provider Incentive Program (FIPIP) (cont.)

Target Provider Types:

- PCPs
- Pediatricians
- OBs
- BH professionals
- Emergency medicine providers

FIPIP Overview

Providers will be asked to administer a short **2-question screening: Hunger Vital Sign™***

- 2-question screening tool based on the *US Household Food Security Scale* to identify young children in households at risk of food insecurity.
- Measures families' concerns about and access to food, much the way healthcare providers check other key vital signs, such as pulse and blood pressure.

If a member has been identified as food insecure, the provider will submit a **Z59.4** Dx code (lack of adequate food and safe drinking water) on their claim with **4551F** Category II code, which is how we will determine incentive payment eligibility.

The Hunger Vital Sign™ identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):

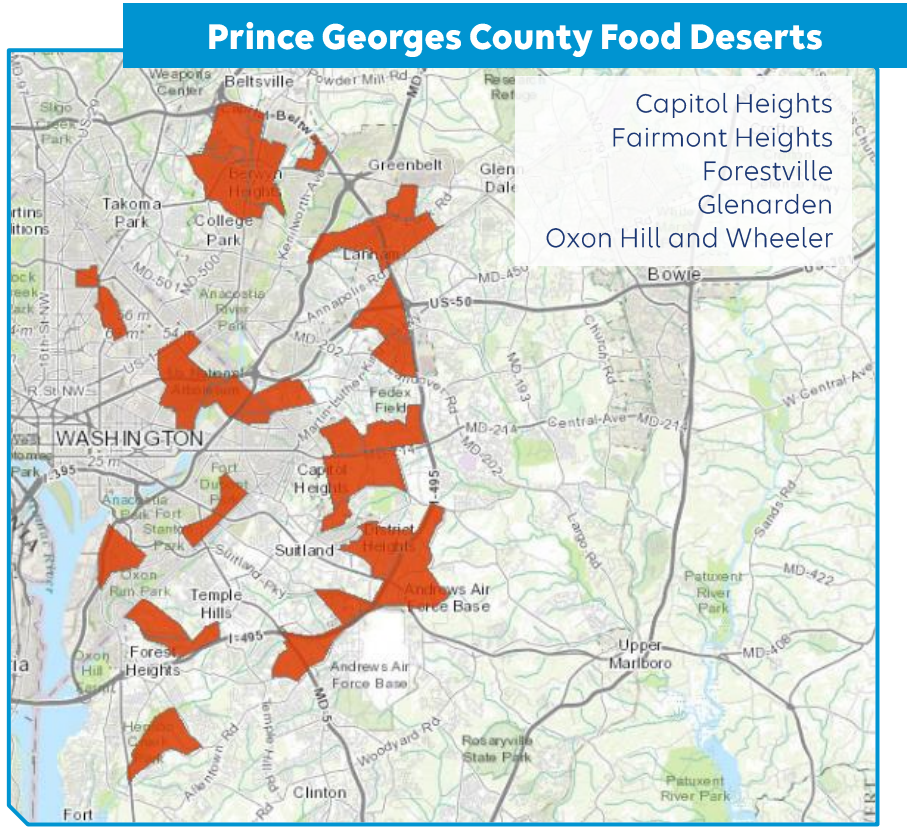
> **" Within the past 12 months we worried whether our food would run out before we got money to buy more."**

> **" Within the past 12 months the food we bought just didn't last and we didn't have money to get more."**

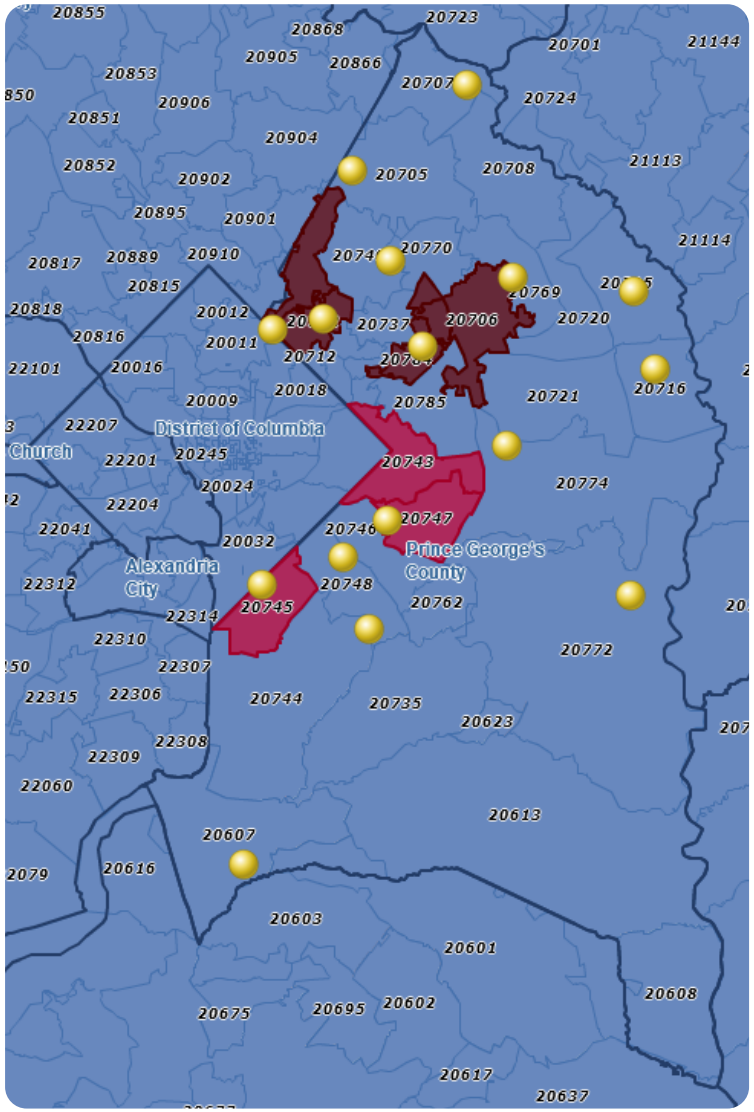
Required documentation	
Diagnosis code: Z59.4	Lack of adequate food and safe drinking water
Category II code: 4551F	Nutritional support offered

Produce Rx

- **Produce Rx** equips medical professionals at participating clinics to prescribe produce vouchers and nutrition education to patients experiencing diet-related chronic disease.
- Successful D.C. implementation
- **Target population**
  - Chronically ill Latino and African American;
  - Adults chronically ill (diabetes/hypertension); adult pre-diabetic;
  - Pilot for 100 to 200 Wellpoint members



Prince Georges County — food deserts/COVID cases



Zip	City	COVID (#)
20743	Capitol Heights/Fairmount Heights	843
20747	Forestville	862
20706	**Glenarden**	**1,578**
20745	Oxon Hill	740
20782	**Hyattsville**	**1,414**
20783	**Hyattsville**	**2,730**
20784	**Hyattsville**	**1,350**

Giant Food locations (in Prince Georges County)

Documenting SDOH

Food Insecurity Provider Incentive Program (FIPIP)

Coding for SDOH

- Z59-Z60 identify persons with potential health hazards related to SDOH.
- A minority of encounters/physicians capture SDOH.
- Opportunity to leverage SDOH assessments are embedded in electronic medical records.
- Official ICD-10 coding guidelines allow the entire clinical care to document social risk in the electronic health record.

SDOH: ICD-10 crosswalk

Social determinant	ICD-10 code/description
Difficult/unstable housing or housing support services instability	• Z59.0: Lack of housing • Z59.1: Inadequate housing • Z59.8: Other problems related to housing and economic circumstances
Environmentally compromised housing (for example, lead)	• Z77.1: Contact with and (suspected) exposure to other environmental pollution
Food insecurity	• Z59.4: Lack of adequate food and safe drinking water
Transportation difficulty	• Z91.89: Other specified personal risk factors, no elsewhere classified
Interpersonal violence	• Z91.419: Personal history of adult abuse

SDOH: ICD-10 crosswalk (cont.)

Social determinant	ICD-10 code/description
Economic difficulties	• Z59.9: Problem related to housing and economic circumstances, unspecified
Lack of social support	• Z60.4: Social isolation, exclusion, and rejection

Next steps

- Implement/maintain a team-based approach to addressing SDOH:
  - Chronically ill Latino and African American;
- Leverage SDOH screening tools, such as the AHC Screening Tool.
- Familiarize team with local health department and state-wide resources that address SDOH.
- Establish/maintain workflows for referring patients to SDOH resources in the community/case management.

References

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National Academy of Medicine, *Social Determinants of Health 1010 for Health Care: Five Plus Five* (2017)

American Journal of Preventative Medicine, *County health rankings: relationships between determinant factors and health outcomes* (2016)

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https://provider.wellpoint.com/md/

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