Social Determinants of Health (SDOH)

A Guide to SDOH for Providers

EmblemHealth®

Social Determinants of Health (SDOH)

What are Social Determinants of Health (SDOH)?

SDOH are the non-medical factors that influence health outcomes. They are the conditions of the environments where people are born, live, learn, work, play, worship, and age, including:

- Economic Stability
- Education Access & Quality
- Neighborhood & Environment
- HealthCare Access & Quality
- Community & Social Supports*

*Social Determinants of Health - Healthy People 2030 | health.gov

SDOH Assessment Tools

The following assessment tools are considered best in class for SDOH and cover food, housing, transportation and other SDOH.

Assessment Tool	Food	Housing	Transportation
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	X	X	X
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	X	X	X
Children's Health Watch Housing Stability Vital Signs™ *		X	
Comprehensive Universal Behavior Screen (CUBS)			X
Health Leads Screening Panel® *	X	X	X
Hunger Vital Sign™ (HVS) *	X		
PROMIS® *			X
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE]®*	X	X	X
Safe Environment for Every Kid (SEEK)® *	X		
U.S. Household Food Security Survey [U.S. FSS]	X		
U.S. Adult Food Security Survey [U.S. FSS]	X		
U.S. Child Food Security Survey [U.S. FSS]	X		
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	X		
WE CARE Survey	X	X	
WellRx Questionnaire	X	X	X

* Proprietary; may have a cost/licensing requirement if used.

Understanding the Impacts of SDOH

- SDOH account for 30%-55% of our health outcomes.*
- Healthy People 2030, an initiative from the U.S. Dept. of Health and Human Services, has an increased and overarching focus on SDOH.
- Promoting healthy choices alone will not eliminate health disparities.
- Addressing SDOH appropriately is fundamental for improving health and reducing long-standing inequities in health.

*World Health Organization [WHO], 2022

Develop Your Practice's SDOH Strategy

The complexities of addressing SDOH necessitate the coordination of each person in the patient's health care office setting. Supportive office policies that address environmental, geographical, occupational, educational, and nutritional SDOH should be implemented to reduce health disparities and encourage health equity.

Administrators

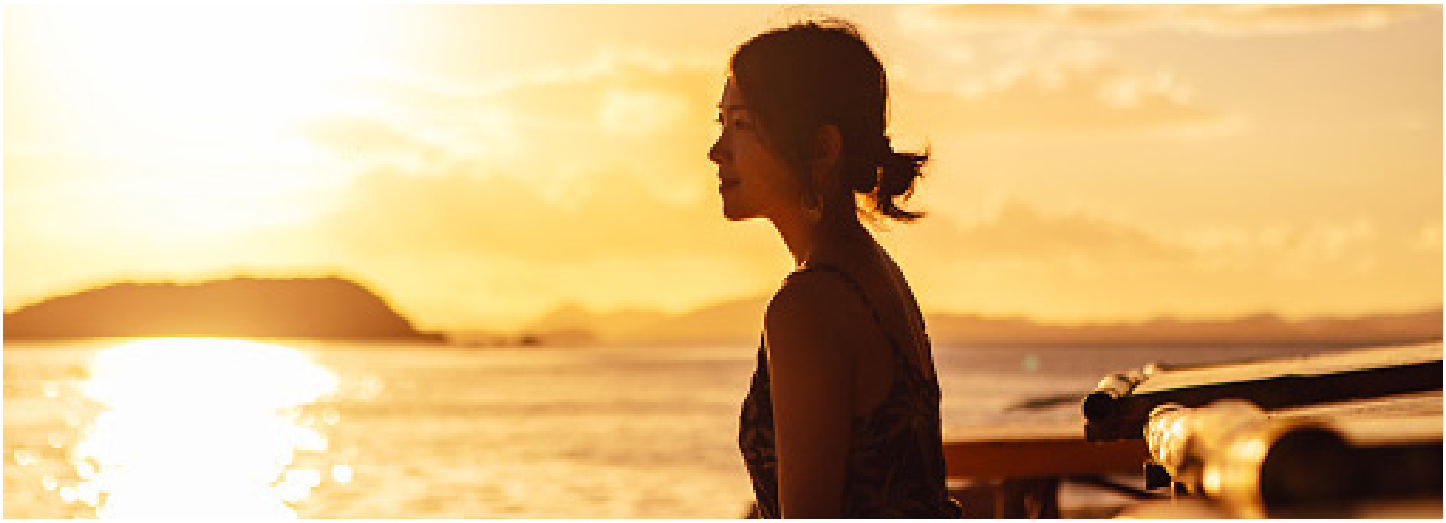
- Create or update your SDOH screening
- Define your SDOH playbook & priorities
- Review your EMR workflows for assessment opportunities
- Make or leverage existing educational materials
- Ensure adequate resources and staffing to screen and provide action plan.
- Communicate staff member responsibilities for the care coordination continuum (from initial assessment to follow-up).
- Provide SDOH staff training and education, for example, addressing staff responsibilities, assuring new staff are also trained, etc.

Receptionists/Medical Assistants

- Recommend members complete SDOH assessments as part of routine patient paperwork/on-line forms prior to appointment.
- Distribute the SDOH screening tool to member upon arrival.
- Make educational materials and resources available in waiting areas and exam rooms.

Physicians

- Review the completed SDOH screening tool prior to the visit and incorporate into the plan of care.
- Consider action at each visit with information available.
- Refer members to additional team members for education, such as an on-site social worker, as needed.



Where are You on Your SDOH Journey?

Recommendations:

New to SDOH

- Review workflow and electronic medical record (EMR) for assessment opportunities.
- Identify and pilot assessment tool.
- Identify SDOH resources.

Already Addressing SDOH

- Coding for SDOH assessments, interventions, diagnoses.
- Evidence-based interventions and linkages with SDOH resources.

A Leader in the Space

- SDOH playbook of best practices.
- Impact on SDOH and population health outcome.

How Can EmblemHealth Help?

We believe that long-term health can be impacted most by the things people do every day, the places where they live, and the resources available to them.

That's why EmblemHealth Neighborhood Care provides in-person and virtual customer support, access to community resources, and programming to help the entire community learn healthy behaviors. Members and non-members alike can visit Neighborhood Care and take advantage of our classes, resources, and face-to-face support.

Neighborhood Care is located throughout the New York City area. Our Customer Care Navigators are passionate about helping our members and serving the community. That's because we not only work in the neighborhood – we live here, too. Find a location near you, on our website here: **Neighborhood Care Locations | EmblemHealth**.

We can also provide:

- Monthly gap-in-care reporting that includes SDOH indicators.
- SDOH measure built in EmblemHealth's Provider Quality Incentive Program ($50 - $100 for each Medicare and Medicaid member once targets are met).
- Care Management & Care Coordination activities that integrate SDOH needs.
- In-home programs that address care gaps and connect members to community resources.
- Screening events in targeted neighborhoods focused on addressing health disparities.

Community Resources

Identify resources in the community that can assist with social needs. Build a high-quality referral network, for example:

- Call 211 for **Essential Community Services | United Way 211**
- **findhelp.org**, by findhelp - The Social Care Network

Coding

Disparities in quality and outcomes of care often reveal social risk. Data describing a person's social needs—the immediate necessities that reflect a person's preferences and priorities—are necessary for whole-person care, which includes coordination of physical health, behavioral health and social services to promote better health outcomes and more effective use of resources.[8]

Billing SDOH Z codes captures standardized data that allows physicians, hospitals, health systems and payers to better track patient needs and prioritize solutions to improve the health of communities. Data can be collected through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

[8]Thomas H, Mitchell G, Rich J, Best M. Definition of whole person care in general practice in the English language literature: a systematic review. British Medical Journal. 2018;(8):12. Accessed June 3, 2020. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6303638**

Quality Measure – 2022 EmblemHealth SDOH Measure

Measure: % of members ages 18 and above who were screened for SDOH in the Measurement Year as indicated by use of an HCPCS code (G9919 or G9920) in conjunction with a Z Diagnosis code if screening was positive.

- HCPCS code G9919 – Screening performed and positive.
- HCPCS code G9920 – Screening performed and negative.

Quality Measure – 2023 New HEDIS® SDOH Measure

In 2023, EmblemHealth is introducing a new SDOH measure based on updated NCQA guidelines. This measure looks at social need screening and intervention (SNS-E). This is a first-year measure involving the percentage of members who were screened, using pre-specified tools, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. The measure will also consider intervention when an SDOH was identified.

This measure applies to commercial, Medicare, and Medicaid members within the following age ranges:

- ≤ 17 years.
- 18-64 years.
- 65 and older.

Key SDOH Strategy Considerations

Uncovering SDOH needs is vital. Are you asking your members about SDOH?

- If so, what tools do you use?
- If a member screens positive for SDOH, are you linking them to appropriate resources for assistance?
- Do you have a playbook of community resources by SDOH type?
- Is your practice submitting claims with SDOH codes when assessments are completed, and interventions performed?
- Is your practice capturing survey data results in a reportable system?
- What successes/difficulties are you experiencing in your office when billing and documenting in your electronic medical records (EMR)?

See the following sections (pages 6 and 7) for some nationally recognized tools your practice can use today.

2023 SDOH Data Collection – Use of LOINC* Codes for Food

NCQA has create a new set of codes to identify screening utilized for each domain and also when a positive finding is identified. It is imperative that you leverage the positive code associated to obtain credit for the measure/screening used.

Assessment Tool	Screening Item	Positive Finding
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7 88123-5	LA28397-0 LA6729-3
Health Leads Screening Panel® **	95251-5	LA33-6
Hunger Vital Sign™ (HVS) **	88124-3	LA19952-3
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE]® **	93031-3	LA30125-1
Safe Environment for Every Kid (SEEK)® **	95400-8 95399-2	LA33-6
U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
WE CARE Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

** Proprietary; may have a cost/licensing requirement if used.

2023 SDOH Data Collection – Use of LOINC* Codes for Housing

Assessment Tool	Screening Item	Positive Finding
Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3 96778-6	LA31994-9 LA31995-6 LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6 96778-6	LA33-6 LA32691-0, LA28580-1, LA32693-6, LA32694-4, LA32695-1, LA32696-9, LA32001-2
Children's Health Watch Housing Stability Vital Signs™ **	98976-4 98977-2 98978-0	LA33-6 ≥3 LA33-6
Health Leads Screening Panel® **	99550-6	LA33-6
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE]® **	93033-9 71802-3	LA33-6 LA30190-5
WE CARE Survey	96441-1	LA33-6
WellRx Questionnaire	93669-0	LA33-6

*LOINC refers to Logical Observation Identifiers Names and Codes, which is a set of identifiers, names, and codes for identifying health measurements, observations, and documents.

2023 SDOH Data Collection – Use of LOINC* Codes for Transportation

Assessment Tool	Screening Item	Positive Finding
Accountable Health Communi-ties (AHC) Health-Related So-cial Needs (HRSN) Screening Tool	93030-5	LA33-6
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
Comprehensive Universal Be-havior Screen (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
Health Leads Screening Panel®	99553-0	LA33-6
PROMIS® **	93030-5	LA30133-5 LA30134-3
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences [PRAPARE]® **	92358-1	LA30024-6 LA30026-1 LA30027-9
WellRx Questionnaire	93669-0	LA33-6

** Proprietary; may have a cost/licensing requirement if used.

Takeaways

EmblemHealth encourages our network partners to invest in the meaningful exchange of SDOH data. Achieving this aim takes coordination and alignment amongst providers, payers and the community at large. We encourage you to leverage your staff and resources to improve patient and population health. We are in this initiative with you and are happy to provide tools and webinars that speak to SDOH. Please review the EmblemHealth Quality Improvement web page for more SDOH resources here: **https://www.emblemhealth.com/providers/clinical-corner/quality**.

Remember:

- Addressing SDOH can lead to improvements in health outcomes.
- Members can complete assessments both in-office or remotely.
- Select your screening tool based on the needs of your member population.
- Link members with SDOH needs to appropriate services.
- Document the completion of SDOH assessments with appropriate coding.

55 Water Street, New York, NY 10041-8190 | emblemhealth.com

EMB_PR_BRO_59774_Social_DeterminantsofHealth(SDOH) 6/23