# Social Determinants of Health and Increasing Access to Care

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**DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES**

# Learning Objectives

- *Overview of the Social Determinants of Health (SDOH) and it's Importance to Medicaid*

- *Clinical Access to Care Projects – including SDOH screeners and workflows*

- *Understanding Health Literacy*

- *Electronic Health Records, Coding and Reimbursement*

- *Referral Process - Bidirectional referrals, CONNECT and Resource Mapping*

- *SDOH Training*
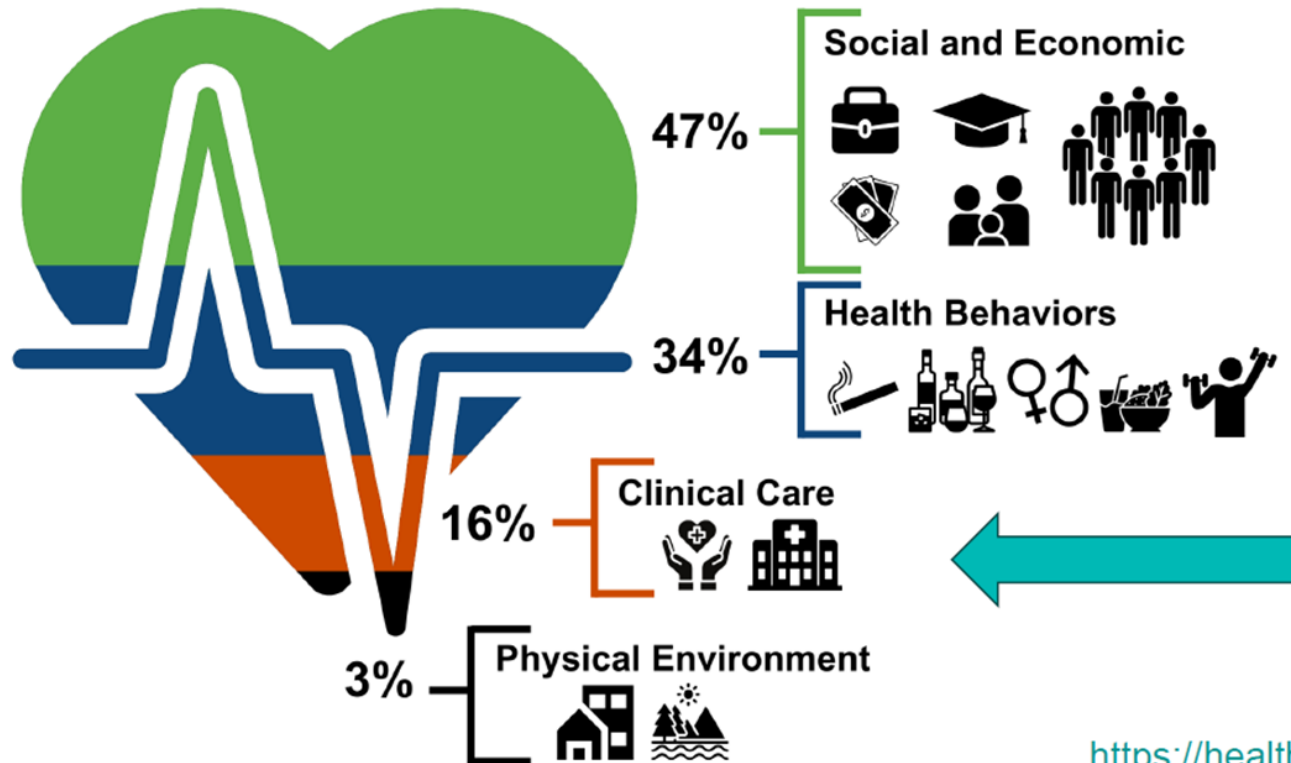
- *Guidance on E/M codes*

# Five Domains of SDOH

- Economic stability.

- Education access and quality.

- Health care access and quality.

- Neighborhood and built environment.

- Social and community context.

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# Social Drivers of Health



**Health Factors and Their Effect on Health Outcomes**

47% — Social and Economic

34% — Health Behaviors

16% — Clinical Care

3% — Physical Environment

https://health.gov/healthypeople

# Why is SDOH Important in Medicaid?

Examples of adverse health outcomes linked to social and economic factors include:

- Asthma due to certain home environments.
- Diabetes-related hospital admissions related to food insecurity.
- Falls due to physical barriers/inadequate safety equipment at home.
- Frequent use of ED/Urgent care due to homelessness.
- Risk of stress-related illness resulting from unemployment.
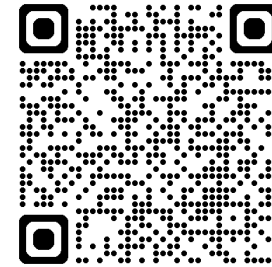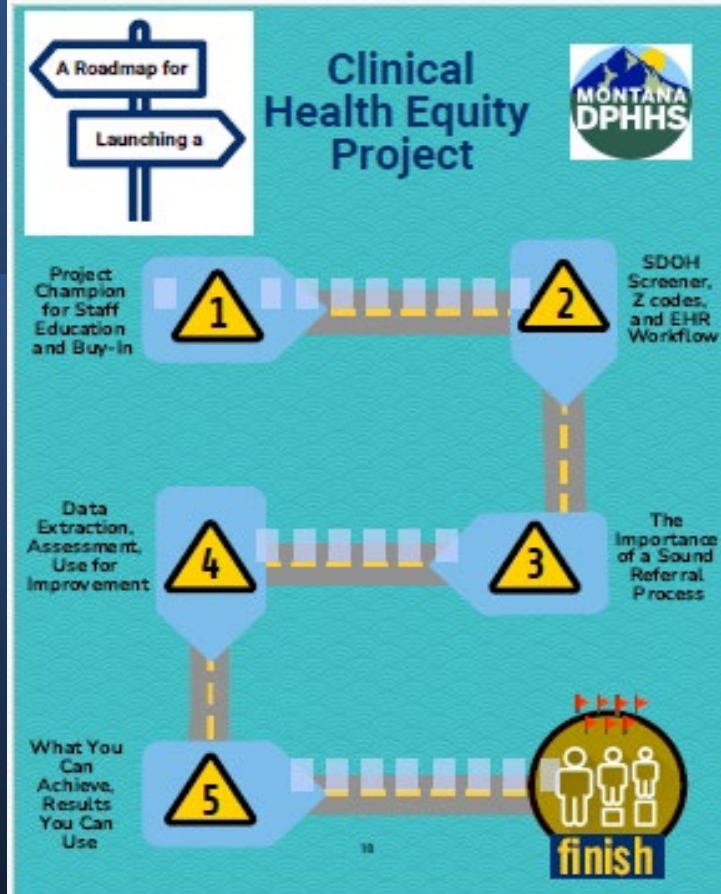
Montana Asthma Home Visiting Program
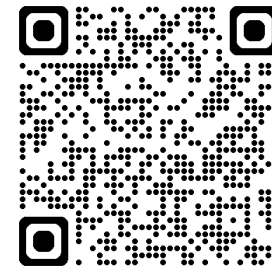
Montana Diabetes Prevention & Self-Management Education and Support

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# Clinical Access to Care Projects

# 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 run out before you got money to buy more.[1]
   - ☐ 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.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

### 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 to you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

**The EveryONE Project**
*Advancing health equity in every community*

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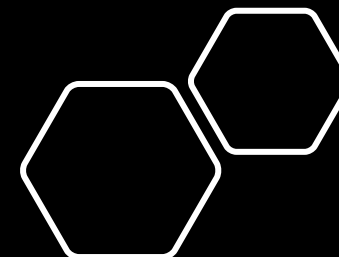
# SDOH Screening - guidelines



- Clarify the purpose.

- Ensure privacy and patient comfort.

- Listen and observe.

- Phrase questions using simple, plain language and provide examples

- Prioritize needs.

- Allow for conversation flow.

# SDOH Screening Tips

- Do not make assumptions or generalizations.

- Proactively ask questions.

- Use open-ended questions

- Make space to discuss, clarify and elaborate on responses.

- Respect patient's right to decide what information they disclose.

- Explain next steps.

# Personal vs. Organizational Health Literacy

- The National Institute of Health uses two different definitions of health literacy.

- **Personal Health Literacy**: the degree to which someone can find, understand, and use information and services to make health-related decisions for themselves (and others).

- **Organizational Health Literacy:** the degree to which organizations equitably enable individuals to find, understand, and use information and services to make health-related decisions for themselves (and others).

# Health Literacy Tips

- Some tips on making your practice accessible to those who may struggle with health literacy:
    - The reading level in Montana is sixth-grade or lower.
    - Know your audience and define the purpose of your message before you begin making materials.
    - Put the important message first.
    - Break text up.
    - Use headings and text boxes.
    - Delete unnecessary words, sentences, and pictures.
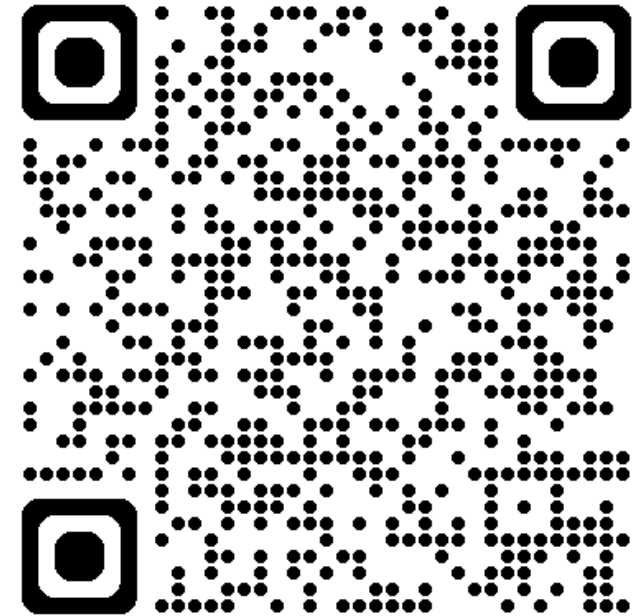
Link to the Flesh-Kincaid Calculator

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# Health Literacy Tips (Cont.)

- Some tips on making your practice accessible to those who may struggle with health literacy, continued.
  - Use the "Everyday Words for Public Health Communication" guide by CDC.
  - Utilize pictures or ways for people to point/ rate their conditions in a standardized way.
  - Advancing Health Literacy with Inclusive Communication toolkit for patients with a disability or impairment. Go down to the "resources" page to find it.
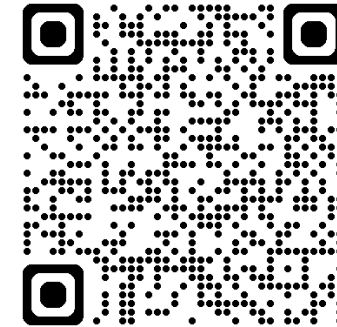
Link to CDC's "Everyday Words for Public Health Communication"
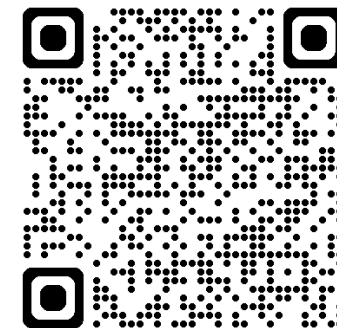
Link to "Advancing Health Literacy with Inclusive Communication" tool.

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# Health Literacy

**Hypertension:** High blood pressure

**Original Sentences:**

Hypertension is a primary or contributing cause of cardiovascular disease and premature deaths.

**Plain Language Sentences:**

High blood pressure is one of the leading risk factors for heart attack and stroke.

# Health Literacy





"Financial assistance is generally determined by a sliding scale of total household income based on the Federal Poverty Level (FPL). If you and/or the responsible party's income combined are at or below 100% of the federal poverty guidelines, you will have no financial responsibility for care."

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# EHR capabilities (or lack thereof)

EHR capabilities can be a make it or break it when screening and following up with patients.

# EHR capabilities (or lack thereof)

Some <u>useful</u> capabilities when screening patients:

- Predetermined questions embedded in the rooming/ intake forms.
- Staff can see if they are "due" for screening.
- If a patient screens positive for an insecurity, having an automatic flag or alert in their chart.
  - o Bonus point: if a positive screen populates referral options.
- Patient portal usage before the appointment.

# EHR capabilities (or lack thereof)

Some <u>EHR barriers</u> when screening patients:

- Cannot see the date they were last screened or if they are "due" for screening.
- The screening questions are too cumbersome or take too long.
- "Built in" screener vs. paper screening and entering into the EHR manually.
- Relying on paper forms/ flyers to refer a patient to a needed resource.

# Bidirectional Referrals for Patients

Call 211 – Free and Confidential; 24/7

FindHelp.org or Aunt Bertha – search by zip code for free/low-cost help near you

Medicaid Transportation (for eligible patients):

National Resource Directory (NRD) – database of validated resources that support recovery, rehab, and integration for service members

AAFP's Neighborhood Navigator – interactive tool to connect patients with supportive local resources

CONNECT – State system allows provider and community-based organization to communicate directly.

2·1·1 Montana — Get Connected. Get Help.

NRD

findhelp

CONNECT Electronic MONTANA REFERRAL SYSTEM

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**Welcome to the online Montana Medicaid Transportation Request Application.**

Please sign in to start your transportation request. If you do not already have a Microsoft account, please create an account to get started.

Sign In/Register

The Medicaid Transportation Coverage Guide includes new policies to help bolster access to necessary transportation services, including when beneficiaries may encounter extended wait times and long-distance trips. Medicaid transportation is a critical service that assists beneficiaries with accessing covered Medicaid services and has a direct impact on health outcomes. CMS encourages states to use this guide as an aid when developing and updating policies and procedures that facilitate robust transportation programs.

# SDOH Staff Training

- *Train staff over a six-month period who interact with patients in a clinic setting to address topics related to a patient's social determinants of health (i.e., housing, food insecurity, transportation).*

- *The purpose of the training is to improve knowledge, comfort level and competence addressing issues encountered when administering and responding to SDOH screeners… understanding terminology, cultural sensitivity, implicit bias and referrals*

- *Trainings are virtual and can be done at times that accommodate varied schedules. Minimal requirements, $500-$1000 depending on number of employees trained*

- *QR code for participants so we can evaluate usefulness and improve options as need dictates.*

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# Coding Practices for SDOH

- Clinicians, insurance, state and federal programs recognize that SDOH can have significant effects on patient outcomes and care plans.

- 2021 CPT E/M outpatient- and office-visit coding guidelines, the level of the E/M service is based on either the total time on the date of the encounter or the level of medical decision-making (MDM).

- SDOH factors may raise the risk of complications, morbidity or mortality by limiting treatment options and diagnosis capability.

# Coding Practices for SDOH

**Table 2 – CPT E/M Office Revisions**
**Level of Medical Decision Making (MDM)**

**Revisions effective January 1, 2021:**
*Note: this content will not be included in the CPT 2020 code set release*

AMA AMERICAN MEDICAL ASSOCIATION

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Number and Complexity of Problems Addressed | Elements of Medical Decision Making | | Risk of Complications and/or Morbidity or Mortality of Patient Management |
|---|---|---|---|---|---|
| | | | Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.* | | |
| 99211 | N/A | N/A | N/A | | N/A |
| 99202 99212 | Straightforward | Minimal • 1 self-limited or minor problem | Minimal or none | | Minimal risk of morbidity from additional diagnostic testing or treatment |
| 99203 99213 | Low | Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury | Limited *(Must meet the requirements of at least 1 of the 2 categories)* Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* | | Low risk of morbidity from additional diagnostic testing or treatment |
| 99204 99214 | Moderate | Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury | Moderate *(Must meet the requirements of at least 1 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) | | Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health |
| 99205 99215 | High | High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function | Extensive *(Must meet the requirements of at least 2 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | | High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis |

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# Coding Practices for SDOH

**Moderate risk of morbidity from additional diagnostic testing or treatment**

*Examples only:*
- Prescription drug management
- Decision regarding minor surgery with identified patient or procedure risk factors
- Decision regarding elective major surgery without identified patient or procedure risk factors
- Diagnosis or treatment significantly limited by social determinants of health

# Coding Practices for SDOH

An example:

A patient with a history of a cardiac event presents with extreme fatigue, blueish fingers and poor blood circulation. A provider orders a cardiac MRI and a consult with a cardiologist.

This patient doesn't not have the means to access or afford this care. In this situation, it is important to consider how SDOH may significantly limit the patient's ability to attain appropriate diagnosis and treatment.

A provider may document: "Patient cannot afford to obtain a cardiac MRI at this time because of the cost and due to limited healthcare access, is scheduled out for six months with the cardiologist. This significantly limits my ability to confirm the diagnosis beyond physical examination findings and presenting symptoms."

# A Note on Z Codes:

B



| Z code Categories | |
|---|---|
| **Z55** – Problems related to education and literacy | **Z60** – Problems related to social environment |
| **Z56** – Problems related to employment and unemployment | **Z62** – Problems related to upbringing |
| **Z57** – Occupational exposure to risk factors | **Z63** – Other problems related to primary support group, including family circumstances |
| **Z58** – Problems related to physical environment | **Z64** – Problems related to certain psychosocial circumstances |
| **Z59** – Problems related to housing and economic circumstances | **Z65** – Problems related to other psychosocial circumstances |

This list is subject to revisions and additions to improve alignment with SDOH data elements.

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# HCPCS Code G0136

- HCSPCS code G0136: "Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every six months."

- For MediCARE recipients

- You have to use a standardized tool. CMS does not specify which tool, but they do give examples.

- *"The agency's final rule also states that the assessment must include the following SDOH categories, or "domains:" food insecurity, housing insecurity, transportation needs, and utility difficulties. Clinicians may choose to assess patients for other SDOH categories as well, but those four are required."*
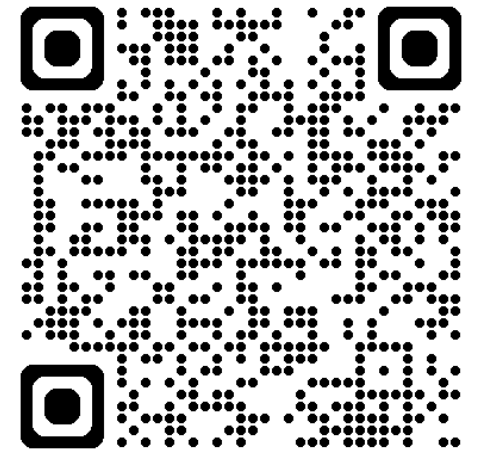
Link to the AAFP article about G0136

# Conclusion

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# Resources

Heart of Healthy Communities Toolkit:  https://dphhs.mt.gov/publichealth/chronicdisease/ProgramResources

Health Equity in the Health Care Setting:
https://dphhs.mt.gov/publichealth/chronicdisease/SDOH/Resourcesextension://efaidnbmnnnibpcajpcglclefindmkaj/https://dphhs.mt.gov/assets/publichealth/ChronicDisease/SDOH/HealthEquityResourceGuide.pdf

DPHHS Chronic Disease Prevention and Health Promotion Program Links:
A Healthier Montana
Montana Asthma Home Visiting Program
Diabetes Program
bing.com/ck/a?!&&p=4b0ae3e5a2651e615d8b41d59c1da98e11851fabaa37bc408a8a09cbf08fded2JmltdHM9MTc2NTQ5NzYwMA&ptn=3&ver=2&hsh=4&fclid=2a092615-44e9-6e11-25cb-32e845826f78&psq=z+codes&u=a1aHR0cHM6Ly93d3cuY21zLmdvdi9maWxlcy9kb2N1bWVudC9jbXMtMjAyMy1vbWgtei1jb2RlLXJlc291cmNlLnBkZg&ntb=1
Flesch Kincaid Calculator | Good Calculators
Everyday Words for Public Health Communication | The CDC Clear Communication Index | Centers for Disease Control and Prevention
CMS Provides New Guidance for SDOH Risk Assessments - AAPC Knowledge Center

DPHHS SDOH Website:  https://dphhs.mt.gov/publichealth/chronicdisease/SDOH/

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