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:

- Financial Resource Strain
- Food Insecurity
- Housing Instability
- Transportation
- Health Care/Medical Access/ Affordability
- Childcare
- Employment
- Utilities
- Clothing

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 Medicaid in 2022 for eligible practices. **High-performing Medicaid sites can earn up to $1.25 PMPM for the SDoH measure.**

Steps to Achieving Success

1. Adopt or Develop a Screening Tool

A screening tool is the first step in capturing SDoH measures. Practices may develop their own screening tool or adopt an existing tool; see page 5 of this guide for examples.

2. Define a Workflow

Determine how SDoH screening will function operationally at your practice.

Consider screening opportunities outside of annual/well visits, such as sick visits, vaccination clinics and pediatric visits.

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. Your practice can also leverage telehealth visits and phone calls to completed screenings.

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 a SDoH platform (your own or leverage HPP's subscription with FindHelp) for referrals and connections to community organizations.

4. Establish Billing Procedures

Staff should become familiar with diagnosis codes and the submission of both negative and positive screening claims.

Screening Result	Coding
No Barriers Identified	G9920 only
Barriers Identified	G9919 and all other appropriate diagnosis codes

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.

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 a 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 the provider portal to identify member-level SDoH screening opportunities.
- Communicate expectations, accountability, and responsibility for referrals to your staff.

SDOH SCREENING

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ACTION PLAN/REFERRAL

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SERVICE DELIVERY

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ONGOING INCLUSION IN PATIENT CARE PLAN

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FOLLOW-UP

HPP Resources

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

FindHelp: Visit hpp.findhelp.com to access our premium search platform for community resources. FindHelp 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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