HealthTech

Social Determinants of Health
Assessment Process

April 13, 2024

Faith Jones, MSN, RN, NEA-BC
Director of Care Coordination and Lean Consulting

1

Disclosures to Participants

Notice of Requirements for Successful Completion:

Learners must participate in the full activity and complete the evaluation in order to claim continuing education credit/hours.

Presenter has No - Conflicts of Interest/Financial Relationships Disclosures:

Faith Jones

Disclosure of Relevant Financial Relationships and Mechanism to Identify and Mitigate Conflicts of Interest: No conflicts of interest

Non-Endorsement of Products: Accredited status does not imply endorsement by ADCES or Joint Accreditation of any commercial products displayed in conjunction with this educational activity

Off-label Use: None

2

Objectives

Social Determinants of Health

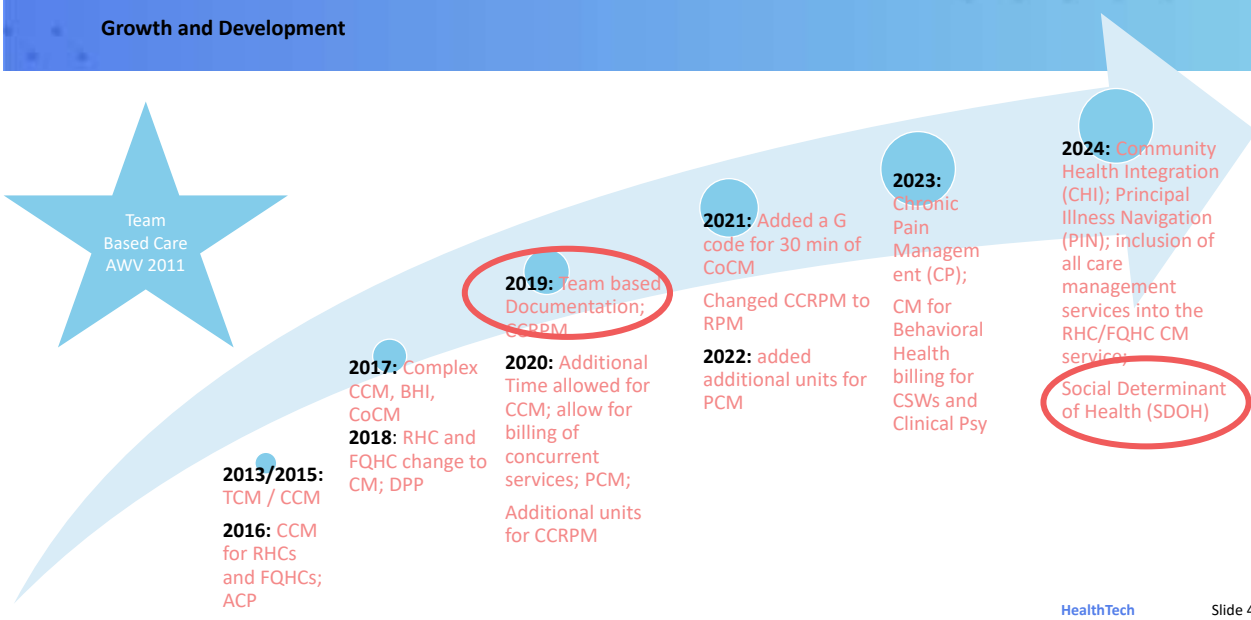
Upon completion of the webinar, the participant will be able to:

1. Identify the components of a SDOH assessment
2. Select the appropriate SDOH Z code
3. Identify the key values in SDOH screening

3

Care Coordination

Growth and Development



4

Defining Social Determinants of Health

Who should do this work?

Social Determinants of Health are defined as:

"...the conditions in the environments where 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."

-Healthy People 2030

5

The Five Domains of SDoH

Effect Everyone

6

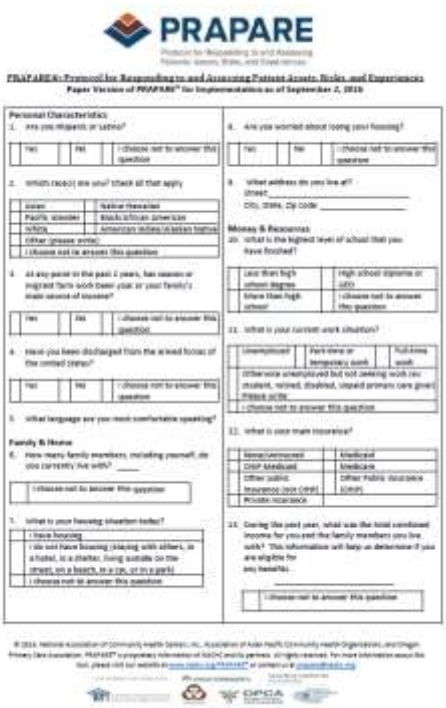
Social Determinant of Health Background

CMS's comments in proposed rules

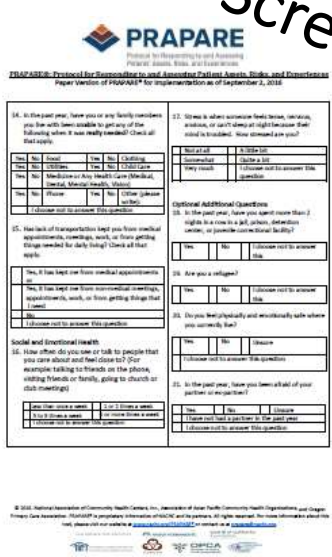
"There is increasing recognition within the health care system of the need to take SDOH into account when providing health care services, given that it is estimated that around 50 percent of an individual's health is directly related to SDOH. Healthy People 2030 define the broad groups of SDOH as: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context, which include factors like housing, food and nutrition access, and transportation needs."

CMS 2024 Proposed Rules page 206 of 1920
Scheduled for publication 8/7/2023

7



Screening Tool

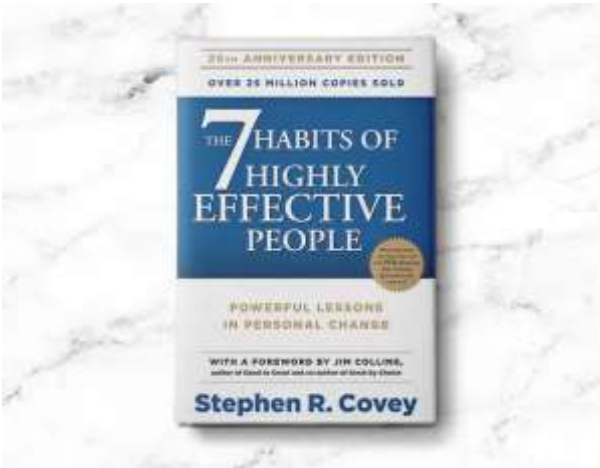


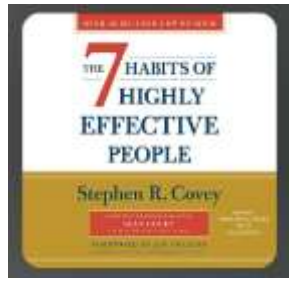
https://prapare.org/the-prapare-screening-tool/

8

Begin with the End in Mind

Habit Number 2





HealthTech Slide 9

9

Mapping general screening to specific

General vs Specific

General Screening → Specific Screening

Results of general responses may indicate need for more specific assessment

HealthTech Slide 10

10

SDOH Screening and Assessment

Getting to the Diagnosis

BP = 148/84

Does the patient have Hypertension?

Maybe?

What else do we need to know?

11

Hypertension?

What kind?

- I10 Essential (primary) hypertension
- I11.9 Hypertensive heart disease without heart failure
- I15.0 Renovascular hypertension
- I15.1 Hypertension secondary to other renal disorders
- I15.2 Hypertension secondary to endocrine disorders
- I15.8 Other secondary hypertension
- I15.9 Secondary hypertension, unspecified
- I16.0 Hypertensive urgency
- I16.1 Hypertensive emergency
- I16.9 Hypertensive crisis, unspecified

https://www.icd10data.com/ICD10CM/DRG/304

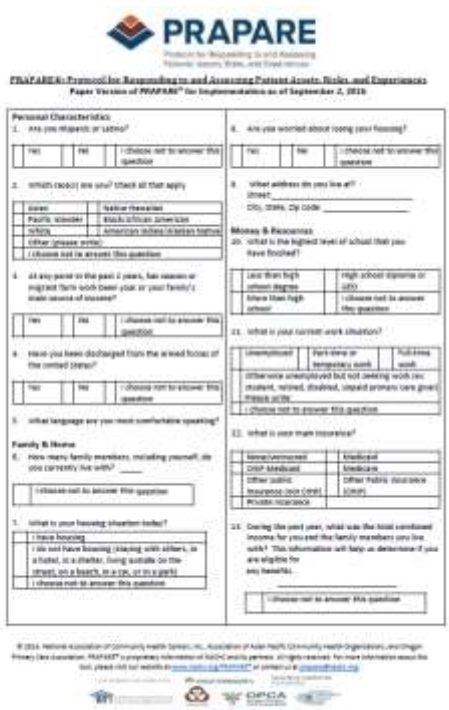
12

What is a Z code?

Ten Categories

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

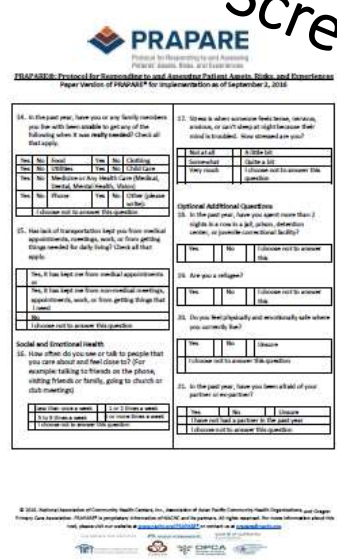
https://www.cms.gov/files/document/zcodes-infographic.pdf


PRAPARE

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Screening Tool


PRAPARE

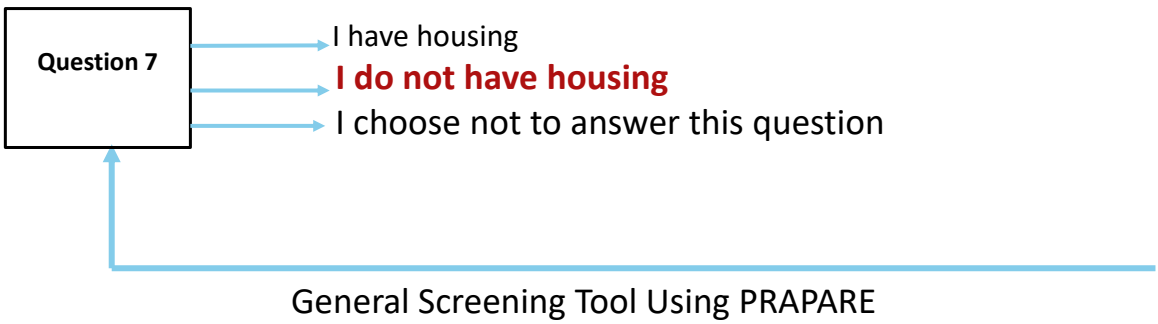
PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

https://prapare.org/the-prapare-screening-tool/

Mapping general screening to Z code

After assisting our patient with completing the general screening tool, we review the responses. Our patient's response to question 7 ("What is your housing situation today?") was "I do not have housing."



https://prapare.org/wp-content/uploads/2021/10/PRAPARE-English.pdf

SDOH Screening and Assessment

Follow up questions

Start a conversation....

Where do you sleep?

Where do you stay?

Be an Active Listener

Mapping general screening to Z code

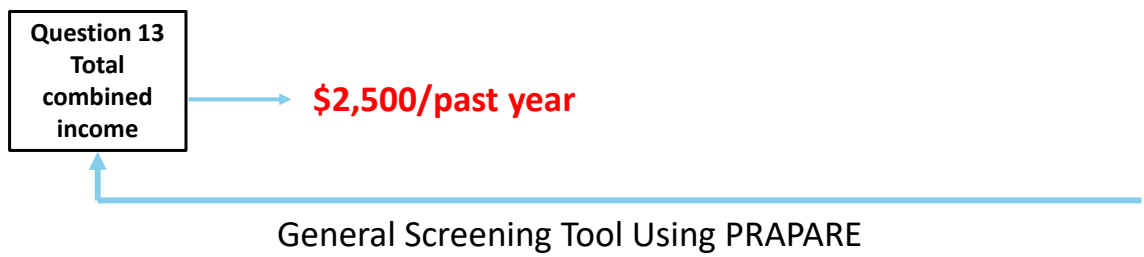
How do I collect SDOH data?

Z59	**Problems related to housing and economic circumstances**
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers, and/or landlord
Z59.3	Problems related to living in a residential institution
Z59.4	Lack of adequate food and/or safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

17

Mapping general screening to Z code

After assisting our patient with completing the general screening tool, we review the responses. Our patient's response to question 13 ("During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.") was "Less than $2,500 a year."



https://prapare.org/wp-content/uploads/2021/10/PRAPARE-English.pdf
https://ourworldindata.org/from-1-90-to-2-15-a-day-the-updated-international-poverty-line

18

Mapping general screening to Z code

How do I collect SDOH data?

Z59	**Problems related to housing and economic circumstances**	
	Z59.0	Homelessness
	Z59.1	Inadequate housing
	Z59.2	Discord with neighbors, lodgers, and/or landlord
	Z59.3	Problems related to living in a residential institution
	Z59.4	Lack of adequate food and/or safe drinking water
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.8	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified

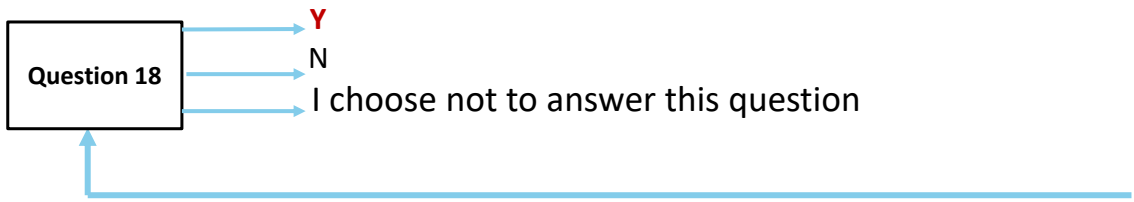
"World Bank also sets two higher global poverty lines for measuring poverty: one that reflects the definitions of poverty adopted in lower-middle income countries, and one that reflects the definitions adopted in upper-middle income countries. Within the updated methodology, these lines are set at $3.65 and $6.85 in 2017 international-$, replacing the previous $3.20 and $5.50 lines expressed in 2011 international"

$6.85 x 365 = $2,500.25

https://ourworldindata.org/from-1-90-to-2-15-a-day-the-updated-international-poverty-line

Mapping general screening to Z code

After assisting our patient with completing the general screening tool, we review the responses. Our patient's response to question 18 ("In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center or juvenile correctional facility?") was "Yes."



General Screening Tool Using PRAPARE

https://prapare.org/wp-content/uploads/2021/10/PRAPARE-English.pdf

Mapping general screening to Z code

Z65 **Problems related to other psychosocial circumstances**

- Z65.0 Conviction in civil and/or criminal proceedings without imprisonment
- Z65.1 Imprisonment and other incarceration
- Z65.2 Problems related to release from prison
- Z65.3 Problems related to other legal circumstances
- Z65.4 Victim of crime and/or terrorism
- Z65.5 Exposure to disaster, war, and other hostilities
- Z65.8 Other problems related to psychosocial circumstances
- Z65.9 Problem related to unspecified psychosocial circumstances

Mapping general screening to Z code

Diagnoses

Z59.0 Homelessness

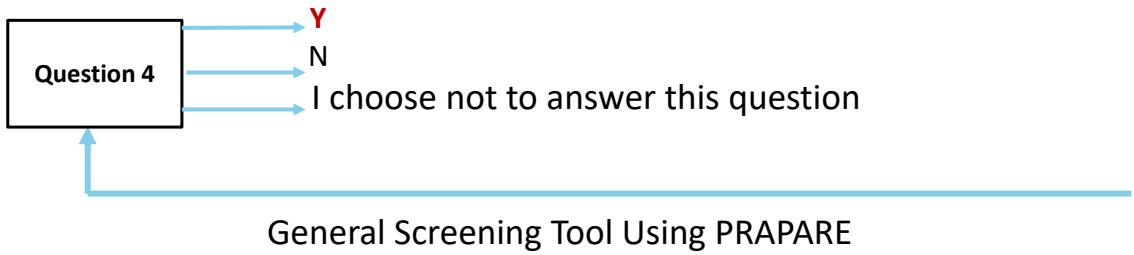
Z59.5 Extreme poverty

Z65.2 Problems related to release from prison

Reminder to Begin with the End in Mind

Mapping to the Z code

Have you been discharged from the armed forces of the United States?
The Response was "Yes."



https://prapare.org/wp-content/uploads/2021/10/PRAPARE-English.pdf

23

Mapping general screening to Z code

Z65	**Problems related to other psychosocial circumstances**	
	Z65.0	Conviction in civil and/or criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances
	Z65.4	Victim of crime and/or terrorism
	Z65.5	Exposure to disaster, war, and other hostilities
	Z65.8	Other problems related to psychosocial circumstances
	Z65.9	Problem related to unspecified psychosocial circumstances

24

What do I do with this information?

Patient

-Document in the patient's paper or EHR.
-Can use to improve care coordination and referrals.
-Identify community resources, social services for those in need of them.
-Involve the patient and caregivers in patient care planning.

Organization

-Add to key reports for executive leadership and Board of Directors.
-Create policies and procedures.
-Track health outcomes.
-Data can be used for tracking quality measures at the organization and community levels.

25

Social Determinate of Health Risk Assessment

2024

SDOH Risk Assessment guidelines

- Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months per patient per provider
- SDOH Risk Assessment that is furnished in conjunction with a qualifying visit
  - E/M visit
  - AWV
  - TCM visit
  - Psychiatric diagnostic evaluation
  - Health Behavior Assessment and Intervention service
- SDOH risk assessment through a standardized, evidence-based tool can more effectively and consistently identify unmet SDOH needs and enable comparisons across populations.
- SDOH Risk Assessment must be billed with the qualifying visit, however data gather of the screening and assessment may be done in advance of the visit
- Billed by a practitioner with an established relationship with the patient and the ability to refer to services to address unmet needs.
- Although not required to report the SDOH diagnosis on the claim – it is recommended to use the Z-codes (Z55-Z65)

26

SDOH Risk Assessment

Reimbursements

NEW in 2024

2024

Completion of SDOH screening and risk assessment not more than once every 6 months per patient per provider

- CPT G0136 RVU 0.18
- National Average Reimbursement ~18.66

Optional Service Offered with AWV

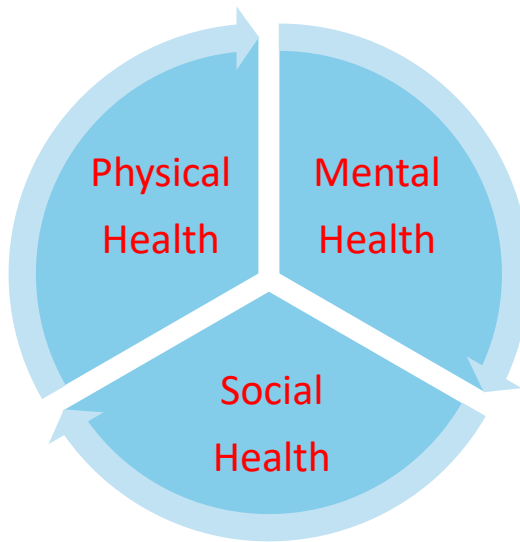
Paid at 100%

27

Whole Person Care

Ongoing Care Coordinator

28



28

Community Health Integration (CHI)

2024

Practice Eligibility

- Provider qualified to bill E/M codes
- Certified (State Specific) or trained auxiliary personnel as a Community Health Worker (CHW)
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources
- Primary Care Provider general supervision of CHW
- Only 1 provider may bill for CHI per patient per month

Patient Eligibility

- Medicare Patient (other Insurances)
- CHI initiating visit with their established provider
- Provider identification of the presence of SDOH need(s) that significantly limit the provider's ability to diagnose or treat the patient's medical condition(s) and establish an appropriate treatment plan.
- The treatment plan specifics how addressing the unmet SDOH need(s) would help patient's medical condition
- Patient Consent – written or verbal
- Time tracking of at least 60 min per calendar month including face to face visits by the CHW in the community with the patient

29

Community Health Integration (CHI)

2024

Practice Eligibility

- Provider qualified to bill E/M codes
- Certified (State Specific) or trained auxiliary personnel as a Community Health Worker (CHW)
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources
- Primary Care Provider general supervision of CHW
- Only 1 provider may bill for CHI per patient per month

Just like CCM

Patient Eligibility

- Medicare Patient (other Insurances)
- CHI initiating visit with their established provider
- Provider identification of the presence of SDOH need(s) that significantly limit the provider's ability to diagnose or treat the patient's medical condition(s) and establish an appropriate treatment plan.
- The treatment plan specifics how addressing the unmet SDOH need(s) would help patient's medical condition
- Patient Consent – written or verbal
- Time tracking of at least 60 min per calendar month including face to face visits by the CHW in the community with the patient

30

Community Health Integration (CHI)

2024

Practice Eligibility

- Provider qualified to bill E/M codes
- Certified (State Specific) or trained auxiliary personnel as a Community Health Worker (CHW)
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources
- Primary Care Provider general supervision of CHW
- Only 1 provider may bill for CHI per patient per month

Patient Eligibility

- Medicare Patient (other Insurances)
- CHI initiating visit with their established provider
- Provider identification of the presence of SDOH need(s) that significantly limit the provider's ability to diagnose or treat the patient's medical condition(s) and establish an appropriate treatment plan.
- The treatment plan specifics how addressing the unmet SDOH need(s) would help patient's medical condition
- Patient Consent – written or verbal
- Time tracking of at least 60 min per calendar month including face to face visits by the CHW in the community with the patient

31

Community Health Integration (CHI)

2024

Practice Eligibility

- Provider qualified to bill E/M codes
- Certified (State Specific) or trained auxiliary personnel as a Community Health Worker (CHW)
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources
- Primary Care Provider general supervision of CHW
- Only 1 provider may bill for CHI per patient per month

Patient Eligibility

- Medicare Patient (other Insurances)
- CHI initiating visit with their established provider
- Provider identification of the presence of SDOH need(s) that significantly limit the provider's ability to diagnose or treat the patient's medical condition(s) and establish an appropriate treatment plan.
- The treatment plan specifics how addressing the unmet SDOH need(s) would help patient's medical condition
- Patient Consent – written or verbal
- Time tracking of at least 60 min per calendar month including face to face visits by the CHW in the community with the patient

32

Community Health Worker (CHW)

2024

Practice Eligibility

- Certified (State Specific) or trained auxiliary personnel as a Community Health Worker (CHW)
  - Patient and family communication
  - Interpersonal and relationship–building
  - Patient and family capacity-building
  - Service coordination and system navigation
  - Patient advocacy
  - Facilitation
  - Individual and community assessment
  - Professionalism and ethical conduct
  - Development of an appropriate knowledge base of local community-based resources
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources

33

Community Health Integration (CHI)

2024

Practice Eligibility

- Provider qualified to bill E/M codes
- Certified (State Specific) or trained auxiliary personnel as a Community Health Worker (CHW)
- Collaboration and communication with practitioners, social service providers, caregivers, healthcare facilities, home and community resources
- Primary Care Provider general supervision of CHW
- Only 1 provider may bill for CHI per patient per month

Patient Eligibility

- Medicare Patient (other Insurances)
- CHI initiating visit with their established provider
- Provider identification of the presence of SDOH need(s) that significantly limit the provider's ability to diagnose or treat the patient's medical condition(s) and establish an appropriate treatment plan.
- The treatment plan specifics how addressing the unmet SDOH need(s) would help patient's medical condition
- Patient Consent – written or verbal
- Time tracking of at least 60 min per calendar month including face to face visits by the CHW in the community with the patient

34

CHI
Reimbursements

NEW in 2024

2024

Billed per calendar month for 60 min of care coordination in the community by community health worker

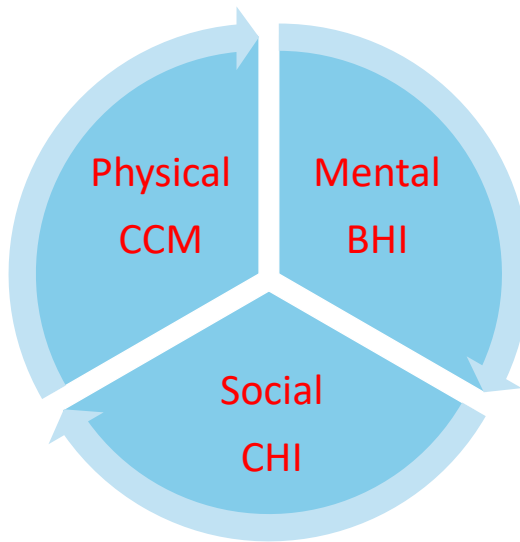
- CPT Code G0019 RVU 1.0
- National Average Reimbursement ~$79.24

Billed with G0019 for additional 30 min per calendar month of care coordination in the community by community health worker

- CPT Code G0022 RVU .70
- National Average Reimbursement ~$49.44

35

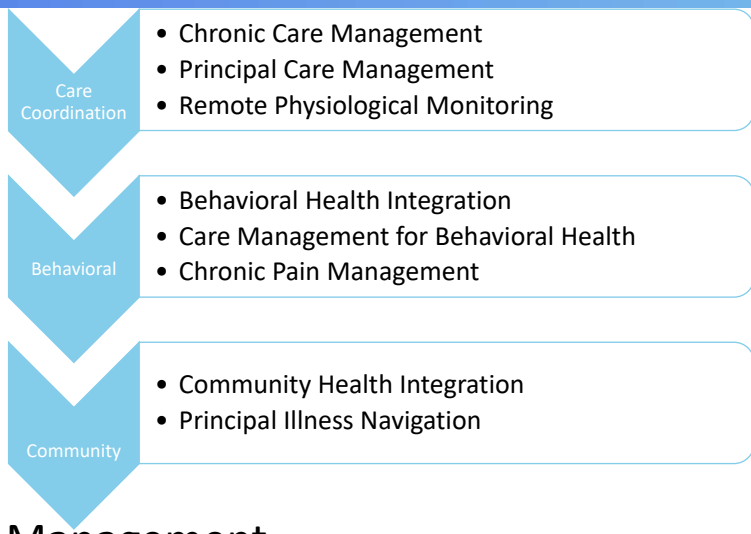
Care Management Service Lines
Concurrent Service lines



36

Rural Health & Federally Qualified Health Clinics

General Care Management



2024

G0511

RVU = 1.17

$71.71

Care Management

37

Rural Health & Federally Qualified Health Clinics

General Care Management

Billing for Multiple G0511 codes

- The general care management code applies to all of the care management services
- A patient may be enrolled in more than one service line
- A G0511 may be billed for each service line in a calendar month where all elements are met:
  - Chronic Care Management (at least 20 minutes)
  - Behavioral Health Integration (at least 20 minutes)
  - Principal Care Management (at least 30 minutes)
  - Chronic Pain Management (at least 15 minutes)
  - Care Management for Behavioral Health by LCSW or CP (at least 20 minutes)
  - Remote Physiological Monitoring (at least 20 minutes)
  - Community Health Integration (at least 60 minutes)
  - Principal Illness Navigation (at least 60 minutes)

"An RHC or FQHC may bill HCPCS code G0511 multiple times in a calendar month as long as all requirements are met and there is not double counting."

Page 772 of the 2024 final rules

38

Questions?

39

Thank you.

HealthTech

www.health-tech.us | faith.jones@health-tech.us

40