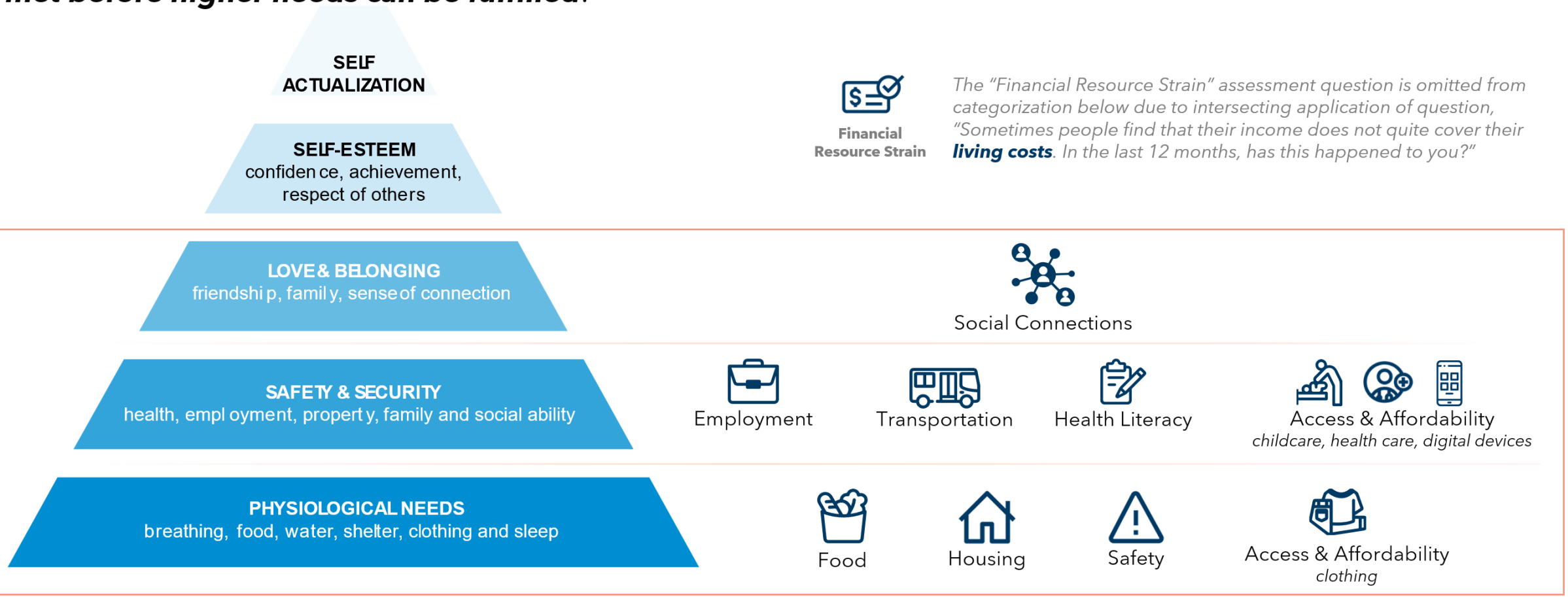
Social Health Assessment & Resources

Health Related Social Needs Assessment Screening Tools & Coding

HIGHMARK WHOLECARE

Health Related Social Needs (HRSN) are the foundation for better health

Maslow's hierarchy of needs– ***lower levels must be met before higher needs can be fulfilled***.[1]



HRSN Impact Conditions and Utilization

Overview

Health related social needs (HRSN) have a profound impact on individual and population's health and well-being. Individuals whose HRSN needs are not being properly addressed are more likely to have chronic diseases and rely on ED for care.[4]

The Cost of Poor Health to Employers[4]

90%	6 in 10	$36.4B
Healthcare dollars spent on chronic diseases	**Americans that have been diagnosed with a chronic disease**	**Cost of chronic disease/unhealthy behaviors borne by employers each year**

SDOH Cost and Impact

Food Insecurity

Patients with food insecurity have a 56% probability of developing chronic disease

Social and Community Context

Socially isolated adults resulted in an additional $6.7 billion in Medicare spend[1]

Neighborhood and Physical Environment

Individuals experiencing housing insecurity used the ED 2.8x as often

Economic Stability

Individuals in lower income households visit the ED for preventable reasons 2.5x those with higher incomes[2]

Education

Those who do not complete high school have a 37% higher chance of having cardiovascular disease[3]

References

1. Aging & Independence Policy Briefs, *Social Isolation & Loneliness*, March 2021. https://cdn.atlantaregional.org/wp-content/uploads/policybriefing-isolation-final.pdf
2. Udalova, Victoria, et al. *Most Vulnerable More Likely to Depend on Emergency Rooms for Preventable Care.* U.S. Censes Bureau, January 2022. https://www.census.gov/library/stories/2022/01/who-makes-more-preventable-visits-to-emergency-rooms.html
3. Choi, Andy I. et al., *Association of Educational Attainment with Chronic Disease and Mortality: The Kidney Early Evaluation Program*, Am J Kidney, May 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3144262/
4. Collective Health, *Social Determinants of Health: Why They Should Matter to Employers.*, April 2022. https://collectivehealth.com/blog/insights/social-determinants-of-health-importance-for-employers/

Highmark Wholecare's Universal Social Health Assessment

SOCIAL CONNECTIONS

- ❑ How often do you feel isolated from others? (UCLA Loneliness Screening)

TRANSPORTATION NEEDS

- ❑ Has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (PRAPARE)

FINANCIAL RESOURCE STRAIN

- ❑ Sometimes people find that their income does not quite cover their living costs. In the last 12 months, has this happened to you? (OECD)

HEALTH LITERACY

- ❑ How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacist? (SILS)
- ❑ I know how to find helpful health resources on the Internet. (eHealth Literacy Scale)

FOOD INSECURITY

- ❑ "Within the past 12 months we worried whether our food would run out before we got the money to buy more." (Children's Health Watch Hunger Vital Signs)
- ❑ "Within the past 12 months the food we bought just didn't last and we didn't have money to get more." (Children's Health Watch Hunger Vital Signs)

SAFETY

- ❑ Do you feel physically and emotionally safe where you currently live? (PRAPARE)

HOUSING STABILITY

- ❑ Are you worried about losing your housing? (PRAPARE)
- ❑ In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home? (AHC)

ACCESS & AFFORDABILITY

- ❑ In the past year, have you been unable to get childcare when it was really needed? (PRAPARE)
- ❑ In the past year, have you been unable to get clothing when it was really needed? (PRAPARE)
- ❑ In the past year, have you been unable to get medicine or any health care when it was really needed? (PRAPARE)
- ❑ Do you have access to any of the following devices? (ACORN)

EMPLOYMENT

- ❑ What is your current work situation? (PRAPARE)

Standardized HRSN Coding for Assessments

HCPCS codes

- HCPCS are 5-character codes used to bill Medicare and 3rd party payers
- G and Z codes should both be used when identifying a positive HRSN screening.

Z-codes

- Z codes ranging from **Z55 –Z65** are the ICD-10-CM diagnosis codes used to documents **HRSN data** (e.g., housing, food insecurity, transportation, etc.)
- Follow the ICD 10 CM coding guidelines (https://www.cms.gov/)
- Use the CDC National Center for Health Statistics ICD-10 CM Browser tool to search for ICD 10 CM codes and information on code usage.
- https://www.cms.gov

LOINC (Logical Observation Identifiers Names and Codes)

- LOINC is a code system (i.e., set of identifiers, names, and codes) for clinical and laboratory observations, health care **screening/survey instruments**, and document type identifiers
- LOINC **Codes** for both **Questions and Answers** must be used
- https://loinc.org

Standardized HRSN Coding for Interventions

SNOMED codes (Systemized Nomenclature of Medicine)

- SNOMED codes can be used to track and measure HRSN interventions.
- www.snomed.org

Intervention Type	Example
Assistance	Assistance with application to Homelessness Prevention program
Coordination	Coordination of care plan
Counseling	Counseling for readiness to implement food insecurity care plan
Education	Education about area agency on aging program
Evaluation	Evaluation of eligibility for a fuel voucher program
Referral	Referral to area agency on aging or community program
Provision	Provision on home-delivered meals

Resources for Social Needs

HIGHMARK WHOLECARE

Extra Benefits & Programs- Lehigh Capital (LC) & Southwest (SW)

Areas Supported	Program	Zone	Program Description
Transportation	**Non-Emergent Transportation**	**LC SW**	Transportation for Medicaid members who have exhausted all other means including friends/family, public transit, and MATP. Transportation is provided to any **medical location and select SDOH locations.**
Utilities	**Utility Relief Program**	**LC SW**	Eligible members may receive support to prevent or delay a **gas, electric, water or sewage** shut off or to pay for a utility security deposit for start of service.
Housing	**Community Housing Coordination**	**LC SW**	Housing Coordinators provide education and referral assistance to state, regional and local resources to **address housing needs** including issues related to rent/utility assistance, desire for relocation, eviction, homelessness, temporary housing, home modification, landlord disputes, lead abatement, and budgeting skills.
Housing	**Bethlehem Haven**	**SW**	Partnership with Bethlehem Haven **Medical Respite Facility** to provide respite and medical stabilization care for members experiencing homelessness.
Housing	**A Path to Home**	**SW**	Allegheny County/DHS Area Agency on Aging (AAA) to provide support to Medicaid members admitted to Bethlehem Haven medical respite facility, who are interested in securing **permanent housing**.
Food	**Post-Discharge Meals**	**LC SW**	Offering up to 42 **home delivered meals** over a 3-week period for members returning to a home environment following an acute physical health-related inpatient hospital admission, SNF or rehab stay
Food	**Food Box Program**	**LC SW**	Partnership with a Community Based Organization offering two months of **food boxes** (dry goods) delivered to members who screen positive for food insecurity. Members receive 4 boxes of shelf-stable, healthy foods (low sodium, packed in water vs. sugar, whole-grain pastas and cereals, etc.).

Extra Benefits & Programs- Lehigh Capital (LC) & Southwest (SW)

Areas Supported	Program	Zone	Program Description
Food	**Kellyn Intensive Therapeutic Lifestyle Change (ITLC)**	**LC**	The ITLC program goal is to educate and support members diagnoses with **Type 2 diabetes** in zip codes 18101 and 18102 through twelve weeks of in-person sessions hosted by a chef creating healthy meals and health educators to educate health habits and goals.
Food	**AHN Healthy Food Center**	**SW**	Partnership with the Allegheny Health Network (AHN) Center for Inclusion Health (CIH) to be able to directly refer our food insecure members to the **Healthy Food Centers** (HFC) located within select AHN Hospitals.
HRSN & Medical Appointments	**Contact to Care**	**LC**	Partnership with the United Way of the Capital Region in which **non-clinical CHWs** employed by Hamilton Health assist members living in Perry or Northern Dauphin County with meeting their healthcare goals.
HRSN & Medical Appointments	**La Conexión**	**LC**	Partnership with a hospital system and a Community Based Organization in **which 2 bilingual CHWs** connect members with medical appointments, close care gaps and address social needs
HRSN & Medical Appointments	**Thrive 18**	**SW**	Partnership with Project Destiny who operates the Thrive 18 program. Utilizing the use of **a non-clinical CHW** model that has family support and CM practices, community organizing and outreach approaches.
HRSN & Medical Appointments	**AHN CIH Street Medicine Program**	**SW**	Partnership with **AHN Center for Inclusion Health's (CIH) Street Medicine Program**. The team conducts street rounds multiple times per week and works closely with other outreach teams to connect individuals to services such as referrals for unmet mental health needs, substance use disorders, health related social needs, and navigating healthcare.

Extra Benefits & Programs- Lehigh Capital (LC) & Southwest (SW)

Areas Supported	Program	Zone	Program Description
HRSN & Medical Appointments	**AHN CIH Post Incarceration Program**	**SW**	Partnership **with AHN Center for Inclusion Health's (CIH)** Post Incarceration Program. The Post Incarceration program is in collaboration with the **RIvER clinic**. The RIvER Clinic is dedicated to managing the healthcare and life needs of individuals recently discharged from jail or prison.
Education/ Employment	**GED Program**	**LC SW**	Access to online portal including study materials, practice tests, and **GED test** with support of a GED advisor.
Education/ Employment	**Peer to Career**	**LC SW**	Collaboration with Community Based Organizations that help members gain access to **education**, **training**, and **employment** resources.
Education/ Employment	**Success Champions**	**LC SW**	Success Champions are community health workers who help members in **coordinating education and/or employment** needs by linking them to a variety of resources such as GED Testing, and Peer to Career partnerships.
Education/ Employment	**Boys & Girls Clubs of Western PA**	**SW**	Partnership with the **Boys and Girls** clubs to pay for monthly STEAM/After School program and Teen Careerworks programs.
Education/ Employment	**Olivet Boys & Girls Club**	**LC**	Partnership with the **Boys and Girls Clubs** to pay for yearly membership and summer camp fees at 10 Clubhouse locations in Reading and Berks County.

HRSN Referral Process

To connect an eligible member with a Highmark Wholecare HRSN program, please call our Enhanced Member Service Unit team:

1-800-392-1147

Questions?
Contact Taylor Wong
taylor.wong@highmark.com