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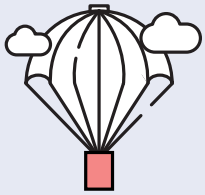


Understanding Social Determinants of Health: The Regulations and Opportunities

Introduction

In the pursuit of comprehensive healthcare, it is crucial to recognize the profound impact of Social Determinants of Health (SDOH). As defined in the Healthy People 2030 report, SDOH encompasses the conditions in the environments where people are born, live, learn, work, play, worship, and age. These conditions significantly influence health, functioning, and overall quality of life.

Research indicates that SDOH contributes to at least 50% of what determines our health. To achieve substantial improvements in population health, a holistic approach that addresses SDOH is imperative. There are five (5) categories of social determinants that contribute to overall health outcomes. These encompass a variety of factors such as housing, food and nutrition access, transportation, and family and community dynamics. These categories were identified in the Healthy People 2030 as:

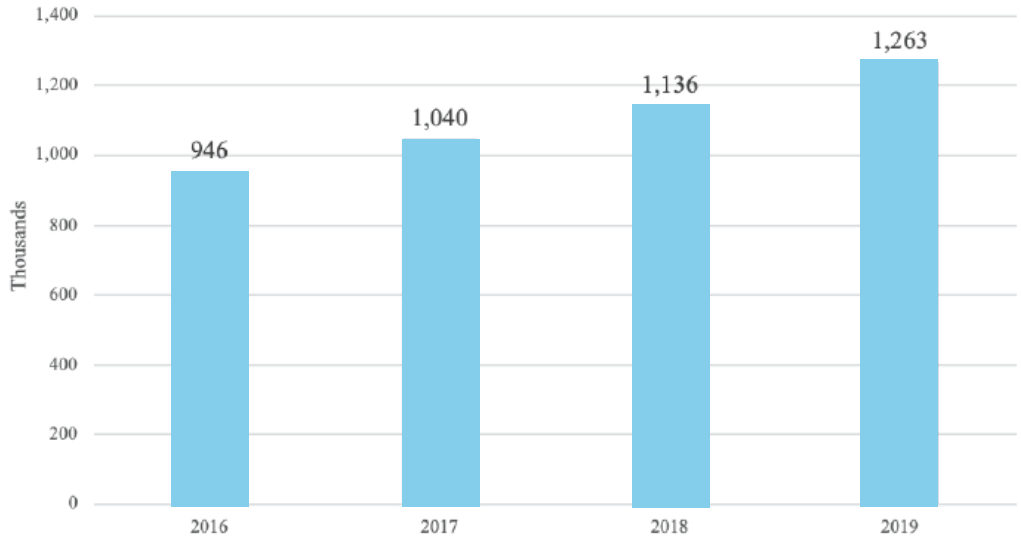
- economic stability,
- education access and quality,
- healthcare access and quality,
- neighborhood and built environment, and
- social and community context.

Regulations and Reimbursement: A New Era for Social Determinants of Health Screening

Starting January 1, 2024, a paradigm shift in healthcare regulations encourages Social Determinants of Health (SDOH) screening across all settings. This change represents a significant stride toward recognizing the impact of social factors on overall health. Notably, in the primary care setting, there is now a reimbursement opportunity for practitioners engaging in SDOH risk assessments.

For healthcare professionals, especially nurses, the nursing process provides a familiar framework to navigate the complexities of SDOH. The process involves assessment, diagnosis, planning, implementation, and evaluation, and it serves as a robust tool for addressing SDOH systematically. The nursing process, like other scientific frameworks must begin with assessment. When applying the nursing process to determining SDOH, assessment begins with data gathering, often initiated through screening tools. The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) Tool, a commonly used option, facilitates identifying SDOH concerns. It's essential to approach screening without judgment, utilizing evidence-based, validated tools to ensure clarity and objectivity.

Although screening and diagnosing for the SDOH was first introduced in 2016 with codes available to include on claim forms, the voluntary use of screening and recording the diagnosis on claim forms has not become a standard practice. As noted in the CMS September 2021 Data Highlights report, less than one percent of claims reported any of the SDOH diagnoses without much improvement over the course of four years.



The total number of Z code claims was 945,755 in 2016, 1,039,790 in 2017, and 1,135,642 in 2018. In 2019, there were 1,262,563 Z code claims, representing 0.11% of all FFS claims that year (N=1,124,319,144) and an increase of 95,852 (9.2%) from 2018 and an increase of 189,887 (20.1%) from 2016.

In 2024, screening for SDOH is being imbedded into quality measures and regulations throughout several settings in healthcare. However, in the Physician Fee Schedule (PFS) 2024 final rules published in the Federal Register November 2023, in addition to the encouragement to screen for SDOH, there is also an additional opportunity for reimbursement when a full risk assessment is completed.

Differentiating between screening and assessment is vital. While screening evaluates the possible presence of a problem with a yes or no outcome, assessment delves deeper into defining the nature of a problem, determining a diagnosis, and developing specific treatment recommendations.

The PFS final rules introduce the use of HCPCS code G0136, which entails the administration of an evidence-based, validated screening tool such as the PRAPARE tool to screen for SDOH followed by a risk assessment to determine the significance of the impact of the unmet social needs on the ability for the patient to engage in a prescribed treatment plan.

The full risk assessment is estimated to take 5-15 minutes of the provider's time to determine the significance of the unmet social need upon the treatment plan and therefore the HCPCS code G0136 has been assigned a relative value unit (RVU) to reflect that amount of time (0.18 RVU). This code is specifically designed to identify and value the work involved in conducting an SDOH risk assessment, contributing to a comprehensive social history during Evaluation and Management (E/M) visits as well as other types of visits performed by the provider who has an established relationship with the patient. The rules outline that this risk assessment can be reimbursed no more than once every six (6) months per Medicare beneficiary per provider.

The provider who is eligible to bill for the service must have an established relationship with the patient and is responsible to make the proper referrals to ensure the patient receives assistance to meet the identified social needs. Originally CMS envisioned that HCPCS code G0136 would only be used in outpatient office settings, after reviewing the variety of public comments received in response to the proposed rule, it was determined that the code can also be applied to behavioral health office visits, psychiatric diagnostic evaluations, and Health Behavior Assessment and Intervention services. Moreover, it can be performed in conjunction with an Annual Wellness Visit or Transitional Care Management (TCM) visits for discharged individuals from hospitals, observation units, or post-acute care.

Elements for SDOH Risk Assessment:

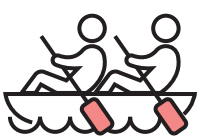
Practitioners utilizing HCPCS code G0136 must utilize a standardized, evidence-based SDOH screening tool validated through research. As stated, PRAPARE is one such tool but it is not required to use that specific tool. Any research validated tools can be used as long as it includes domains such as food insecurity, housing insecurity, transportation needs, and utility difficulties. Additionally, providers have the flexibility to assess for other prevalent social determinants based on community needs.

Given the multifaceted nature of unmet SDOH needs, appropriate follow-up is emphasized. Although the regulations do not mandate providers to have the capacity for Care Management Services within their practice or formalized partnerships with community-based organizations, there is an expectation that providers will, at a minimum, refer patients to relevant resources and incorporate assessment results into medical decision-making. However, the utilization of Care Management Services such as Chronic Care Management, Behavioral Health Integration, Principal Care Management, Community Health Integration or Principal Illness Navigation will allow for close monitoring and the closure of social gaps in care that often create barrier to the full implementation of an effective treatment plan and are encouraged.

Team-Based Approach to SDOH Screening and Risk Assessment:

Regulations acknowledge the operational ease for providers by not requiring the SDOH risk assessment to be performed on the same date as associated approved visit type such as an evaluation and management visit, annual wellness visit, transitional care management visit, or behavioral health visits. This flexibility aligns with the nature of HCPCS code G0136 as an assessment rather than just a screening.

Additionally, this flexibility allows for the use of a team-based approach to care related to screening, assessing, identifying potential diagnoses, proposing interventions, and evaluating outcomes. These elements are inherent in the nursing process. Registered nurses working in ambulatory care are well suited to work in partnership with the provider. As a care team member, the RN in the practice, especially those in a care coordinator role, have trusting relationships with patients that encourage honest communications in the discovery of unmet social needs.



The ideal workflow for utilizing the team-based approach to care in the SDOH screening and risk assessment is in the pre-visit planning process. As the RN reaches out to the patient in preparation for their visit with the provider, the RN can administer the screening tool, review any positive responses, conduct an in-depth assessment, review potential and propose diagnoses for the unmet social need, and investigate planning options. All these elements of the nursing process can be documented in a pre-visit planning note to the provider prior to the visit.

At the visit, the provider will have the benefit of this pre-work and then have the ability to spend the 5-15 minutes discussing with the patient and determining if the unmet needs do indeed have a negative impact in the ability of the patient to adhere to their treatment plan. The provider will determine if and which SDOH diagnoses codes need to be added to the problem list, the visit note, and the claim. Additionally, in a team-based approach to care practice environment, the provider works with the RN and the care team to ensure the patient receives the appropriate follow-up and referrals; ideally into a care management program.

Conclusion:

Any identified SDOH needs should be documented in the medical record using ICD-10-CM codes known as "Z codes" (Z55-Z65). The use of these codes facilitates effective communication between providers, care team members, and referral resources. Although the 2024 PFS final rules do not require that the diagnoses be included in all claims, it is highly encouraged. Capturing these diagnoses codes and reporting them on all claims will also provide population health data on the practice level, community level, and the entire Medicare population level. The analysis of this data could provide options for funding to address the community's social needs in the future.

In navigating the intricate landscape of healthcare, understanding and addressing social determinants of health is indispensable. By employing evidence-based tools, focusing on collaboration, and embracing a holistic approach, healthcare professionals can pave the way for healthier communities and more comprehensive patient care.