Improve outcomes through whole-person health:

A guide to addressing social determinants of health in patients

Humana
Healthy Horizons™
in Louisiana

A HELPFUL RESOURCE GUIDE

to support physicians, clinicians and care teams as you screen and address the social health needs of patients

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INTRODUCTION

Improving health starts with supporting the whole person

60% of a person's health is impacted by:[1]

- Social conditions
- Environmental conditions
- Behavioral conditions

While the clinical aspects of patient health remain the highest priority for diagnosis and treatment, understanding the patient's social needs can inform a more complete picture. Your patients' home environment and daily behaviors can often put them at higher risks for health challenges like obesity, depression and heart disease, and can sometimes lead to multiple emergency department (ED) visits.[2] In fact, food insecurity—as one example described on page 3—is closely associated with higher ED use and inpatient stays, as well as longer hospitalizations.[3]

Understanding your patients' lifestyle and community can help improve patient care, enrich a culture of health equity and eliminate social barriers to health.[4] The good news: You and your care team can address and support the health-related social needs of patients. Humana has resources to help you.

This guide is designed to support you with:

1. Understanding the health impacts of social determinants of health (SDOH)
2. Screening your patients for SDOH and connecting them with resources for support
3. Tracking, documenting and coding your patients' screening results in the electronic health record (EHR) so your practice can best meet the needs of your patients, leading to better health outcomes

The health impacts of specific social determinants of health

Due to their direct impact on Healthy Days and clinical outcomes, **Humana focuses on 5 specific SDOH, though patients may experience a unique spectrum of social needs**.

Food insecurity

Food insecurity occurs when people have limited or uncertain access to enough food to live a healthy, active life.

In 2019, 1 in 10 Americans were food insecure—equating to 35 million Americans.[5] **63%** of senior households who experience food insecurity report having to choose between food and medical care.[6] For Humana Medicare Advantage (MA) members in Louisiana, **29%** are food insecure.[7]

Food insecure adults and seniors have a higher risk of hypertension, coronary heart disease, hepatitis, stroke, cancer, asthma, diabetes, arthritis, chronic obstructive pulmonary disease and kidney disease. While income is strongly correlated with several of these diseases, food insecurity is strongly associated with all 10 illnesses.[8]

Rates of cost-related medication underuse (skipping medications, taking less medicine than prescribed, delaying filling a prescription, using lower-cost medications and not being able to afford medicine) **among adults ages 65 and older are:**[9]

25% for those experiencing **marginal food security** (low level of food insecurity)

40% for those experiencing **low food security** (moderate level of food insecurity)

56% for those experiencing **very low food security** (most severe level of food insecurity)

Financial strain

Financial strain is a mix of cognitive, emotional and behavioral responses to financial hardship that prevents patients from meeting their financial obligations. It also encompasses other core needs, such as housing instability and food insecurity.[10]

For Humana MA members in Louisiana, **40%** report being financially strained.[7]

Patients experiencing financial strain may forgo medical care and prescriptions to meet their essential needs, such as housing and food, and may make more affordable, but less healthy, food choices.[10]

Loneliness and social isolation

Loneliness refers to the quality of relationships within a person's network, while social isolation refers to the quantity and structure of a person's social network.

1 in 5 Americans always or often feel lonely or socially isolated.[11] For Humana MA members in Louisiana, **30%** report feelings of loneliness and/or social isolation.[7]

For older adults, up to **43%** feel the impact of loneliness, which can have significant implications for their health,[12] including:

- **40%** increased risk of dementia
- **30%** increased risk of stroke or the development of coronary heart disease
- Increased risk of early death
- Raised levels of stress, depression and sleep impediment

Transportation

A lack of transportation can impact healthcare access, leading to poorer management of chronic illness—and poorer health outcomes.[13]

For Humana MA members in Louisiana, **12%** have a transportation barrier.[7]

- **3.6 million** Americans are unable to obtain medical care due to transportation barriers and, in 2017, medical transportation was the leading cause of patient no-shows.[14]
- When older adults are asked about barriers to care, transportation is the third-most frequently mentioned obstacle.[15]
- **65%** of patients said transportation assistance would assist them with prescription fills after discharge.[13]

Housing

A lack of access to quality and safe housing can lead to various chronic illnesses that can have lasting negative effects on patients.

For Humana MA members in Louisiana, **24%** report having one or more housing quality issues, which could include pests, mold, water leaks and other issues.[7]

Health challenges associated with poor housing conditions include:[16]

- Heart damage and neurological impairment from increased exposure to carbon monoxide from damaged appliances, peeled paint and exposed nails
- Allergic, respiratory, neurological and hematological issues from dust and toxic chemicals in old and dirty carpeting
- Hypertension from lead exposure

Steps to address social determinants of health in your patients

While we continue to screen members for SDOH, especially those at high risk or with chronic conditions, there are millions of Americans with ever-changing needs—and we can't do it alone. Given the strong, trusting relationships between patients and physicians, we see this as an ideal opportunity for physicians, practices and care teams to screen patients and talk to them about their social health needs.

5 steps to identifying, tracking and triaging SDOH:

STEP 1:

Screen for one or various social determinants to assess patient for social health challenges.

STEP 2:

Discuss the significance of SDOH and how it relates to the patient's health.

STEP 3:

Connect the patient to resources and support.

STEP 4:

Track, document and code the screening results in the patient's EHR.

STEP 5:

Follow up with the patient within 1 to 2 months of resource referral.

STEP 1

Screen patients for social determinants of health

Screening a patient for SDOH is quick, easy and can be conducted during an annual wellness exam, when a life event has occurred or when you feel appropriate. By simply asking your patients a few questions, it may reveal an opportunity to improve their health by connecting them to the necessary resources and support that may be available right in their own community.

Health-Related Social Needs Screening Tool

This tool is adapted from the Accountable Health Communities Health-Related Social Needs Screening Tool, developed by Center for Medicare & Medicaid Innovation (CMMI).

Food insecurity

Some people have made the following statements about their food situation. Please answer whether the statements were **often**, **sometimes** or **never true** for you and your household in the last 12 months.

1a. Within the past 12 months, you were worried that your food would run out before you got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

1b. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

Calculation: A response of sometimes true or often true to either question should trigger a referral for food resources.

Loneliness and social isolation

2. How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Calculation: A response of sometimes, often or always should trigger a referral for loneliness resources.

Transportation

3. Within the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or getting things needed for daily living?

☐ Yes ☐ No

Calculation: A response of yes should trigger a referral for transportation resources.

Housing

4a. What is your living situation today?

☐ I have a steady place to live.

☐ I have a place to live today, but I am worried about losing it in the future.

☐ I do not have a steady place to live.

Calculation: A response of "I have a place to live today, but I am worried about losing it in the future" or "I do not have a steady place to live" should trigger a referral for housing resources.

4b. If you have a place to live, do you have problems with any of the following? (Choose all that apply.)

- ☐ Pests such as bugs, ants or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above
- ☐ All of the above

Calculation: Any responses other than "None of the above" should trigger a referral for housing resources.

Financial strain

5. How hard is it for you to pay for the very basics like food, housing, medical care and heating? Would you say it is:

☐ Very hard ☐ Somewhat hard ☐ Not hard at all

Calculation: A response of very hard or somewhat hard should trigger a resource referral.

To view the full screening tool developed by CMMI and review the research and methodology behind the tool, please visit the Accountable Health Communities Health-related Social Needs Screening Tool at innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.

STEP 2

Discuss the significance of SDOH and how it relates to the patient's health

If your patient screens positive for one or more SDOH, consider the following approach when discussing screening results:

1. Acknowledge the situation. Affirm the difficulty of the situation and your awareness of some of the challenges they may face given their social health barrier(s).
2. Open the conversation. Learn more about the patient's perspective and realities in meeting their health needs.
3. Ask if they are willing to accept help and connect with resources for support.
4. Discuss how important addressing the social health barrier(s) is to their unique health conditions/needs and overall health journey.

STEP 3

Connect the patient to resources and support

If your patient agrees to accept help, use the following Resource Referral Guide as a starting point to connect them to resources and support that may be available through their medical coverage, government agencies, nonprofit organizations and in their community. Additional resources also may be available in the patient's community.

Resource referral guide

Patient coverage and benefits

Some health plans may provide eligible members with resources for food and nutrition, medical transportation, behavioral health, prescription drugs and/or housing. Plans also may include virtual appointments for medical and/or behavioral healthcare, allowing your patients to receive care without leaving their home. Your patients can call the number on the back of their member ID card to see what benefits may be available.

RESOURCES FOR ANY SOCIAL HEALTH CONCERN

211 Helpline Center

Provides community information and referrals to social services for everyday needs and in times of crisis. Calls are free and confidential.
Dial 211 from any phone, 24 hours a day, 7 days a week
www.211.org

Eldercare and Area Agencies on Aging

Helps seniors and their caregivers find trustworthy, local support resources for various social health concerns, including food insecurity, loneliness, transportation, financial strain and housing challenges.
800-677-1116 (TTY: 711),
Monday – Friday, 9 a.m. – 8 p.m., Eastern time
eldercare.acl.gov

FOOD INSECURITY RESOURCES

Feeding America affiliate food bank

Offers local resources for feeding programs in your community. Resources and requirements vary by food bank.
www.feedingamerica.org/find-your-local-foodbank

Meals on Wheels

Provides free or low-cost home-delivered meals for seniors. Focuses on caring for individuals whose diminished mobility makes it hard to shop for food, prepare meals or socialize with others.
www.mealsonwheelsamerica.org

Supplemental Nutrition Assistance Program (SNAP)

Provides money to purchase food at grocery stores, farmers markets and other retailers (formerly known as food stamps). In 2018, the average benefit was about $127 per month per person.[17]
www.fns.usda.gov/snap

LONELINESS AND SOCIAL ISOLATION RESOURCES

Anxiety & Depression Association of America

Offers useful articles, local assistance and an online support group to help with anxiety and depression struggles.
www.adaa.org

Connect2Affect

Offers free or reduced-cost services to support or prevent social isolation. These services include transportation, volunteer programs, senior centers and more.
www.connect2affect.org

Resources continued ⟶

Far From Alone
Find loneliness resources. Additionally, if there is a community organization in your area that helps people make a difference and feel more socially connected, we encourage you to share their story by sending an email to **partner@farfromalone.com**.
www.farfromalone.com

Institute on Aging's Friendship Line
Lends a caring ear for friendly conversation if a senior is feeling lonely, socially isolated or depressed.
800-971-0016 (TTY: 711),
24 hours a day, 7 days a week
www.ioaging.org/services/all-inclusive-health-care/friendship-line

HOUSING RESOURCES

U.S. Department of Housing and Urban Development
Offers support in connecting with local resources and creating a long-term housing plan.
www.hud.gov/findshelter

Volunteers of America
Provides a range of support services including eviction prevention, emergency services, transitional housing and permanent affordable housing.
www.voa.org/find-housing

VETERAN RESOURCES

AMVETS Heal
Assists veterans who need immediate assistance with ensuring their social health needs and healthcare needs are met, including mental health and specialized services.
833-VET-HEAL (838-4325),
Monday – Friday, 9 a.m. – 5 p.m., Eastern time
VETHEAL@amvets.org
www.amvetshealprogram.org

PATRIOTlink
Offers an online resource database that includes thousands of programs tailored to the military and veteran community. Users can search vetted, direct, cost-free services specific to their needs.
www.patriotlink.org

Veterans Crisis Line
A free confidential service for veterans in crisis or anyone concerned about a veteran. There are caring, qualified responders standing by to help.
800-273-8255 and press 1
Text 838255
24 hours a day, 7 days a week
www.veteranscrisisline.net

Vets4Warriors peer support
Connects veterans with other fellow veterans to talk anytime.
855-838-8255 (TTY: 711),
24 hours a day, 7 days a week
www.vets4warriors.com

Resources continued ⟶

Make the Connection

Provides social withdrawal and isolation information, treatment options, self-help tools and resources to aid veterans in recovery.
www.maketheconnection.net/symptoms/social-withdrawal

FINANCIAL STRAIN RESOURCES

Support from your patient's health plan

Some health plans may provide eligible members with:

- Help enrolling in programs to reduce medical and prescription costs such as Medicare Savings Programs and Medicaid
- Plan benefits that provide food resources and assistance, including meal delivery
- Medical and/or nonmedical transportation services
- Assistance for housing quality and/or instability

Your patients can call the number on the back of their member ID cards to see if additional benefits are available.

Helpful SDOH resources to provide patients

Visit **PopulationHealth.Humana.com** and select the "News & Resources" tab for additional materials on food insecurity, loneliness and social isolation, transportation, housing and financial strain. You'll also find **helpful flyers** to share with patients that offer guidance and **resources**. Physician resources are also available for additional screening and referring support.

STEP 4

Track, document and code the screening results in the patient's EHR

Best practices with SDOH include documenting your patient's screening results in their electronic health record (EHR) so you and your care team can track patient progress over time and, more importantly, have a holistic view of the patient's overall health. This also allows you to track the prevalence of SDOH factors in your overall patient panel or clinic population.

For instance, are transportation barriers a big contributor to patient no-shows and administrative burden? Are patients from certain demographic sectors—such as age, ethnicity, insured status and ZIP code—more likely to be food insecure? Understanding these characteristics can help physician practices create referrals, relationships and programs that best meet the needs of patients and their families.

It's a best practice to document patient screening results in the EHR so you and your care team can track patient progress and communicate results to the patient's insurer. By using ICD-10-CM codes in categories Z55–Z65 (like those below), you provide clear documentation that's useful across payer systems. The Gravity Project offers coding guidelines for specific SDOH domains at https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard.[18]

ICD-10-CM Official guidelines for coding and reporting for fiscal year 2022 Oct. 1, 2021 – Sept. 30, 2022

You'll find codes for social determinants of health primarily in the Z categories below. This list of codes is incomplete and shows only the series available for your use. Please consult your ICD-10 book for full codes.

Z55 Problems related to education and literacy
- **Z55.1 Schooling unavailable and unattainable**
- **Z55.5 Less than a high school diploma**

Z56 Problems related to employment and unemployment

Z57 Occupational exposure to risk factors

Z58 Problems related to physical environment
- **Z58.6 Inadequate drinking-water supply**

Z59 Problems related to housing and economic circumstances
- **Z59.0 Homelessness**
  - **Z59.00 Homelessness, unspecified**
  - **Z59.01 Sheltered homelessness**
  - **Z59.02 Unsheltered homelessness**
- **Z59.4 Lack of adequate food**
  - **Z59.41 Food insecurity**
- **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**
  - **Z59.81 Housing instability, housed**
    - **Z59.811 Housing instability, housed, with risk of homelessness**
    - **Z59.812 Housing instability, housed, homelessness in past 12 months**
    - **Z59.819 Housing instability, housed unspecified**

Z60 Problems related to social environment (loneliness/social isolation)
- **Z60.2 Problems related to living alone**
- **Z60.4 Social exclusion and rejection (exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behavior)**

Z62 Problems related to upbringing

Z63 Other problems related to primary support group, including family circumstances [inadequate social support]
- **Z63.8 Other specified problems related to primary support group**
- **Z63.9 Problems related to primary support group, unspecified**

Z64 Problems related to certain psychosocial circumstances

Z65 Problems related to other psychosocial circumstances

Z91* Personal risk factors, not elsewhere classified
- **Z91.1 Patient's noncompliance with medical treatment and regimen**
  - **Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship**

* Not included in SDOH code category but may be used to document "factors influencing health status and contact with health services"

STEP 5

Follow up with the patient within 1 to 2 months of resource referral

After screening and referral, be sure to follow up with your patient within 1 to 2 months to monitor progress and answer the questions below. It will be helpful to understand if the resource referral provides the needed support and how it impacts the patient's health status.

1 Did the patient connect with, visit or accept resources from the referrals you made? If so, how frequently?

> If they were unsuccessful at connecting, you can ask them to sign a release form, which allows you to obtain their permission to then share their name and contact information with the organization directly, e.g., food banks, transportation services and other community organizations that your clinic works with. Those organizations can then contact patients to determine what kind of support they need and refer them to the appropriate locations in their community.

2 What's the current status of the patient's health and how did it improve, decline or stay the same, given the resource support or lack thereof?

Humana partners nationally to address SDOH

Humana is committed to supporting physician practices, hospitals, health systems and health institutions by working together to co-create innovative solutions to address SDOH and health-related social needs for patients and communities.

Humana works to address SDOH by:

- **Investing in and sponsoring physician and medical organizations like the American Academy of Family Physicians (AAFP), American Medical Association (AMA), Medical Group Management Association** and others to work collaboratively on population health efforts.
- Taking advantage of new flexibility from the Centers for Medicare & Medicaid Services (CMS) to **include richer social health benefits into our Medicare Advantage and Medicaid plans**, such as medical transportation, a HealthyFood Shopping Card and behavioral health resources.
- Partnering with academic institutions, such as the University of Houston, to **train future healthcare leaders on whole person, collaborative care** to improve health outcomes.
  - The Humana-Integrated Health System Sciences Institute at the University of Houston **fosters interprofessional, team-based care** in the colleges of medicine, nursing, optometry, pharmacy and social work.
  - This collaboration **graduates healthcare professionals** who are skilled in advancing population and community health and have a propensity for working with the underserved.
- **Sponsoring the Gravity Project**, a national public collaborative focused on the development and implementation of standardized interoperable SDOH data. Additional sponsors include AAFP, AMA, Agency for Healthcare Research and Quality and others.
- **Investing in technology** to make resource referral a more end-to-end process via our social health access referral platforms within communities, making patient referrals to community resources easier.
- **Partnering with national community-based organizations**—like **Feeding America, Volunteers of America, Boys & Girls Clubs of America** and the **Institute on Aging**—to make resources and services available to Humana Healthy Horizons® in Louisiana-covered patients.
- **Working with EHR companies** to streamline the workflow of capturing and tracking patient SDOH screening data.
- **Developing and releasing Population Insights Compass**, a population health management platform that provides actionable insights on SDOH through predictive modeling and assessment data.
- **Developing SDOH courses for continuing medical education (CME) credit,** which expands the content in this guide, providing physicians with more comprehensive lessons on identifying, tracking and triaging patients for SDOH.
  - Check out our Value-Based Care Specialization CME course at **www.coursera.org/specializations/value-based-care/.**

Improving population health is a long-term investment and journey, and Humana is fully committed. We continue to cultivate relationships with physicians, clinicians and care teams, so we're addressing the unique and important health needs of patients and communities. **Together, we can build a future filled with better health outcomes.**

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Humana
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Be a part of the solution.
Learn more at **PopulationHealth.Humana.com**
or email us at **BoldGoal@humana.com.**

Member/provider services in Louisiana: **800-448-3810**
(Monday through Friday, 7 a.m. to 7 p.m., Central time)

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