

SDOH SCREENING TOOLS FOR PUBLIC HOUSING RESIDENTS

LEARNING COLLABORATIVE

Accountability: Navigating
Reimbursement and Evaluating
Impacts

June 15, 2021



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National Center for Health in Public Housing
a project of North American Management



www.nchph.org

Strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees.



- Webinars
- Monographs
- Provider and Resident-Centered Factsheets

- Training Manuals
- Newsletters
- Annual symposiums
- One-on-One

An illustration of a hand holding a laptop. The laptop screen displays the Zoom logo in blue lowercase letters. The background is a blue sky with stylized clouds. The hand is wearing a white shirt cuff and a yellow tie.

zoom

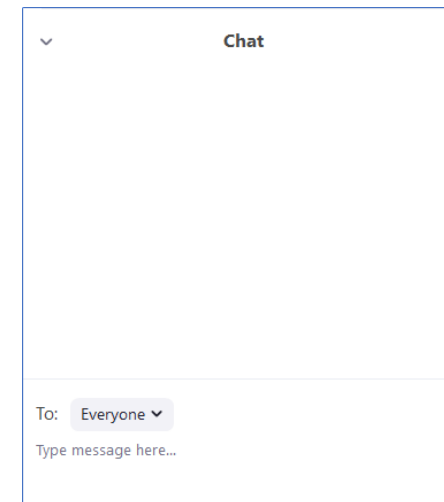
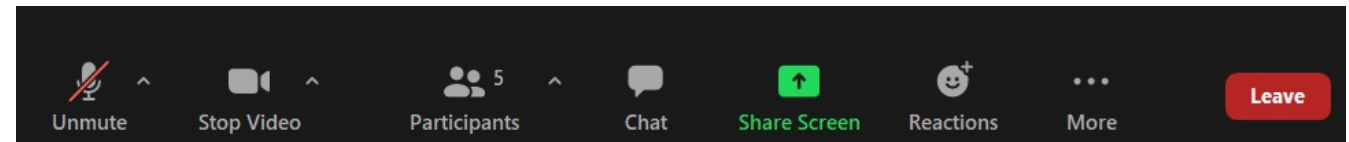
Housekeeping

- All participants muted upon entry
- Cameras on (if possible)
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email and posted to Moodle within a week after session

Icebreakers

In the Chat

- Name and role
- Health center name
- City and State



Moderator and Facilitators



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Guest Speaker

- Dr. Zara Marselian
- CEO, LaMaestra Health Center



Agenda

- Sessions 1-4 Reminder
- Session 5 Overview
- Select ICD-10, SNOWMED, and CPT codes for SDOH
- Guest Speaker Presentation-Dr. Zara Marselian
- Q&A
- **EVALUATION**

Quick Recap of Previous Sessions

1

Screening 101: The Basics

2

A Guided Tour of Screening Tools

3

Implementing a Screening Process with Whole Families in Mind

4

Integrating Screening Practices into EHRs and Managing Workflows



Accountability: Navigating Reimbursement and Evaluating Impacts

- Learning Objectives
 - Define SDOH - related Z codes.
 - Describe an evaluation plan for measuring and monitoring the impact of SDOH screening on patient outcomes and health center procedures.
 - List promising practices on reimbursement and funding strategies to pay for SDOH screening and referrals.
 - Summarize key concepts needed to implement an SDOH screening process in your organization.

Select ICD-10, SNOWMED, and CPT codes for SDOH

[Compendium of Social Risk Factor Codes](#)

Developed by the UCSF Social Interventions Research and Evaluation Network (SIREN) in Winter 2018. The spreadsheet is intended to help interested parties (including clinical and SDH providers, measure developers, informaticists, EHR industry stakeholders, and researchers) more easily identify the set of existing codes related to Social Risk Factors (SRF) and Social Determinants of Health (SDH), and to serve as background to inform an impending, larger effort to develop a comprehensive SDH measure set.

	Assessment Codes			Referral codes	Counseling/Education codes	Provision of Services/Orders codes	
Domain	ICD-10-CM	SNOMED Parent codes	SNOMED Child codes	SNOMED	SNOMED	SNOMED	CPT
Transportation	Z59.8 Other Problems Related to Housing and Economic Circumstances	266934004 Transport problems	713458007 Lack of Access to Transportation	410365006 Transportation case management	410320002 Transportation education, guidance, and counseling	428632006 Transportation request 716730006 Provision of taxi 410423004 Transportation surveillance 716736000 Provision of commercial flight 710351004 Transportation to home 228615008 Provision of transport	99082 Unusual travel (eg, transportation and escort of patient)

Source: Arons A, DeSilvey S, Fichtenberg C, Gottlieb L. Compendium of medical terminology codes for social risk factors. Social Interventions Research and Evaluation Network. June 21, 2018.

Guest Speaker

1. How was the patient handed off to a community referral?

2. How do you use that data from the referral organization (or SDOH data from your screening) to measure and monitor quality of care delivered to that patient?

3. How do you pay for the many SDOH programs that you have at LaMaestra?

4. How have you used evaluation data to secure additional funding opportunities?

5. Summary of the lessons you've learned.

Q&A

Please unmute yourself to ask a question

Resources

Brief to Help Practices Collect and Use Social Needs Data

AHRQ has published a new brief to help primary care practices screen and refer patients for social needs.

Identifying and Addressing Social Needs in Primary Care Settings is located in the EvidenceNOW Tools for Change curated collection of tools and resources that help practices implement the best evidence.

You can find other tools to address social determinants of health (SDOH) on AHRQ's SDOH & Practice Improvement page.

Evaluation Poll

- Answer the poll...
- Add to the chat **to Organizer**
 - Which aspects of this learning collaborative session did you find most useful?
 - How could this learning collaborative session be improved in the future?
 - What other topics would you like training and technical assistance on?

End of LC Evaluation Survey

<https://www.surveymonkey.com/r/MFP3FB6>

Thank You

- Please fill out evaluation!
- Contact us for any questions
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