Improve outcomes through whole-person health:

A guide to addressing social determinants of health in patients

A HELPFUL RESOURCE GUIDE

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

Humana.

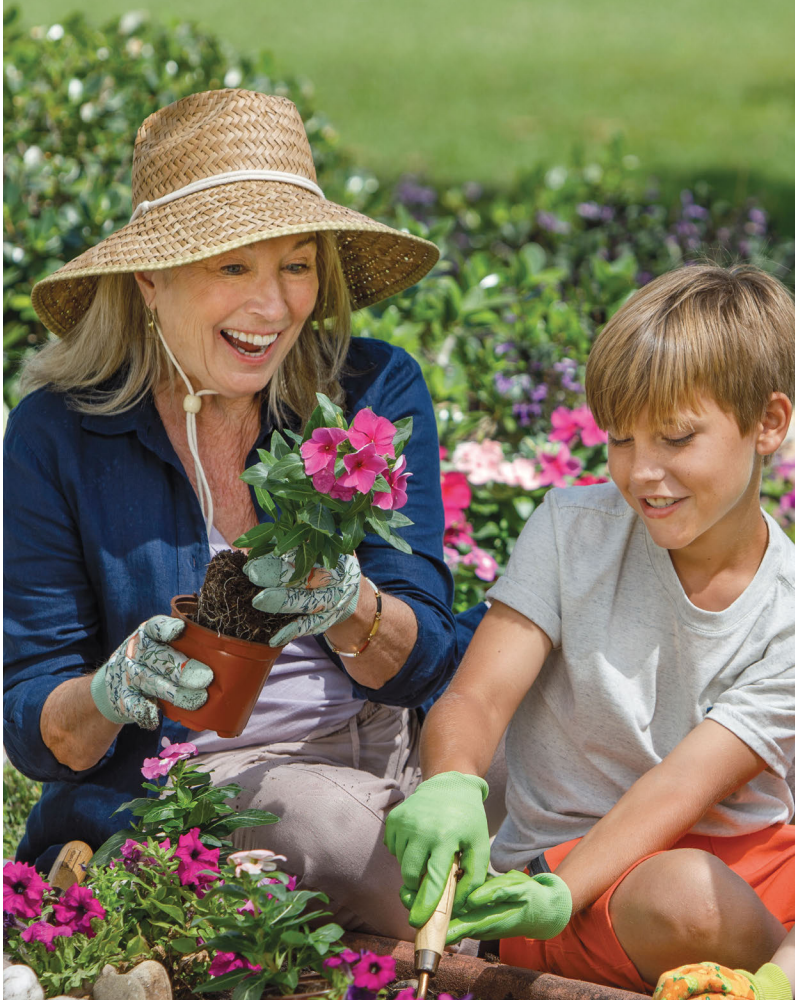
healthequity.humana.com

INTRODUCTION

Improving health starts with supporting the whole person

80% **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 form a more complete picture. Your patient's 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 and significantly associated with higher ED use and inpatient stays, as well as longer hospitalizations.[3]

Understanding your patient's 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, and Humana has the 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 and improve health outcomes.

The health impacts of specific social determinants of health

Addressing social determinants of health can help patients live healthier, happier lives.[5] Due to their direct impact on clinical outcomes, **five specific social determinants of health remain Humana's focus, though patients may experience a unique spectrum of social needs.**

Food insecurity

Food insecurity occurs when people have limited or unreliable access to enough food to nourish them.

In 2021, 10% of Americans were food insecure —equating to 13.5 million households.[6] In fact, **63%** of senior households experiencing food insecurity report having to choose between food and medical care.[7] For Humana Medicare Advantage (MA) members, **30%** are food insecure. For Humana Florida Medicaid members, **64%** are food insecure, and for Humana Kentucky Medicaid members, **81%** are food insecure.[8]

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.[9]

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 over are:**[10]

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 composed of cognitive, emotional and behavioral responses to financial hardship where patients cannot meet financial obligations. It also encompasses other core needs, such as housing instability and food insecurity.[11]

For Humana MA members, **47%** report being financially strained.[8]

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.[11]

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.

In fact, **1 in 5** Americans always or often feels lonely or socially isolated.[12] For Humana MA members, **30%** report feelings of loneliness and/or social isolation.[20] For Humana Florida Medicaid members, **50%** were identified as lonely or socially isolated.[8]

For older adults, up to **43%** feel the impact of loneliness, which can have significant implications for their health, including:[13]

- **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 thus, poorer health outcomes.[14]

For Humana MA members, **11%** have a transportation barrier, and for Humana Florida Medicaid members, it's **30%**.[8]

- **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.[15]
- When older adults are asked about barriers to care, transportation is the third-most frequently mentioned obstacle.[16]
- **65%** of patients said transportation assistance would help them with prescription fills after discharge.[14]

Housing

Housing insecurity can expose individuals and families to a number of health hazards that can lead to injury, disease, mental illness and behavioral health issues.

For Humana MA members, **5%** report housing insecurity, meaning they either do not have a steady place to live or are worried about losing their housing in the future.

Just some of the health challenges associated with poor housing conditions include:[17]

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

Taking 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 health-related social needs (HRSN).

The 5 steps to identifying, tracking and triaging SDOH:

STEP 1:

Discuss the significance of HRSN and how those needs relate to your patient's health.

STEP 2:

Screen your patient with one or more standardized HRSN screening tools to assess for social health challenges.

STEP 3:

Connect your patient to resources and support.

STEP 4:

Track, document and code the screening results and discussed resources in the patient's electronic health record (EHR).

STEP 5:

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

STEP ONE

Discuss the significance of HRSN and how those needs relate to your patient's health.

Many patients may not expect to talk about their SDOH during their healthcare visit. It's helpful to remind your patients that you care about their whole health, as HRSN are personal and may feel stigmatizing.

Consider the following approaches when discussing:

- Emphasize the importance of addressing social health barrier(s) to your patient's unique health conditions, needs and overall health journey.

- Open the conversation to learn more about your patient's perspective and realities in meeting their health needs.

STEP TWO

Screen your patient with one or more standardized HRSN screening tools to assess for social health challenges

Screening your patients for HRSN is quick and easy. Screenings can be conducted during annual wellness exams, if a life event has occurred or when you feel it is appropriate.

There are many standardized, validated HRSN screening tools that can be used during discussions with your patients. Some EHRs have enhancements that integrate the HRSN screening tools as an assessment. If you have questions, Humana can help you identify and use a validated screening tool.

If your patients indicate a social need, consider the following approaches when discussing screening results:

- Acknowledge the situation. Affirm the difficulty they're experiencing and your awareness of some of their challenges, given the social health barrier(s).

- Offer support. Ask if they are willing to accept help and connect with resources for assistance.

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 and 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 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 from 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, check out: **Accountable Health Communities Health-related Social Needs Screening Tool**.

STEP THREE

Connect your patient to resources and support

If your patients agree 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 insurance, government and nonprofit organizations, and in their community. Additional resources also may be available in your patients' local area.

Resource referral guide

Patient's insurance benefits

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

RESOURCES FOR ANY SOCIAL HEALTH CONCERN

Humana Community Navigator®

Search within your community today to connect to utility services, food resources, housing support, transportation programs and more. humana.findhelp.com

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
www.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.[18] www.fns.usda.gov/snap

LONELINESS AND SOCIAL ISOLATION RESOURCES

Anxiety & Depression Association of America

Offers useful articles, local help and an online support group to help with anxiety and depression struggles. 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.
connect2affect.org

Far From Alone

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

Resources continued →

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

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

Veteran 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.
Call 800-273-8255 and press 1
Text 838255
24 hours a day, 7 days a week
www.veterancrisisline.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

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

You can encourage your patients to call the number on the back of their medical insurance ID card to see what plan benefits may be available.

Helpful SDOH resources to provide patients

Visit Healthequity.humana.com and select the Resources tab for additional materials on food insecurity, loneliness and social isolation, transportation, housing and financial strain. This includes helpful flyers to share with patients that offer guidance and resources such as Humana.findhelp.com, which helps to find community resources for those in need. Physician resources also are available for additional screening and referring support.

STEP FOUR

Track, document and code the screening results and discussed resources in your patient's electronic health record (EHR)

As a best practice, use the structured fields available in your EHR to document your patient's results from standardized screening tools and the assistance offered for their identified social needs. These enhanced EHR capabilities can automate coding, allowing you and your care team to track a patient's progress over time and have a holistic view of your patient's overall health.

It's also important to communicate screening results with your patient's health insurer to better coordinate efforts and provide assistance to patients with social health barriers.

By using ICD-10-CM codes in categories Z55–Z65 (like those below), you are able to provide clear documentation that's interoperable across payer systems. **The Gravity Project** offers an online resource with coding guideline assistance for specific SDOH domains.[19]

ICD-10-CM Official Guidelines for Coding and Reporting for Fiscal Year 2024, Oct. 1, 2023 – Sept. 30, 2024

Social determinants of health codes are located primarily in the Z code 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 FIVE

Follow up with your 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. This will be helpful to understand if the resource referral provides the needed support and how your patient's health status is being impacted.

1 Did your 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 your patient's health and how did it improve, decline or maintain, given the resource support or lack thereof?

How Humana is partnering nationally to address SDOH

Humana is committed to supporting physician practices, hospitals, health systems and health institutions. We are working together to co-create innovative solutions to address SDOH and HRSN for patients and communities.

We are doing this now 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 Centers for Medicare & Medicaid Services 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 inter-professional, team-based care** in the colleges of medicine, nursing, optometry, pharmacy and social work.
    - This collaboration will **graduate 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, allowing visibility to resource eligibility, accessibility and utilization at the patient level.
- **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-insured 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 eases friction in care by steering healthcare teams around data silos and providing actionable insights on SDOH through predictive modeling and assessment data.
- **Developing SDOH courses for continuing medical education (CME) credit** that expand upon the content within this guide to provide physicians with a more comprehensive lesson 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 we are fully committed. We will 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 help build a future filled with better health outcomes.**

Sources

1. "County Health Rankings Model," University of Wisconsin Population Health Institute, last accessed April 12, 2023, **https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model**
2. "Social Determinants of Health (SDOH)," NEJM Catalyst, SDOH, December 2017, **https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0312**
3. Berkowitz, Seligman et al (2018) "Food Insecurity, Healthcare Utilization, and High Cost: A Longitudinal Cohort Study," Am J Manag Care. 2018;24(9):399-404.
4. "Addressing Social Determinants of Health in Primary Care," The EveryONE Project™, last accessed April 12, 2023, **www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/team-based-approach.pdf**
5. Barbara Prainsack (2020) The value of healthcare data: to nudge, or not?, Policy Studies, 41:5, 547-562, DOI: 10.1080/01442872.2020.1723517, **https://www.tandfonline.com/doi/pdf/10.1080/01442872.2020.1723517?needAccess=true**
6. "Household Food Security in the United States in 2021," Economic Research Service USDA, last accessed April 12, 2023, **www.ers.usda.gov/publications/pub-details/?pubid=104655**
7. "Facts About Senior Hunger in America," Feeding America, last accessed April 12, 2023, **www.feedingamerica.org/hunger-in-america/senior-hunger-facts**
8. Humana SDOH comprehensive member survey conducted Nov. 2020–Jan. 2021.
9. Gregory, C. A., & Coleman-Jensen, A. (2017). "Food insecurity, chronic disease, and health among working-age adults." Economic Research Report, 235. Washington, DC: U.S. Department of Agriculture, Economic Research Service.
10. Food Research & Action Center, Hunger & Health, December 2017, **https://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf**
11. "Social determinants of health guide to social needs screening," American Academy of Family Physicians, 2019, **https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf**
12. Kaiser Family Foundation, Aug 2018, **https://www.kff.org/report-section/loneliness-and-social-isolation-in-the-united-states-the-united-kingdom-and-japan-an-international-survey-introduction/**
13. "Researchers Confront an Epidemic of Loneliness," The New York Times, September 2016, **https://www.nytimes.com/2016/09/06/health/lonliness-aging-health-effects.html**
14. "Traveling Towards Disease: Transportation Barriers to Health Care Access," J Community Health. 2013 Oct; 38(5): 976–993. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/**
15. Social determinants of health series: "Transportation and the role of hospitals." Chicago, IL: Health Research & Educational Trust. (2017, November). **www.aha.org/transportation**
16. "Transportation Equity for Older Adults," From the source **https://www.rand.org/content/dam/rand/pubs/perspectives/PEA1600/PEA1615-1/RAND_PEA1615-1.pdf**
17. Krieger, James, and Donna L Higgins. "Housing and health: time again for public health action." American Journal of Public Health vol. 92,5 (2002): 758-68. doi:10.2105/ajph.92.5.758.
18. U.S. Department of Agriculture, "SNAP Data Tables," September 2019. **https://www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap**
19. The Gravity Project, May 2021, **https://confluence.hl7.org/display/GRAV/Terminology+Workstream+Dashboard**
20. Humana SDOH General Medicare Advantage Population Survey conducted June – July 2022.

Be a part of the solution.
Learn more at **healthequity.humana.com**
or email us at **HealthEquity@humana.com**.

321606ALL1023 GCHKV5NEN