MO HealthNet Managed Care
(Medicaid)

Healthy Blue

Health-related social needs overview

Partnering with GroundGame Health network

Contents

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- Partnership with Healthy Blue:
  - Program value
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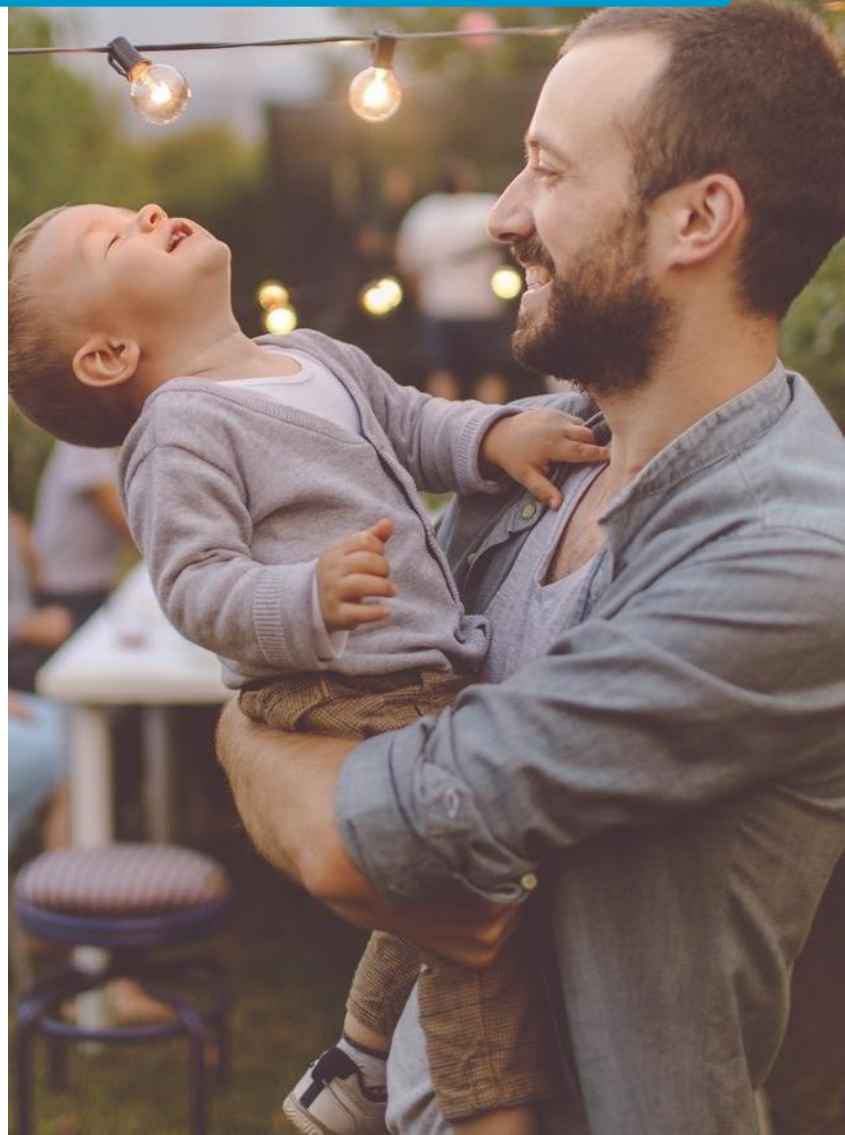
- Next steps and resources



What are health-related social needs (HRSN)?

Healthy Blue is committed to the needs of our members, your patients, and requests your partnership in identifying and referring patients to GGH to address HRSN.

Customers and members are increasingly demanding that payers address HRSN.

Unmet social needs, such as unstable housing, food insecurity, and lack of reliable transportation, exacerbate poor health and quality-of-life outcomes. We will use this term going forward in lieu of social determinants of health (SDOH).

Food

Transportation

Housing

Employment

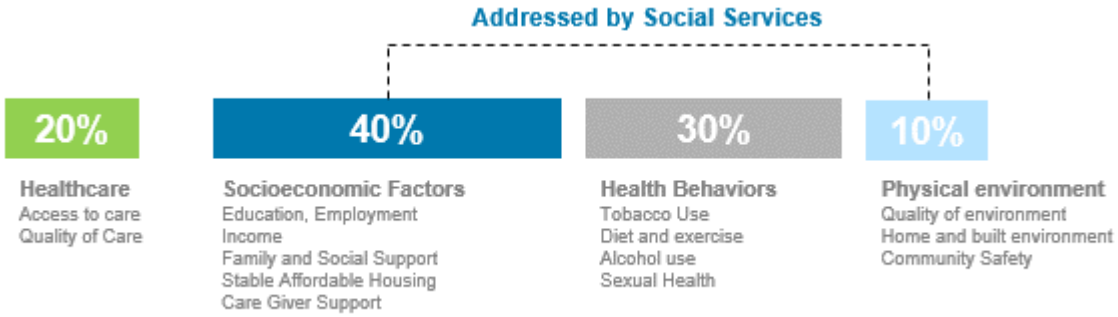
Community safety

Social Support

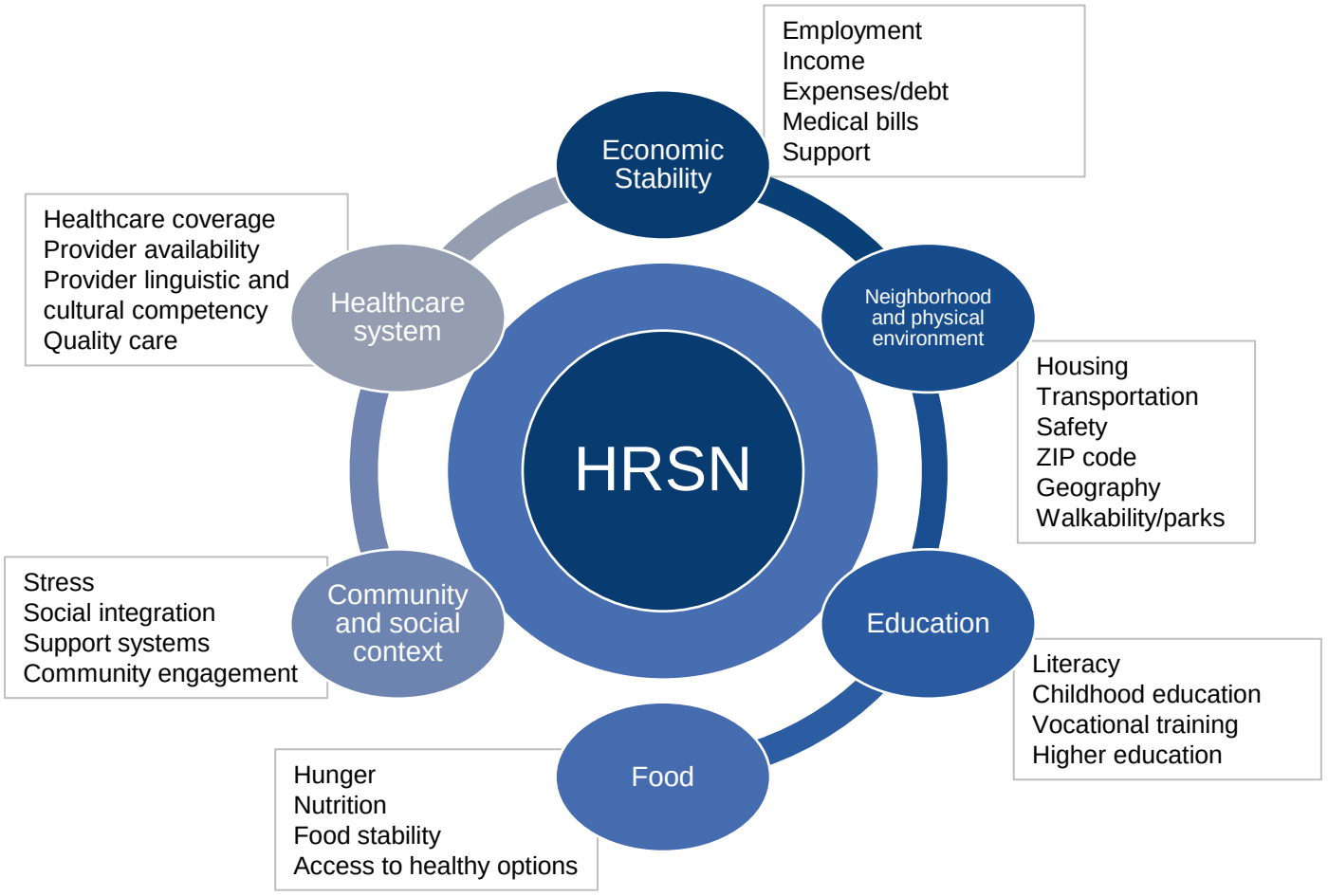
Impact and prevalence

Many factors impact a person's health:

- Half of health outcomes can be explained by socio-economic factors and physical environment factors, and another 30% by health behaviors.
- Social factors cannot be solved by the medical sector alone.



HRSN key factors



Health outcomes

Mortality, increased life expectancy, fewer health expenditures, better health status, and decrease in functional limitations

Initiative with GGH network

- Beginning [insert date], providers participating in one of our qualifying value-based programs will have the ability to refer Healthy Blue members with suspected HRSN needs to GGH.
- Provider can refer any Healthy Blue member suspected to have an HRSN need.
- Provider will be kept informed of member engagement with GGH via Provider Care Management Solutions (PCMS).
- GGH will also work directly with the referring provider when medical needs are identified.
- Resources to address social barriers will allow providers to focus on clinical care plans with their patients, while still addressing HRSN.
- Addressing patients' social barriers supports reduction of unnecessary inpatient and ER utilization, positively impacting total cost of care, and improving outcomes and overall health.

Collective impact – value and benefit to closing HRSN gaps

Patient

- Improves quality of health, life, and well-being
- Decreases costs from acute care utilization
- Increases patient engagement and satisfaction
- Engages caregiver support

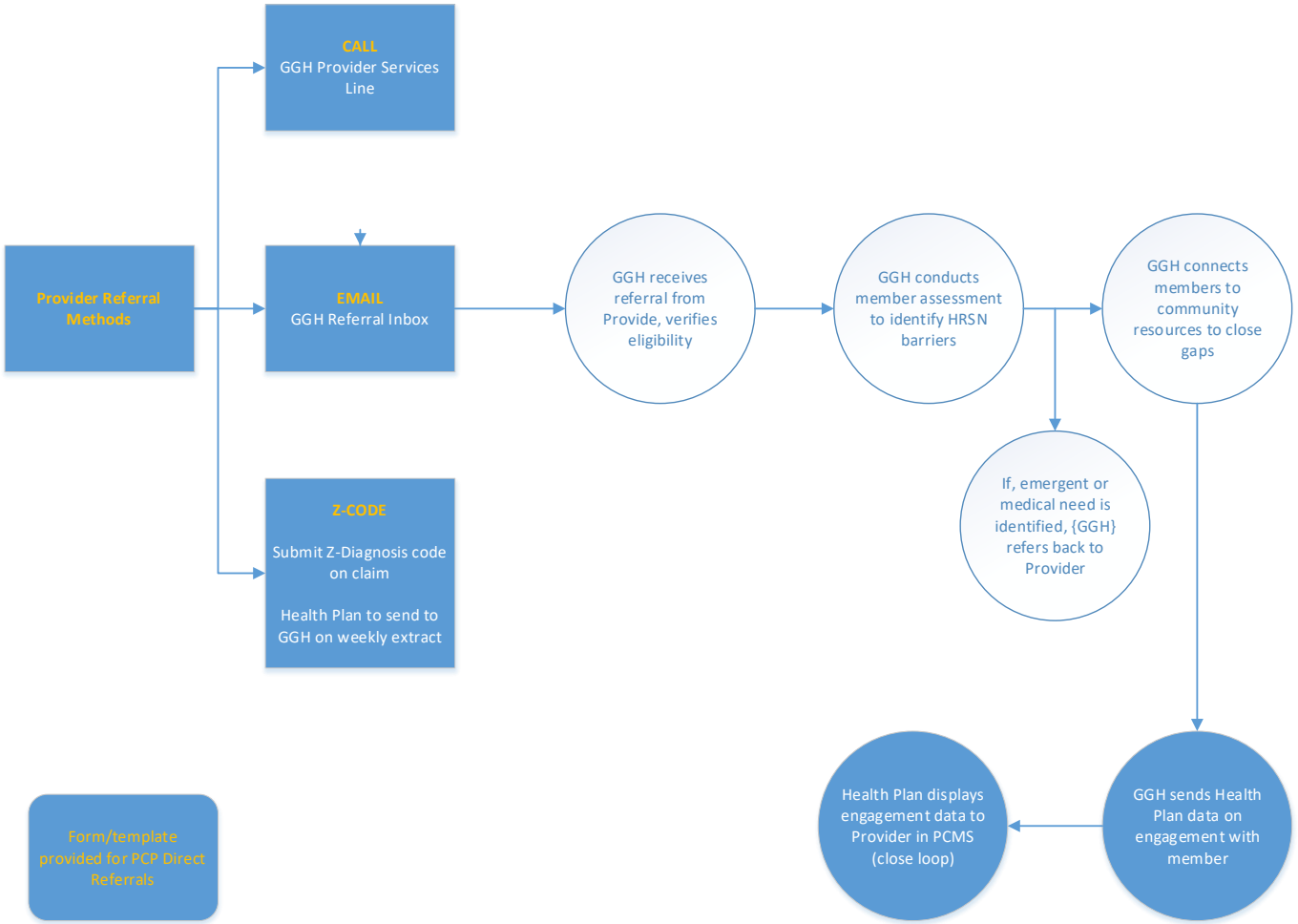
Provider

- Enhances access to services that accommodate the patient's needs
- Patient management that promotes quality outcomes
- Opportunity to help manage the total cost of care
- Increases efficiency of provider to patient face-to-face time

Payer

- Healthy members
- Reduces cost of care
- Supports high performing provider network
- Provides another avenue for payor to connect with members
- Assists with member concerns

High level process for HRSN provider referrals to GGH



Use of Z-diagnosis codes

What are Z-diagnosis codes?

- Z-diagnosis codes are ICD-10 CM codes that identify persons with potential health hazards related to socioeconomic and psychosocial circumstances.
- Z-codes allow providers to capture social factors such as food, housing, transportation, education, and employment on a patient's claim.

Using Z-diagnosis codes as referral to GGH:

- Z-diagnosis codes can be used as a referral mechanism to GGH.
- Healthy Blue will send GGH weekly extracts containing Z-codes submitted by providers on claims.
- GGH will use this extract to identify patients with suspected HRSN disparities, conduct outreach, and schedule face-to-face assessments.

Use of Z-codes (cont.)

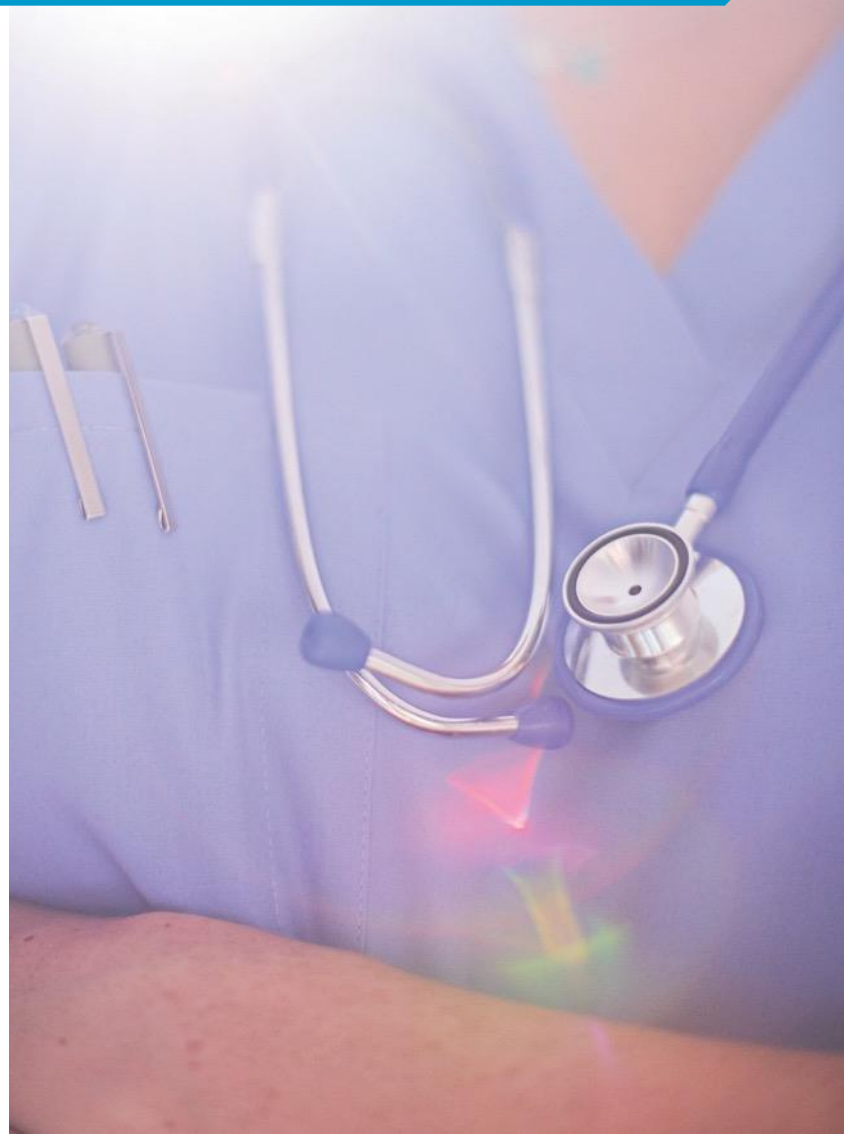
Commonly used HRSN Z-diagnosis code categories

ICD-10 CM codes included in categories Z55 to Z65 identify persons with potential socioeconomic and psychosocial circumstances and can be submitted to Healthy Blue on claims:

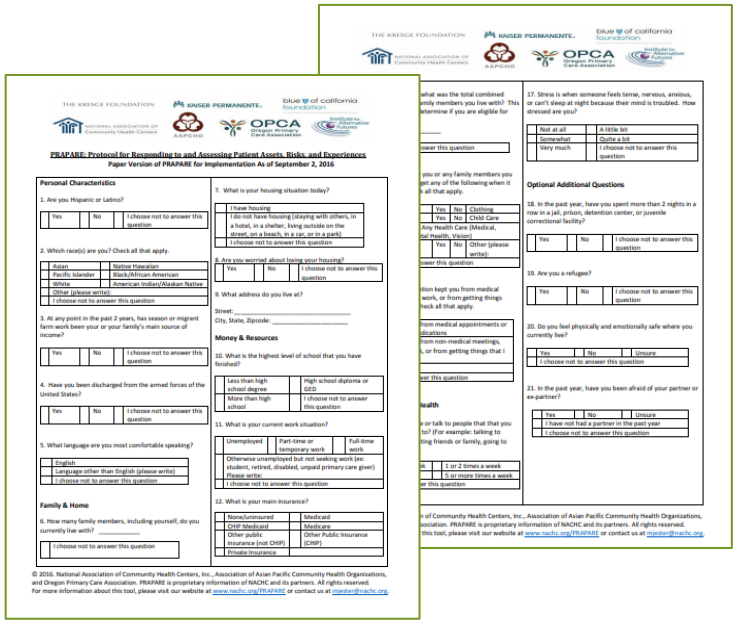
- Z55 — problems related to education and literacy
- Z56 — problems related to employment and unemployment
- Z57 — occupational exposure to risk factors
- Z59 — problems related to housing and economic circumstances
- Z60 — problems related to social environment
- Z62 — problems related to upbringing
- Z63 — other problems related to primary support group, including family circumstances
- Z64 — problems related to certain psychosocial circumstances
- Z65 — problems related to other psychosocial circumstances

How to identify HRSN gaps

- While engaging with a patient, ensure questions are asked regarding overall health and well-being (for example, housing stability, access to food, social situation, etc.).
- There are several screening tools that providers can use to drive these conversations with patients.



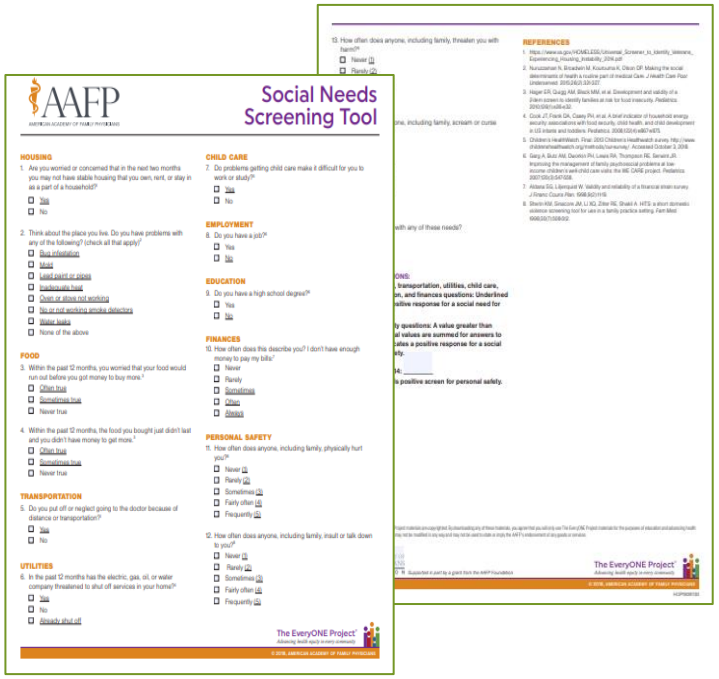
Example tools



PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE for Implementation As of September 2, 2016

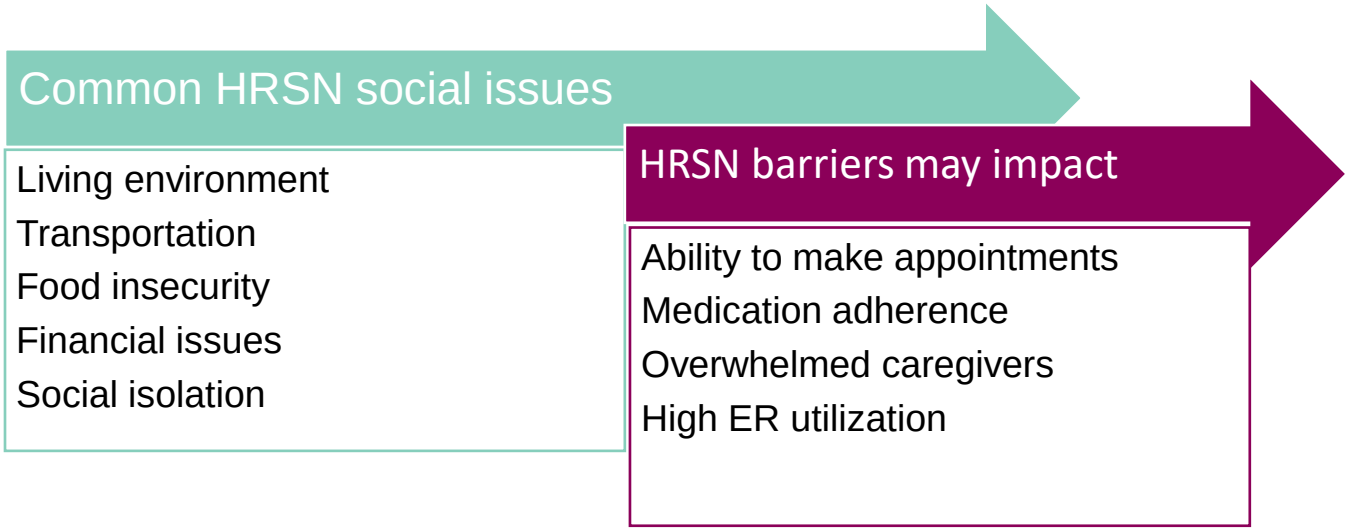
http://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf



AAFP Social Needs Screening Tool

http://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf

Common HRSN social issues and impacts



HRSN program associated costs

- GGH bills Healthy Blue directly based on the length of engagement with a patient.
- There is no fee to the referring provider or patients for engaging with GGH.
- When working to address HRSN gaps, patients are connected with low and/or no-cost community resources.
- Successful closure of HRSN barriers contributes to a lower cost of care by reducing unnecessary inpatient and ER utilization.

HRSN program associated costs (cont.)

GGH is setup as a provider in our system:

- GGH can only bill four CPT® codes (99401 to 99404) if covered by the state.
- The service codes are not a measure of intensity or number of gaps, but rather an indication of the length of engagement.
- GGH can only bill a series of codes one time per year per member. This means they are expected to work with the member to close all of their HRSN gaps (whether it's just one or five) within the single billing cycle.

GGH network success stories

- From care coordinator: “I just wanted to share some really great news from a client — that honestly made me tear up, since it seems good news has been hard to come by lately. My Level 2 client just called me to let me know that he received a letter from the hospital regarding the financial assistance application we submitted. They are covering his medical expenses 100%!!!!! He had been unemployed for the winter due to his seasonal line of work, then suffered a third stroke and thought he was not going to be able to go back to work. Member reported that he is well enough now that he is working! His line of work is considered essential, so he will finally have a paycheck coming in!! This was my final phone call with him, and I couldn’t be happier that it all resolved as well as it did.”

GGH network success stories (cont.)

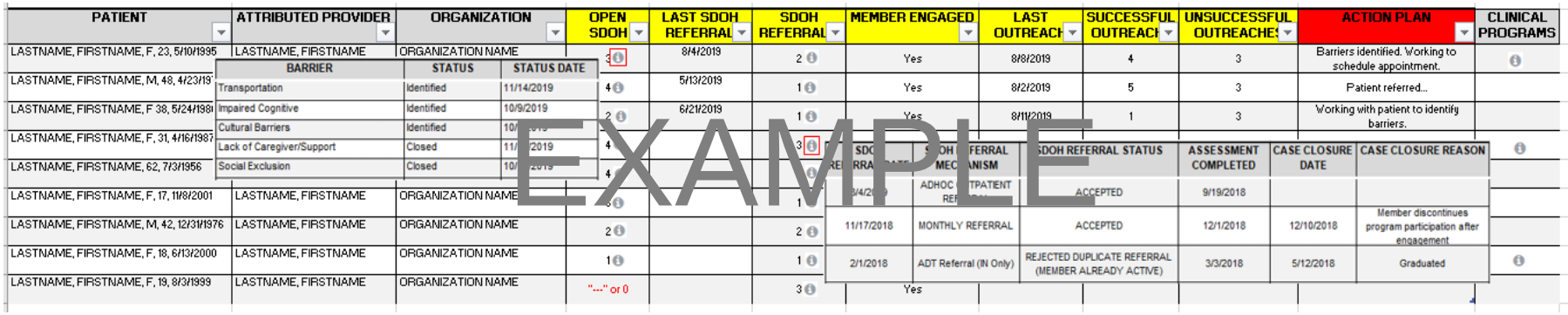
- “Provided member with information about local cancer support groups for member and spouse. Also, provided general information about the local cancer community support and a local resource guide.”
- “Provided member with information about local depression support groups and resources for substance abuse and depression.”
- “Care coordinator had a member who was on a C-PAP machine and had difficulty getting his supplies. Member only had enough for a few days and the care coordinator was able to call the medical company and have supplies expedited to his home before he ran out and ended up the hospital. Care coordinator expedited the member’s medical appointment for his sleep study to ensure meds would not run out after he had been scheduled in late May. They scheduled him in May with only two weeks left of medication. To me, this is a success because most patients are unable to advocate for themselves and are unsure of who/what to say. The care coordinator believes the intervention prevented a hospitalization.”

GGH network success stories (cont.)

- “57 year old member diagnosed with ESRD, dialysis. The member is out of work with highly engaged spouse trying to fit all the pieces together of a changed life. Member’s biggest concern is losing their home as they have not been able to keep up with the mortgage. Care coordinator worked with member on supplementing lack of income, maximizing money stream to prevent foreclosure, completed forms for mortgage assistance. Home Safe application was approved and member is able to keep his home. Therefore, member was able to focus more on health and began walking with his spouse, four miles, three days a week.”
- “Member was overwhelmed and had no idea of where to start on the road to retirement. Care coordinator talked at length about Medicare and the Missouri SHIP known as CLAIM. And, when he expressed concern about being bored, Sue was able to share information about the local senior center that provides activities, adult education classes, etc.”

Patient engagement information in PCMS

Healthy Blue has built an HRSN report in PCMS to reflect the data received from GGH. Providers can view HRSN gaps identified, action plan, communication efforts, etc.



PATIENT	ATTRIBUTED PROVIDER	ORGANIZATION	OPEN SDOH	LAST SDOH REFERRAL	SDOH REFERRAL	MEMBER ENGAGED	LAST OUTREACH	SUCCESSFUL OUTREACH	UNSUCCESSFUL OUTREACHES	ACTION PLAN	CLINICAL PROGRAMS
LASTNAME, FIRSTNAME, F, 23, 5/10/1995	LASTNAME, FIRSTNAME	ORGANIZATION NAME	3	8/4/2019	2	Yes	8/8/2019	4	3	Barriers identified. Working to schedule appointment.	
LASTNAME, FIRSTNAME, M, 48, 4/23/19			4	5/13/2019	1	Yes	8/2/2019	5	3	Patient referred...	
LASTNAME, FIRSTNAME, F 38, 5/24/198			2	6/21/2019	1	Yes	8/11/2019	1	3	Working with patient to identify barriers.	
LASTNAME, FIRSTNAME, F, 31, 4/16/1987			4		3						
LASTNAME, FIRSTNAME, 62, 7/3/1956			4								
LASTNAME, FIRSTNAME, F, 17, 11/8/2001	LASTNAME, FIRSTNAME	ORGANIZATION NAME	3		1						
LASTNAME, FIRSTNAME, M, 42, 12/31/1976	LASTNAME, FIRSTNAME	ORGANIZATION NAME	2		2						
LASTNAME, FIRSTNAME, F, 18, 6/13/2000	LASTNAME, FIRSTNAME	ORGANIZATION NAME	1		1						
LASTNAME, FIRSTNAME, F, 19, 8/3/1999	LASTNAME, FIRSTNAME	ORGANIZATION NAME	"---" or 0		3	Yes					

BARRIER	STATUS	STATUS DATE
Transportation	Identified	11/14/2019
Impaired Cognitive	Identified	10/9/2019
Cultural Barriers	Identified	10/
Lack of Caregiver/Support	Closed	11/ 2019
Social Exclusion	Closed	10/

SDOH REFERRAL MECHANISM	SDOH REFERRAL STATUS	ASSESSMENT COMPLETED	CASE CLOSURE DATE	CASE CLOSURE REASON
ADHOC	ACCEPTED	9/19/2018		
MONTHLY REFERRAL	ACCEPTED	12/1/2018	12/10/2018	Member discontinues program participation after engagement
ADT Referral (IN Only)	REJECTED DUPLICATE REFERRAL (MEMBER ALREADY ACTIVE)	3/3/2018	5/12/2018	Graduated

EXAMPLE

Sample report data will be covered in PCMS training and included in *Provider PCMS User Guide*.

Next steps

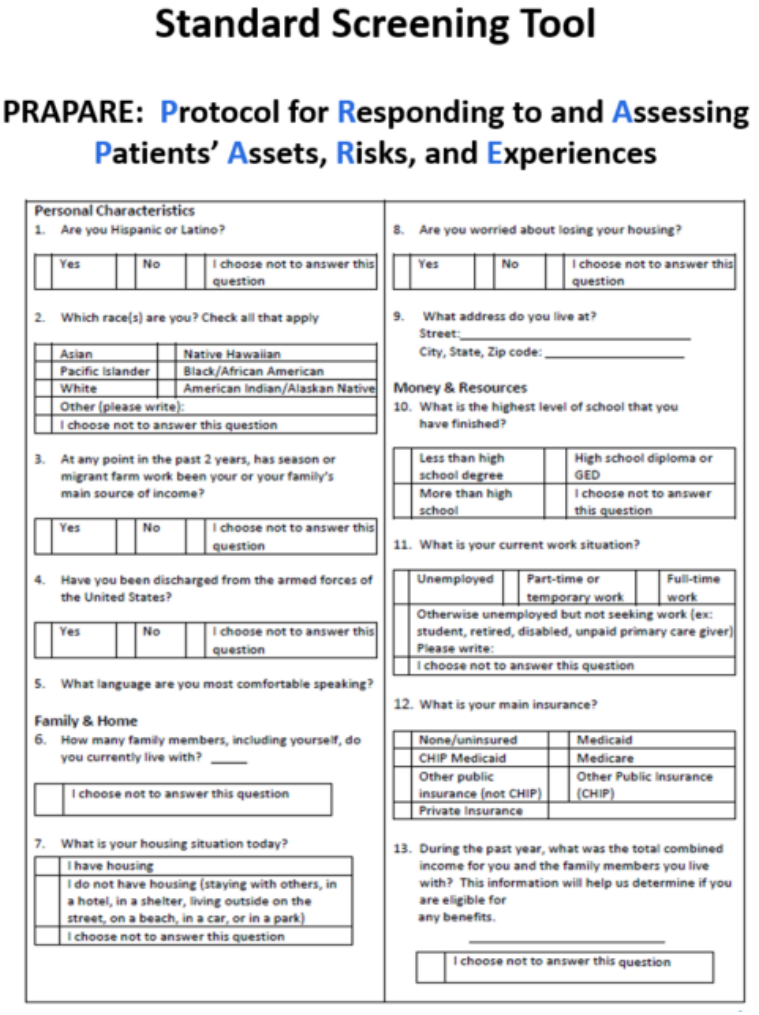
- Providers to identify and adopt assessment tools to ask patients about their HRSN needs.
- Beginning [date], refer patients to GGH to assist the patient in addressing HRSN barriers.
- Utilize new HRSN reporting available in PCMS.
- Contact your Care Delivery Transformation lead with any questions about the program.

For further information on GGH, please contact PCHP:

- Via email: Physicianreferral@preferredchp.com
- Via phone: **866-739-6323**
- Via website: **https://groundgame.health/.**

Resources

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PREPARE): a national effort to help health providers collect the data needed to better understand and act on their patients' SDOH. http://www.nachc.org/research-and-data/prapare



Standard Screening Tool

PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Personal Characteristics

1. Are you Hispanic or Latino?

☐	Yes	☐	No	☐	I choose not to answer this question

2. Which race(s) are you? Check all that apply

☐	Asian	☐	Native Hawaiian
☐	Pacific Islander	☐	Black/African American
☐	White	☐	American Indian/Alaskan Native
☐	Other (please write):		
☐	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐	Yes	☐	No	☐	I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

☐	Yes	☐	No	☐	I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? ____

☐	I choose not to answer this question

7. What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

8. Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐	Less than high school degree	☐	High school diploma or GED
☐	More than high school	☐	I choose not to answer this question

11. What is your current work situation?

☐	Unemployed	☐	Part-time or temporary work	☐	Full-time work
☐	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
☐	I choose not to answer this question				

12. What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	CHIP Medicaid	☐	Medicare
☐	Other public insurance (not CHIP)	☐	Other Public Insurance (CHIP)
☐	Private Insurance		

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

☐	I choose not to answer this question

Resources (cont.)

- HealthyPeople 2020 — HRSN: offers an overview, objectives, interventions and resources to addressing the needs of this vulnerable population **https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health**
- Patient Centered Primary Care Institute — HRSN: tools and resources; provides links to tools and resources gathered by the Oregon Primary Care Association to address HRSN in clinical practices **http://www.pcpci.org/social-determinants-health-tools-resources**

* GroundGame Health is an independent company providing health-related social needs services on behalf of Healthy Blue.

https://provider.healthybluemo.com

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