SDOH and Community Health Workers

Louisiana

LPCA
LOUISIANA PRIMARY CARE ASSOCIATION
Louisiana's Community Health Centers

Community HEALTHWAYS

Helping to improve the quality of life for Louisiana residents by helping to address individuals' health-related social needs (HRSN)and the community factors that drive them.

CDC

CDC https://www.cdc.gov/

Social Determinants of Health (SDOH)

What are social determinants of health? According to Healthy People 2030:

- Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- SDOH can be grouped into 5 domains:
  - Economic Stability
  - Education Access and Quality
  - Health Care Access and Quality
  - Neighborhood and Built Environment
  - Social and Community Context

SDOH Impacts

- Social determinants/drivers of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:
  - Safe housing, transportation, and neighborhoods
  - Racism, discrimination, and violence
  - Education, job opportunities, and income
  - Access to nutritious foods and physical activity opportunities
  - Polluted air and water
  - Language and literacy skills

How SDOH/Drivers affect Health?

- An estimated 20 percent of health outcomes are linked to medical care; the remaining 80 percent stem from socioeconomic, environmental and behavioral factors referred to as drivers of health (DOH) (Magnan, 2017).
- These factors such as homelessness, food insecurity, and exposure to intimate partner violence (IPV)–are linked to poorer health, disproportionately impact communities of color, and have escalated due to COVID-19. Quality ID #487: Screening for Social Drivers of Health (cms.gov)

In addition to SDOH Affecting Health

- **CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies** CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies | CMS 1/7/21
- MIPS CLINICAL QUALITY MEASURES (CQMS)
  - DESCRIPTION: Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
- New social determinants of health (SDOH) quality measures will be required by hospitals, health plans, and multi-payer federal and state programs to help identify and address these nonmedical needs in a clinical setting. The Centers for Medicare & Medicaid Services (CMS) have mandated that hospitals reporting to the Inpatient Quality Reporting (IQR) program submit two new measures, SDOH-1 and SDOH-2. These measures are voluntary in 2023 and will be required by 2024. New CMS Measures to Track Social Determinants of Health (letsgetchecked.com)

Who are Community Health Workers?

While specific CHW job titles and scope of practice may vary, their roles share some common elements across most organizations. For example, CHWs typically act **as liaisons between the community and health care organizations.** They work to improve the delivery of health education, follow-up care, and case management. The CHW job title is sometimes—but not always—used interchangeably with titles of lay health worker, *promotora,* community health representative, peer health educator, or care/patient navigator, among other titles. These roles may provide services for differing audiences, disease types, community make-ups, or other known issues."

-Source CMS report

How the LA Primary Care Association and LDH are addressing SDOH

- Utilizing Community Health Workers in Public Health
- Training Care Teams on integration of CHW
- Training CHW through Grants
- Utilizing CHW in Medicaid Unwind
- Outreach in Communities
- Education to the Various Care settings
- Resources

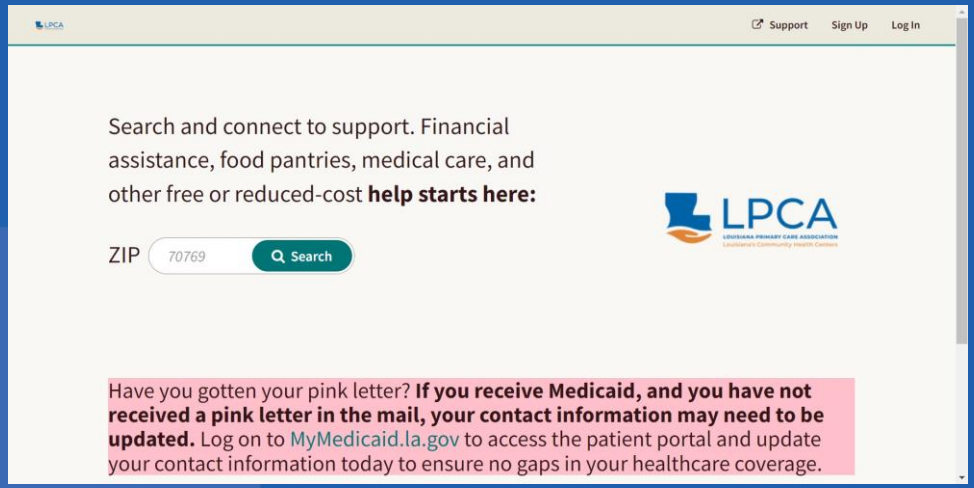
Vaccine Hesitancy

Community Outreach

What We Learned

Best Practices

- Conducted Monthly Meetings
- Up to Date COVID education
- Bidirectional referrals
- Partnerships with Vaccinations Sites
- Canvassing the Community
- Social Media Outreach and Education
- LPCA Assist “Find Help”



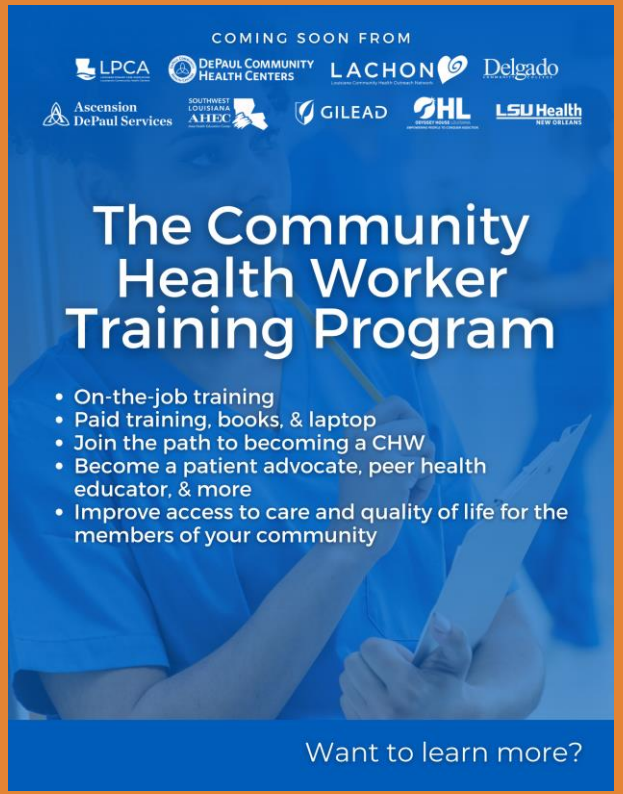
In Process and On the Horizon

CHW Training Program

What's Next:

Louisiana will train 280 people to enter the workforce as :

- Community Health Workers
- Peer Support Specialist
- Patient Advocate
- Peer Educator
- CHW Supervisor



Professional Development

UCLA/J&J Community Health Advocate Management Program (CHAMP)

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Community HealthWays Model

Program is designed to:

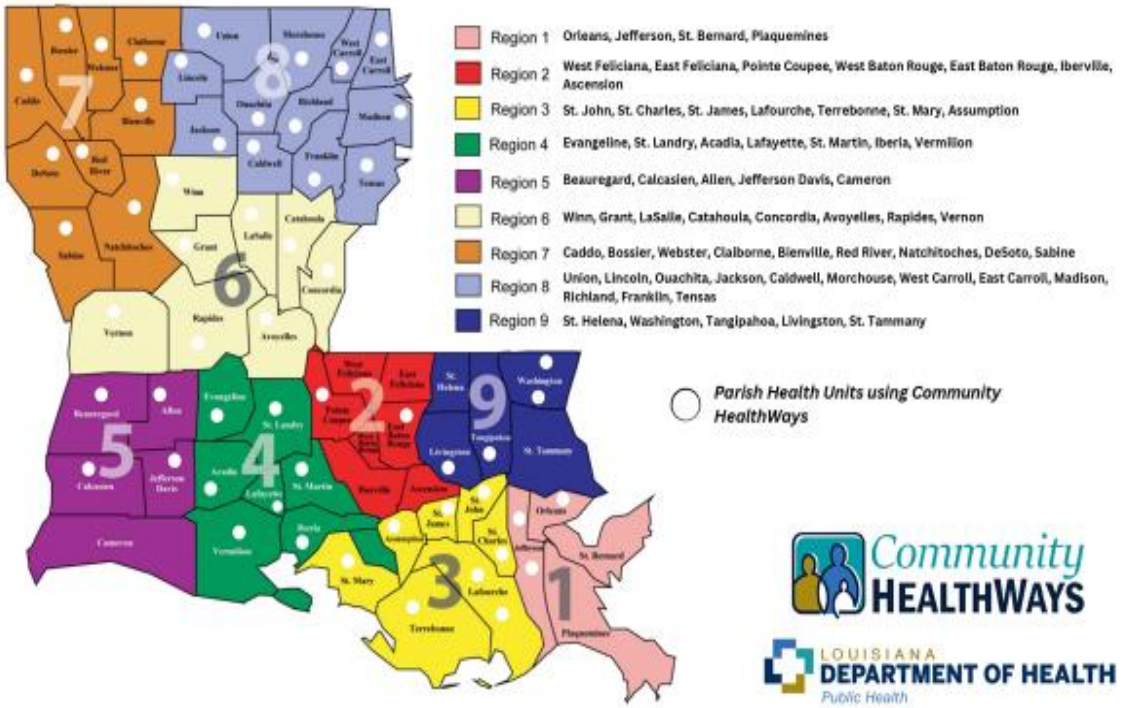
- Support systematic screening for health-related social needs,
- Provide individualized navigation services to help address unmet needs, and
- Convene community-level public and private sector leaders to address structural factors fostering poor health through data-driven investments in new partnerships and businesses.

Where We Are

2023	2023	2023	2023-2024
Expand outreach of CHW to Rural Hospitals and Rural Health Clinics	Expand within LA Dept. of Health	Expand locations & billing for CHWs	Workforce Expansion
• Cardiovascular Grant • LRHA Outreach • Participate in Community Coalitions & Collaborations • Community Outreach	• 1115 CMS Waiver approved 2022 • Public Health Unit Standing Order Developed • Developing billing processes • Inclusion in LDH Business Plan	• Baseline established Current agencies billing for CHW services-7. No denials as of 5/31/23 • Program expanding Partner locations • Education on billing for CHW across the state	• CHW Workforce Task Force • Work with partner organizations in training CHWs

Community HEALTHWAYS

Service Area



Sustainability

- Return on Investment
- Value to Health Care and Communities
- Valued Team Member
- Access, Appointments, No Shows
- Medicaid Reimbursement
- SDOH – Social Determinant's of Health
- Grants to Build the Program

CHW Services

Medicaid Reimbursement for CHW services is effective for the dates of service January 1, 2022, and ongoing.

- Who can receive CHW services?
  - Beneficiaries with one or more chronic health (including behavioral health) conditions;
  - Beneficiaries with suspected or documented unmet health-related social needs; or
  - Beneficiaries who are pregnant.

- CHW Qualifications
  - An individual who has completed state-recognized training curricula approved by the Louisiana Community Health Worker Workforce Coalition; or
  - An individual who has a minimum of 3,000 hours of documented work experience as a CHW.

***Providers must verify and maintain documentation that individuals have met the above qualifications.**

Covered Services

- **Health promotion and coaching:** *This can include assessment and screening for health-related social needs, setting goals and creating an action plan, on-site observation of beneficiaries' living situations, and providing information and/or coaching in an individual or group setting.*

- **Care planning with the beneficiary and their healthcare team:** *This should occur as part of a person-centered approach to improve health by meeting a beneficiary's situational health needs and health-related social needs, including time-limited episodes of instability and ongoing secondary and tertiary prevention.*

- **Health system navigation and resource coordination services:** *This can include helping to engage, re-engage, or ensure patient follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions.*

Non-Covered Services

Insurance enrollment and insurance navigator assistance;

Case management;

Direct provision of transportation for a beneficiary to and from services; and

Direct patient care outside the level of training an individual has attained.

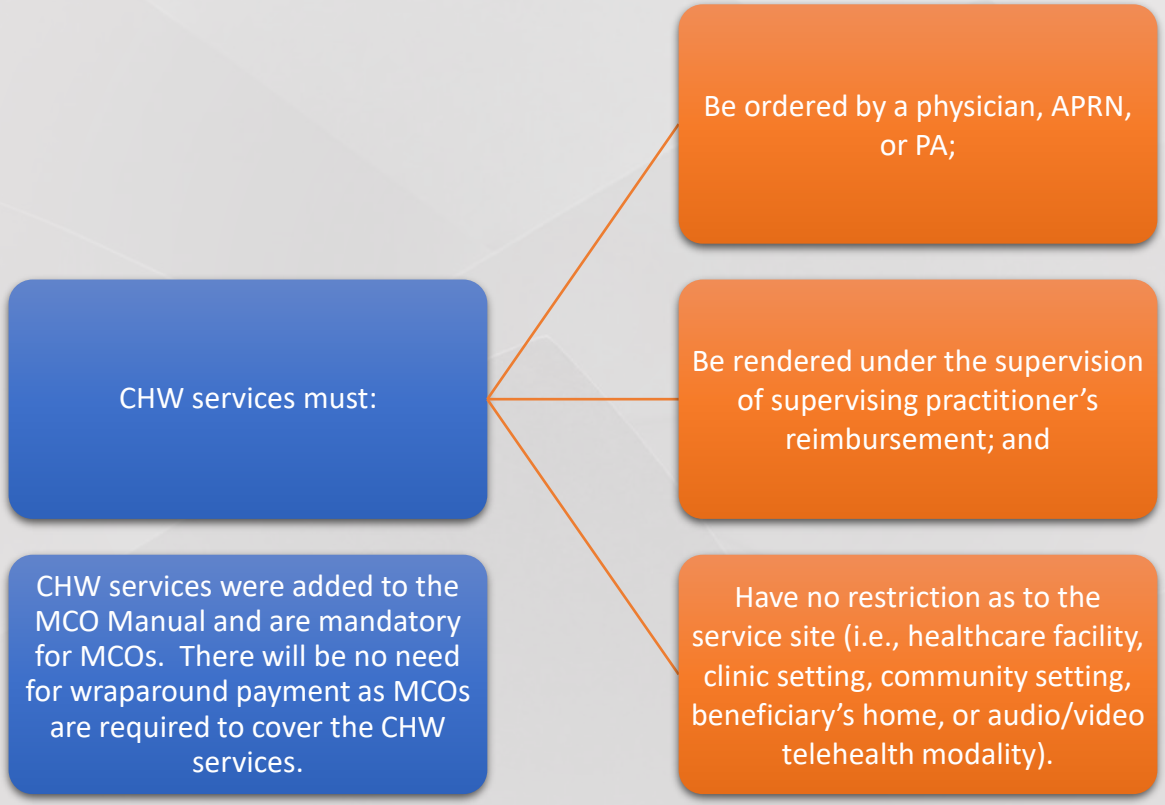
CHW Services Billing Guidance

- Billable CPT Codes: (See Professional Service Fee Schedule)
  98960 – Individual CHW services-$ 18.11
  98961 – Group CHW services -$ 6.04 (2pts -4 pts) each
  98962 – Group CHW services- $ 2.79 (5pts- 8 pts) each

  *Group CHW CPT codes must be billed for each beneficiary attending the session.

- Maximum reimbursement is two hours per day and ten hours per month per enrollee.
- CHW services are “incident to” the supervising physician, APRN, or PA. The physician, APRN, or PA presence in the facility is not required during the performance of the service.
- The rendering provider for the “incident to” services is the supervising physician.
- Both individual and group sessions are allowed.

Reimbursement Guidelines



Billing of CHW Services

- Group sessions are limited to eight unique beneficiaries.
- Clinical records and billing must be documented appropriately based on the number of beneficiaries per session.
- Professional services policy must be followed when billing CHW services as a detail line in an FQHC setting.
- To be considered for reimbursement, FQHC claims for CHW service reimbursement must include **ALL** of the following:
  - A Healthcare Common Procedure Coding System (HCPCS) for the visit (T1015, H2020, or D0999);
  - An evaluation and management code; and
  - The corresponding Current Procedural Terminology (CPT) code for the CHW services to receive reimbursement.

SDOH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation) o Z codes refer to factors influencing health status or reasons for contact with health services that are not classifiable elsewhere as diseases, injuries, or external causes

IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes (cms.gov)

Z Codes? What the Heck?

Z Codes continued

- SDOH information can be collected before, during, or after a health care encounter through structured health risk assessments and screening tools
- • These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor that influences the patient's health
- • Coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record

PROBLEMS RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES
Z59

Food Insecurity

		CODE USING THIS HCPCS CODE
LACK OF ADEQUATE FOOD	Z59.4 (5TH DIGIT REQUIRED TO CODE)	
	FOOD INSECURITY	Z59.41
	OTHER SPECIFIED LACK OF ADEQUATE FOOD	Z59.48

QUESITON 12b
Housing Insecurity

HOMELESSNESS	Z59.0 (5TH DIGIT REQUIRED TO CODE)	
	HOMLESNESS UNSPECIFIED	Z59.00
	SHELTERED HOMLESSNESS	Z59.01
	UNSHELTERED HOMELESNESS	Z59.02

INADEQUATE HOUSING	Z59.1 (5TH DIGIT REQUIRED TO CODE)	
	INADEQUATE HOUSING UNSPECIFIED	Z59.10
	INADEQUATE HOUSING ENVIRONMENTAL TEMPERATURE	Z59.11
	INADEQUATE HOUSING UTILITIES	Z59.12
	OTHER INADEQUATE HOUSING	Z59.19
	DISCORD WITH NEIGHBORS, LODGERS AND LANDLORD (5TH DIGIT NOT REQUIRED)	Z59.2
	PROBLEMS RELATED TO LIVING IN RESIDENTIAL INSTITUTION (5TH DIGIT NOT REQUIRED)	Z59.3

FINANCIAL STRAIN	EXTREME POVERTY	Z59.5
	LOW INCOME	Z59.6
	INSUFFICIENT SOCIAL INSURANCE AND WELFARE SUPPORT	Z59.7
	FINANCIAL INSECURITY	Z59.86
	MATERIAL HARDSHIP DUE TO LIMITED FINANCIAL RESOURCES, NOT ELSEWHERE CLASSIFIED	Z59.87
OTHER PROBLEMS RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES	Z59.8 (5TH DIGIT REQUIRED TO CODE)	

HOUSING INSTABILITY, HOUSED Z59.81 (6TH DIGIT REQUIRED TO CODE)	
HOUSING INSTABILITY, HOUSED, WITH RISK OF HOMELESSNESS	Z59.811
HOUSING INSTABILITY, HOUSED, HOMELESSNESS WITHIN PAST 12 MONTHS	Z59.812
HOUSING INSTABILITY, HOUSED, UNSPECIFIED	Z59.819

Lack of Transportation or Lack of Access to Public Transportation		
TRANSPORTATION	TRANSPORTATION INSECURITY	Z59.82
	OTHER PROBLEMS RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES	Z59.89
	PROBLEM RELATED TO HOUSING AND ECONOMIC CIRCUMSTANCES, UNSPECIFIED	Z59.9

Important Links

- MAC PAC –Medicaid coverage of CHW services Medicaid Coverage of Community Health Worker Services Issue Brief (macpac.gov)
- Louisiana Medicaid's informational bulletin on Medicaid Coverage for CHWs IB22-21_revised_07.07.22.pdf (la.gov)
- Healthy People 2031 Social Determinants of Health - Healthy People 2030 | health.gov
- IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes (cms.gov)

Thank You!

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