Social Determinants of Health (SDOH) Overview

Shawn Maria Bromley

Northeast PHO

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SDOH Reduces Health Disparities

- SDOH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. The connection between people's access to and understanding of health services and their own health.
- Health outcomes are driven by an array of factors, including genetics, health behaviors, social and environmental factors, and health care.
- Studies suggest that health behaviors, such as smoking, diet, and exercise, and social and economic factors are the primary drivers of health outcomes, and social and economic factors can shape an individual’s health behaviors.
- Efforts to improve health in the US have traditionally looked to the health care system as the key driver of health and health outcomes. There is increased recognition that improving health and achieving health equity will require multiple approaches that address social, economic, and environmental factors that influence health.
- With more focus on SDOH, public health organizations and their community partners can take action to improve the conditions in people’s environments.

What Organizations Make Up the SDOH Workgroup

- The SDOH Workgroup has been established with the cooperation of government agencies, including:
  - Office of Disease Prevention and Health Promotion (ODPHP)
  - National Institutes of Health (NIH)
  - Centers for Disease Control and Prevention (CDC)
  - Health Resources and Services Administration (HRSA)
  - National Center for Health Statistics (NCHS)
- Members of the SDOH Workgroup are experts in various areas, like health equity, health disparities, economics, vulnerable populations, and other SDOH matters. This group created objectives related to the social determinants of health.

The 5 SDOH Domains

- There are five overall domains within the SDOH:
  - **Economic stability**
    - This domain focuses on improving objectives that impact an individuals ability to obtain or maintain a steady income. It includes things related to employment programs, reliable child-care, and early interventions on factors that may limit someone's ability.
  - **Health care access and quality**
    - Objectives within this domain area are focused on improving levels of education throughout the population. It has been well documented over the years that individuals with higher education levels tend to live longer and experience improved health and wellness when compared to those that are less educated.
  - **Social and community context**
    - Objectives within this domain area are focused on improving individuals health by working towards increasing the number of individuals with access to a primary care provider; decreasing the number of individuals without appropriate health insurance coverage; and improving access to services and medications where affordability may be a factor.

5 SDOH Overall Domains (continued)

- **Education access and quality**
  - The domain is focused on measuring and working to improving safety for individuals in all areas where they may live, socialize, congregate, and work. Health risks are unfortunately plentiful in areas where there are high levels of crime, poor sanitation, unsafe air quality, and increased incidents of domestic violence.
- **Neighborhood and built environment**
  - An individual's health can often be impacted by the nature of their relationships with others. Those that have strong ties to family, friends, and community are more likely to take better care of themselves. A strong social network can also assist with mitigating some of the negative impacts associated with other SDOH domains.

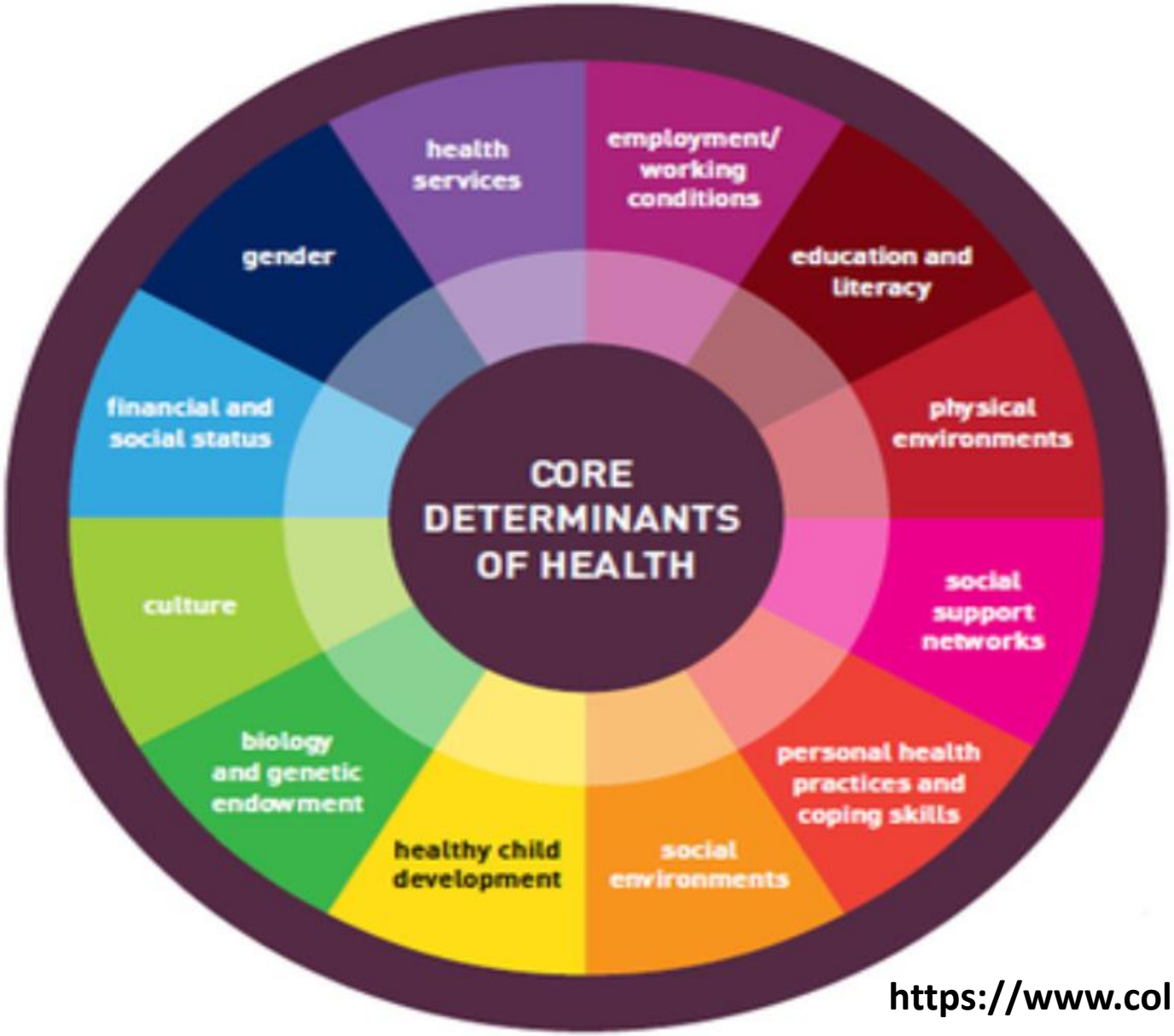
Social Determinants of Health (SDOH) Examples

- The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:
  - Income and social protection
  - Education
  - Unemployment and job insecurity
  - Working life conditions
  - Food insecurity
  - Housing, basic amenities and the environment
  - Early childhood development
  - Social inclusion and non-discrimination
  - Structural conflict
  - Access to affordable health services of decent quality

Efforts To Address SDOH

- **SDOH Workgroup Efforts:**
  - Healthy People 2030 is the 10 year plan to help attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death. Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
  - Healthy People 2030 includes 355 core objectives as well as developmental and research objectives.
  - The development of Healthy People 2030 includes establishing a framework for the initiative, vision, mission, foundational principles, plan of action, and overarching goals, while identifying new objectives.
- **Supporting Health Equity:**
  - Inequities in health are socially determined, preventing poorer populations from moving up in society and making the most of their potential.
  - Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
  - Action requires not only equitable access to healthcare but also means working outside the healthcare system to address broader social well-being and development.
  - ***"Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically".***

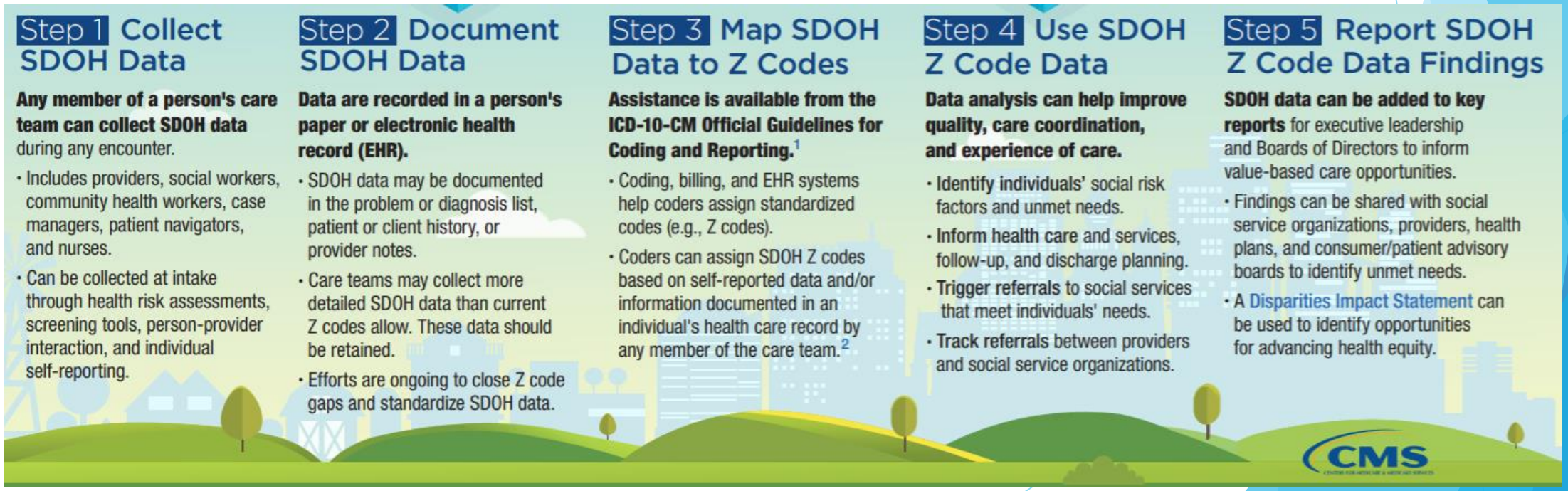
Core Determinants of Health



https://www.colleaga.org/article/what-are-determinants-health

SDOH Coding Guidelines

- **Updates to the ICD-10-CM Official Coding Guideline state:**
  - Documentation by Clinicians Other Than the Patient's Provider, has made assigning SDOH-related Z codes easier. These updates allow for the use of health record documentation from clinicians involved in the care of the patient who are not the patient's provider since the information represents social information rather than medical diagnoses. Additionally, patient self-reported documentation may be used to assign SDOH-related codes as long as the patient information is signed-off by and incorporated into the health record by either a clinician or provider.
  - **Capturing SDOH Z Codes:**



SDOH Documentation Updates

- SDOH should be reported when the information is documented, and that this information may be obtained from the following documentation sources:
- The patient's provider (physician, nurse practitioner)
- Clinicians other than the patient's provider whose documentation is included in the official medical record (social workers, community health workers, case managers, nurses)
- Patient self-reported documentation, as long as the documentation is signed-off by and incorporated into the medical record by either a clinician or a provider
- The new guidelines focus on Medical Decision Making (MDM), and are intended to more closely reflect the provider's actual work performed in treating a patient's conditions. Depending on the significance of the impact of a patient's socioeconomic situation on his or her diagnostic or treatment options, the encounter may be considered moderate risk.

Improving Patient Health Care Outcomes

- The acknowledgment of these social, economic, and environmental issues is integral to providing value-based care. Some examples of social determinants of health include, but are not limited to:
- Availability of resources to meet daily needs (safe housing and local food markets)
- Access to educational, economic, and job opportunities
- Access to health care services
- Quality of education and job training
- Transportation options
- Public safety
- Social support
- Socioeconomic conditions (concentrated poverty and the stressful conditions that accompany it)
- Language/Literacy
- Access to emerging technologies (cell phones, telehealth)
- Availability of community-based resources
- When the assessment and plan is developed with consideration of these social determinants of health, the documentation should clearly describe the circumstances and how they affect the patient's treatment or management.

SDOH Impact to Community Health Care

- Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual's health outcomes.
- For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls.
- Effectively implementing programs to identify and attend to these social factors depends on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.
- Empowering providers to address SDOH allows them to discuss behaviors and social factors that influence a patients health outcomes.
- Reporting SDOH-related codes on readmissions helps support NEPHO on reduction of readmissions and addressing potential community/location impact.
- SDOH capture will help drive Referrals to social service organizations and appropriate support services through local, state, and national resources.

SDOH Examples

- Lack of transportation can prevent individuals from accessing goods and services, including healthy foods, medication, education, employment, and health care visits.
- Difficulty paying utility bills and receiving shut-off notices are indicators of utility needs. Utility shut offs can lead to dangerous living environments, including unsanitary conditions and temperature extremes.
- Lack of consistent access to child care impacts parents as they may forgo health needs, such as scheduled medical appointments to care for their children. Additionally, lack of child care is a barrier to educational and employment opportunities for parents.
- Individuals with lower levels of education are less likely to engage with their physicians, tend to have medical non-compliance, and have higher rates of hospitalization.
- Financial strain is composed of cognitive, emotional, and behavioral responses to financial hardship where an individual cannot meet financial obligations.
- Exposure to violence, whether interpersonal or community violence, effects an individual's physical and emotional health.

Documentation Example

- Patient is seen for Annual visit. The Patient's A1c and Hypertension have increased significantly. It has also been noted that the patient has missed some follow up appointments and has not requested refills on his medications to manage his health conditions. This is not typical behavior for this patient.
- **Provider:** "How have you been feeling? I've noticed you have missed a few follow up appointments with me, and I see your labs have increased. Are you currently taking your medications to help manage your Diabetes and Hypertension?"
- **Patient:** "I apologize for missing my last few appointments, I lost my job 6 months ago and I have not been able to afford some of my medications. I am afraid to get bills from doctor visits that I just can't afford right now."
- **Provider:** "I am very sorry to hear about you losing your job. As your Doctor I want to help you manage your health and chronic conditions. There are resources available to you that could help with the cost of medications. I am going to refer you to the community social worker that will be able to help guide you to potential services to better support your current living situation. I would like you to check in with me through the online portal to stay connected through this situation. We will discuss a plan to ensure you can stay on track with your plan of care.
- Discuss with your patient Social Determinants of Health (SDOH) and available community-based resources.
  - SDOH status of a patient can change. For example, opportunities for good health can be constrained after a job loss(Z56.0 Unemployment, unspecified).
  - Show sensitivity to your patient's feelings about disclosing his or her financial status. Discuss with your patients their SDOH and available community-based resources.
  - Drug discount cards can be helpful to patients as it can help to pay for partial prescription costs.

SDOH Coding Examples

- A patient requiring dialysis treatments has no transportation and no access to public transportation. Therefore, her circumstance require discussions with home health for home treatments and/or researching community service options for help with transportation for those in need.
  - **Z59.7** Insufficient social insurance and welfare support
- A patient requiring a specific drug that is very expensive, was recently laid off and has no income or prescription benefits. The decision might be made to try a different drug to ease the cost burden for the patient.
  - **Z56.0** Unemployment, unspecified
  - **Z59.7** Insufficient social insurance and welfare support
- A patient with a complicated medical history that includes multiple medications reports having trouble reading the prescription labels and remembering the medication schedule. He lives alone and currently has no support for these types of situations. This might require initiation of home health or some type of elderly assistance service.
  - **Z55.0** Illiteracy and low-level literacy
  - **Z60.2** Problems related to living alone

Utilizing Z Codes

- Educate staff on the need to screen, document and code data on patients SDOH needs.
- Ask patients about their SDOH needs. Patients may not know to discuss non-medical issues with their provider and may need to be prompted.
- Document any SDOH needs by utilizing the SDOH ICD-10 Z codes add them to claims submitted.
- A patient brings more to the office than the symptoms they present on the surface. SDOH may affect a patient's ability or willingness to follow the recommended treatment plan. Updating a patients environment and living conditions helps support their ability to follow a treatment plan.
- SDOH are conditions in the environments in which people are born, grow, live, work and age. These social factors can impose significant barriers to a person's health and wellness.
- SDOH will help support funding opportunities to improve patient and/or community healthcare outcomes.

SDOH Impacts Health Outcomes

- **Access to healthy food**: Proper nutrition is important to health and wellness. Does a patient have nearby options to shop for fresh, healthy food?
- **Transportation options**: Does a patient have access to safe, convenient, affordable transportation so they can make and keep health care appointments?
- **Culture, race/ethnicity**: Does a patient have cultural preferences them unique? Are there potential language barriers that they face?
- **Income/financial stability**: Does a patient have financial concerns that may prevent them from keeping appointments? Are they able to take time off from work and do they have childcare if needed?
- **Support/advocacy**: Is the patient connected with family, friends or community groups if they need support? Are there resources available to provide information/education to live a healthy life?
- **Health coverage**: Does a patient have insurance? Do they understand their benefits and are they aware of the importance of preventive care and do they know where to find it?

Importance SDOH Data Collection

- SDOH data supports efforts to improve the health of their patients and communities.
  - A standardized approach enables hospitals/organizations to:
    - SDOH data will help identify grant opportunities to support patient healthcare equity.
    - SDOH data will support grant funding opportunities/applications.
    - SDOH will track the social needs that impact patients, supporting personalized care that identifies a patients medical and non-medical needs.
    - SDOH identifies population health trends and guide community partnerships.
    - SDOH data enables system-wide research to gain a better understanding of the health-related social needs of patients and communities across the state and nationally.
    - Federal and State programs could be driven by data collected.
    - Claims data connected on SDOH can support policy, reimbursement, and appropriate risk- adjustment.

SDOH Z Codes

- 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
- Z75 – Problems related to medical facilities and other health care

NEPHO Practice to Improve SDOH Coding Capture

- Pull reports to determine which SDOH codes are being assigned.
- Audit a sampling of records to assess the types of cases and documentation for which the codes were assigned.
- Set up meetings with providers to educate on SDOH.
- Develop internal coding guidelines to identify the categories of clinical support (community health worker, case manager) from whom documentation can be used for coding capture and the location of this information in the EHR system.
- Educate practice and administrative support on the importance of SDOH code capture.
- Educate providers and clinical support on the importance of consistently documenting SDOH information.
- Monitor for improvement (increased reporting) of SDOH code capture by patient type, diagnosis, provider and SDOH domain.
- Conduct audits on the quality of SDOH documentation and ICD-10-CM coding accuracy.
- Provide feedback , as needed.

Resources

- **shawn.m.bromley@lahey.org**
- https://www.healthypeople.gov/2020/topics-objectives
- https://health.gov/healthypeople/objectives-and-data/about-objectives
- https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework
- https://www.cms.gov/files/document/zcodes-infographic.pdf
- https://journal.ahima.org/improving-icd-10-cm-coding-for-social-determinants-of-health/#:~:text=Social%20determinants%20of%20health%20(SDOH,%2C%20social%20isolation%2C%20and%20unemployment
- https://www.hopkinsmedicine.org/johns_hopkins_healthcare/providers_physicians/resources_guidelines/provider_communications/2021/PRUP135_ICD10-km.pdf
- https://www.bcbsil.com/pdf/clinical/ICD-10_Z_codes_flier.pdf
- https://www.healthcarefinancenews.com/news/unitedhealthcare-using-predictive-analytics-developed-collaboration-optum-address-social