Social Determinants of Health (SDOH) Mid-Year Review

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Agenda

- Social Determinants of Health (SDOH) Review
  - SDOH Workgroup
  - Core Determinants of Health
- Health Equity Overview
- What Is NEPHO Doing
  - Provider Education
  - Overview of ICD-10 CM Coding
- SDOH Coding Capture
  - Coding Supports Patient Care
  - Coding Supports Potential Resources
    - Resources will help improve patient care outcomes
- Presentation Resources

SDOH Overview

- **What is SDOH?**
  - The environment in which a person lives that can affect their health status and health outcomes.
- **How does it affect a patients health outcomes?**
  - Living day-to-day life can present challenges due to current living environment or past living environment.
- **Why is it important to capture a patients living environment?**
  - Chronic condition care, medication adherence, staying on track with plan of care, managing healthy living, support resources, financial resources.
- **Who can capture SDOH in a patients health record?**
  - SDOH can be collected by anyone involved in the patient's care, including providers, social workers, community health workers, case managers, patient navigators, and nurses. SDOH can also be collected at intake through screening tools or self-reporting forms.
- **Does SDOH offer financial support or services?**
  - Data collection will offer opportunity to additional resources to support patient care.

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.

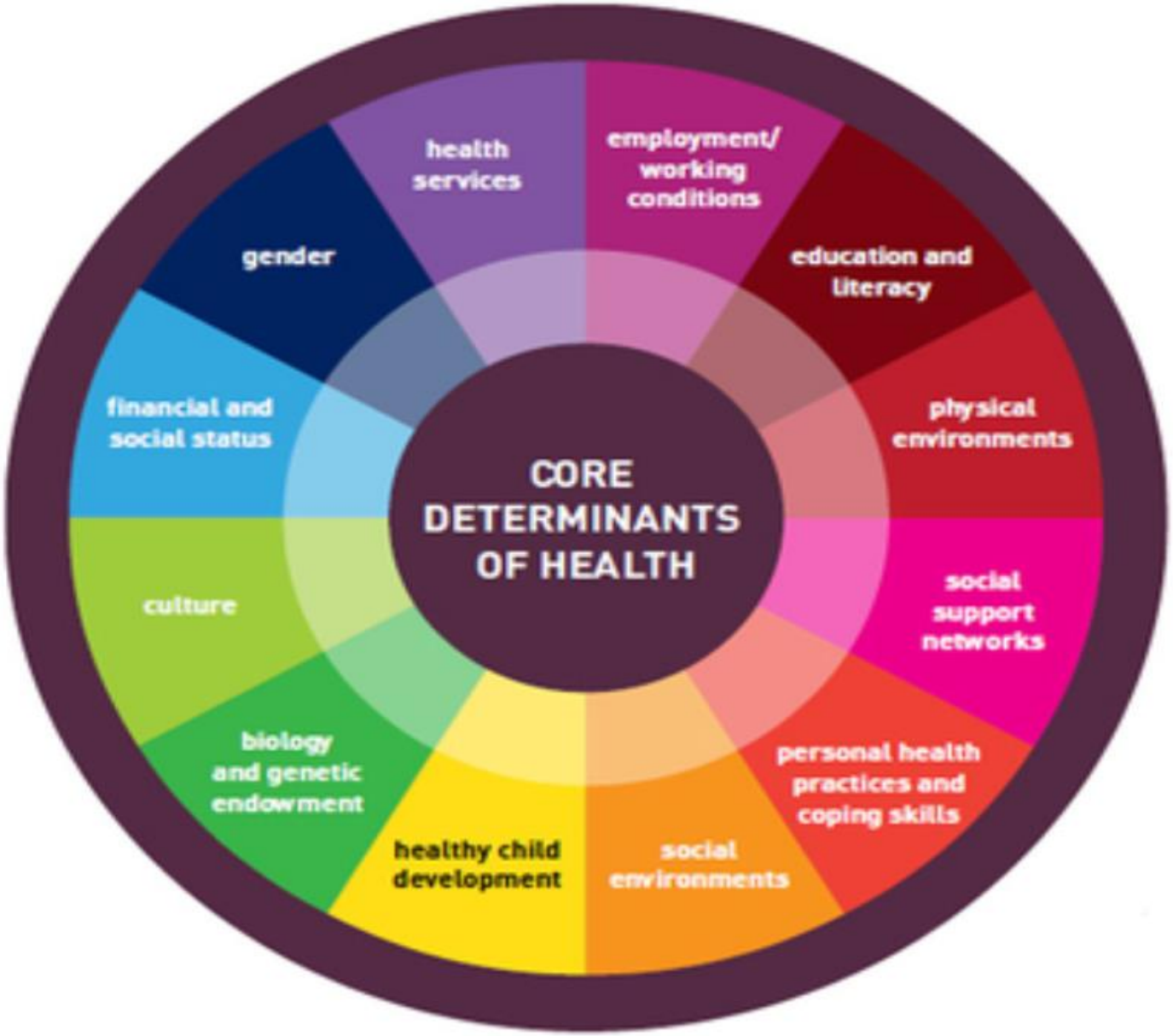
What Organizations Make Up the SDOH Workgroup

- 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.

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



Health Equity Definition

- Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.
- People’s living conditions are often made worse by discrimination, stereotyping, and prejudice based on sex, gender, age, race, ethnicity, or disability, among other factors. Discriminatory practices are often embedded in institutional and systems processes, leading to groups being under-represented in decision-making at all levels or underserved.
- Progressively realizing the right to health means systematically identifying and eliminating inequities resulting from differences in health and in overall living conditions.

NEPHO Education Plan

- Researching and educating ourselves on the importance of SDOH in relation to a persons overall health care.
- Providing education sessions on SDOH.
- Reviewing a patients social history to better support SDOH coding capture.
- Providing outside speakers who are experts in the field of SDOH.
- Offering provider CMEs to help draw attendance to SDOH education sessions.
- Updating the problem list in EPIC to help capture accurate SDOH codes.
- Researching ways to help providers and practices capture a patients SDOH within EPIC.

NEPHO Practice to Improve SDOH Coding Capture

- Pull reports to determine which SDOH codes are being assigned.
- Auditing a sampling of records to assess the types of cases and documentation for which the codes are assigned.
- Set up 1x1 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.

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 Top 10 SDOH ICD-10 Codes

- Z56.0: Unemployment unspecified: **Example**: Patient was laid off from job
- Z56.6: Physical and mental strain related to work: **Example**: Patient works 3 jobs to manage home
- Z56.89: Other problems related to employment: **Example**: Patient is on disability due to recent injury
- Z63.0:Problems in relationship with spouse or partner: **Example**: Patient is separated from spouse
- Z63.3: Absence of family member: **Example**: Patient has recently gone through a divorce
- Z63.4: Disappearance and/or death of family member: **Example**: Husband/Wife passed away a year ago
- Z62.810: Personal history of physical and sexual abuse in childhood: **Example**: Patient experienced sexual abuse from 6-12 years by family member
- Z62.898: Other specified problems related to upbringing: **Example**: Patient does not speak to biological father
- Z63.7: Stressful events affecting family household: **Example**: Patient is having issues with teenage children
- Z72.3: Lack of physical exercise: **Example**: Patient does not exercise

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

New 2023 Code Updates for SDOH

- Poisoning, adverse effect, et by methamphetamines codes added (T43.6-)
- Significant amount of external cause codes added for electric assisted bicycle accidents (V20-V29)
- New SDOH codes for transportation, financial insecurity or material hardship (Z59-)
- Long term use of several new substances and agents (Z79.6-)
- 9 new personal history codes (Z87.7-)
- 14 new patient or CAREGIVER noncompliance with dietary or medication regimen (Z91-)

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."

Documentation Example (continued)

- **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 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 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?

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.

Factors That Contribute to SDOH

- 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.

SDOH Data Supports Resource Opportunities

- **Using Data Analytics to Support Primary Care and Community Interventions to Improve Chronic Disease Prevention and Management and Population Health:**
  - In 2019, AHRQ awarded $6 million in grants for an initiative that uses data and analytics to support primary care and community interventions to improve chronic disease prevention and management and population health. Over three years, three grantee organizations will integrate data on chronic disease, SDOH, and community services to create actionable dashboards to support better management of high-risk individuals and populations.
  - Department of Health and Human Services (HHS) Office of Minority Health (OMH) announced $500,000 in grant awards to two organizations that will work on demonstration projects to help leverage the use of local data to address health disparities among racial and ethnic minority populations. The new Accessing Social Determinants of Health Data Through Local Data Intermediaries initiative will demonstrate whether existing local data intermediaries can facilitate community stakeholder access to and use of integrated community-level social determinants of health and health data. The initiative will also increase community stakeholders' skills and capacity to use and apply data related to health disparities.
  - The Centers for Disease Control and Prevention has awarded $3 million for 20 planning grants to accelerate public health strategies that reduce the burden of chronic disease among people experiencing health disparities and inequities. The program is part of the AHA-supported Social Determinants Accelerator Act, provisions of which were included in appropriations legislation enacted in December.

Resources

- **shawn.m.bromley@lahey.org**
- **jessica.m.bryan@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