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Social Drivers of Health- The Missing Link

RHPTP HELP Webinar

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Indiana Hospital Association
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Objectives

- Differentiate between social drivers of health, health equity, health equality, and health disparities
- Recognize how social drivers of health influence health outcomes and the role that hospitals can play in identifying gaps in care
- Interpret the history and future expectations of regulatory bodies, including CMS and payors on identification of social drivers of health

Definition-Old

Social Determinants of Health

- Conditions in the environments where people are born, live, learn, work, play, worship, and age.
- Affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- Have a major impact on people's health and well-being.
- Contribute to a wide range of health disparities and inequities.

What Drives Outcomes?

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Healthcare Access & Quality

Health coverage

Provider availability

Provider linguistic & cultural competency

Quality of Care

Education

Literacy

Language

Early childhood education

Vocational training

Higher Education

Economic Stability

Employment

Income

Expenses

Debt

Medical bills

Support

Community & Social Context

Social integration

Support systems

Community engagement

Stress

Exposure to violence/trauma

Neighborhood & Built Environment

Housing

Transportation

Safety

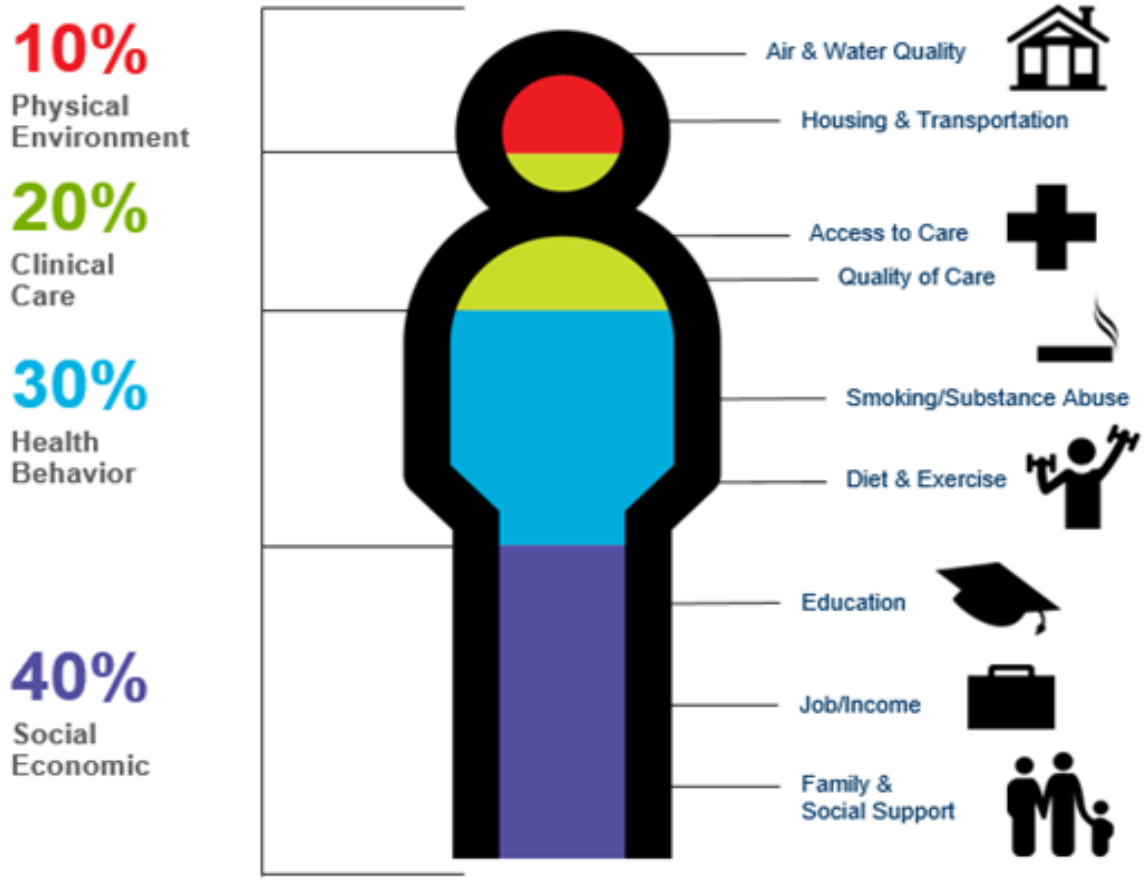
Parks/Playgrounds

Walkability

Zip code/geography

Health Outcomes: Mortality, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Impact of Societal Factors



- The most important truth to know about societal factors is that they make up a staggering 80% of our health.
- If health systems are committed to improving health and well-being for their patients and communities, they need to think and act beyond the walls of the hospital.
- This is a compelling story to tell, and you play a very important role in uncovering the systemic consequence of health inequities.

Definition-New

As a recent *Health Affairs* blog emphasized, "*Now more than ever, it is crucial that we use language that speaks to the realities of peoples' lives and illuminates, rather than obscures, our shared understanding of and responsibility to act on all the factors that drive health.*"

- Shift away from what elements outside of clinical care *determined* the health of a person, to providing support and programs to *drive* better health outcomes.
  - Determined = just the way it is
  - Drivers = over-coming and changing negative influencers

County Health Rankings & Roadmaps

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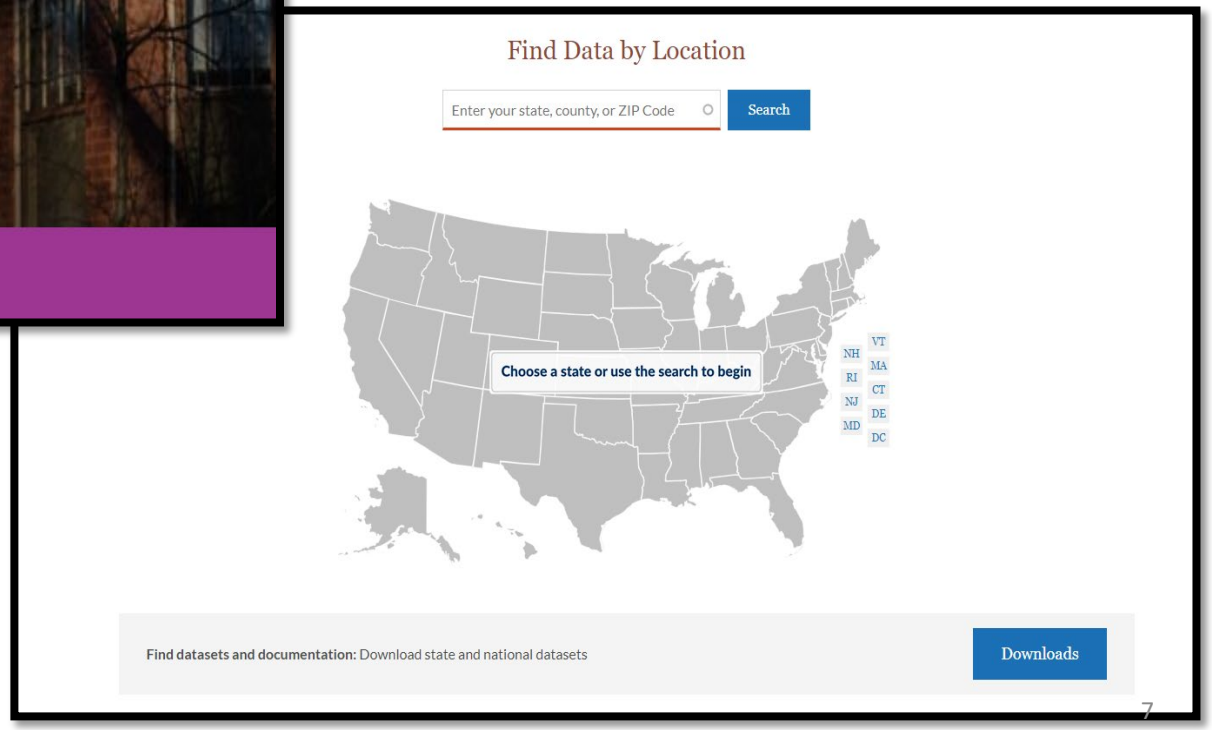

How do Counties Rank for Health Factors?

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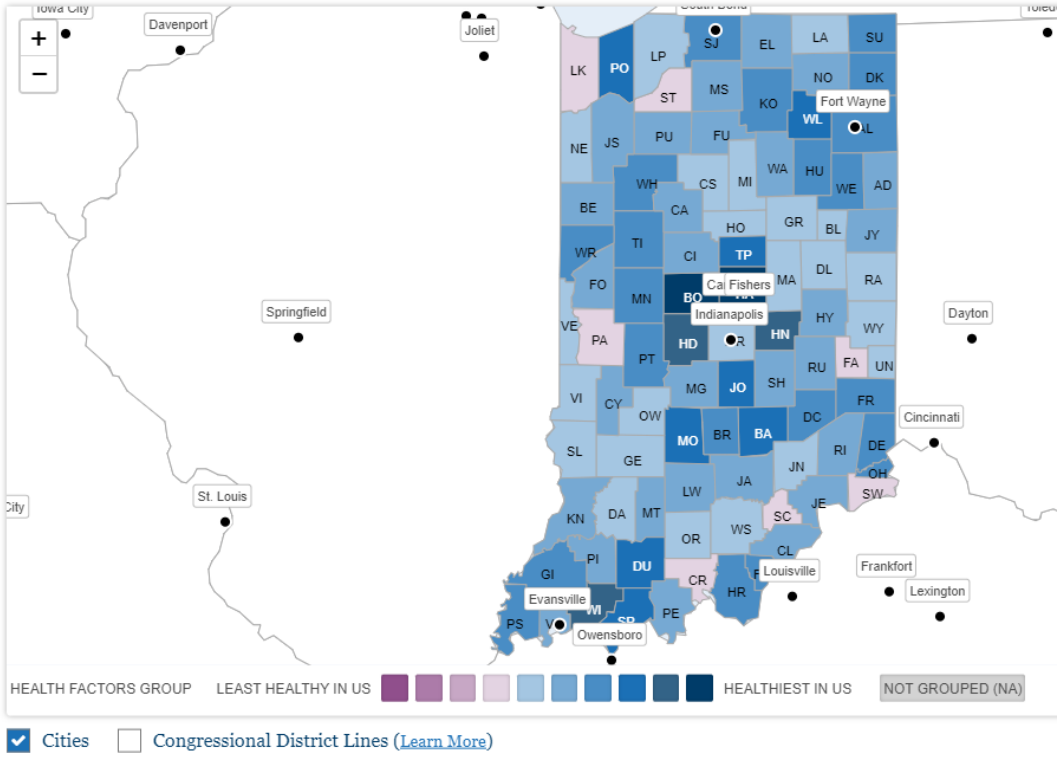
County Health Rankings & Roadmaps

2024 Health Factors - Indiana

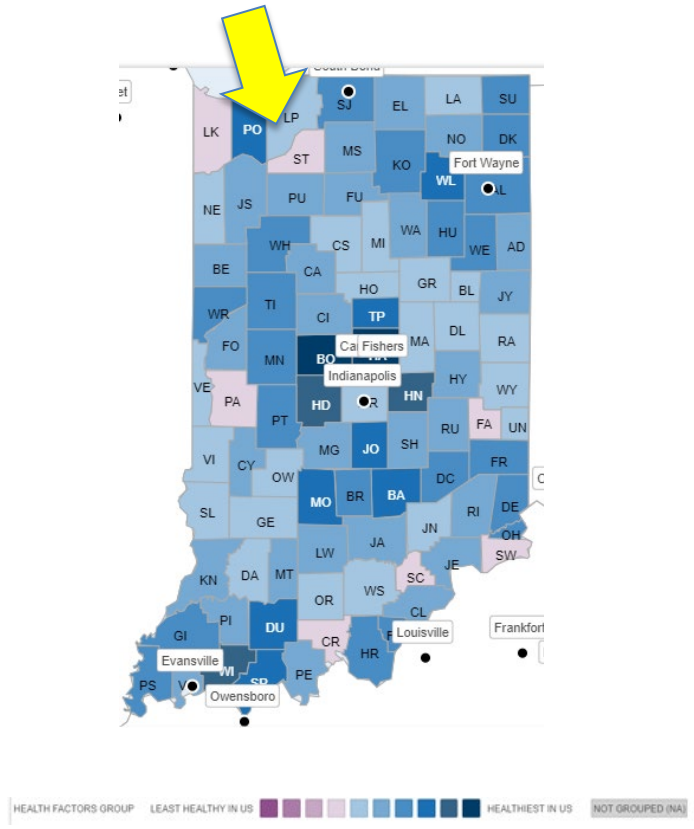


Health factors represent community conditions that we can change to improve health and opportunity, such as access to quality education, living wage jobs, quality clinical care, nutritious foods, green spaces, and secure and affordable housing. We measure four health factor areas.

Health Behaviors	Clinical Care	Social and Economic Factors	Physical Environment
Tobacco use	Access to care	Education	Air & water quality
Diet & exercise		Employment & income	
Alcohol & drug use	Quality of care	Family & social support	Housing & transit
Sexual activity		Community Safety	

https://www.countyhealthrankings.org/health-data/indiana?year=2024&measure=Health+Factors

Starke County, Indiana

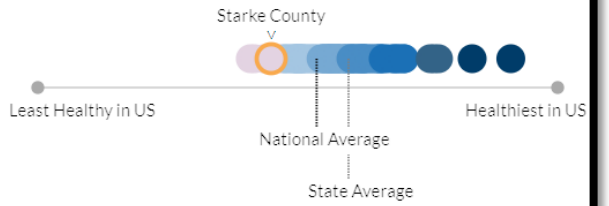


Starke County, Indiana, is Rural. 100% of the population lives in a low population density area.

Starke County Health Factors

Many things influence how well and how long we live. Health Factors represent those things we can improve to live longer and healthier lives. They are indicators of the future health of our communities.

Starke County is faring worse than the average county in Indiana for Health Factors, and worse than the average county in the nation.



Show areas to explore | Show areas of strength | Trends Available

Health Factors			
Health Behaviors	Starke County	Indiana	United States
Adult Smoking	23%	18%	15%
Adult Obesity	42%	37%	34%
Food Environment Index	8.1	6.8	7.7
Physical Inactivity	29%	25%	23%
Access to Exercise Opportunities	67%	77%	84%
Excessive Drinking	17%	18%	18%
Alcohol-Impaired Driving Deaths	14%	18%	26%
Sexually Transmitted Infections	184.0	510.7	495.5
Teen Births	28	20	17
Additional Health Behaviors (not included in summary)			

How Do Counties Rank for Health Outcomes?

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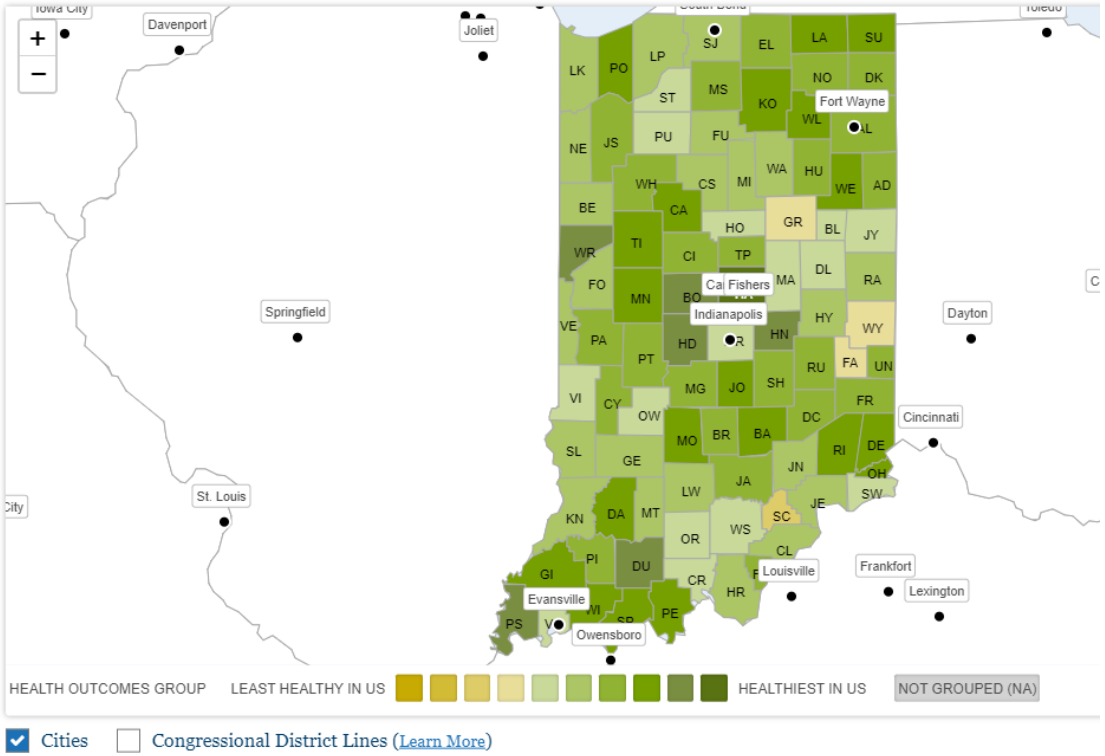
County Health Rankings & Roadmaps

2024 Health Outcomes - Indiana



What are Health Outcomes?

We measure length and quality of life to understand the health outcomes among counties in Indiana.

Length of Life

Premature death
(years of potential life lost before age 75)

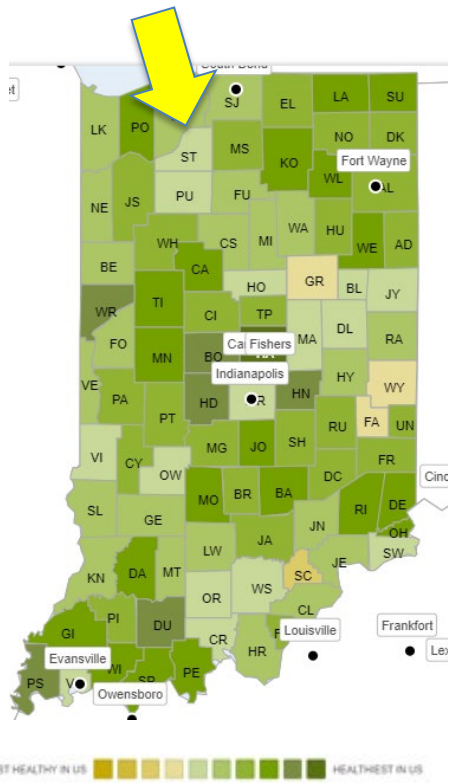
Quality of Life

Self-reported health status

Percent of low birthweight newborns

https://www.countyhealthrankings.org/explore-health-rankings/indiana/data-and-resources

Starke County, Indiana

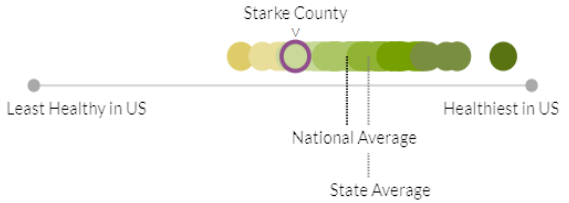


One county over, Porter County,
Has a life expectancy of 77.5 years.

Starke County Health Outcomes

Health Outcomes tell us how long people live on average within a community, and how much physical and mental health people experience in a community while they are alive.

Starke County is faring worse than the average county in Indiana for Health Outcomes, and worse than the average county in the nation.



Trends Available

Health Outcomes			
Length of Life	Starke County	Indiana	United States
Premature Death	12,300	9,300	8,000
Quality of Life	Starke County	Indiana	United States
Poor or Fair Health	19%	16%	14%
Poor Physical Health Days	4.1	3.5	3.3
Poor Mental Health Days	5.8	5.2	4.8
Low Birthweight	8%	8%	8%
Additional Health Outcomes (not included in summary)	Starke County	Indiana	United States
Life Expectancy	72.4	75.6	77.6
Premature Age-Adjusted Mortality	620	450	390
Child Mortality		60	50
Infant Mortality		7	6

Health Equality vs. Equity

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EQUALITY:
Everyone gets the same – regardless if it's needed or right for them.

EQUITY:
Everyone gets what they need – understanding the barriers, circumstances, and conditions.

Where Do We Start?

Data

- -Data can help us to understand what people's greatest social needs are, and can also link with race, ethnicity, sexual orientation, and language barriers.
- -This has been CMS's plan for quite some time.

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History

2015 Equity Plan for Improving Quality in Medicare

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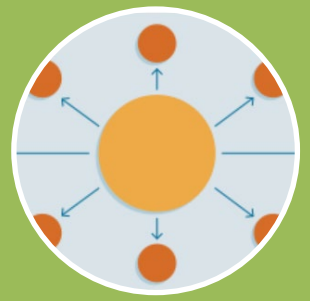
Priority 1: Expand the collection, reporting, and analysis of standardized data

Priority 2: Evaluate disparities impacts and integrate equity solutions across CMS programs



Priority 3: Develop and disseminate promising approaches to reduce health disparities

Priority 4: Increase the ability of the health care workforces to meet the needs of vulnerable populations

Priority 5: Improve communication and language access for individuals with limited English proficiency and persons with disabilities

Priority 6: Increase physical accessibility of health care facilities

https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf

2016 CMS Progress Report on Equity Plan

- Introduction of improving the collection of demographic patient data
- REaL data = Race, Ethnicity and Language
- Began to add sexual orientation data
- Began to add disability status
- Worked with QIN-QIOs and HENS to help understand how to address health equity
- Introduced Accountable Health Community Models which included screening for SDOH

https://www.cms.gov/sites/default/files/2020-10/CMS%20Equity%20Plan%20Progress%20Report%20Oct%202016.pdf

2019 Addition of SPADEs

- In 2019, CMS identified and developed standardized **patient assessment data elements (SPADEs)** to assess social determinants of health and embedded these data elements into the Post-Acute Care Quality Reporting Programs, to be collected starting in 2020.
- Although data collection was delayed due to the public health emergency, this policy change in Medicare's prospective payment system makes collection of social determinants of health data part of the required standardized patient assessments administered in post-acute care settings.
- This extends to long-term care hospitals, skilled nursing facilities, intermediate rehabilitation facilities, and home health agencies.
- The additional SPADEs include race, ethnicity, preferred language/interpreter services, health literacy, transportation, and social isolation.

CMS Framework for Health Equity 2022-2032

CMS Framework for Health Equity 2022–2032

Definition of Health Equity

The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

CMS Framework for Health Equity Priorities

Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data

Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps

Priority 3: Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities

Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

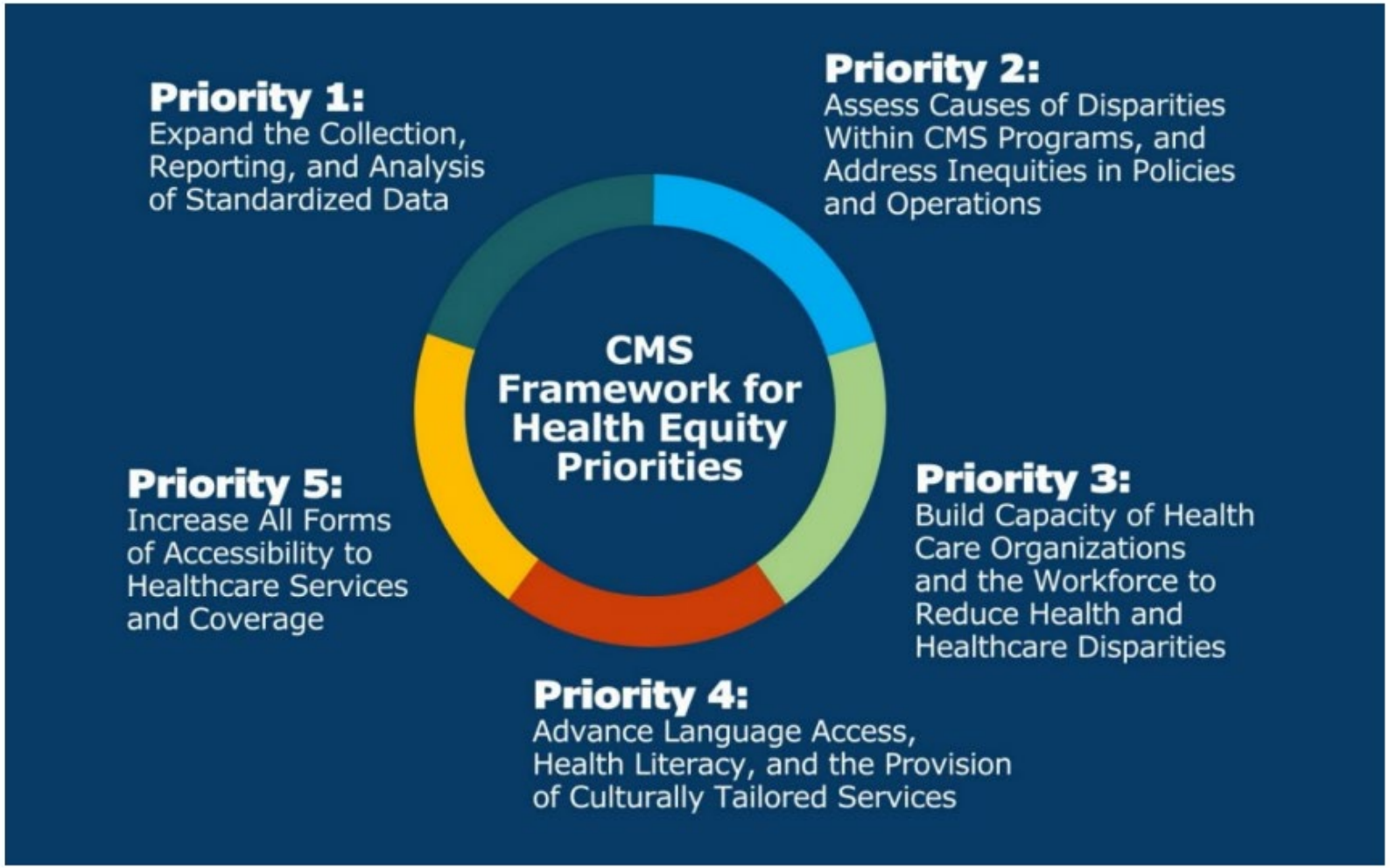
To read the CMS Framework for Health Equity 2022-2032, visit go.cms.gov/framework.

The CMS Office of Minority Health offers health equity technical assistance resources, aimed to help health care organizations take action against health disparities. If you are looking for assistance, visit go.cms.gov/omh or email HealthEquityTA@cms.hhs.gov.

Revision Date: July 2023

https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf

CMS Framework for Health Equity Priorities



https://www.ruralcenter.org/sites/default/files/Rural%20Health%20Equity%20and%20Quality%20Summit%20Report%20FINAL_0.pdf

Culturally and Linguistically Appropriate Services (CLAS)

Note Priority 4: Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services

- Community partnerships can help organizations meet the unique needs of individuals from various cultures through collaboration to develop language access plans, collect language data, and improve equitable communication.

https://www.cms.gov/files/document/cms-2023-hec-post-conference-report-2023.pdf

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How Do We Acknowledge SDOH?

Z Codes

ICD-10 codes that describe social problems, conditions, or risk factors that influence a patient's health.

ICD-10-CM SDOH Categories

Z55 – Problems related to education and literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58-- Problems related to employment and unemployment

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

Examples

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- Many of the "stories" you hear from patients are linked to Z codes.

In the past month, did Poor Physical or Mental Health keep you from doing your usual activities, like work, school or a hobby?			
Code	**Description**	**Code**	**Description**
Z78.9	Poor physical health	Z63.0	Problems in relationship with spouse or partner
Z71.1	Mental health related complaint	Z63.4	Disappearance and death of a family member
Z60	Problems related to social environment	Z63.5	Disruption of family by separation and divorce
Z60.0	Problems of adjusting to life-cycle transitions	Z63.6	Dependent relative needing care at home
Z60.2	Problems related to living alone	Z63.7	Other stressful life events affecting family and household
Z60.4	Social exclusion and rejection	Z63.32	Other absence of family member
Z60.5	Target of (perceived) adverse discrimination and persecution	Z63.72	Alcoholism and drug addiction in family
Z62	Problems related to upbringing	Z63.8	Other specified problems related to primary support group
Z62.0	Inadequate parental supervision and control	Z65	Problems related to other psychosocial circumstance
Z62.82	Parent-child conflict	Z65.3	Problems related to other legal circumstances

If you take Medication, are you not taking it because it is too expensive?			
Code	**Description**	**Code**	**Description**
Z91.14	Patient's other noncompliance with medication regimen	Z59.6	Low income

Do you ever Feel Unsafe in your home or neighborhood?			
Code	**Description**	**Code**	**Description**
Z60.8	Other problems related to social environment	Z62.82	Parent-child conflict
Z63.0	Problems in relationship with spouse or partner	Z59.2	Discord with neighbors, lodgers and landlord
Z60.5	Target of (perceived) adverse discrimination and persecution		

SDoH Z Code Crosswalk.pdf (ospdocs.com)

Developing Z-Code Reporting

- Generally sourced from administrative claims
- Analytics team guidance
- Z-Code position in longitudinal records
- Improving documentation

AHA Resource

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What You Can Do

1. Hospitals should educate key stakeholders, including physicians, non-physician health care providers, and coding professionals of the important need to screen, document and code data on patients' social needs. Utilizing Z codes will allow hospitals and health systems to better track patient needs and identify solutions to improve the health of their communities.

2. As coding professionals review a patient's medical record to identify the appropriate ICD-10-CM codes to include, they should be aware of and begin utilizing the ICD-10-CM codes included in categories Z55-Z65, listed in Table 1.

3. Hospital leaders can prioritize the importance of documenting and coding patients' social needs and allow coders extra time to integrate coding for social determinants into their processes.

Print this off!


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Advancing Health in America

ICD-10-CM Coding for
Social Determinants of Health

ntroduction

lospitals and health systems are working to address their patients' social needs and the broader social
eterminants of health in the communities they serve. This includes societal and environmental conditions such as
ood, housing, transportation, education, violence, social support, health behaviors and employment.

lobust data related to patients' social needs is critical to hospitals' efforts to improve the health of their patients
nd communities. And, employing a standardized approach to screening for, documenting and coding social needs
vill enable hospitals to:

- Track the social needs that impact their patients, allowing for personalized care that addresses patients medical and social needs;
- Aggregate data across patients to determine how to focus a social determinants strategy; and
- Identify population health trends and guide community partnerships.

)ne tool available to hospitals to capture data on the social needs of their patient population is the ICD-10-CM
odes included in categories Z55-Z65 ("Z codes"), which identify non-medical factors that may influence a patient's
ealth status. Existing Z codes identify issues related to a patient's socioeconomic situation, including education
nd literacy, employment, housing, lack of adequate food or water or
ccupational exposure to risk factors like dust, radiation, or toxic agents.

)espite the availability and utility of these ICD-10-CM codes, hospitals
ave not widely adopted the use of Z codes. Adoption has been limited
ue to a lack of clarity on who can document a patient's social needs,
bsence of operational processes for documenting and coding social
eeds, and unfamiliarity with Z codes. In addition, coders may need
ncouragement and support from hospital leaders to collect these codes
hat were once perceived as a lower priority.

Updated Guidance

he AHA is working to increase utilization of Z codes. The AHA Coding Clinic has provided further clarification on
he appropriate documentation and use of Z codes to enable hospitals to adopt their use into their processes.

ny clinician can document a patient's social needs. The initial ICD-10-CM Official Guidelines for Coding
nd Reporting indicated that coding professionals could only report codes that were supported by physician
ocumentation. As a result, many hospitals were unable to report social needs because they are routinely
ocumented by non-physician providers, such as case managers, discharge planners, social workers and nurses. In
arly 2018, the AHA Coding Clinic published advice clarifying that codes from categories Z55-Z65 can be assigned
ased on information documented by all clinicians involved in the care of the patient. That advice was approved by
he ICD-10-CM Cooperating Parties and effective Feb. 18, 2018.

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/2019 American Hospital Association | November 2019

https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Did You Know?

- Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses.

- For example, 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.

- Patient self-reported documentation may be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider.

https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf

Why are Z codes important?

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- Support evaluation and management (E/M) coding
- Justify medical necessity
- Paint a complete picture of the patient's circumstances
- Identify potential barriers to diagnosis and treatment
- Gather data on treatment efficacy and the true cost of care

ICD-10 Z Code Updates for 2023

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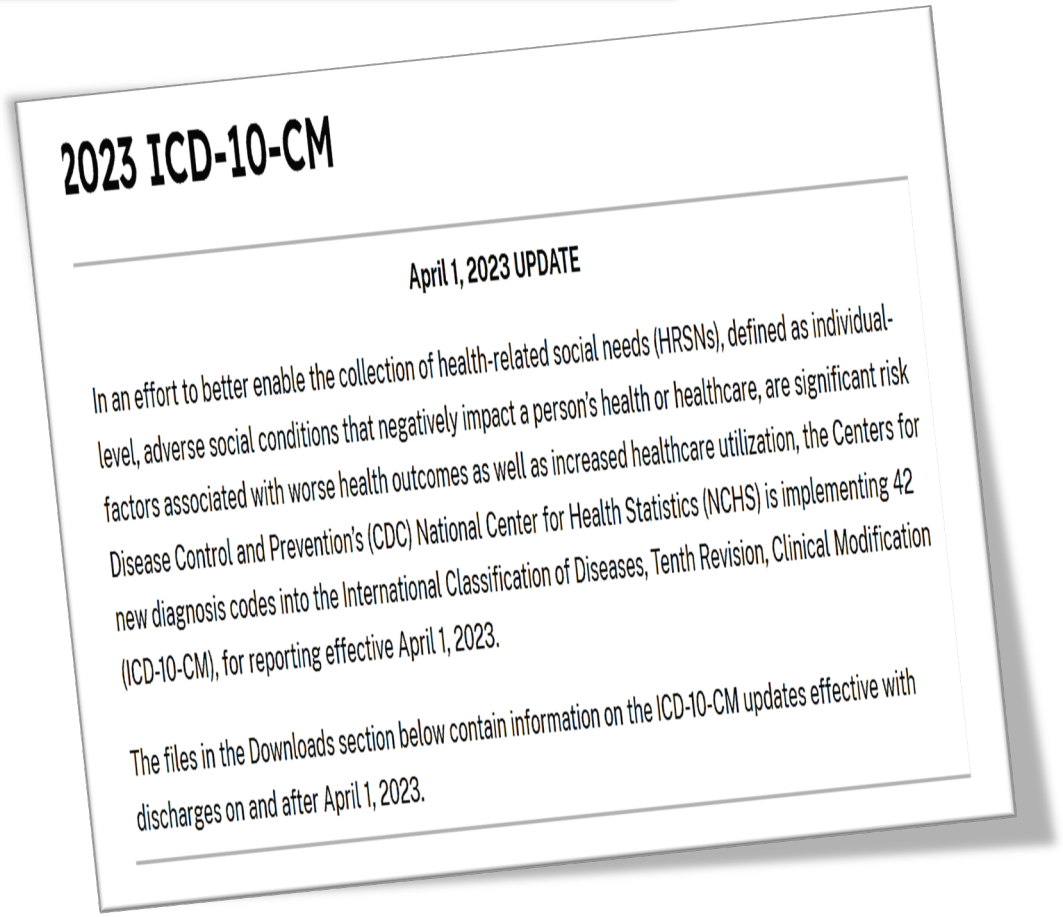
CMS.gov Centers for Medicare & Medicaid Services



2023 ICD-10-CM

April 1, 2023 UPDATE

In an effort to better enable the collection of health-related social needs (HRSNs), defined as individual-level, adverse social conditions that negatively impact a person's health or healthcare, are significant risk factors associated with worse health outcomes as well as increased healthcare utilization, the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) is implementing 42 new diagnosis codes into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), for reporting effective April 1, 2023.

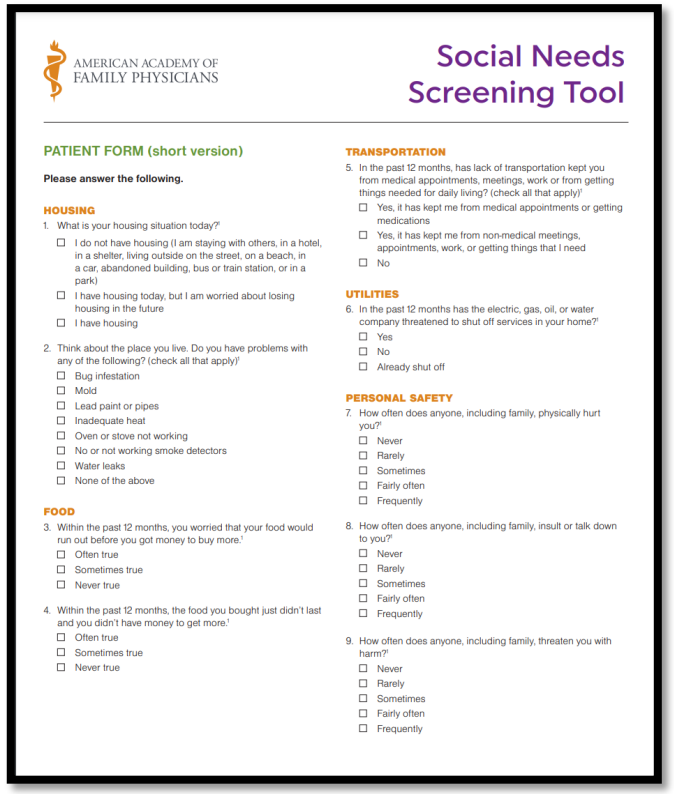
The files in the Downloads section below contain information on the ICD-10-CM updates effective with discharges on and after April 1, 2023.

- **Old News**: Beginning Oct. 1, 2022, updates to Z code Z59.8 have taken effect for the fiscal year 2023. Additional codes have been established to allow for greater specificity.
- **New News**: Effective April 1, 2023, CMS has now implemented updates to codes to occur twice a year in April and October instead of just October.
- In a comparison between the October 22 updates to the April 23 updates, some Z codes have been removed and other codes have become more specific.

https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

Screening Tools

[PRAPARE](#)-25 languages and in many EMRs



AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PATIENT FORM (short version)

Please answer the following.

HOUSING

1. What is your housing situation today?[1]
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☐ I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[1]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)[1]
   - ☐ Yes, it has kept me from medical appointments or getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

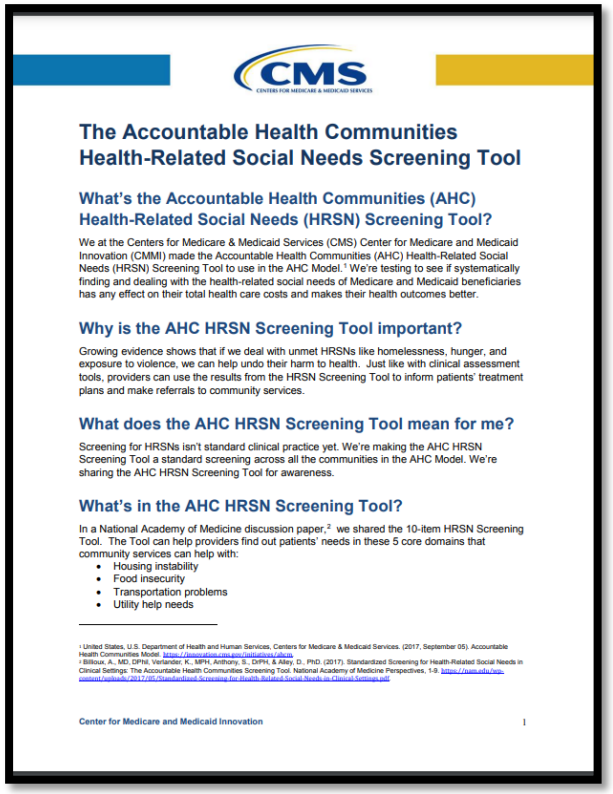
UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently
8. How often does anyone, including family, insult or talk down to you?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently
9. How often does anyone, including family, threaten you with harm?[1]
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Fairly often
   - ☐ Frequently

[AAFP](#)-10 questions



CMS

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

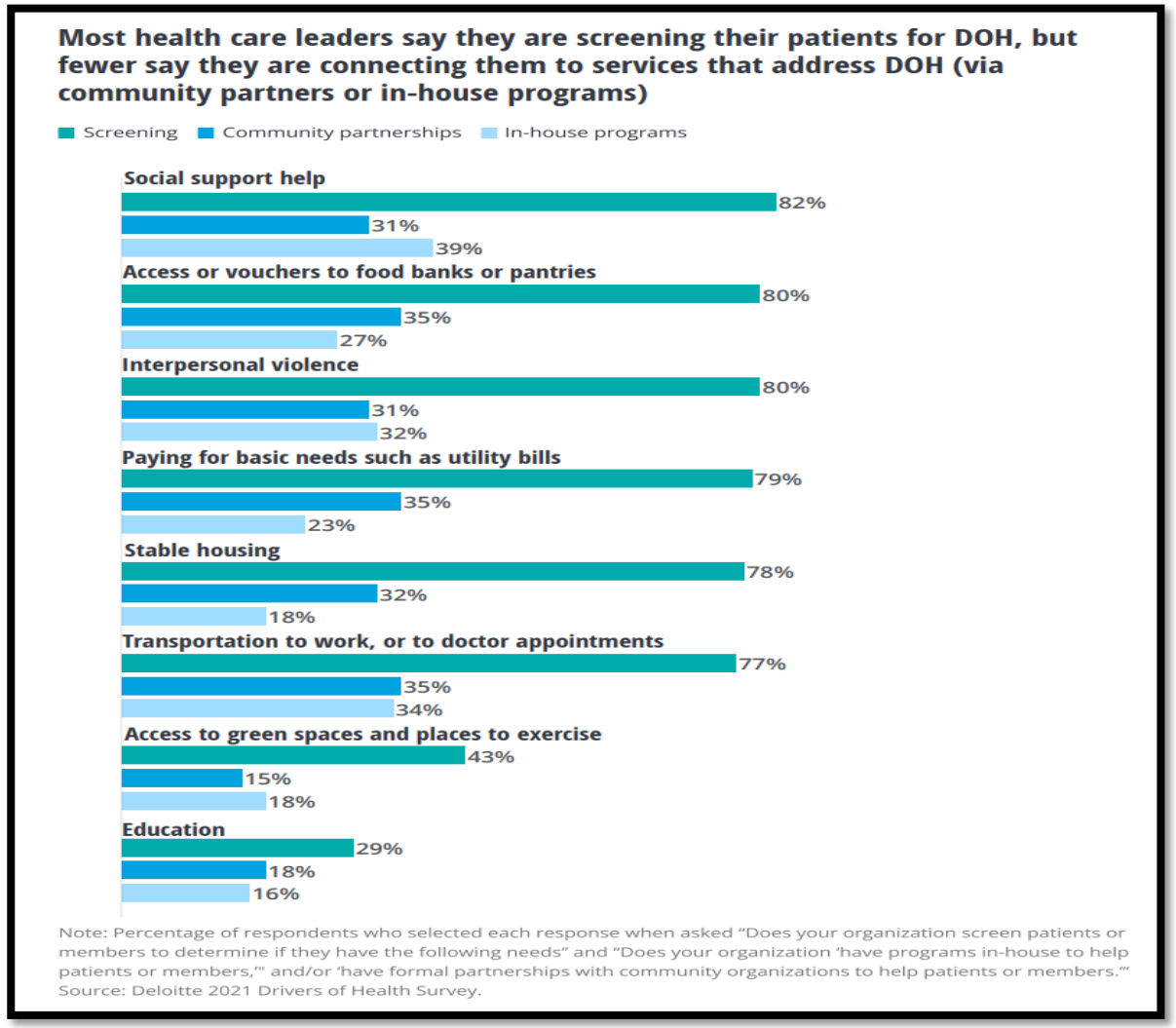
- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

[1] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.

[2] Billioux, A., MD, DPH, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.

Center for Medicare and Medicaid Innovation 1

The GAP



- In 2017, 88% of hospitals who responded to a survey (300) stated they were screening for social needs.
- 33% reported that they had a well-defined process for connecting people with resources.
- A repeat survey in 2021 found that 79% of hospitals (251) screened for social needs, 35% stating they had a process for connecting people to resources.

https://www2.deloitte.com/us/en/insights/industry/health-care/drivers-of-health-equity-survey.html

Team Building

- Hospital Leadership
- Clinical Staff
- Coders
- IT Team
- Social Workers, Navigators
- Providers
- Community Wellness Liaisons

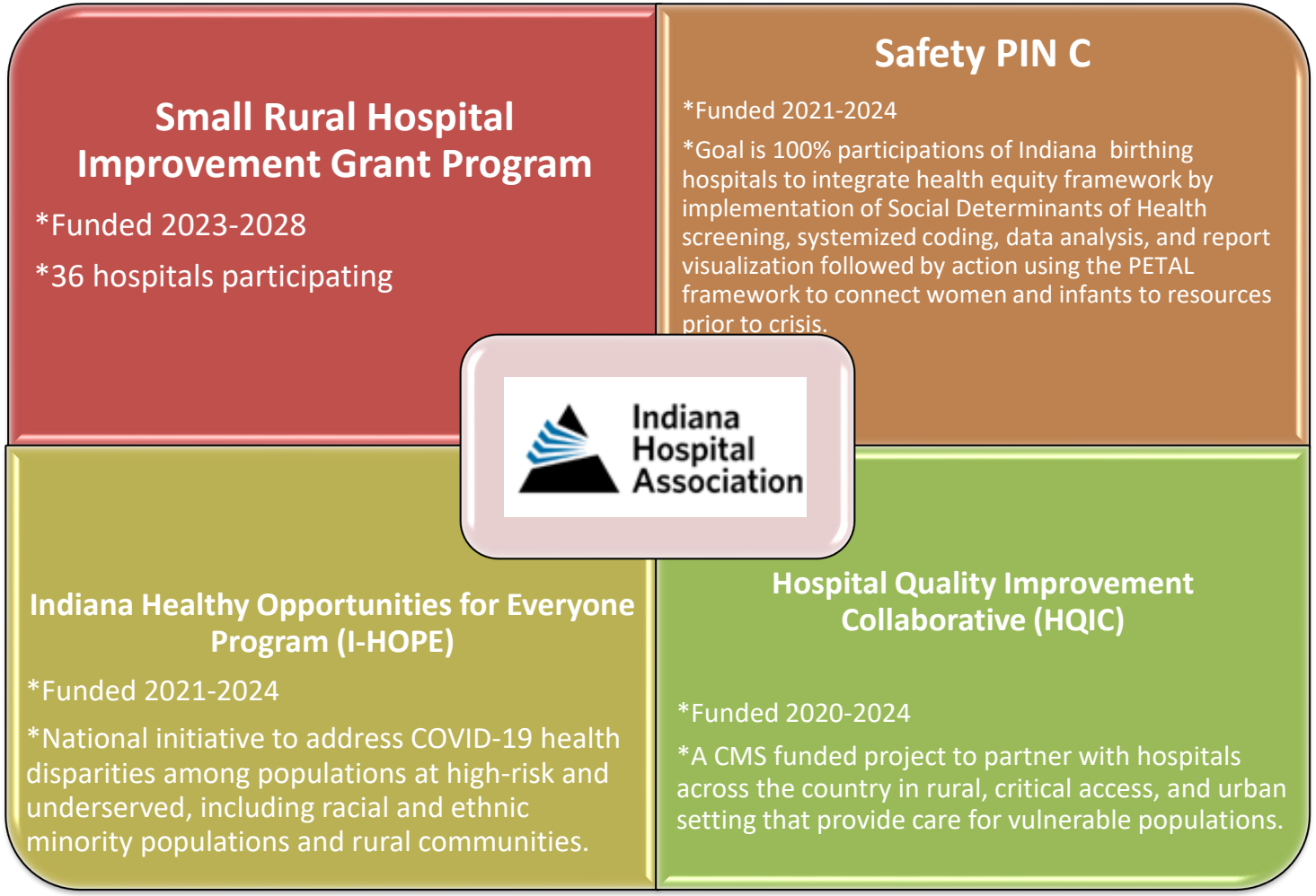
Indiana Hospital Association

IHA and SDOH

Our Foundation

- Healthy People 2030 features many objectives related to SDOH.
- Tracking Data to Improve Health Collaborative efforts at the federal, state, and local levels can help address health disparities.
- Healthy People offers a platform for collaboration; priority alignment, including alignment of federal strategies; and information sharing around disease prevention and health promotion priorities for the Nation.

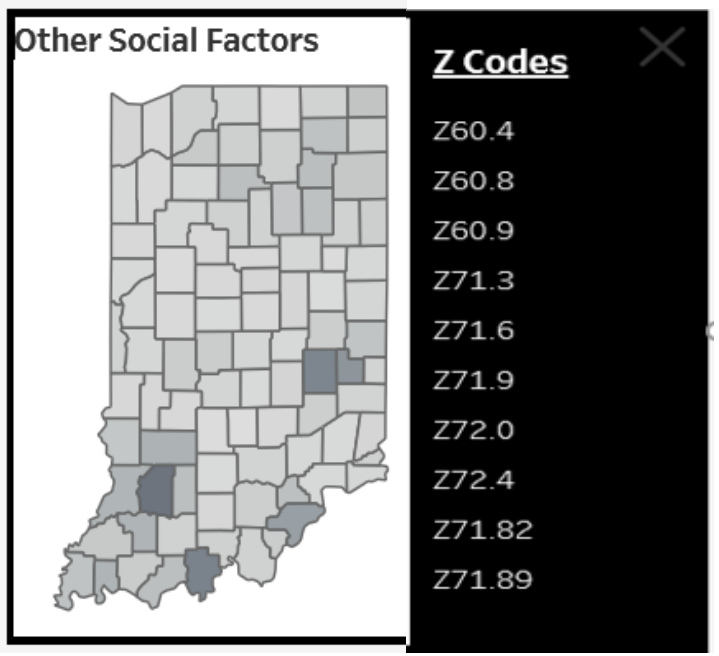
IHA Work on Social Drivers of Health



DataLink

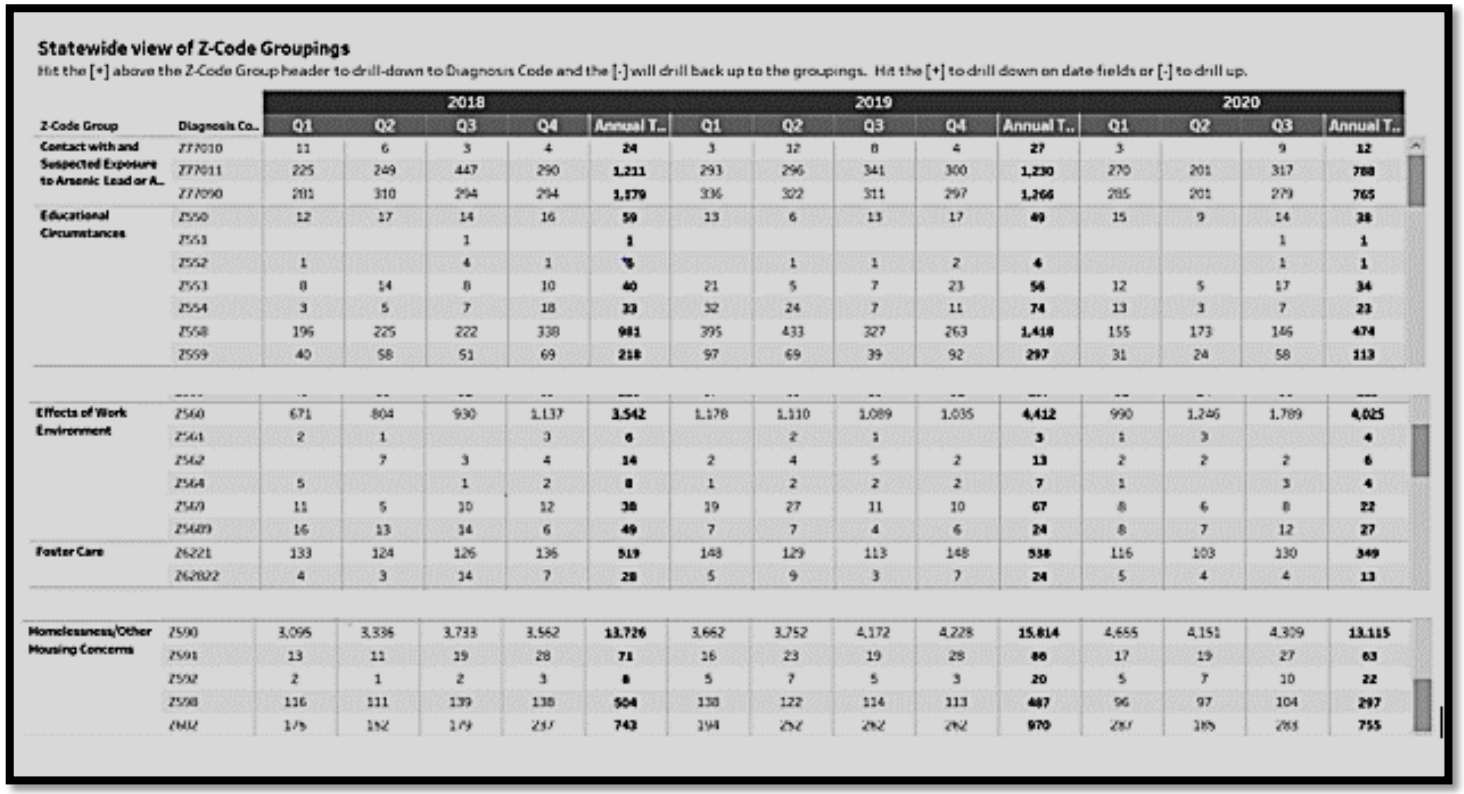
Indiana Hospital Association

Zip Code Data



For access, contact Ryan Prentice at: Rprentice@ihaconnect.org

Individual Hospital Data



Statewide view of Z-Code Groupings

Hit the [+] above the Z-Code Group header to drill-down to Diagnosis Code and the [-] will drill back up to the groupings. Hit the [+] to drill down on date fields or [-] to drill up.

Z-Code Group	Diagnosis Co..	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2018 Annual T..	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2019 Annual T..	2020 Q1	2020 Q2	2020 Q3	2020 Annual T..
Contact with and Suspected Exposure to Arsenic Lead or A..	Z77010	11	6	3	4	24	3	12	8	4	27	3		9	12
	Z77011	225	249	447	290	1,211	293	296	341	300	1,230	270	201	317	788
	Z77090	201	310	294	294	1,179	336	322	311	297	1,266	285	201	279	765
Educational Circumstances	Z550	12	17	14	16	59	13	6	13	17	49	15	9	14	38
	Z551			1		1								1	1
	Z552	1		4	1	6		1	1	2	4			1	1
	Z553	8	14	8	10	40	21	5	7	23	56	12	5	17	34
	Z554	3	5	7	18	33	32	24	7	11	74	13	3	7	23
	Z558	196	225	222	338	981	395	433	327	263	1,418	155	173	146	474
	Z559	40	58	51	69	218	97	69	39	92	297	31	24	58	113
Effects of Work Environment	Z560	671	804	930	1,137	3,542	1,178	1,110	1,089	1,035	4,412	990	1,246	1,789	4,025
	Z561	2	1		3	6		2	1		3	1	3		4
	Z562		7	3	4	14	2	4	5	2	13	2	2	2	6
	Z564	5		1	2	8	1	2	2	2	7	1		3	4
	Z569	11	5	10	12	38	19	27	11	10	67	8	6	8	22
	Z5689	16	13	14	6	49	7	7	4	6	24	8	7	12	27
Foster Care	Z6221	133	124	126	136	519	148	129	113	148	538	116	103	130	349
	Z62822	4	3	14	7	28	5	9	3	7	24	5	4	4	13
Homelessness/Other Housing Concerns	Z590	3,095	3,336	3,733	3,562	13,726	3,662	3,752	4,172	4,228	15,814	4,655	4,151	4,309	13,115
	Z591	13	11	19	28	71	16	23	19	28	86	17	19	27	63
	Z592	2	1	2	3	8	5	7	5	3	20	5	7	10	22
	Z598	116	111	139	138	504	138	122	114	113	487	96	97	104	297
	Z602	175	162	179	227	743	194	252	282	242	970	287	185	283	755

Indiana's Z Code Utilization-88% Improvement

Patients	2018	2019	2020	2021	2022	2023 (3Q)
Z-Code Group	Annual Total	Annual Total	Annual Total	Annual Total	Annual Total	Annual Total
Occupational exposure to risk-factors	537	530	502	365	473	412
Other problems related to primary support group including family circ	5695	8049	6706	8575	12446	10714
Other problems related to upbringing	10002	10633	9538	8891	10519	8300
Problems related to certain psychosocial circumstances	307	265	229	391	391	317
Problems related to education and literacy	1296	1828	955	1030	1407	1651
Problems related to employment and unemployment	3774	4695	5848	7765	10359	8364
Problems related to housing and economic circumstances	15469	17682	18924	20763	27271	32316
Problems related to other psychosocial circumstances	1923	2379	2485	5239	6714	6317
Problems related to social environment	1486	1934	1845	4505	5900	7557
Yearly Total	40489	47995	47032	57524	75480	75948
Total Claims	6,694,854	6,914,042	5,964,135	6,658,232	8,567,069	6,853,309
	0.60%	0.69%	0.79%	0.86%	0.88%	1.10%

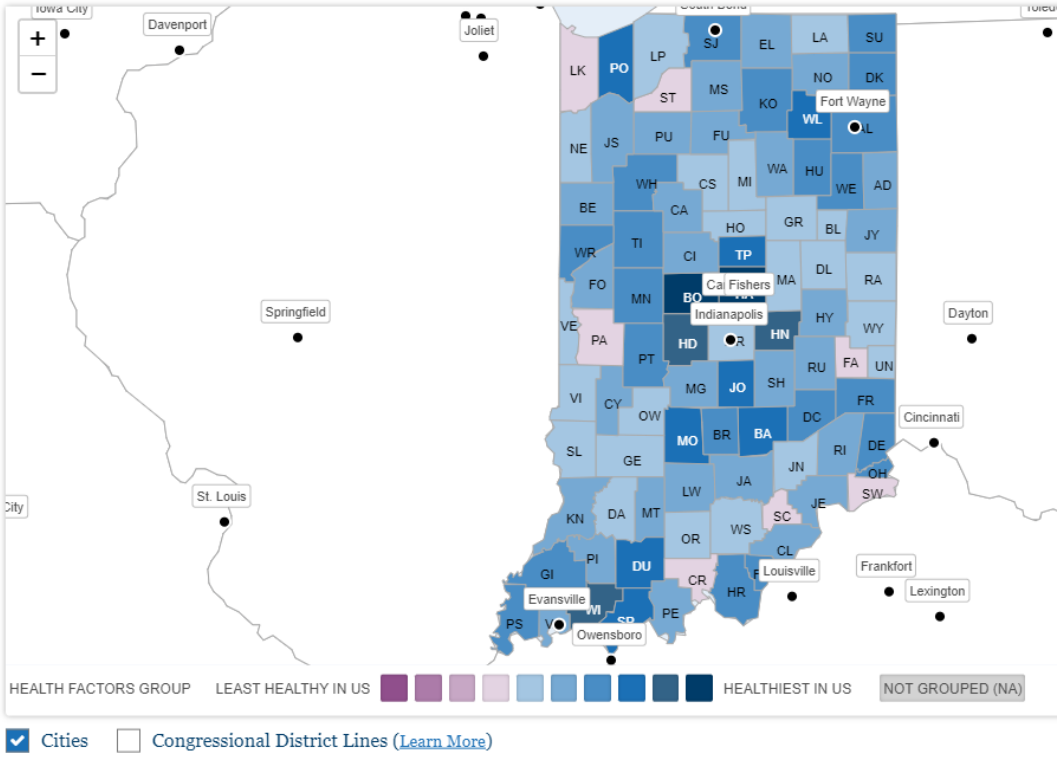
*Data obtained from IHA internal data dashboard- All Payor

Remember This Slide?

Indiana Hospital Association

County Health Rankings & Roadmaps

2024 Health Factors - Indiana



Health factors represent community conditions that we can change to improve health and opportunity, such as access to quality education, living wage jobs, quality clinical care, nutritious foods, green spaces, and secure and affordable housing. We measure four health factor areas.

Health Behaviors	Clinical Care	Social and Economic Factors	Physical Environment
Tobacco use	Access to care	Education	Air & water quality
Diet & exercise		Employment & income	
Alcohol & drug use	Quality of care	Family & social support	Housing & transit
Sexual activity		Community Safety	

https://www.countyhealthrankings.org/health-data/indiana?year=2024&measure=Health+Factors

Opportunity

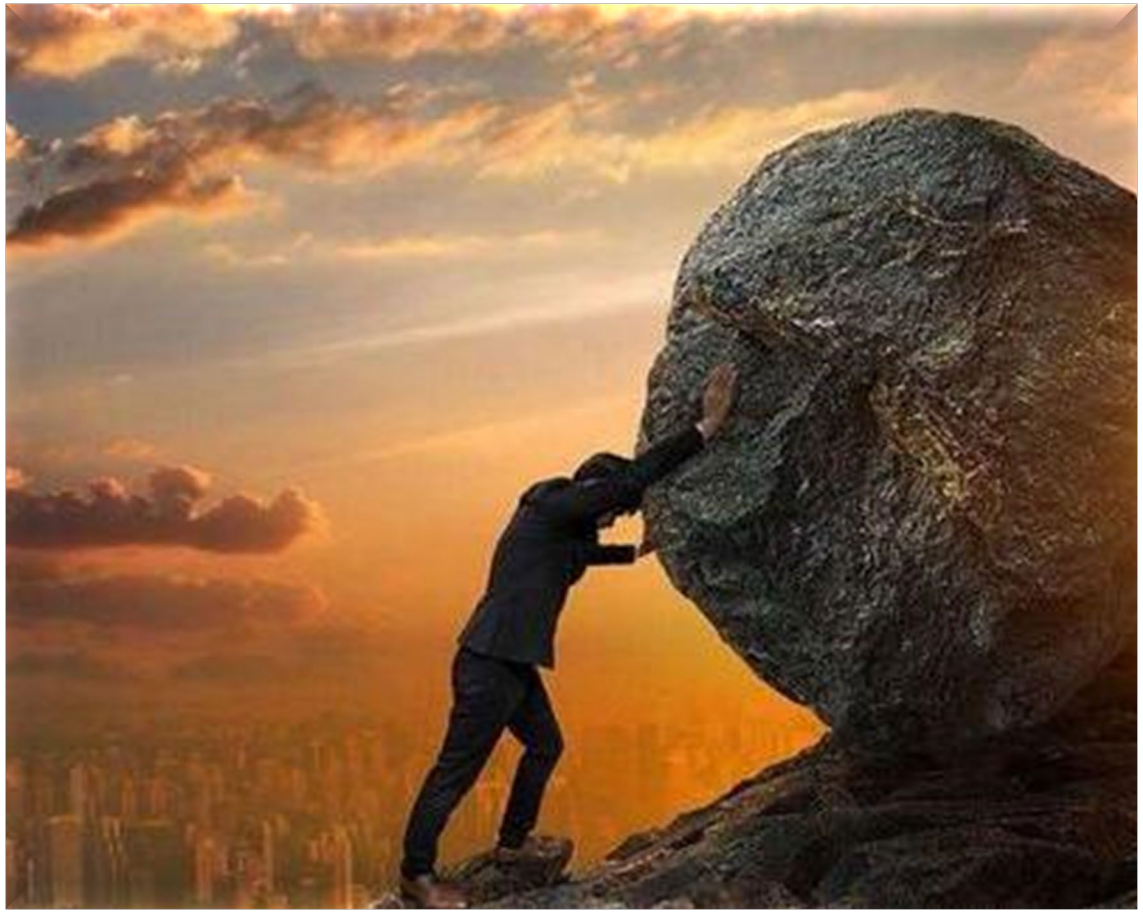
Indiana Hospital Association

Tell policy makers the story of health disparities in communities across the state

Indiana Hospital Association

Current & Future Expectations?

Obstacles in Data Collection



- Lack of definitions for SDOH terms
- Unfamiliarity with social needs
- Providers and coders
- Perceived priority/lack of incentives
- Number of codes that can be captured
- Operational processes
- EHR-based screening tool
- Standard documenting process
- Coding processes
- Lack of clarity about who can screen and document
- Productivity challenges

ACO Model

[CMS redesigns Direct Contracting into an ACO model - Fyne Fettle]

- The Global and Professional Direct Contracting Model was replaced with a more equity-focused and provider-led Accountable Care Organization Model for 2023.
- The redesigned model, called the ACO Realizing Equity, Access, and Community Health Model—or ACO REACH—includes new health equity requirements, changes to risk adjustment and additional application scoring criteria and requires participants to develop a Health Equity Plan that identifies health disparities and highlights actions to mitigate them.

CMS 2023 IPPS Final Rule

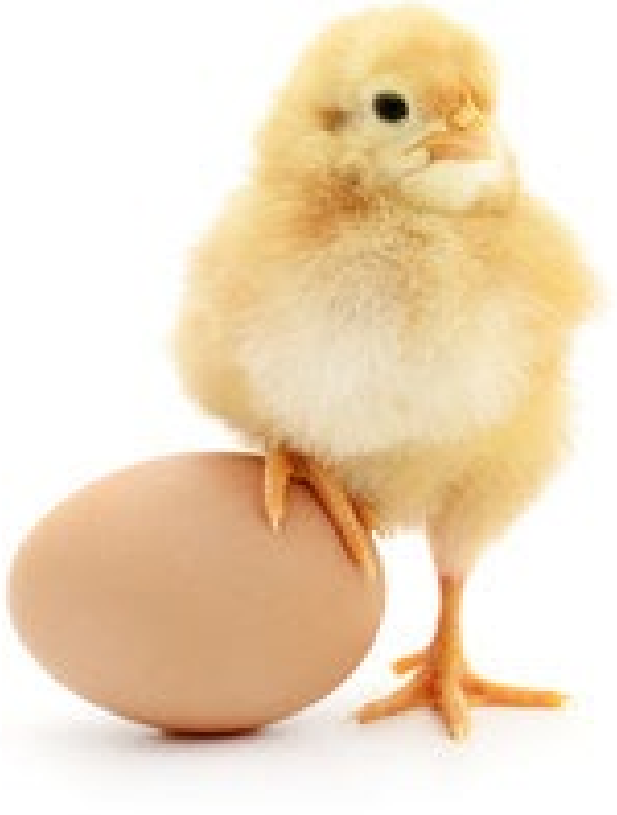
Specifically, CMS is adopting:

- Hospital Commitment to Health Equity measure beginning with the CY 2023 reporting period/FY 2025 payment determination.
- Screening for Social Drivers of Health measure and Screen Positive Rate for Social Drivers of Health measure beginning with voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination.

Measures

- The first measure assesses a hospital's commitment to establishing a culture of equity and delivering more equitable health care by capturing concrete activities across five key domains, including strategic planning, data collection, data analysis, quality improvement, and leadership engagement.

- The second and third measures capture screening and identification of patient-level, health-related social needs — suc as food insecurity, housing instability, transportation needs, utili difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better positi to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.



Medicare Beneficiary Quality Improvement Project (MBQIP)

Indiana Hospital Association

Measures in gold denote **new measures added for MBQIP reporting within the Flex Program** and are to be added to reporting data by calendar year 2025.

Measures in *blue denote **existing measures within the MBQIP Flex Program.**

MBQIP 2025 Core Measure Set				
Global Measures	**Patient Safety**	**Patient Experience**	**Care Coordination**	**Emergency Department**
+CAH Quality Infrastructure *(annual submission)* **Hospital Commitment to Health Equity** *(annual submission)*	***HCP/IMM-3:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(annual submission)* ***Antibiotic Stewardship:** Measured via Center for Disease Control National Healthcare Safety Network (CDC NHSN) Annual Facility Survey *(annual submission)* **Safe Use of Opioids (eCQM)** *(annual submission)*	***Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *(quarterly submission)*	**Hybrid Hospital-Wide Readmission** *(annual submission)* **Social Determinants of Health Screening** *(annual submission)* **Social Determinants of Health Screening Positive** *(annual submission)*	***Emergency Department Transfer Communication (EDTC)** *(quarterly submission)*: ***OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients *(quarterly submission)* ***OP-22:** Patient Left Without Being Seen *(annual submission)*

*Measures in the current MBQIP core measure set
+Data collection began in 2023 to inform state Flex quality programs. Data will continue to be collected going forward.

- The MBQIP 2025 Core Measures is a list of quality measures the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) is adopting for use in the Medicare Beneficiary Quality Improvement Project (MBQIP) within the Medicare Rural Hospital Flexibility Program.
- Starting in calendar year 2025, hospitals will collect data to report on the updated MBQIP core measures set as part of the Flex Program.

TJC Standard Update for 2023

As of Jan. 1, accreditation programs for primary care clinics, behavioral health centers, critical access facilities and hospitals will include new mandates for their leaders. New standards include:

- Designating a leader or leaders to direct activities to reduce healthcare disparities within an organization.
- Assessing patients' health-related social needs and providing information about community resources and support services.
- Identifying healthcare disparities in the patient population by stratifying quality and safety data using socio-demographic characteristics.
- Developing a written action plan that describes how the organization will address at least one of the healthcare disparities identified in its patient population.
- Taking action when the goals in its plan to reduce health disparities are not achieved or sustained.

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

FY 2024 Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule

Indiana Hospital Association

- "The rule also advances one of the goals of the CMS Framework for Health Equity 2022-2032 to more explicitly measure the impact of our policies on health equity. As part of our growing capabilities in this area, we are proposing to add 15 new health equity hospital categorizations for the FY 2024 IPPS payment impacts. Moving forward, one of the priorities of the CMS Framework for Health Equity 2022-2032 is to expand the collection, reporting, and analysis of standardized health equity data. As additional data become available, we plan to incorporate it on an ongoing basis into our impact analyses."

Homelessness a Comorbid Condition?

Indiana Hospital Association

2024 IPPS final rule finalizes DSH payments cuts and coding changes

Wednesday, August 9, 2023 – Revenue Integrity Insider

SDoH and health equity

CMS finalized its proposal to move three codes for homelessness from non-complication/comorbidity (nonCC) status to complication/comorbidity (CC) status. Starting October 1, ICD-10-CM codes Z59.00 (homelessness, unspecified), Z59.01 (sheltered homelessness), and Z59.02 (unsheltered homelessness) will be eligible for additional reimbursement. This change will recognize the increased use of hospital resources and greater costs these codes are associated with, according to CMS.

CMS also finalized its proposal to add 15 health equity categorizations under the Hospital Value-Based Purchasing Program.

https://nahri.org/articles/2024-ipps-final-rule-finalizes-dsh-payments-cuts-and-coding-changes#:~:text=CMS%20finalized%20its%20proposal%20to,homelessness%2C%20unspecified)%2C%20Z59 .

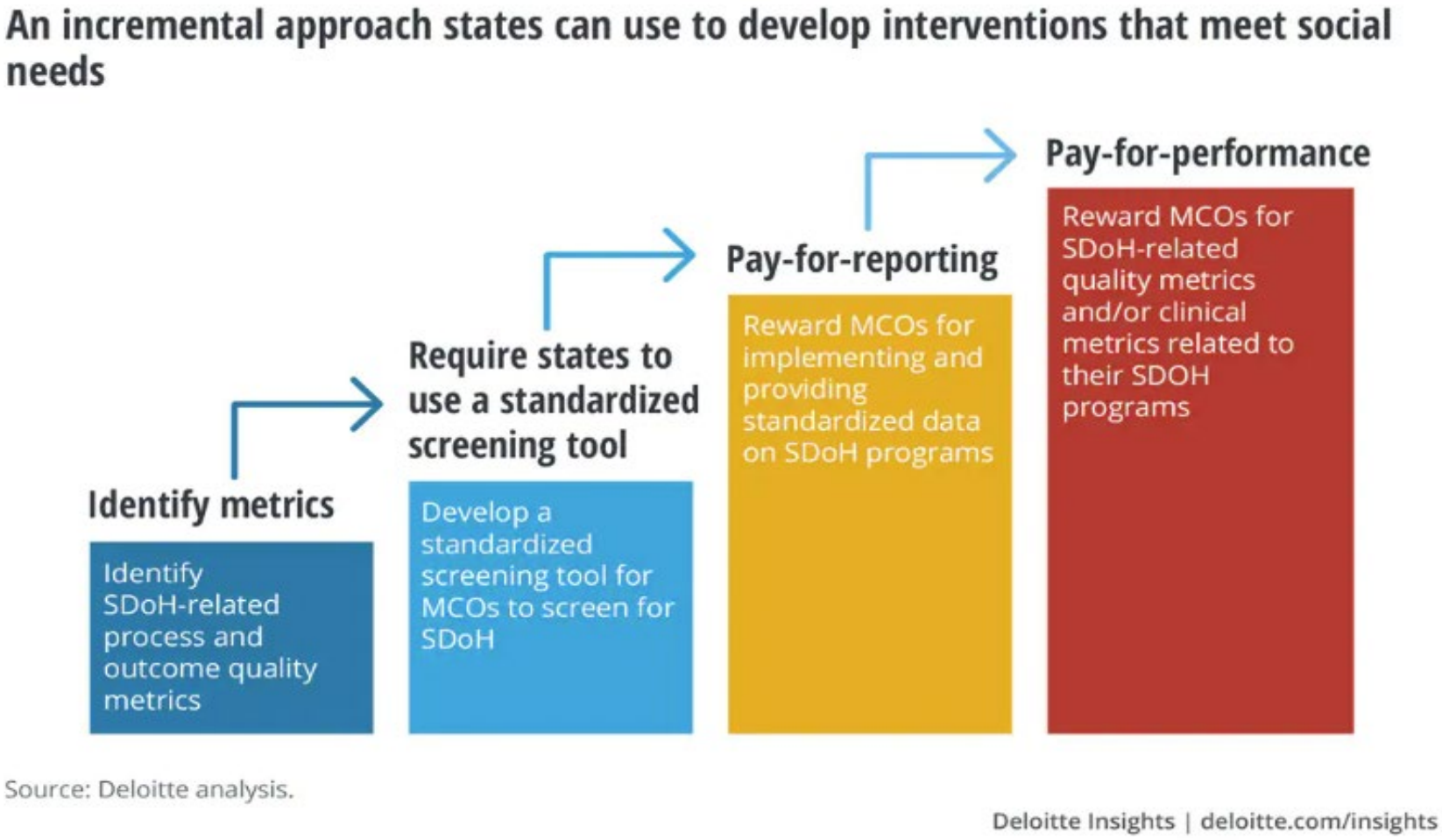
Hospital Value- Based Purchasing (VBP) Program- IPPS FY 2024

Indiana Hospital Association

- Adopt a health equity scoring change for rewarding excellent care in underserved populations, such that a health equity adjustment would be added to hospitals' Total Performance Scores (TPS) based on both a hospital's performance on existing Hospital VBP Program measures and the proportion of individuals with dual eligibility status that a hospital treats. As part of this proposal, CMS is also:
  - Proposing to modify the TPS maximum to be 110, such that the numeric score range would be 0 to 110.
  - Requesting stakeholder feedback on additional health equity changes to the Hospital VBP Program scoring methodology for future consideration

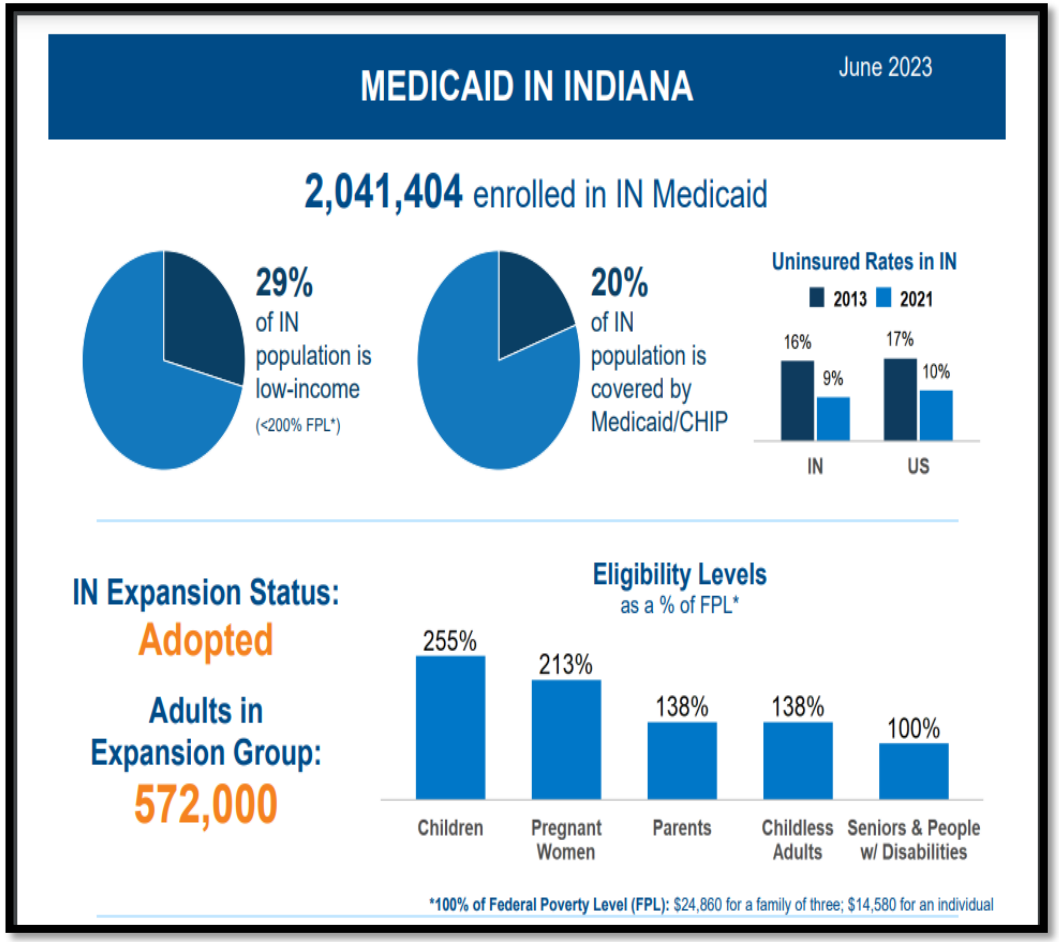
What Medicaid is Trying to Accomplish

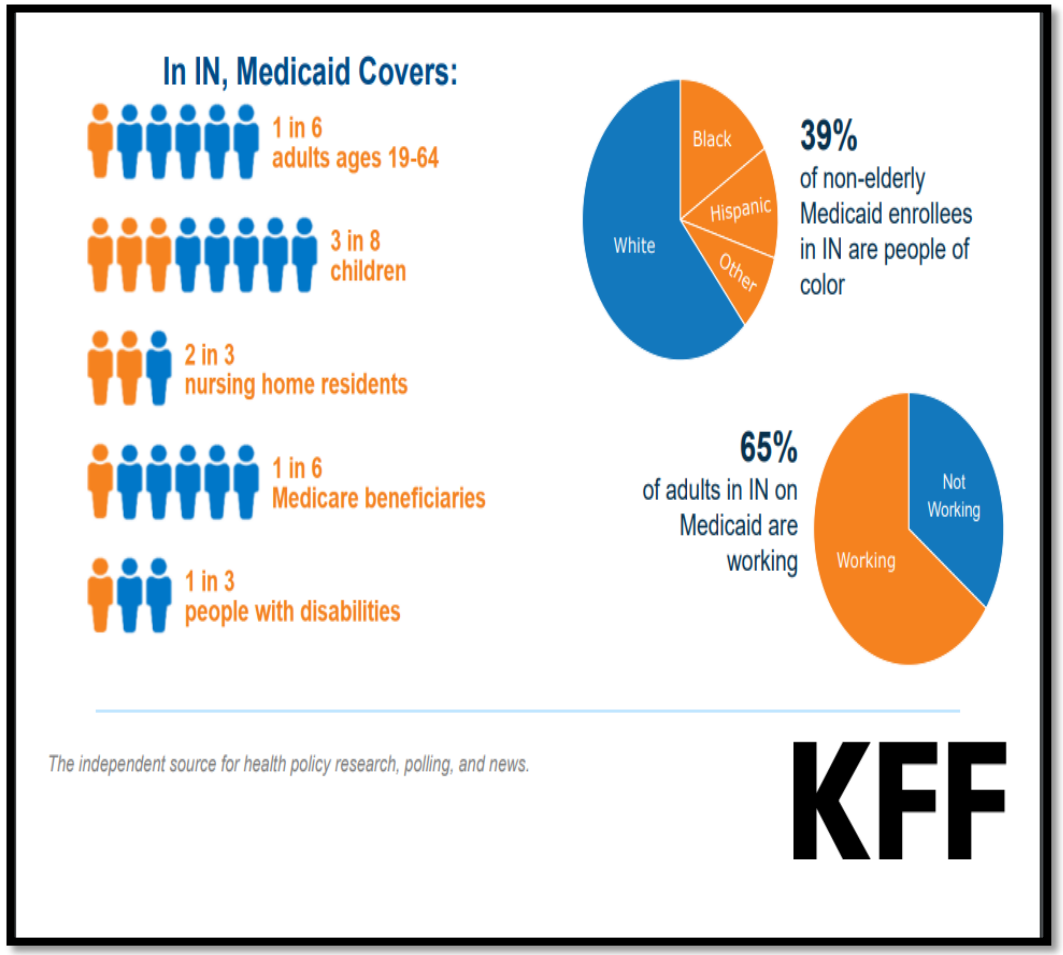
Indiana Hospital Association



Medicaid Numbers

Indiana Hospital Association





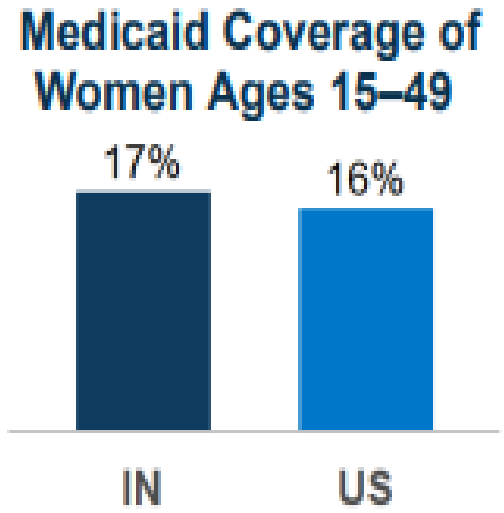
https://files.kff.org/attachment/fact-sheet-medicaid-state-IN

A Win for Indiana

38%
of births in IN were covered by Medicaid

Indiana **has adopted** the Medicaid 12-month postpartum coverage extension

Indiana **provides** 12-months of continuous Medicaid eligibility for a limited group of children



https://files.kff.org/attachment/fact-sheet-medicaid-state-IN

Anthem Health Equity Support

businesswire

Anthem Blue Cross and Blue Shield in Indiana Earns NCQA Health Equity Accreditation Plus

Business Wire
Tue, Jan 9, 2024 • 4 min read

Anthem

Newly established accreditation recognizes Anthem's commitment to health equity, prioritizing the needs of socioeconomically marginalized individuals at the highest risk for adverse health outcomes.

INDIANAPOLIS, January 09, 2024--(BUSINESS WIRE)--Anthem Blue Cross and Blue Shield's Medicaid health plan in Indiana recently earned the National Committee for Quality Assurance (NCQA) Health Equity

- Anthem is advancing its health equity mission through various innovative programs including:
- A dedicated team of associates who are experts in health-related social needs including employment, education, housing, food, and transportation that help members navigate barriers to improved health by collaborating with CBOs.
- The Social Determinants of Health Case Management program which provides interventions that address the social needs and risks of members tailored to their unique needs and circumstances.
- Community health workers who identify and engage key members impacted by physical and behavioral health conditions given their geography, demographics, race, or ethnicity to address their ongoing health needs through a personalized whole health approach.
- Anthem Blue Cross and Blue Shield works with the state of Indiana to offer the Hoosier Healthwise (HHW), Hoosier Care Connect (HCC) and Healthy Indiana Plan (HIP) health insurance programs for 750,000 Medicaid beneficiaries.

What About Reimbursement?

Indiana Hospital Association

United Healthcare Community Plan

Fax Alert

Important Information "You Need to Know!"

Uni2KNOW

2022 Pay for Performance Primary Care Providers Care Coordination Codes and Quality Incentive Program

We've updated our 2022 Care Management and Quality Incentive Program starting Jan. 1, 2022. The program was designed with the goal of helping your patients, who are UnitedHealthcare Community Plan members, become more engaged with their preventive health care.

What's new for 2022?

Z Code Submission:

Primary care providers have a new opportunity to earn incentives for the submission of Social Determinant of Health (SDoH) ICD-10 Z codes (Z55-Z65 and Z75) based on the results of SDoH assessments. Providers who submit SDoH-related Z codes for 5% of their seen members will earn a $0.50 pmpm payment while providers who submit these codes for 10% of their seen members will earn a $1.00 pmpm payment. Membership for the pmpm payment will be based on the provider's entire assigned membership for the year. Z code incentives will be paid annually at the time of quality incentive payments.

https://lakelandcare.com/sites/lakelandcare.com/files/attachments/2022%20P4P%20notice%20%282%29.pdf

DIVE BRIEF

Humana program to reimburse providers for identifying social determinants like homelessness, food insecurity

Published March 5, 2020

By Hailey Mensik

Humana isn't the first payer to try this approach.

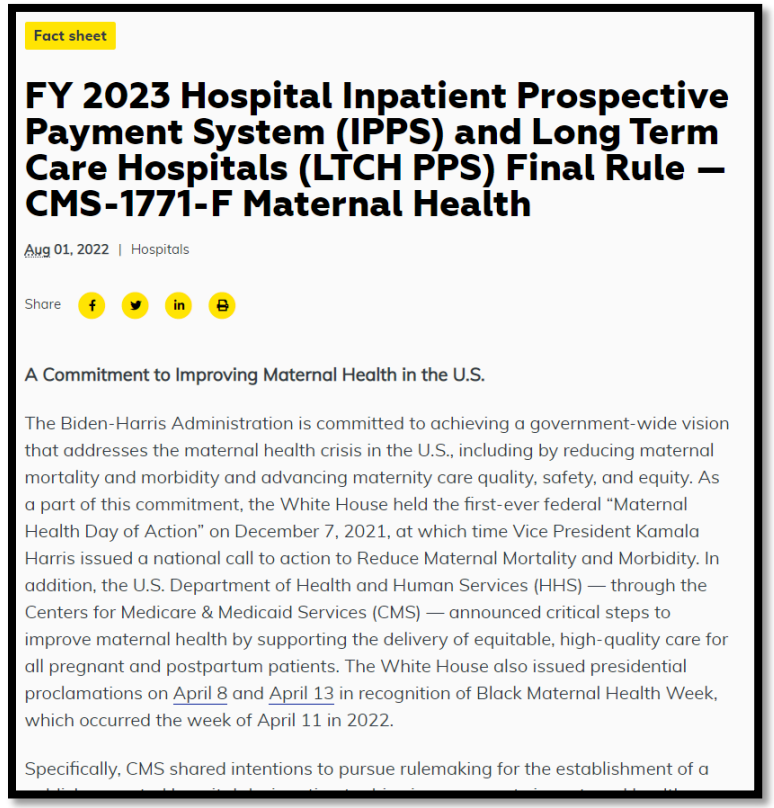
CMS has also aimed to expand value-based programs that reward health care providers for the quality of care they provide, especially in the MA program.

https://www.healthcaredive.com/news/humana-program-to-reimburse-providers-for-identifying-social-determinants-l/573557/

Other Resources

[Remington Report]

[NPIC]



[IPPS]

New Roles

New roles are being established to help with this work!

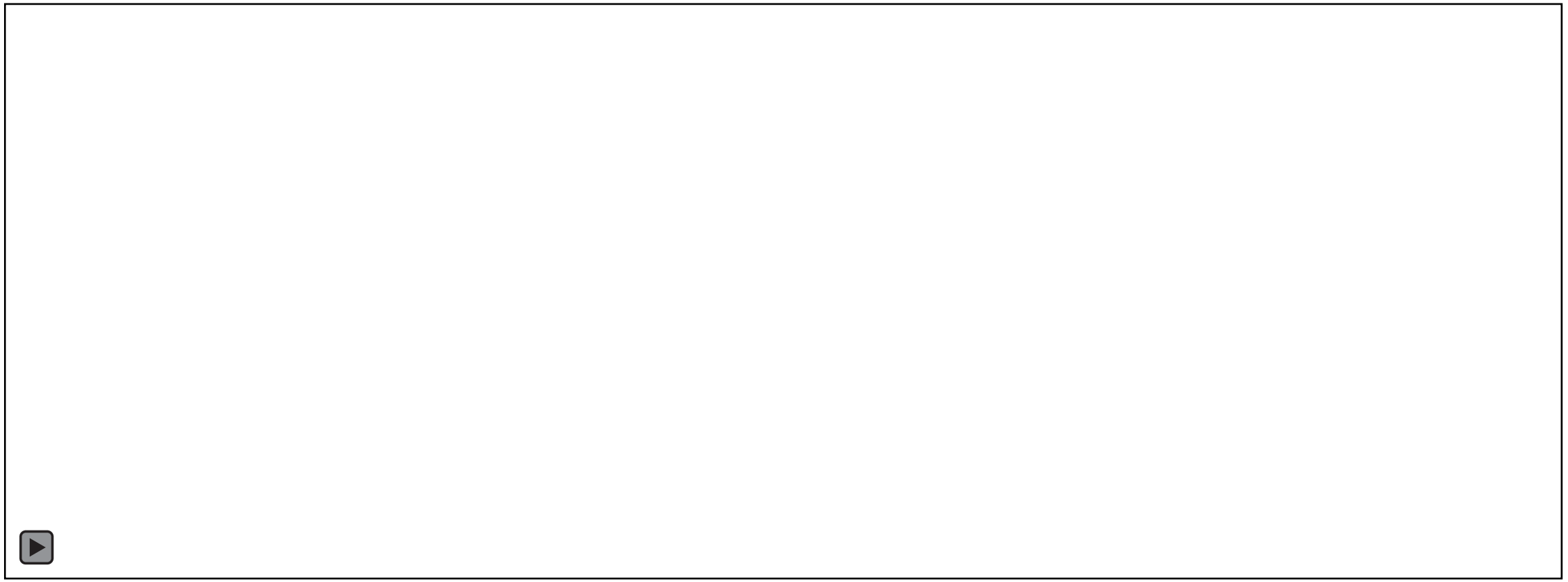
- Community Health Workers (CHWs)-which are frontline public health workers, are now being added to the care team in many organizations. These folks act as the liaison between social services and community and help to facilitate the access to services. They also help to build stronger community programs by the identification of community deficits. This can help with legislation for needed services in your community.

- Some hospitals are also hiring more Social Workers who are working specifically on SDOH screening and resource planning with patients.

New CMS Tool


IMPROVING THE COLLECTION OF
Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes
What Are Z Codes?
What Are SDOH & Why Collect Them?
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)
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
SDOH are the conditions in the environment 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[1]
The World Health Organization (WHO) estimates that SDOH accounts for 30-55% of health outcomes[2]
Collecting SDOH can improve equity in health care delivery and research by:
Empowering providers to identify and address health disparities (e.g., care coordination and referrals)
Supporting quality measurement
Supporting planning and implementation of social needs interventions
Identifying community and population needs
Monitoring SDOH intervention effectiveness for patient outcomes
Utilizing data to advocate for updating and creating new policies
Using Z Codes for SDOH
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
SDOH information can be collected through person-provider interaction or self-reported, as long as it is signed-off on and incorporated into the medical record by a clinician or provider
It is important to screen for SDOH information at each health care encounter to understand circumstances that may have changed in the patient's status
VIEW JOURNEY MAP
ICD-10-CM Z Codes Update
New SDOH Z codes may become effective each April 1 and October 1. New codes are announced prior to their effective date on CDC website.
Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for all the current Z codes.
Join the public process for SDOH code development and approval through the ICD-10-CM Coordination and Maintenance Committee
[1] Healthy People 2030 [2] World Health Organization
go.cms.gov/OMH
For Questions Contact: The CMS Health Equity Technical Assistance Program | ICD-10-CM Official Guidelines for Coding and Reporting FY 2024
CMS

The Journey




ANY QUESTIONS?

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Health Equity Lead

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mwilson@IHAconnect.org