It Takes a Village to Raise the Value of Health Care Close to Home

John Findley, MD

Learning Objectives

Describe the Evolution of a 20-year-old conversation on the topic of improving value in healthcare

Measure and Identify barriers to improved health outcomes

Apply best practices in establishing partnerships with stakeholders and determine actionable next steps

“Value” a 20 Year old conversation

“Value-Based Care” is 25 yrs Old

SAFE
AVOIDING INJURY

EFFECTIVE
IMPLEMENTING SCIENTIFIC KNOWLEDGE

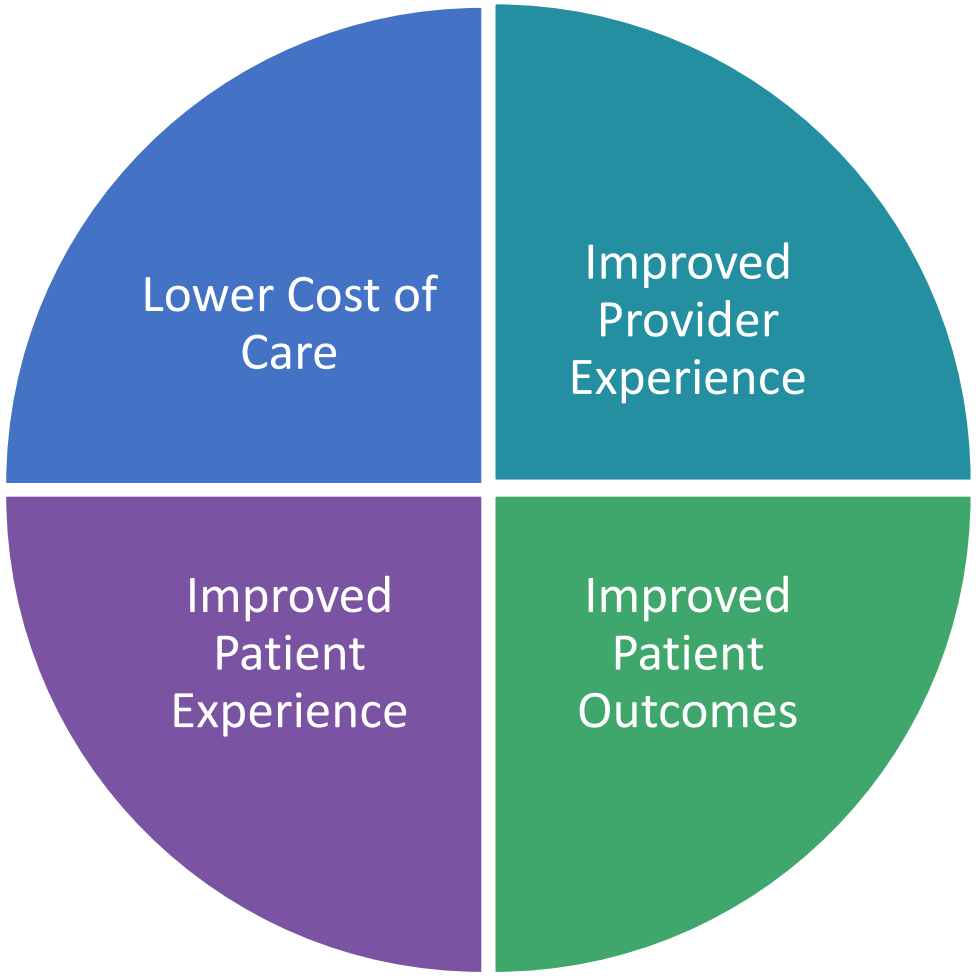
PATIENT CENTERED
PREFERENCES, NEEDS, VALUES

TIMELY
REDUCING DELAYS, WAITS

EFFICIENT
AVOIDING WASTE

EQUITABLE
REDUCING DISPARITY

1999



2007

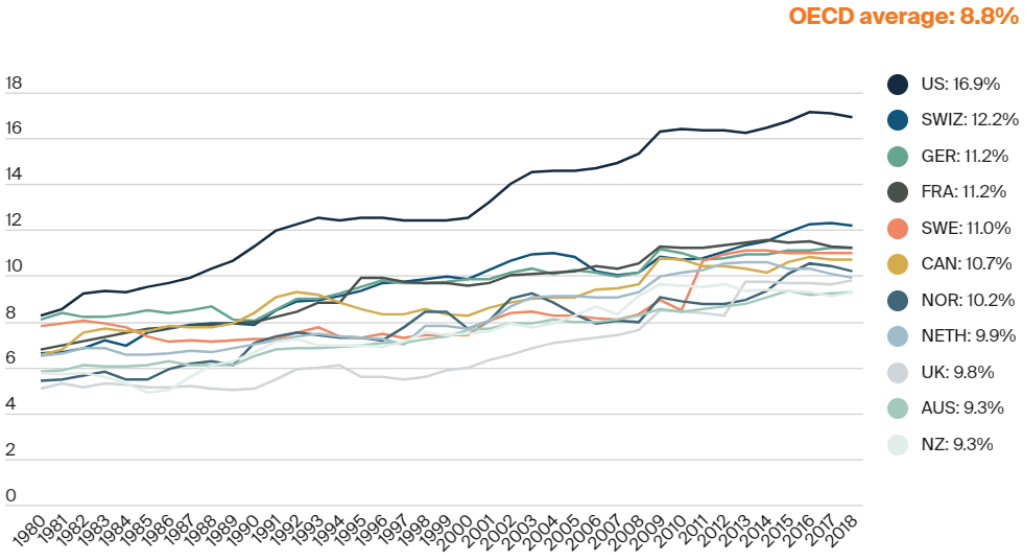
How are we doing 25 years later?

Source: Commonwealth Fund 2020

SPENDING

The U.S. Spends More on Health Care Than Any Other Country

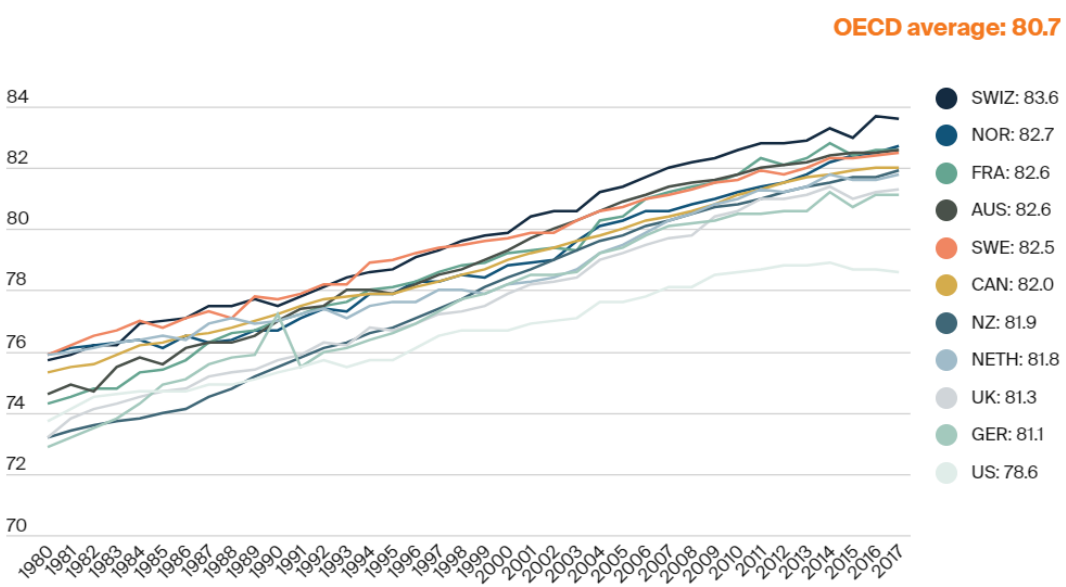
Percent (%) of GDP, adjusted for differences in cost of living
*Legend shows 2018 data**



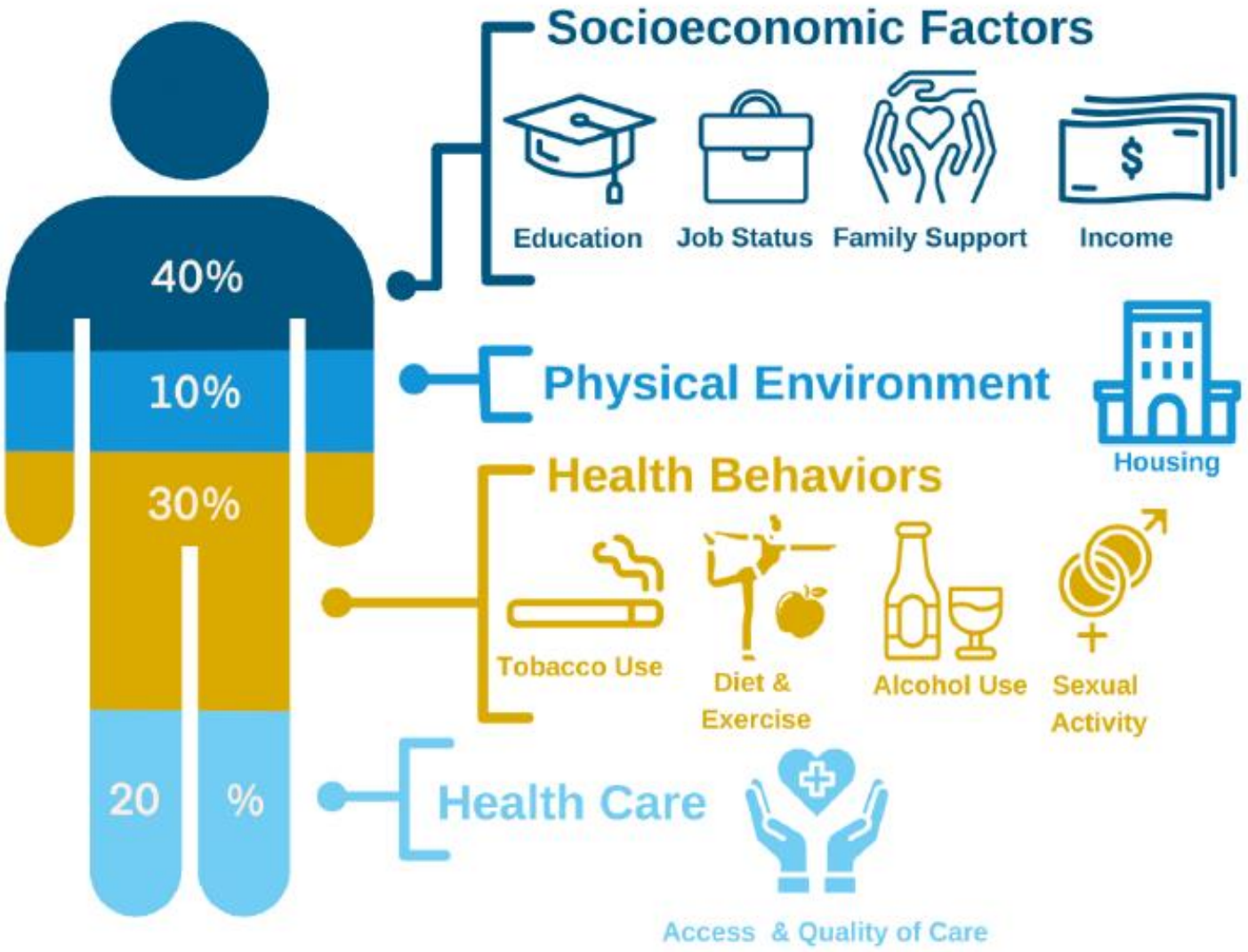
HEALTH OUTCOMES

The U.S. Has the Lowest Life Expectancy

Years
Legend shows 2017 data



Social Drivers of Health (SDOH) is 20 Years Old Too!

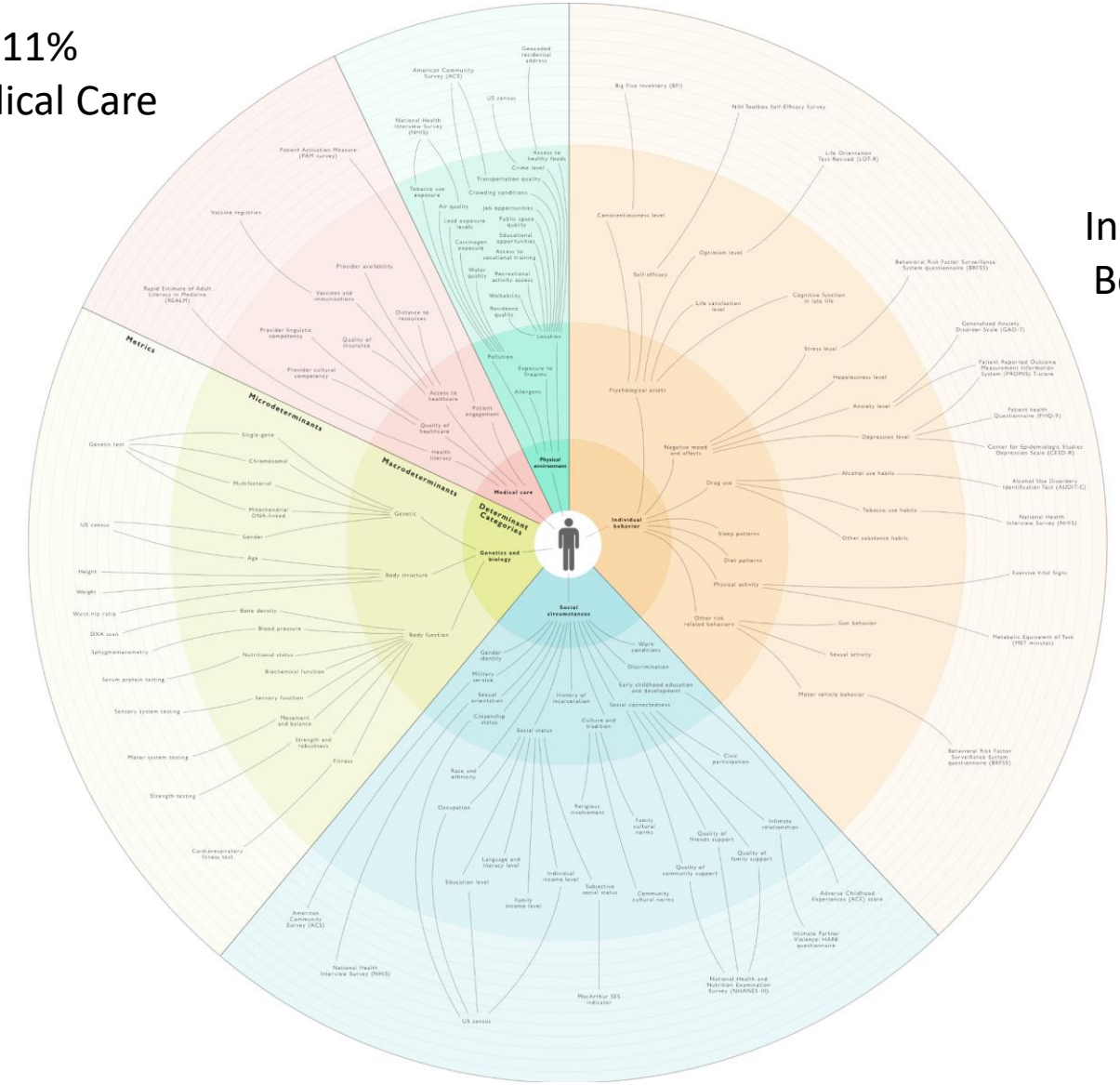


WHO 2003

7%
Physical Environment

11%
Medical Care

36%
Individual Behavior



22%
Genetics
and
Biology

24%
Social Circumstances

Healthy People 2030

“Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.”

What are Social Drivers of Health?

The non-medical factors that influence health outcomes

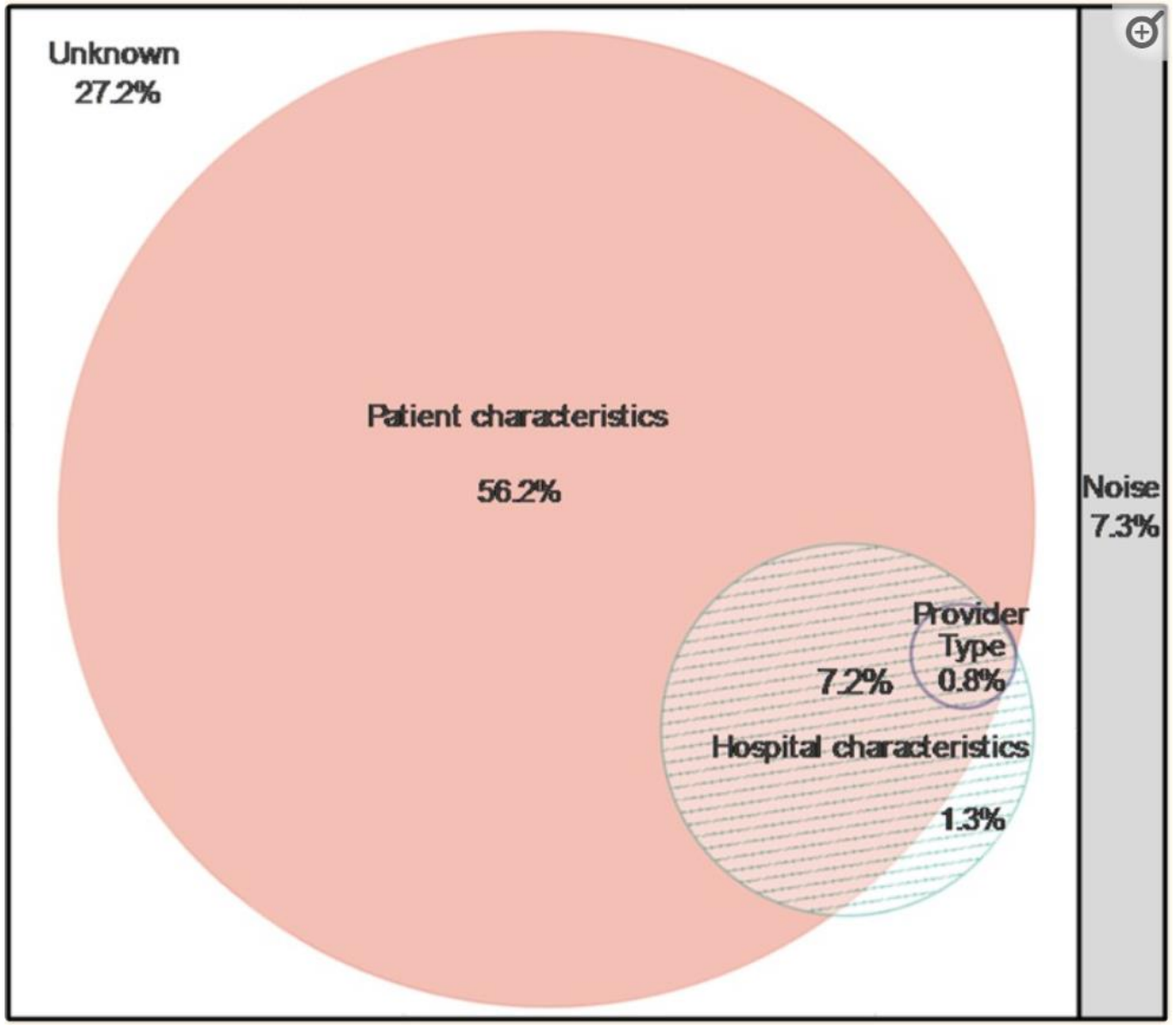
They are the conditions in which people are born, grow, work, live, and age

They are the wider set of forces and systems that shape the conditions of daily life

End Goal:
Getting it Right
Every Patient Every Time

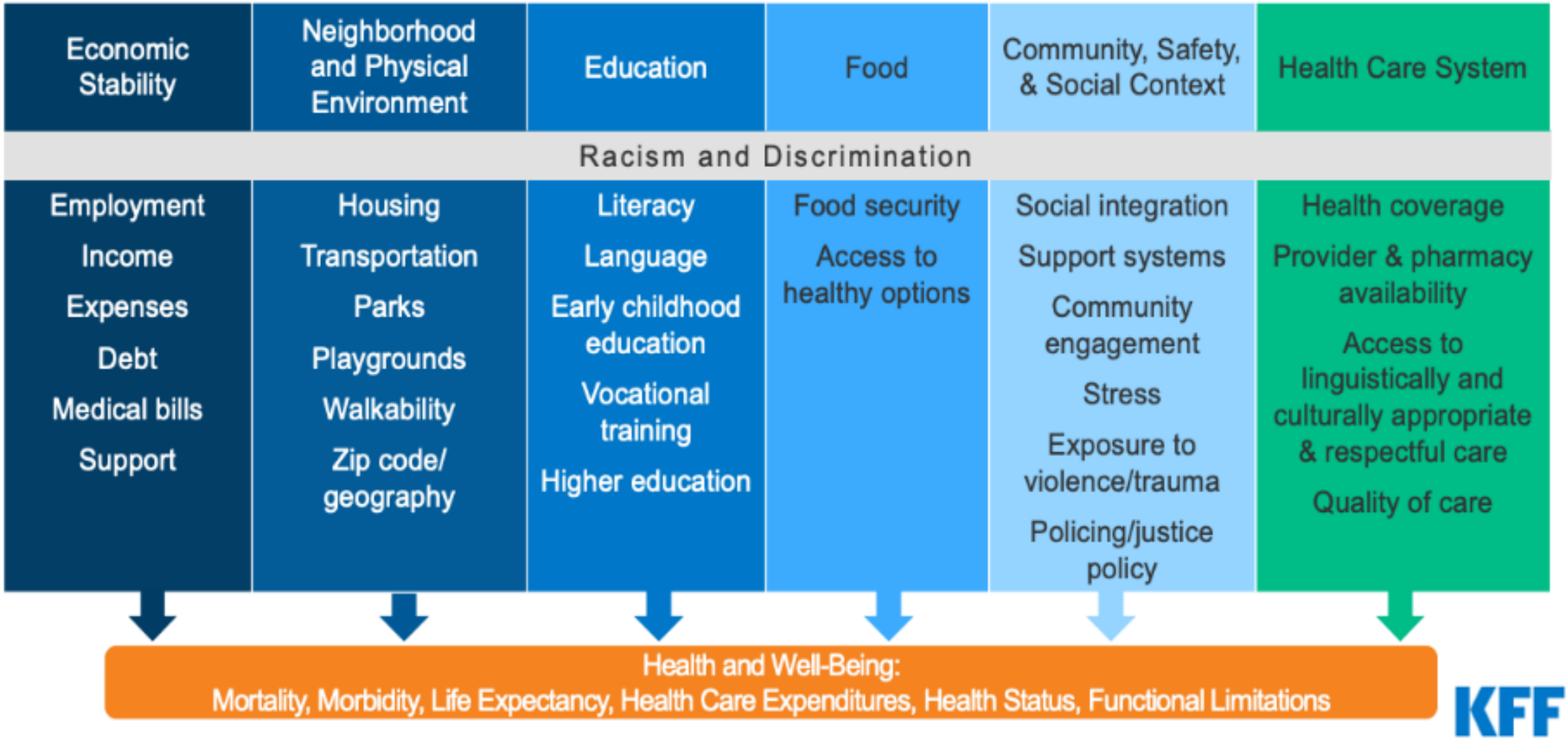
Variation in the Risk of Readmission Among Hospitals: The Relative Contribution of Patient, Hospital and Inpatient Provider Characteristics

J Gen Intern Med



Why Does it Matter in Value-Based Care?

Health Disparities are Driven by Social and Economic Inequities



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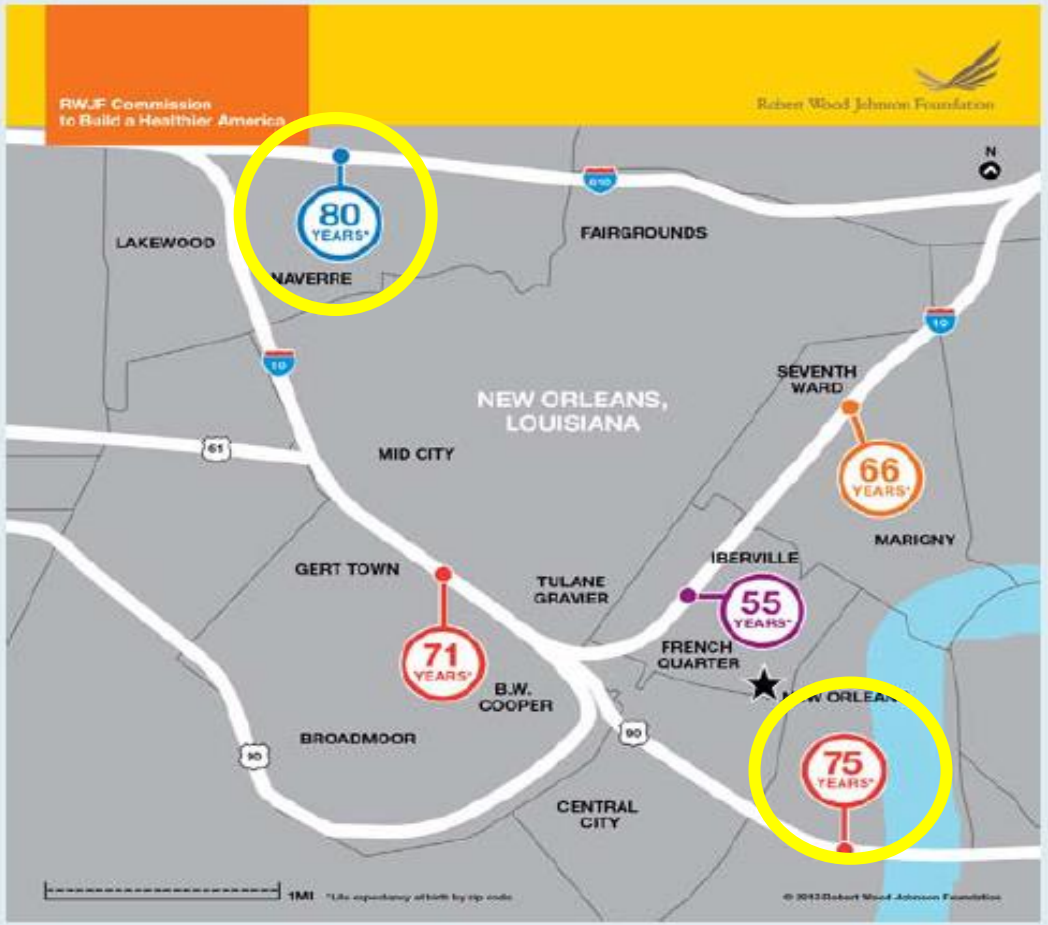
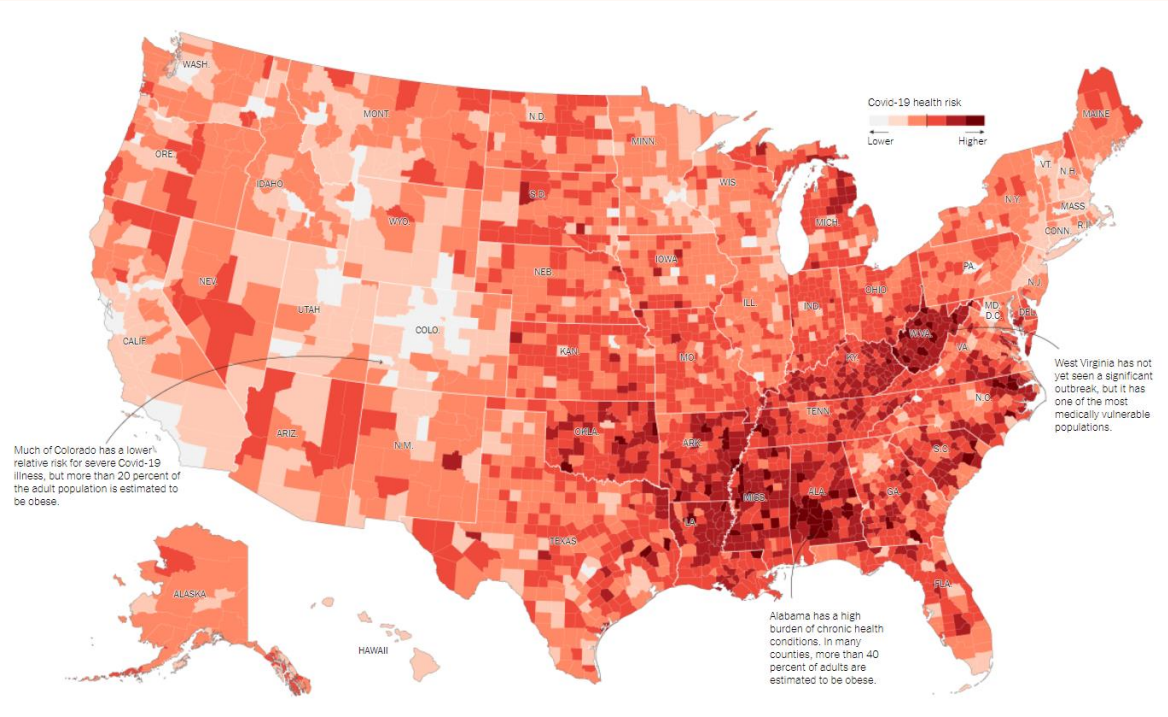
Zip Code Matters



Chronic Disease and Environment



38% OF US DEATHS ARE ATTRIBUTABLE TO 4 BEHAVIORS:

SMOKING

POOR DIET

PHYSICAL INACTIVITY

ALCOHOL USE.

$730.4 BILLION

SOURCE: THE LANCET Health-care spending attributable to modifiable risk factors in the USA: an economic attribution analysis 2020

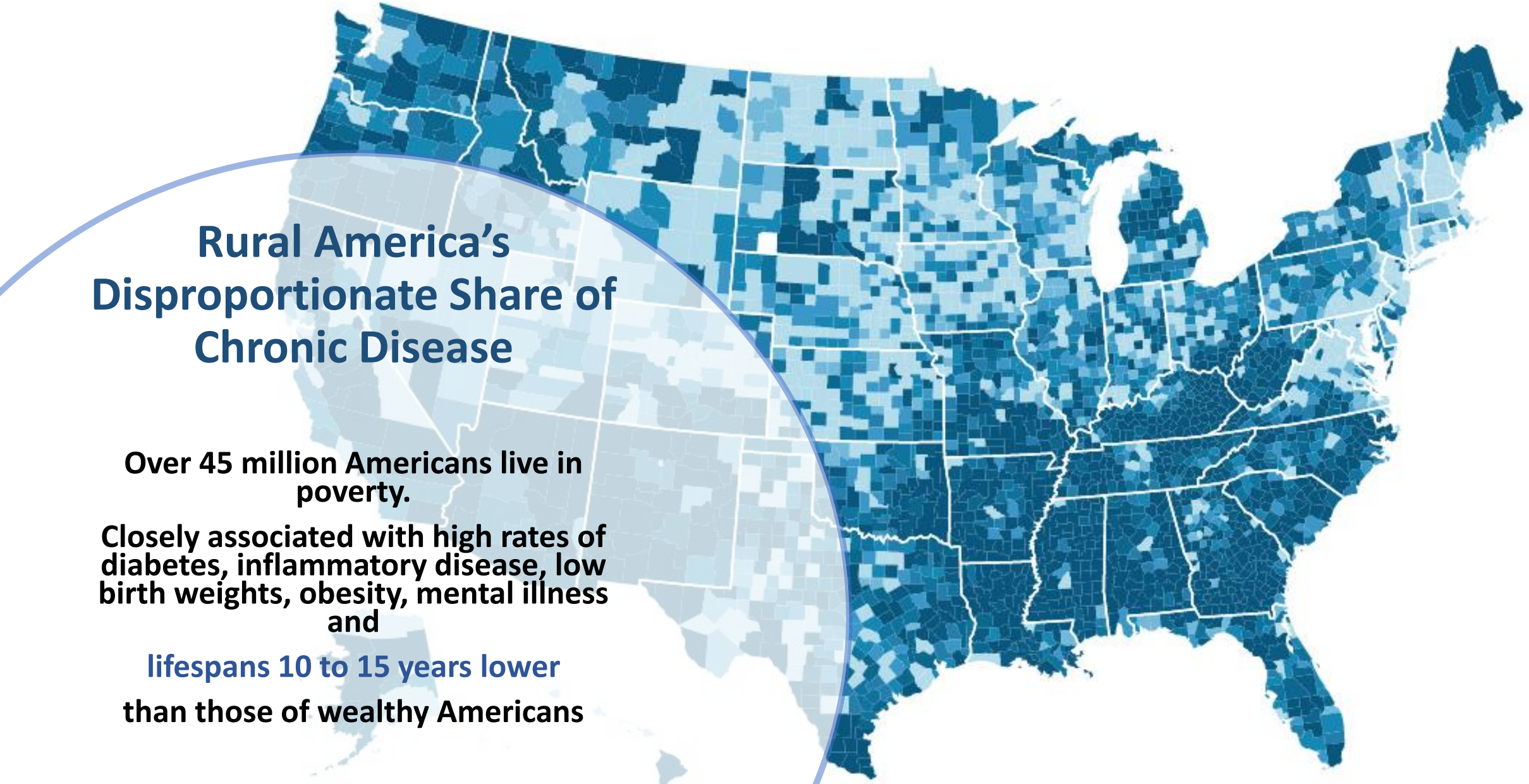
Rural America's Disproportionate Share of Chronic Disease

Over 45 million Americans live in poverty.

Closely associated with high rates of diabetes, inflammatory disease, low birth weights, obesity, mental illness and

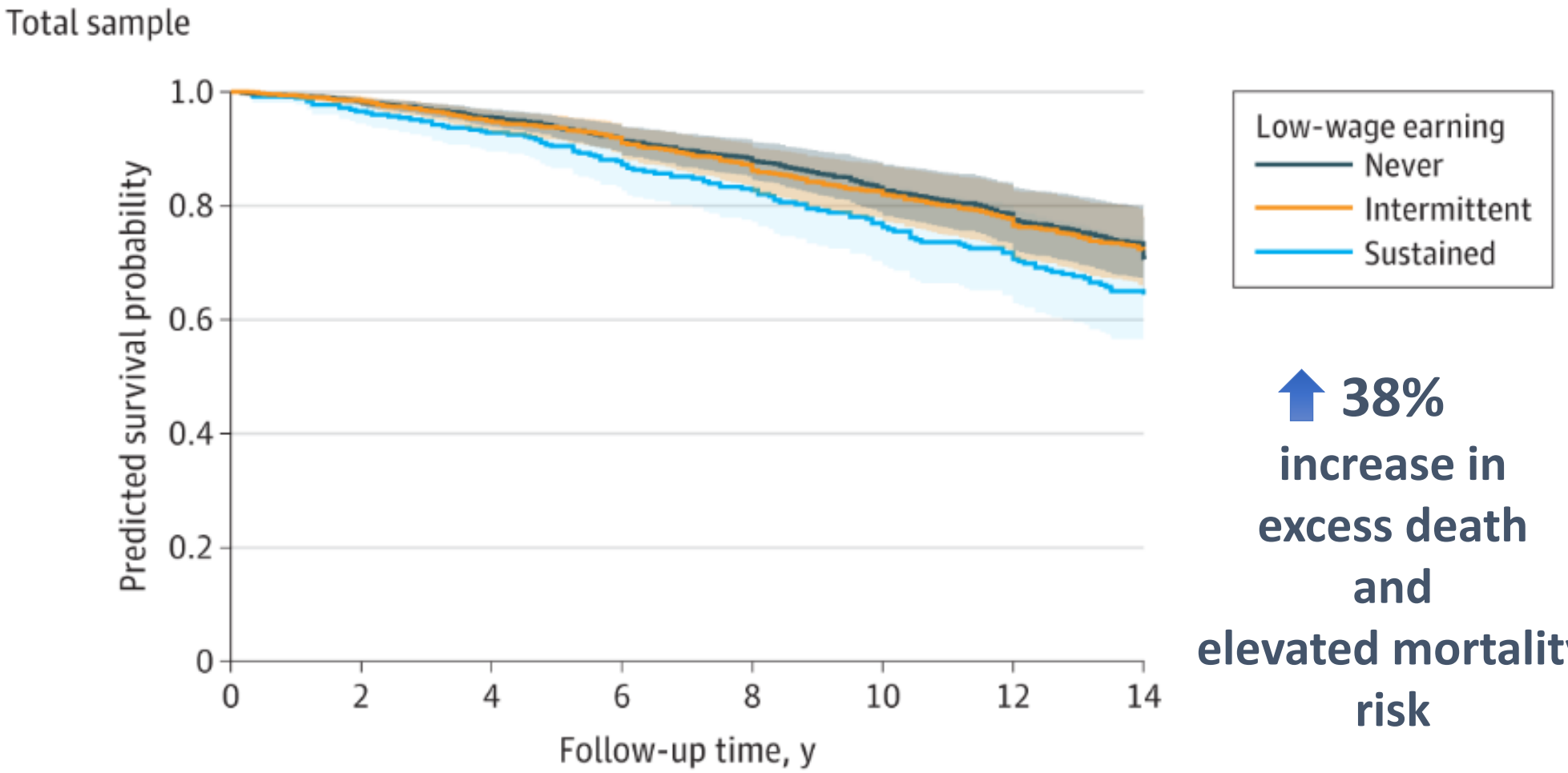
lifespans 10 to 15 years lower

than those of wealthy Americans



Map Source: https://www.povertyusa.org/data

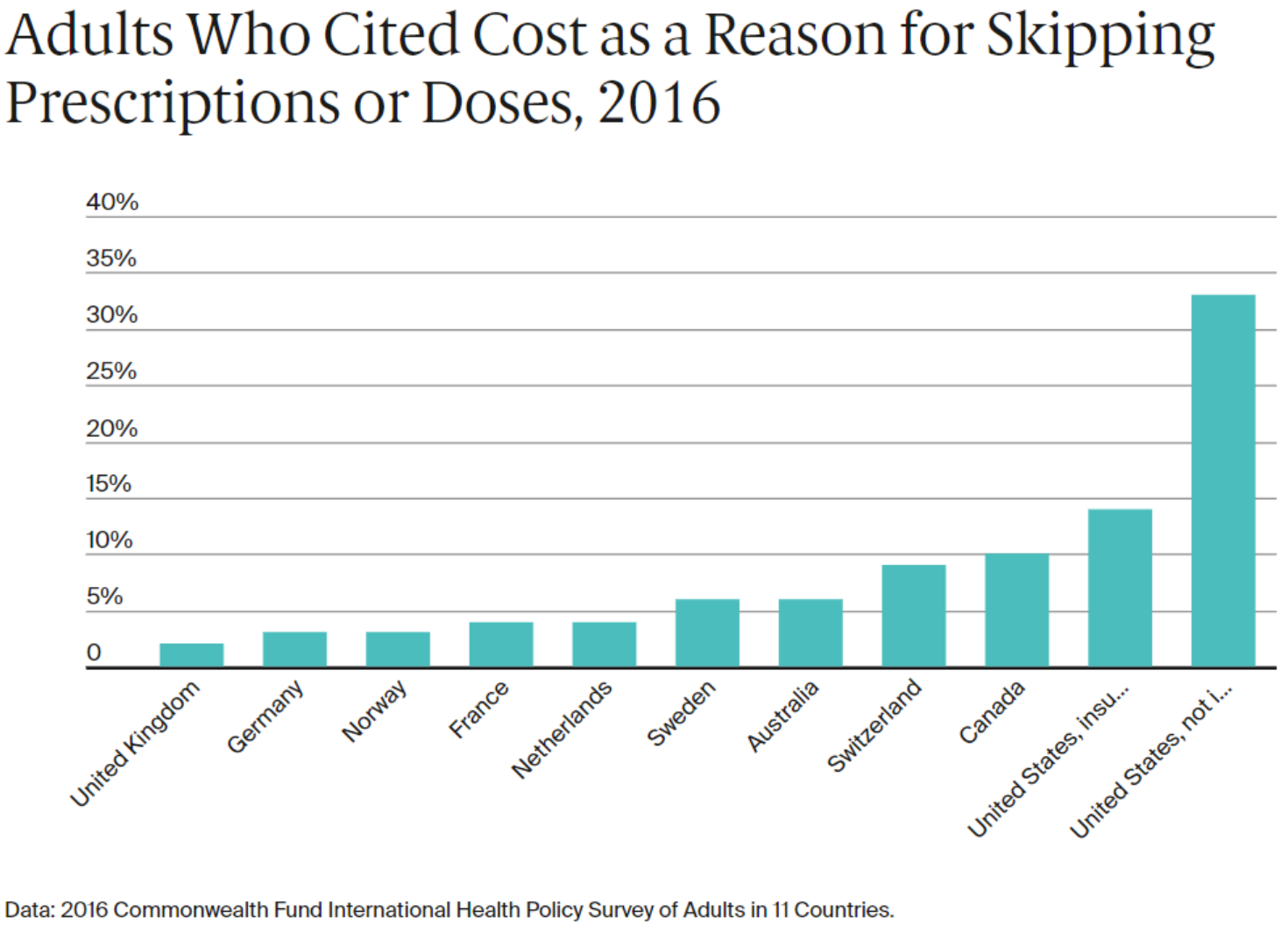
Low Wages and Longevity



38%
increase in excess death and elevated mortality risk

Source: JAMA February 21, 2023 **History of Low Hourly Wage and All-Cause Mortality Among Middle-aged Workers**

Affordability is an Access Issue



33% Patients in US Can't Afford Their Medications

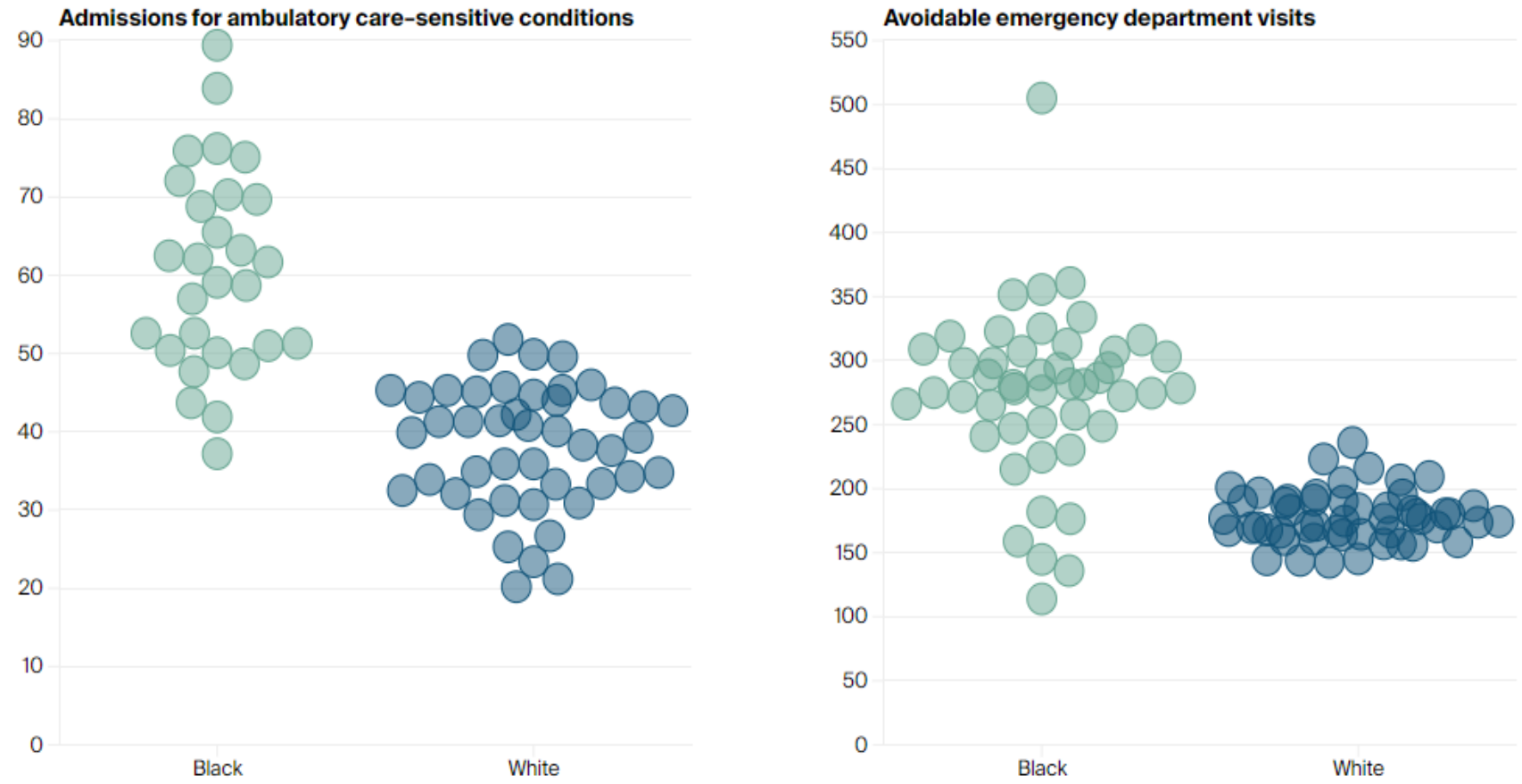
Inequity's Impact

- [Achieving Racial and Ethnic Equity in U.S. Health Care: Scorecard | Commonwealth Fund]

Black Medicare beneficiaries are more likely than white beneficiaries to be admitted to a hospital or to seek care in an emergency department for conditions typically manageable through good primary care.

Per 1,000 Medicare beneficiaries

All



Notes: Dots represent states. Missing dots for a particular group indicates that there are insufficient data for that state. Race data only available for Black and white populations—ethnicity is unknown.

Data: Centers for Medicare and Medicaid Services, 2019 Limited Data Set (LDS) 5% sample. Analysis by Westat.

Burden by **Racial & Ethnic Minority Groups**

Black/African American ○	$310B	69%
Hispanic/Latino □	$94B	21%
American Indian/ Alaska Native ⌘	$26B	6%
Native Hawaiian/ Pacific Islander ◊	$12B	3%
Asian △	$8B	2%

Burden by **Economic Components** and Racial & Ethnic Minority Groups

Excess Premature Deaths $293B

65%

Asian

Lost Labor Market Productivity $81B

18%

All other ethnicities

Excess Medical Care Costs $77B

17%

All other ethnicities

The Solution Will Take the Work of Many Hands

"While COVID has been the driving force behind **high rates of excess deaths** across the U.S., states with historically strong health systems

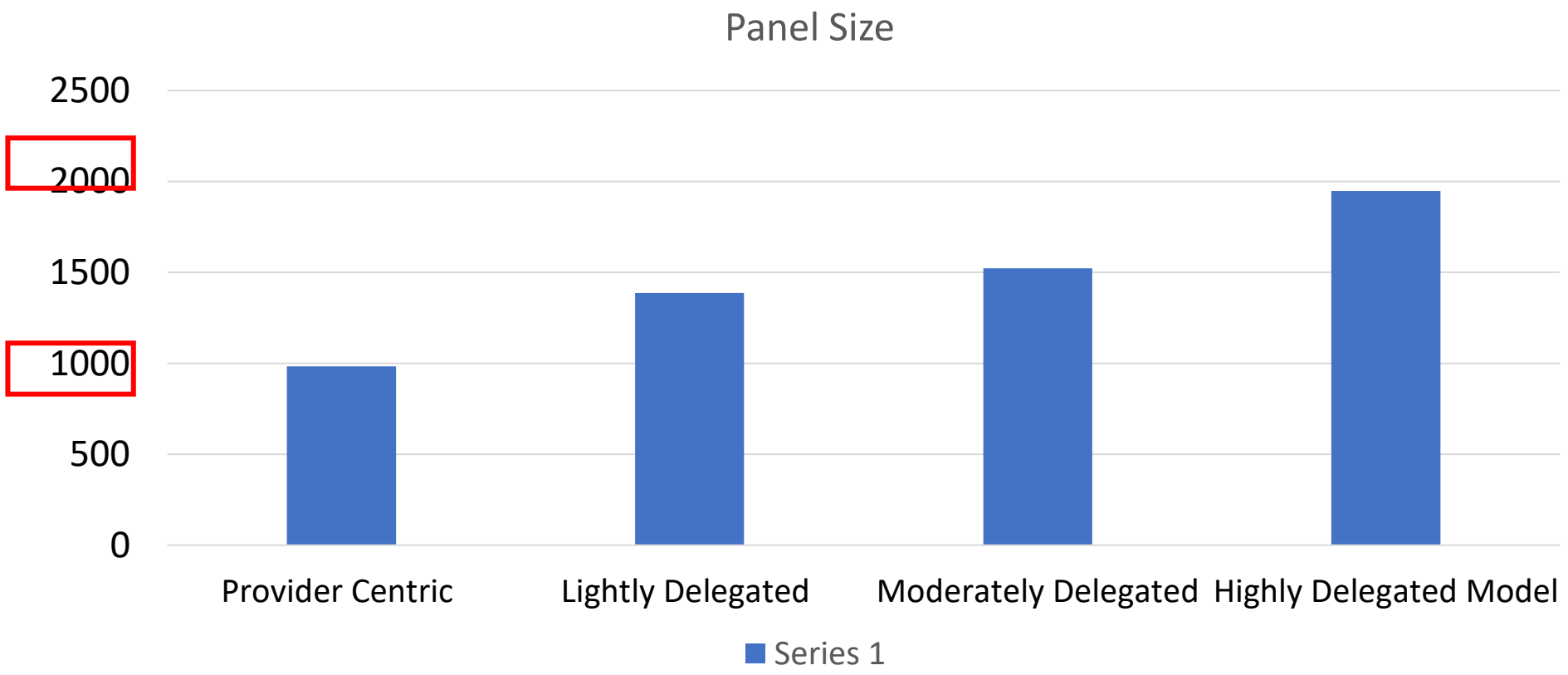
Value-Based Care

generally had **lower rates than states with weaker health systems**."

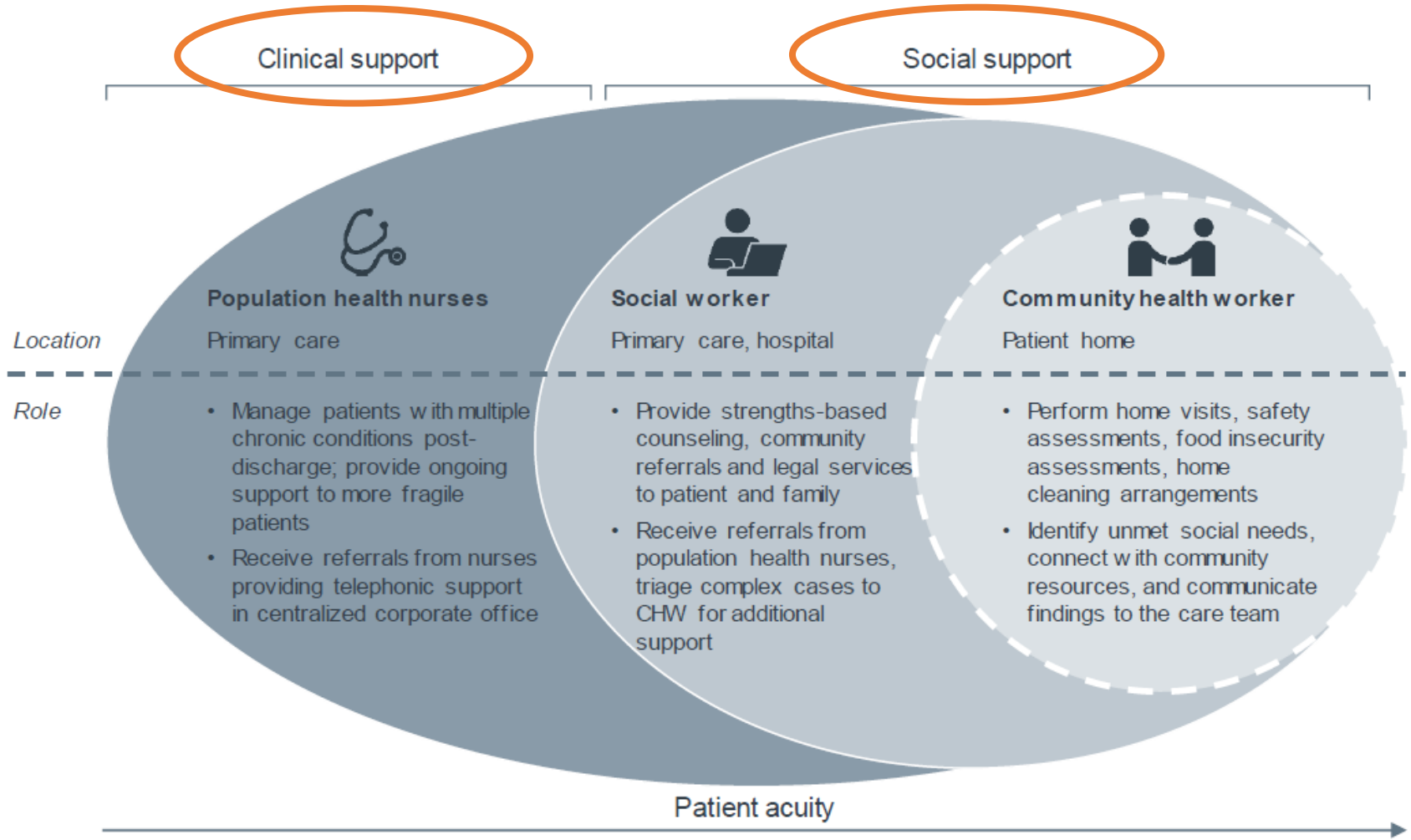
Commonwealth Fund

2022

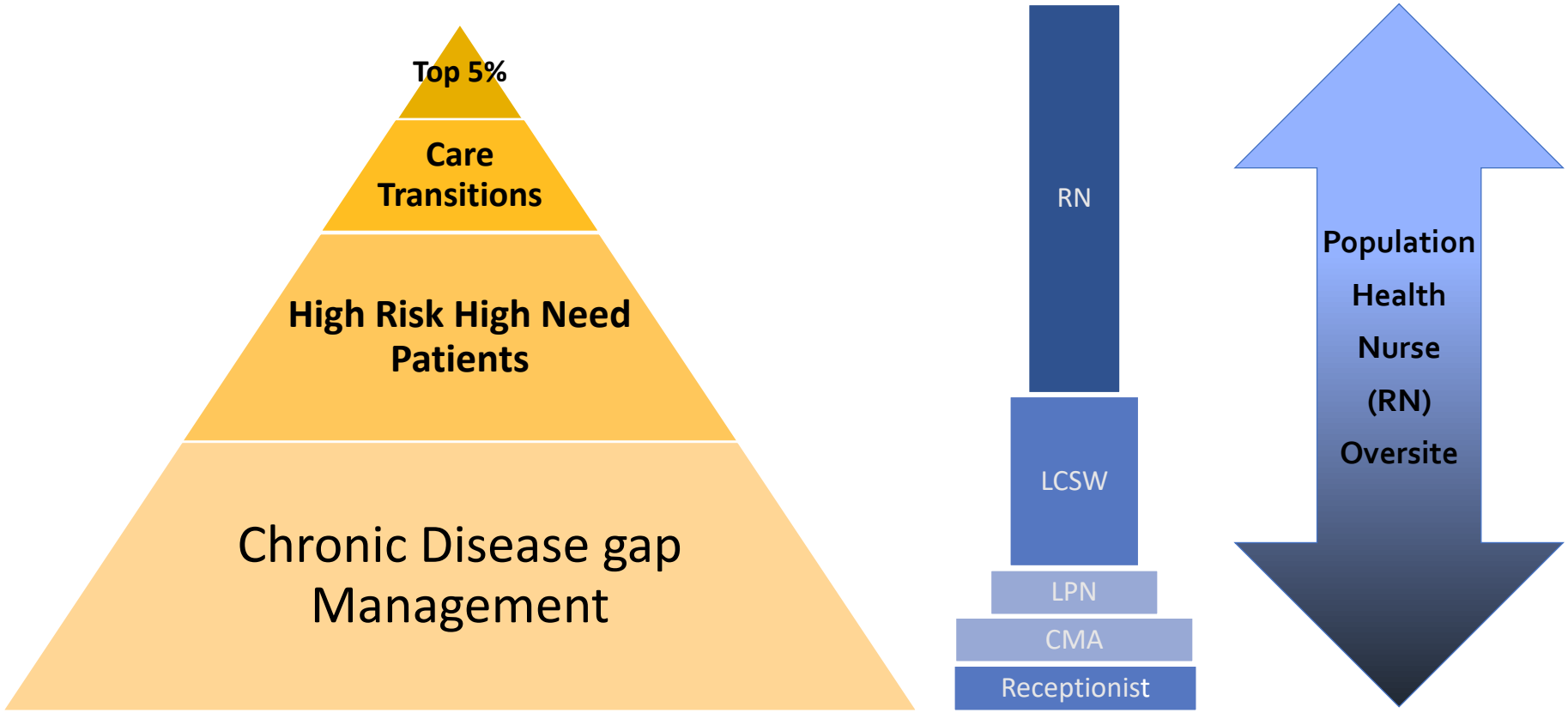
Teams Double Physician Capacity and Improve Access



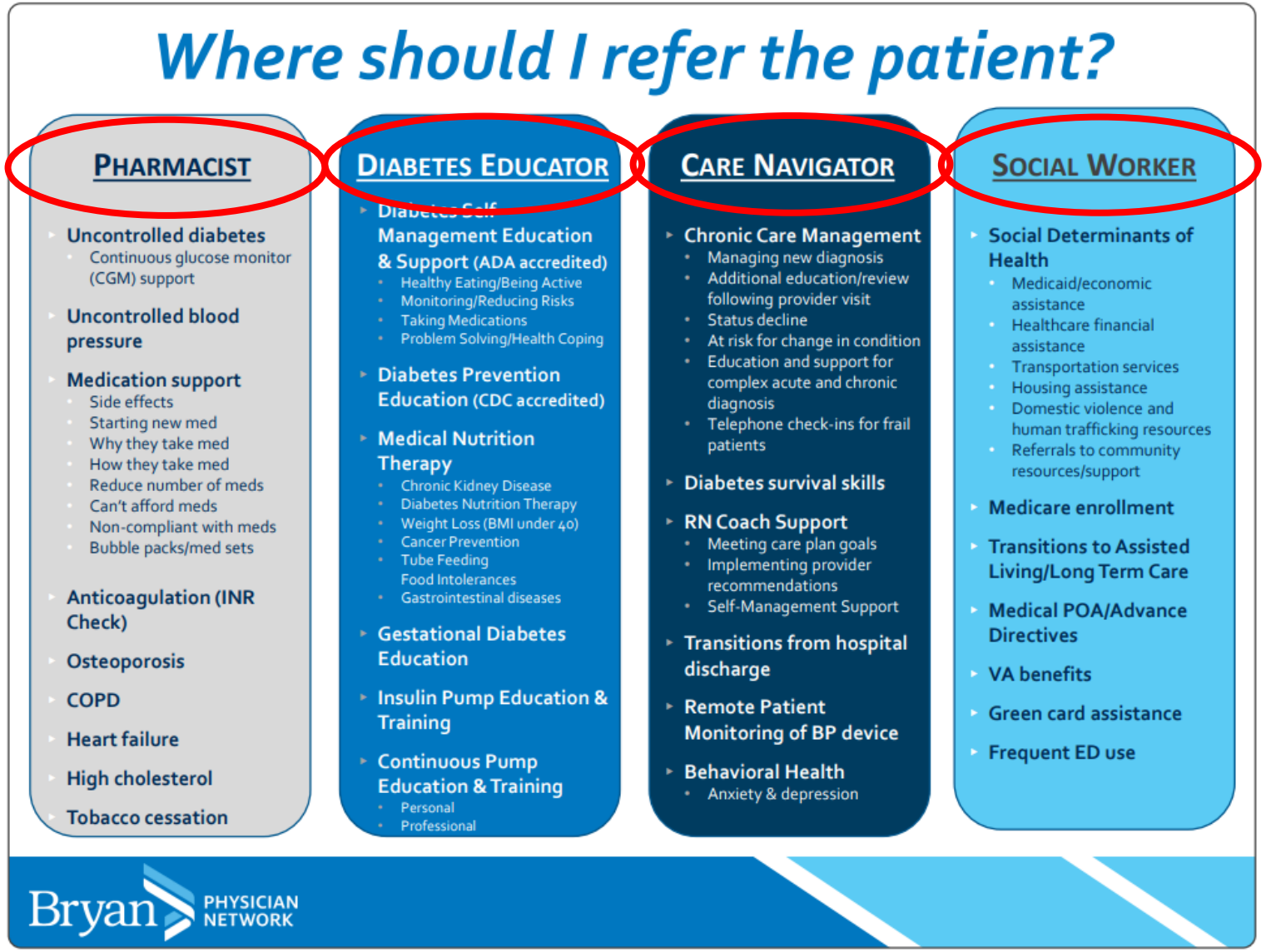
Expanding Beyond a Traditional Team is Essential



Delegating Work to “Top of License” to Achieve Triple Aim

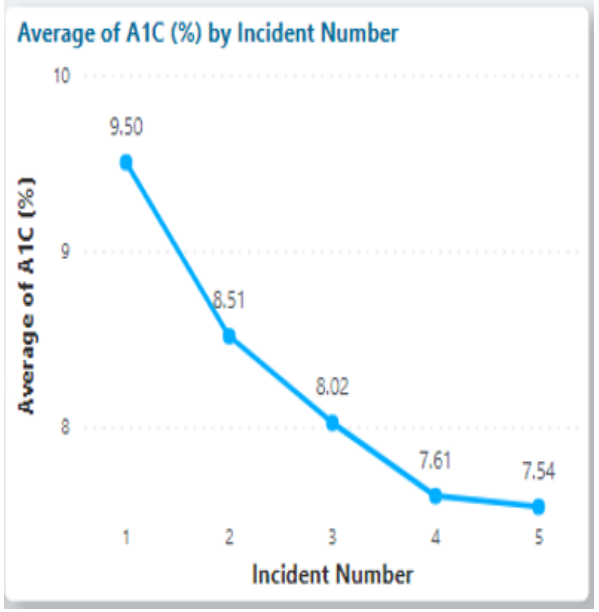


The Work of Many Hands Lightens the Chronic Disease Load



Quality and Value: Promoting Team-Based Care

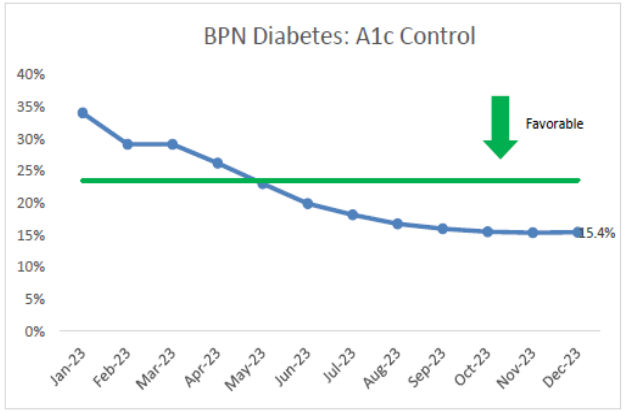
Diabetes Center of Excellence

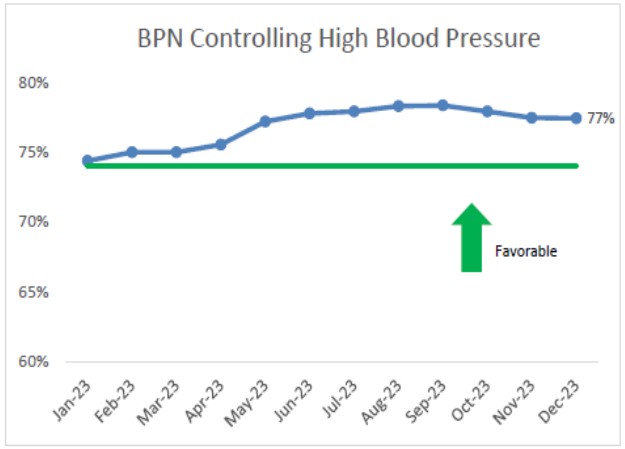


Unique Patients: 100

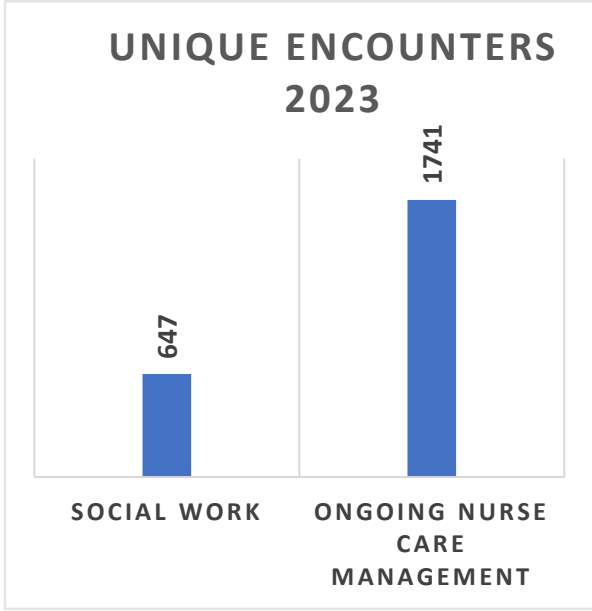
Encounters: 375

Pharmacy Impact

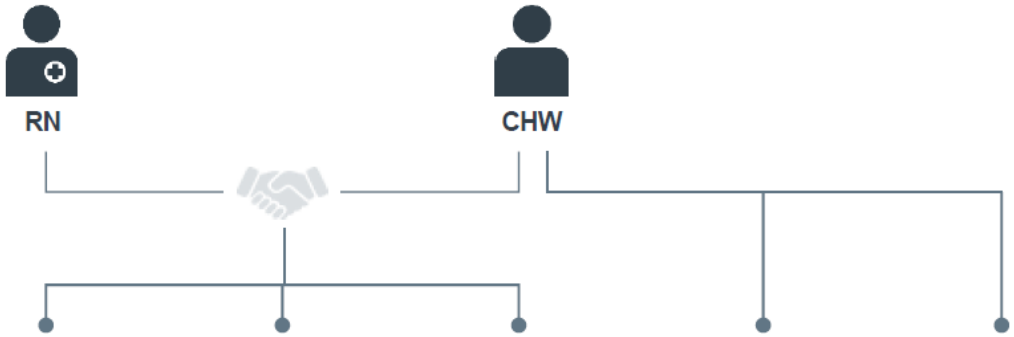




Care Management Outreach



Complex Care dyad relies on CHW to extend RN reach across rural service area



Location	**Hospital**	**Patient's home**	**PCP office**	**Telephone**	**Patient's home**
Role	• RN and CHW meet patient during admission to enroll and build rapport	• Both attend the initial home visit to perform clinical and social needs assessments • Team debriefs and creates care plans with defined next steps	• RN attends first PCP visit one-to-two weeks post-discharge • CHW may attend additional appointments for social and emotional support	• CHW touches base with patient weekly to check on progress and cement patient education	• CHW performs additional home visits as needed to address patient's non-clinical needs • CHW facilitates tele-visit with RN over an iPad to assess clinical status

58%
Reduced inpatient admissions[1]

30%
Reduced observation hospital visits[1]

31%
Reduced emergency department visits[1]

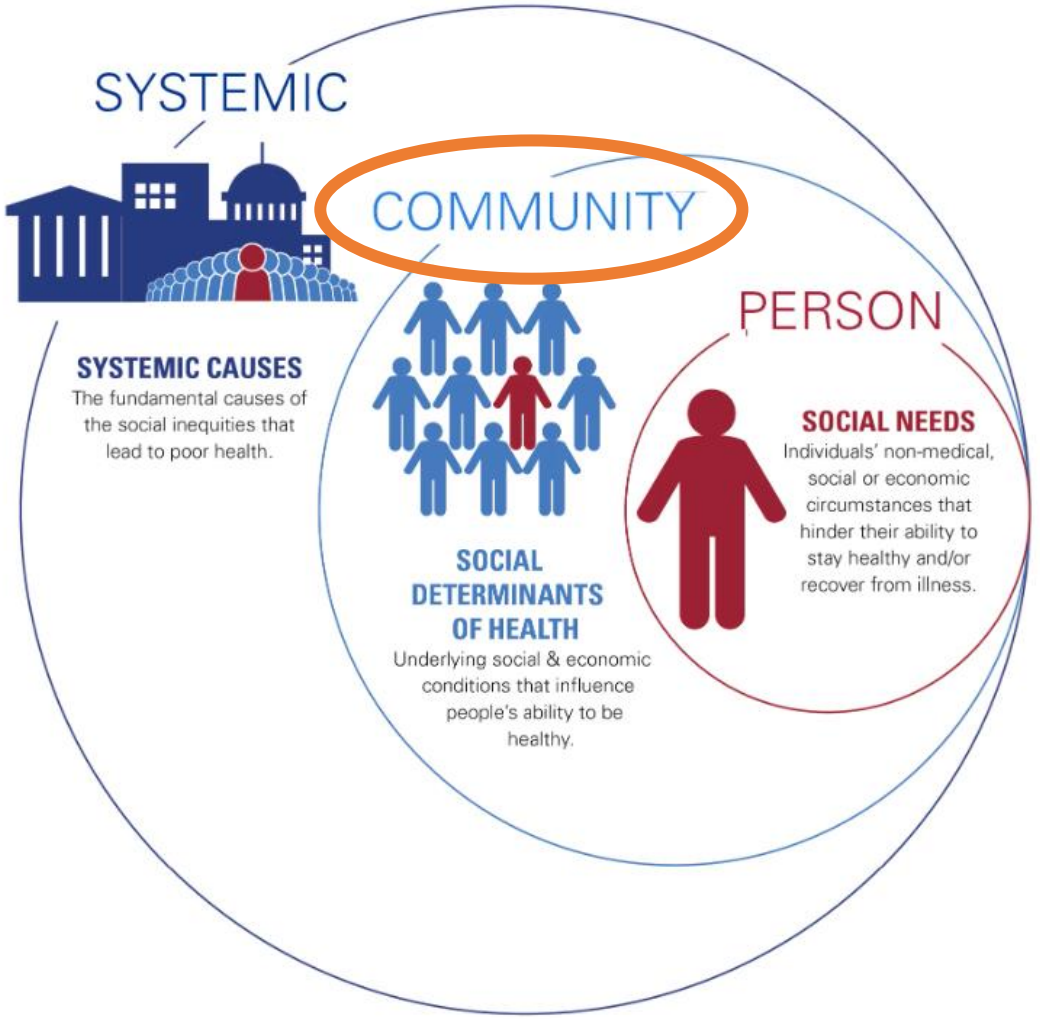
Community Health Worker Programs Reduce Unnecessary Utilization…and Financial Losses

Advisory Board

Where Do You Start?

Precision
&
Control

Societal Factors That Influence Health: A Framework for Hospitals



[Societal Factors That Influence Health | AHA]

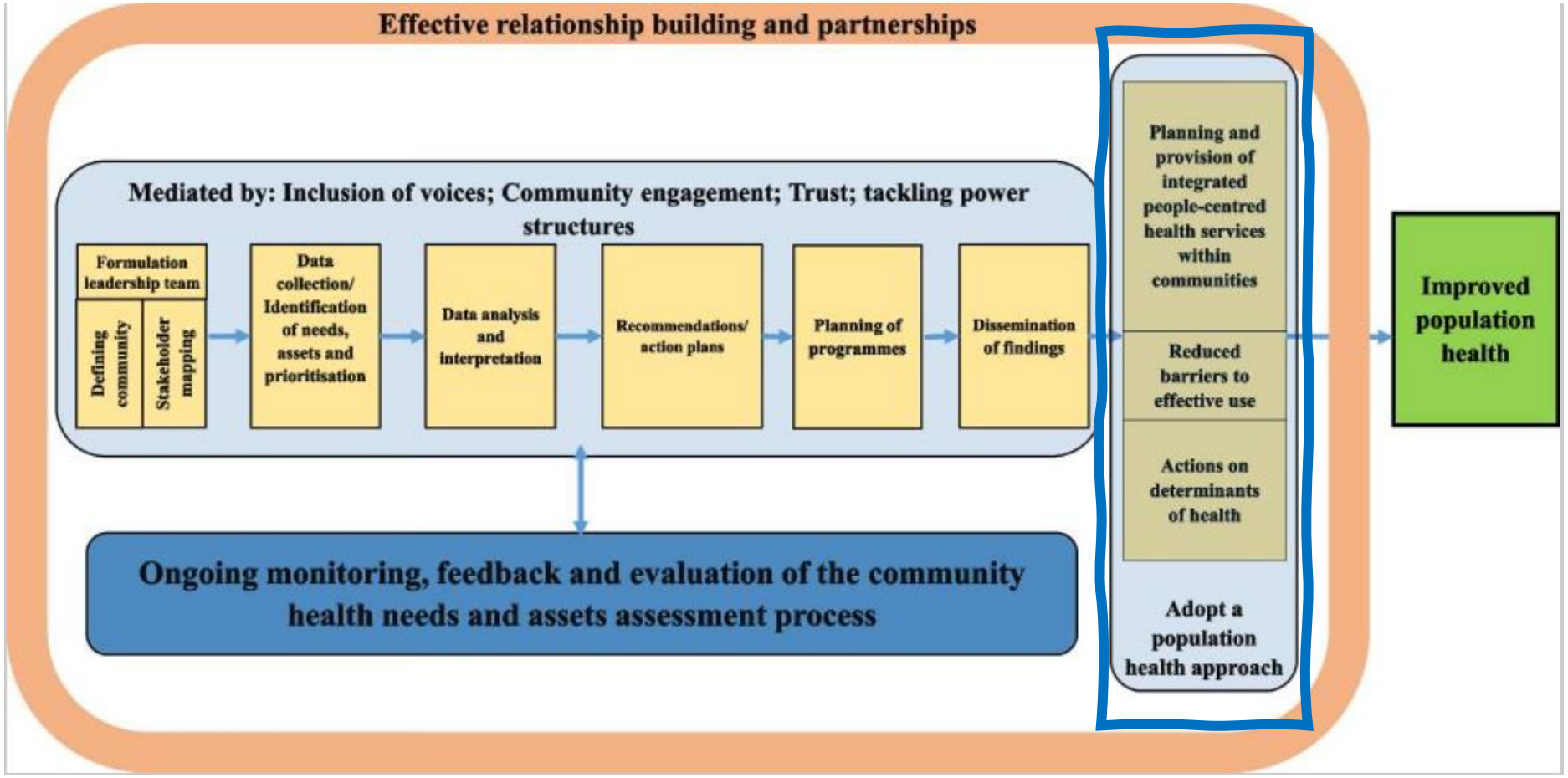
You Have Already Started Down the SDOH Path

"Empowering community members in decision-making at the health system level mirrors a fundamental tenet of the *person-centered care* model, which places the preferences of patients and families at the center of all care decisions."

Center for Healthcare Strategies

[Shifting the Power Balance: Creating Health System Accountability through Trusted Community Partnerships (chcs.org)]
[Community Health Assessment Toolkit | ACHI (healthycommunities.org)]

Community Health Needs Assessments – ACA 2011



Have You Made Good Use of the CHNA?

99% Reported on IRS 990 form that they had completed

60% had a published CHNA and a corresponding strategy online

Source: JAMA US Nonprofit Hospitals' Community Health Needs Assessments and Implementation Strategies in the Era of the Patient Protection and Affordable Care Act | Health Policy | JAMA Network Open | JAMA Network

Do you have a CHNA Team that meets regularly?

Table 1. CHNA and Implementation Strategy Documentation Elements as Required by the Internal Revenue Service

Documentation	Requirements
CHNA	A definition of the community served by the hospital facility and a description of how the community was determined
	A description of the process and methods used to conduct the CHNA
	A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves
	A description of the medically underserved, low-income, or minority populations being represented by organizations or individuals that provided input
	A prioritized description of the significant health needs of the community identified through the CHNA
	A description of resources potentially available to address the significant health needs identified through the CHNA
	An evaluation of impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA
Implementation strategy	The actions the hospital will take to address each health need identified in the CHNA
	The associated resources devoted to and the anticipated impact of each action taken
	Description of the planned collaborations between the hospital and other institutions to address the health need

How Are You Doing?

What was done with your CHNA?

Provider & Staff education?

Board education?

Community education?

Routine Board Agenda?

How have you established a Task Force to Implement a Strategy?

Educate Stakeholders

Evaluate Capabilities

Compile Community Resources

Identified community partnerships

Seek Funding Sources

Improving Awareness is the First Step

[Equity in Medical Health Care | AMA Ed Hub (ama-assn.org)]

CME COURSE

Save to My Courses

Equity in Medical Health Care

Health care in America is beset by wide disparities and inequities. Learn how to promote and enhance equity in all health care fields while earning CME credits at your own pace.

CME 19.75 Credits

Community Engagement Spectrum

Inspiring and Igniting Ownership Drives Change

[Community Health Assessment Toolkit | ACHI (healthycommunities.org)]

The Health Equity Roadmap

A national initiative to drive improvement in health care outcomes, health equity, diversity and inclusion.

American Hospital Association

- The Health Equity Roadmap | Equity (aha.org)

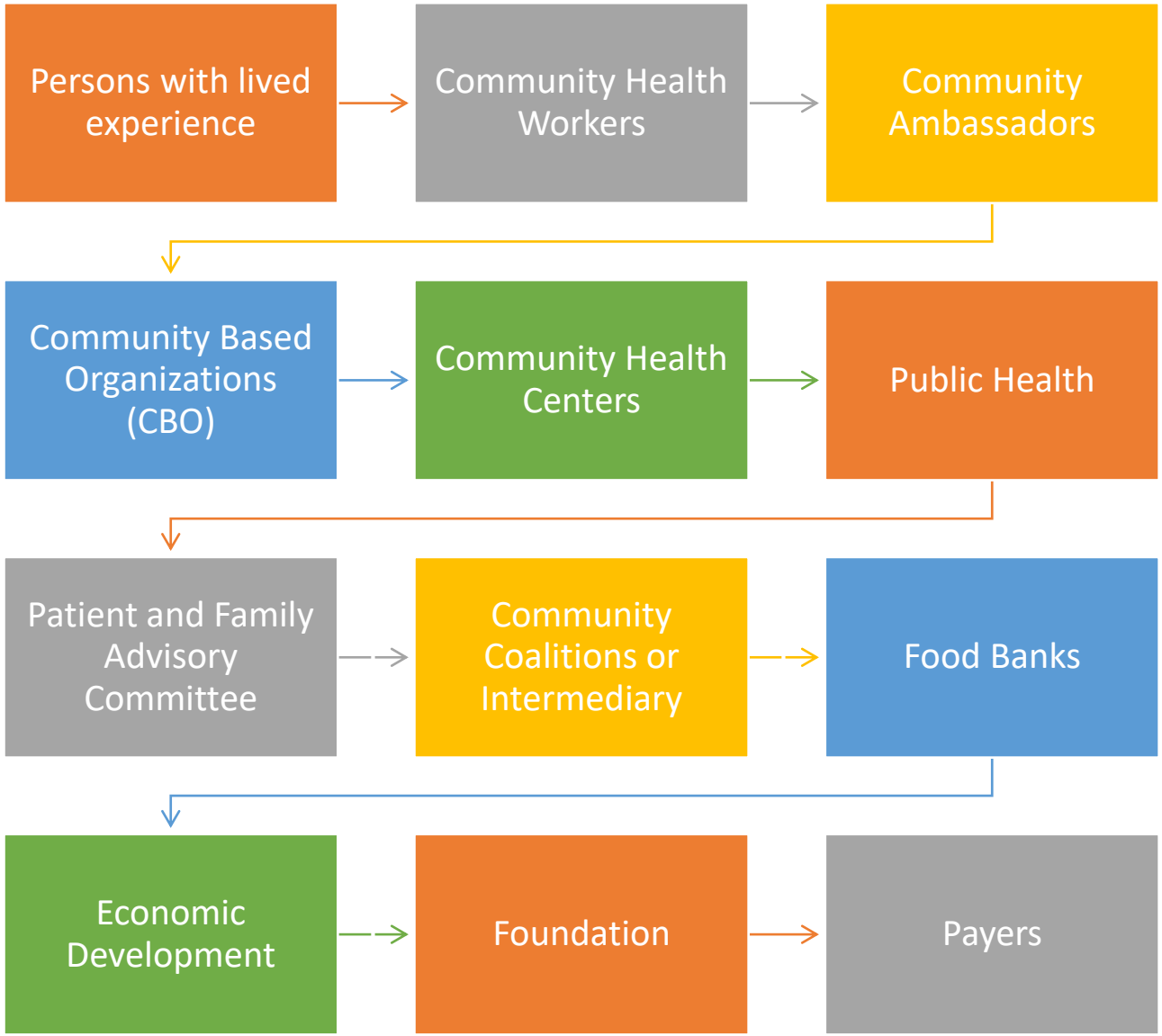
THE SPECTRUM OF COMMUNITY ENGAGEMENT TO OWNERSHIP

Facilitating Power

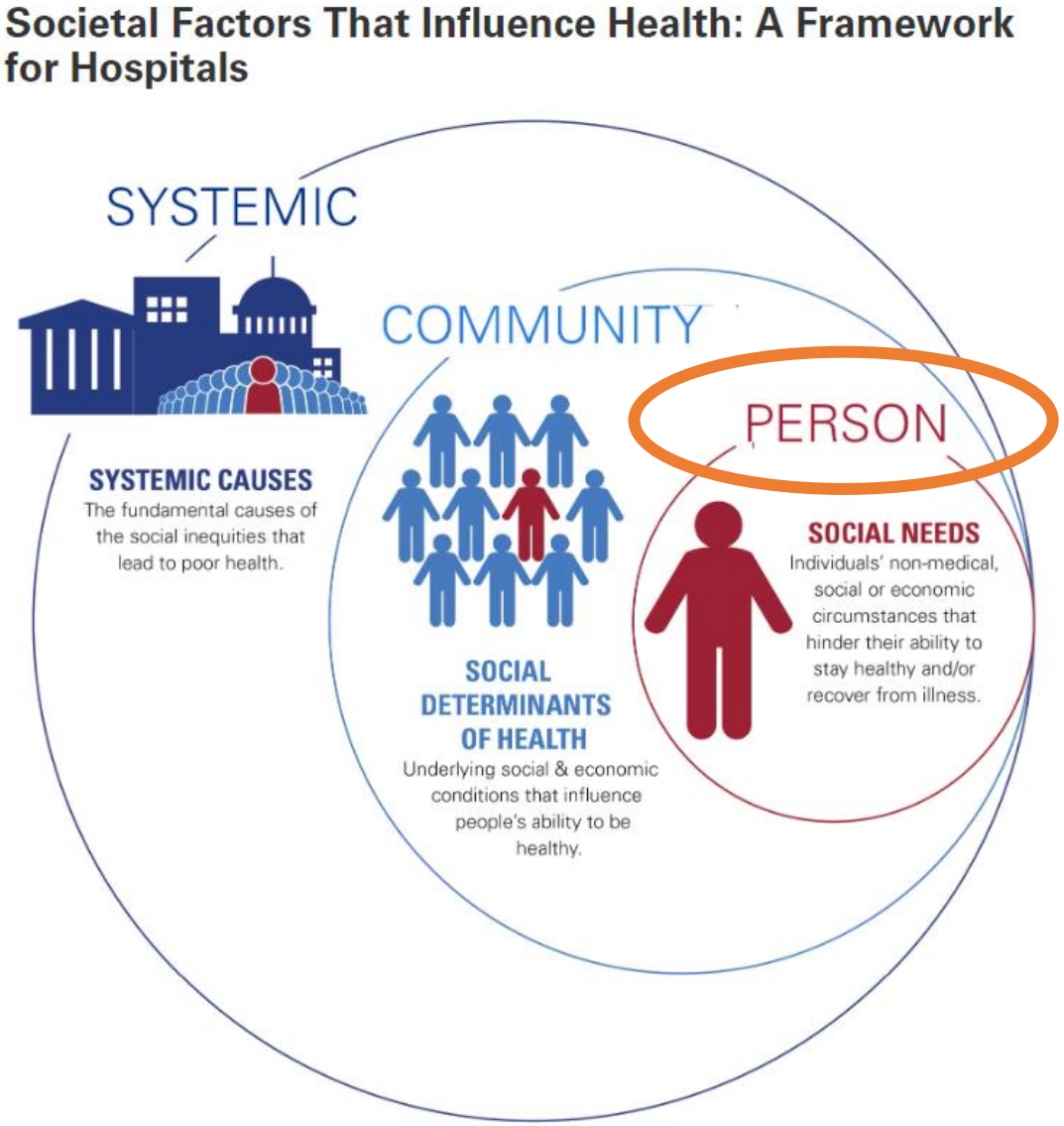
▸▸▸▸▸▸ INCREASED EFFICIENCY IN DECISION-MAKING AND SOLUTIONS IMPLEMENTATION ▸▸▸▸▸▸ EQUITY

STANCE TOWARDS COMMUNITY	0 IGNORE	1 INFORM	2 CONSULT	3 INVOLVE	4 COLLABORATE	5 DEFER TO
IMPACT	**Marginalization**	**Preparation or Placation**	**Limited Voice or Tokenization**	**Voice**	**Delegated Power**	**Community Ownership**
COMMUNITY ENGAGEMENT GOALS	Deny access to decision-making processes	Provide the community with relevant information	Gather input from the community	Ensure community needs and assets are integrated into process & inform planning	Ensure community capacity to play a leadership role in decision-making and the implementation of decisions.	Foster democratic participation and equity through community-driven decision-making; Bridge divide between community & governance
MESSAGE TO COMMUNITY	***Your voice, needs & interests do not matter***	***We will keep you informed***	***We care what you think***	***You are making us think, (and therefore act) differently about the issue***	***Your leadership and expertise are critical to how we address the issue***	***It's time to unlock collective power and capacity for transformative solutions***
ACTIVITIES	Closed door meeting Misinformation Systematic Disenfranchisement Voter suppression	Fact sheets Open Houses Presentations Billboards Videos	Public Comment Focus Groups Community Forums Surveys	Community organizing & advocacy Interactive workshops Polling Community forums Open Planning Forums with Citizen Polling	MOU's with Community-based organizations Citizen advisory committees Collaborative Data Analysis Co-Design and Co-Implementation of Solutions Collaborative Decision-Making	Community-driven planning and governance Consensus building Participatory action research Participatory budgeting Cooperative models
RESOURCE ALLOCATION RATIOS	**100%** Systems Admin	**70-90%** Systems Admin **10-30%** Promotions and Publicity	**60-80%** Systems Admin **20-40%** Consultation Activities	**50-60%** Systems Admin **40-50%** Community Involvement	**20-50%** Systems Admin **50-70%** Community Partners	**80-100%** Community partners and community-driven processes ideally generate new value and resources that can be invested in solutions

Who Do you Need on your SDOH Task Force?



Patient Centered & Personalized

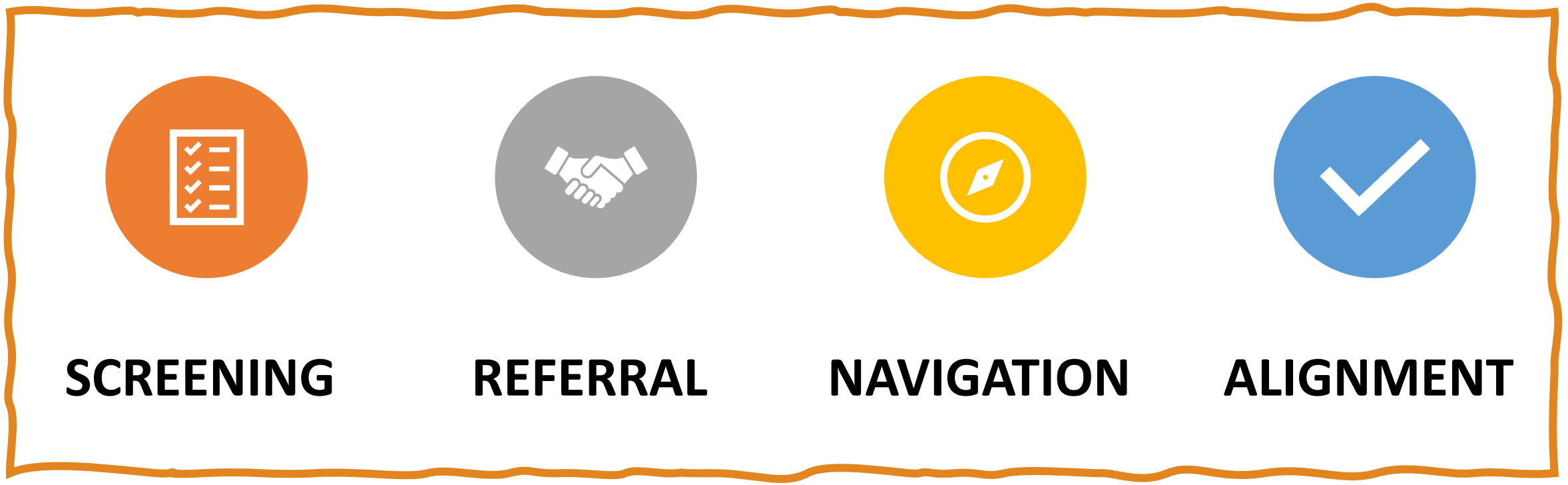


[Societal Factors That Influence Health | AHA]

CMS Accountable Health *Communities* Model

- Testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization
- 28 organizations participating
- 2017-2023 Pilot

CMS Accountable Health Communities Model



CMS Screening Tool - KISS

HOUSING INSTABILITY

FOOD INSECURITY

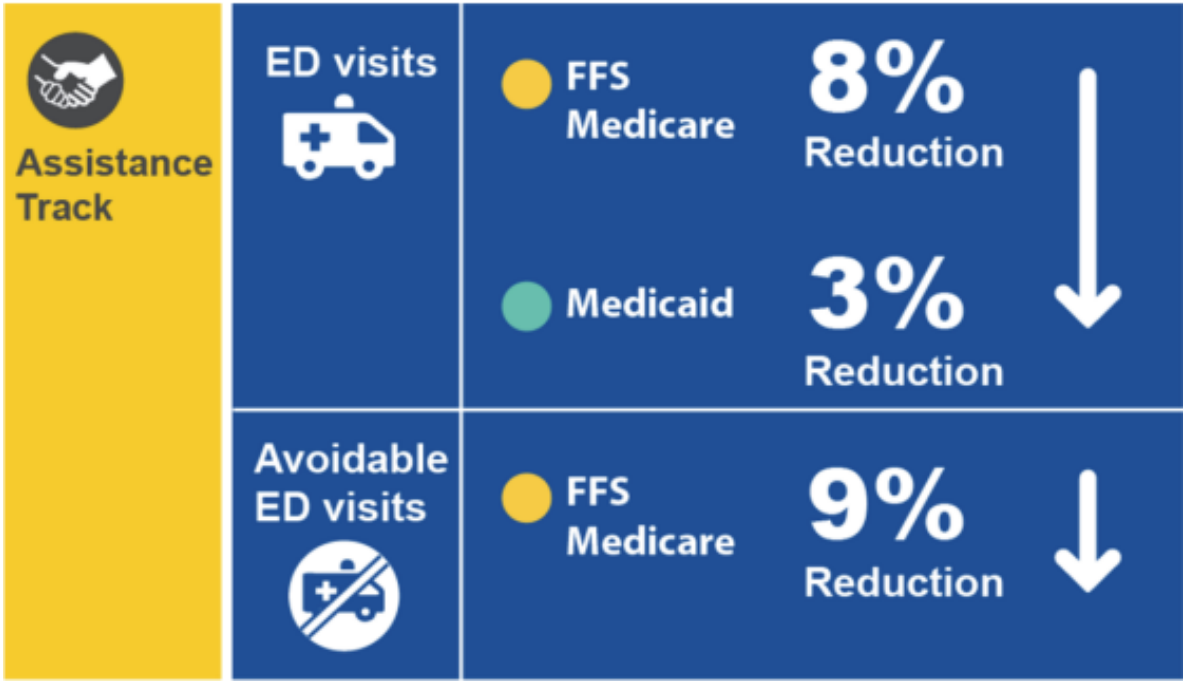
TRANSPORTATION PROBLEMS

UTILITY HELP NEEDS

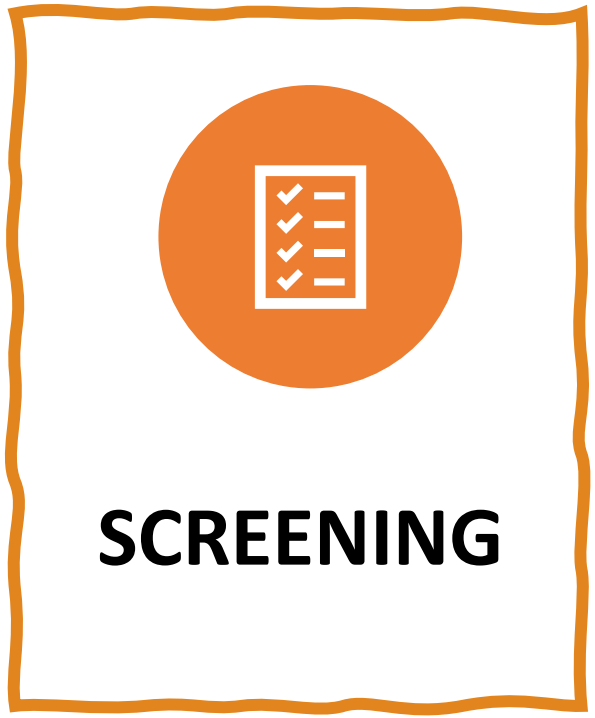
INTERPERSONAL SAFETY

[The AHC Health-Related Social Needs Screening Tool (cms.gov)]

Early Results



CMS Accountable Health Communities Model



SCREENING

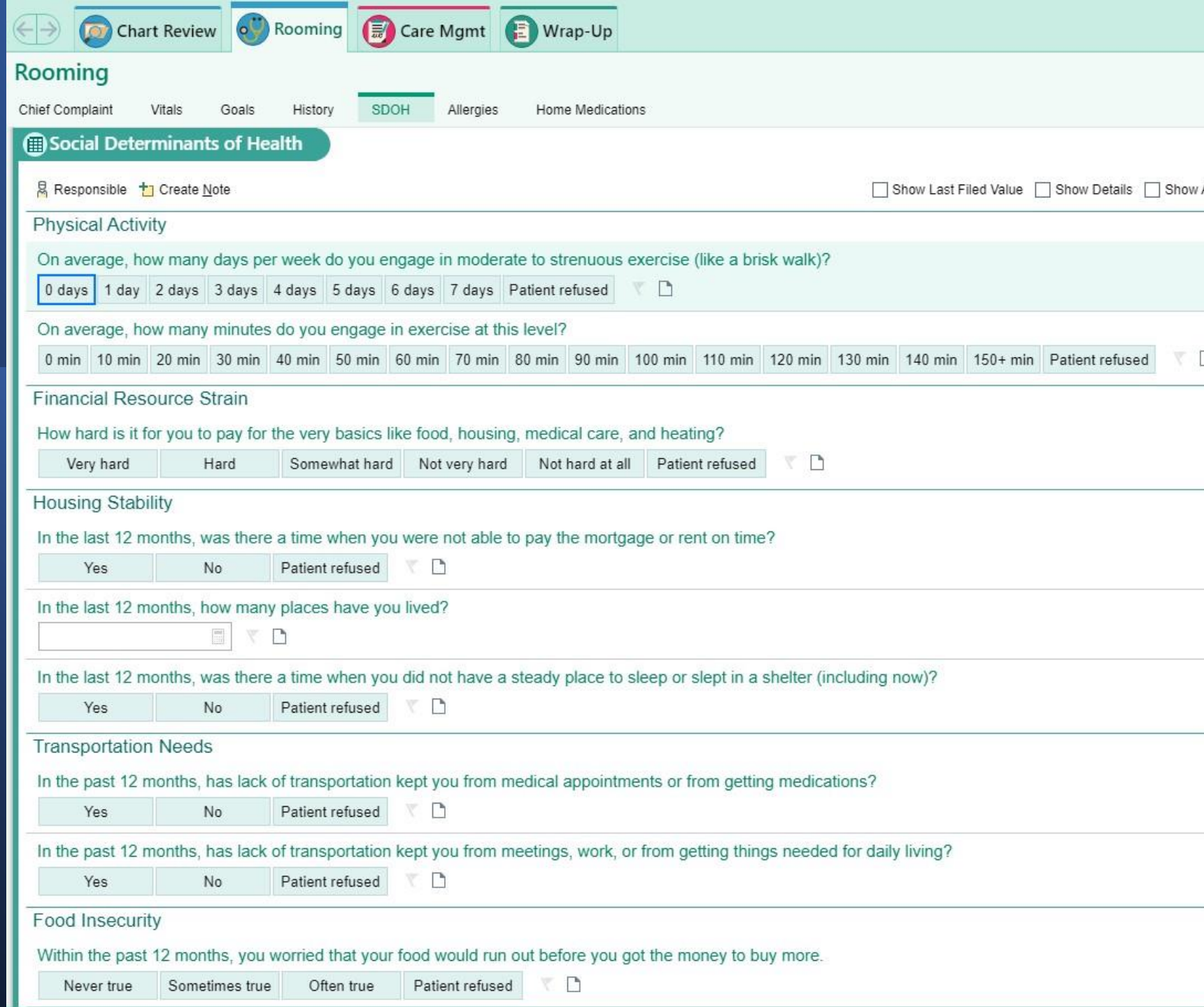
REFERRAL

NAVIGATION

ALIGNMENT

SDOH-Screening and Intervention

Screening for SDOH



SDOH-Screening and Intervention Process

Screening

- Identify a screening tool that works for you
- Screen all patients at least once per year at their annual visit or more often
- Additional screenings for high-risk patients with frequent ER visits or identified as not following care plan

Action for patients screening positive

- Identify barriers and needs
- Provide resources if low risk
- Refer to social work
- Additional referrals if needed:
  - Care team (pharmacy, care navigation)
  - Community based organization
  - Mental health
  - Other

Referral – Navigation – Alignment

Closing the loop

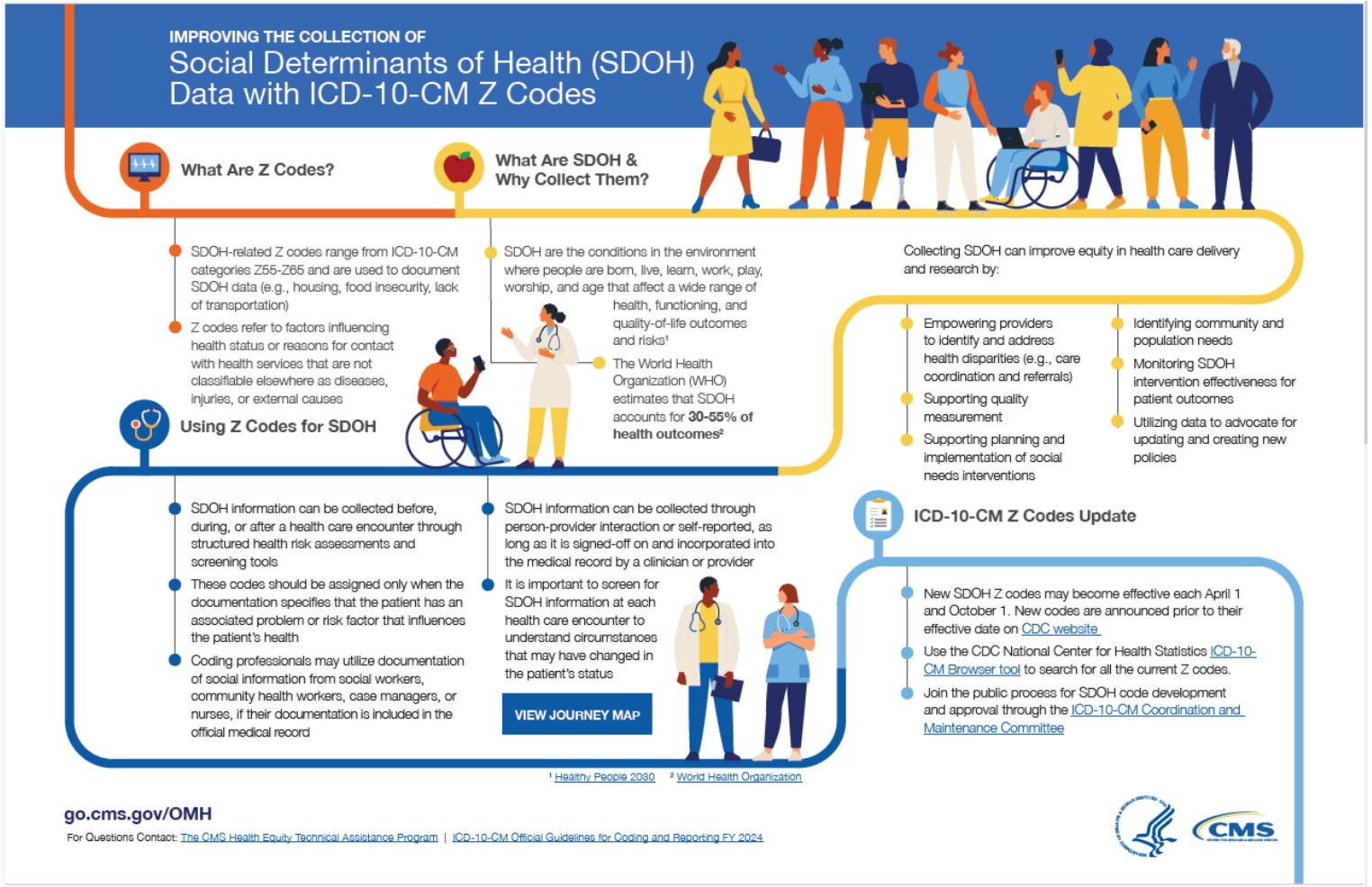
- Is the patient engaging?
- What driver is the patient referred for?
- What did the follow up look like?
  - Action (closing the loop), whole team involvement
- Was there a successful outcome?

Collecting Data

- Who is our population?
- Who are your community partners ?
- Do we have what we need to meet the goals?
- Any workflow changes needed?

Screening & Z-Codes:

If you can’t measure it you can’t manage it



IMPROVING THE COLLECTION OF

Social Determinants of Health (SDOH) data with ICD-10-CM Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy

- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- NEW • Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)

- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)
- NEW • Z58.8 – Other problems related to physical environment
  - NEW • Z58.81 – Basic services unavailable in physical environment
  - NEW • Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances

- Z59.0 – Homelessness (Updated)
  - Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)
  - Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)
  - Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
- Z59.1 – Inadequate Housing (Updated)
  - NEW • Z59.10 – Inadequate housing, unspecified
  - NEW • Z59.11 – Inadequate housing environmental temperature
  - NEW • Z59.12 – Inadequate housing utilities
  - NEW • Z59.19 – Other inadequate housing
- Z59.4 – Lack of adequate food (Updated)
  - Z59.41 – Food insecurity (Added, Oct. 1, 2021)
  - Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)
- Z59.8 – Other problems related to housing and economic circumstances (Updated)
  - Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)
    - Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)
    - Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
    - Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)
  - Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)
  - Z59.86 – Financial insecurity (Added, Oct. 1, 2022)
  - Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)
  - Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing

- Z62.2 – Upbringing away from parents
  - NEW • Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
  - NEW • Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- Z62.8 – Other specified problems related to upbringing (Updated)
  - Z62.81 – Personal history of abuse in childhood
    - NEW • Z62.814 – Personal history of child financial abuse
    - NEW • Z62.815 – Personal history of intimate partner abuse in childhood
  - Z62.82 – Parent-child conflict
    - NEW • Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)
  - Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)
  - Z62.89 – Other specified problems related to upbringing
    - NEW • Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

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Why Utilize Z Codes?

01

Demonstrate patient complexity to payers

02

Assist patients address barriers to care

03

Empower providers to identify and address health disparities

04

Enhance understanding of patient needs across the continuum

- Outpatient
- Hospital
- Specialties
- Post-acute care

Implementing Z Codes at your Practice

- **Educate** – Educate the importance of showing the whole patient picture
- **Start small**—A team of two can move the needle forward
  - Move it to the next step: provider buy in and clinical staff
  - Then: Involve whole team
- **Follow up** – what questions are there and how can we do better as a team to implement
- **Track data**—highlight that utilizing Z Codes makes a positive impact on supporting reimbursement by demonstrating complexity of patients

Patient Story

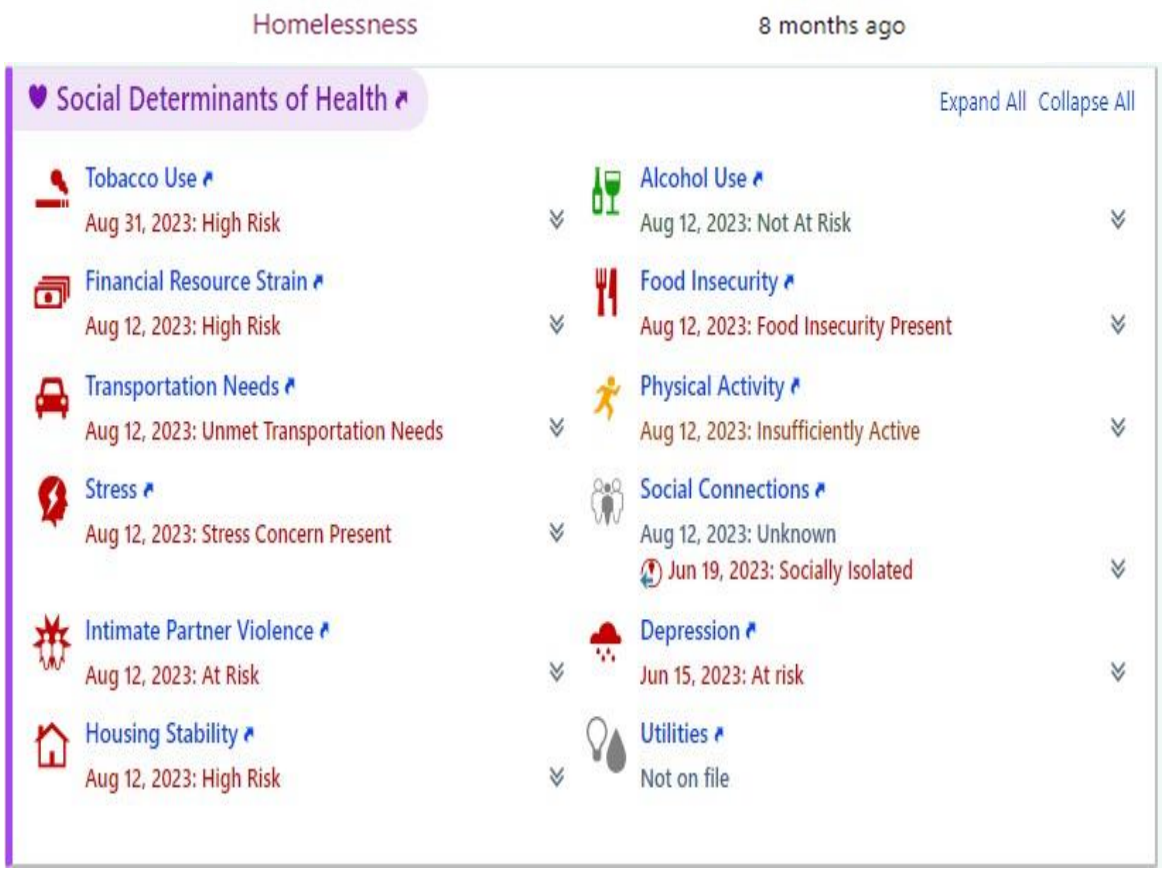
Medical Only Information

History of missed or cancelled appointments

Is knowledgeable about disease but never appears to make needed changes

History of admission for hyperglycemia

A1C ranging 9-11



Purpose Drives Success

Volunteer Time Off – VTO?

28% of employers allow employees to take paid time off to volunteer. *Healthcare is the lowest!*

VTO can be a powerful differentiator that helps your company stand out from your competition.

Do you pay employees to volunteer time for your community at your organization?

Source: Society for Human Resource Management's (SHRM) **2023 Employee Benefits Survey**

Key Elements for an Effectual SDOH Process

- **Multidisciplinary teams**:
  - Hospital leadership, business development staff, physicians, community referral partners, case managers, and social workers.
- **Access to data** to establish the links between social drivers of health and patient outcomes.
- **EHR-based** resources and social needs screening tools.
- **Shrink the Goal** - Identifying the social drivers of highest risk patients and investing in a system to track those patients.
- **Relationships** with community partners and hospitals
- **Team** Additional care navigators

Source: Improving and Promoting Social Determinants of Health at a System Level - ScienceDirect

Source: Enhancing Support for Patients' Social Needs to Reduce Hospital Readmissions and Improve Health Outcomes | PSNet (ahrq.gov)

Lessons Learned—SDOH in Primary Care

Success Tips for Implementation

Closed loop process

Verbiage for staff in asking the questions

Know available resources

Team based approach

Focused needs and Focused population

Start with what you can do and build from there

Supporting Staff

When there's not much you can do

Ensuring adequate time to care for patients with Health Related Social Needs

Equip staff with resources and training

Partner with CBO and/or other care managers

Involve in decisions affecting the program

Action: To-Do-List

EDUCATION

HOSPITAL TASK FORCE

SCREENING TOOL

SDOH IN EMR (Z-CODES)

HIGH-RISK (SHRINK THE GOAL)

INVEST IN TEAM TO EXPAND REACH (CHW, LCSW)

INVENTORY COMMUNITY RESOURCES

IDENTIFY AND SECURE COMMUNITY PARTNERS

COMMUNITY TASK FORCE AS PART OF COMMUNITY HEALTH NEEDS ASSESSMENT

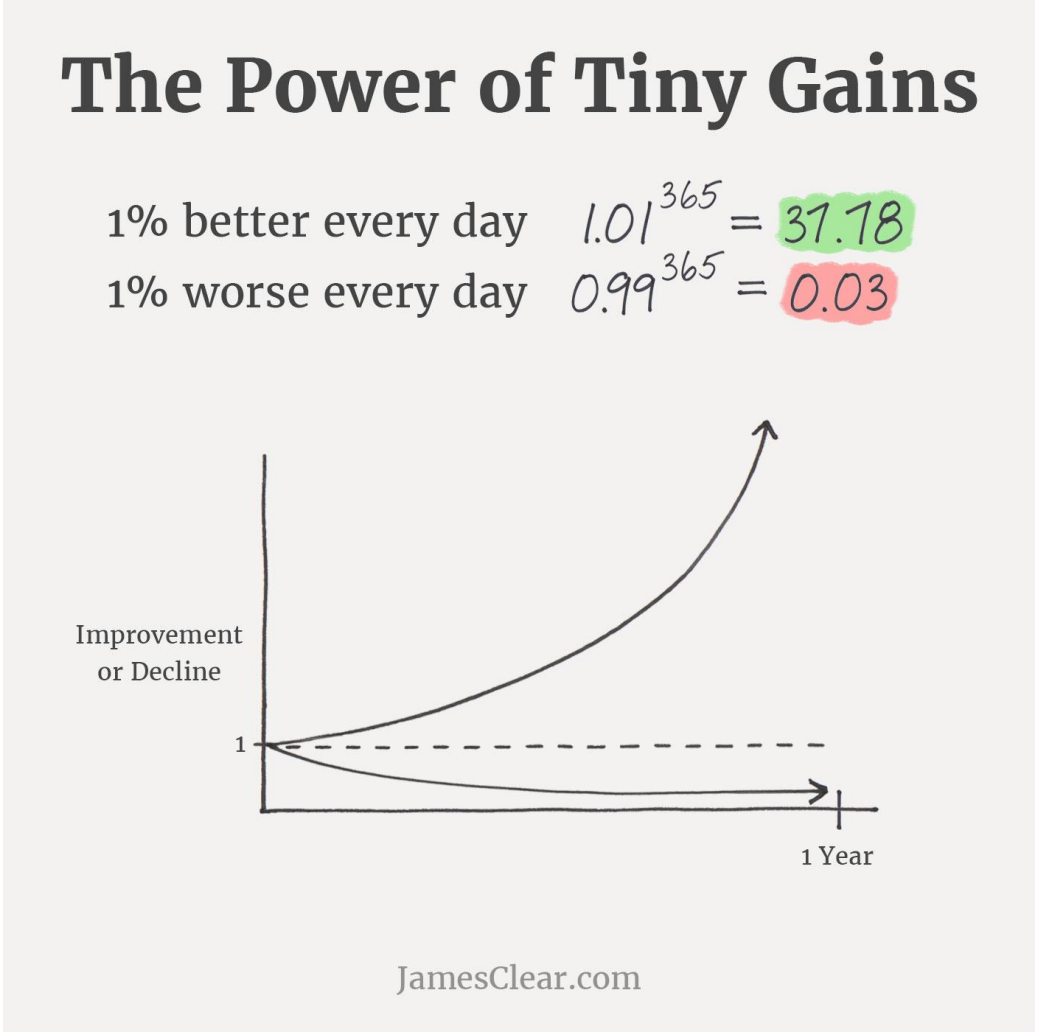
Kubler-Ross Change Curve

Decision Point: Stay in despair or move to commitment

Small Improvements Make Big Differences over Time

"It's easy to overestimate the importance of one defining moment, and underestimate the value of making small improvements on a daily basis."

James Clear – *Atomic Habits*



Questions

Thank you!

Resources:

- Camden Coalition
  - inspire-nine-dimensions.pdf (camdenhealth-website-media.nyc3.digitaloceanspaces.com)
- American Hospital Association –
  - The Health Equity Roadmap | Equity (aha.org)
  - HEAL overview | AHA
- CMS – Accountable Health Communities Model
  - Accountable Health Communities Model | CMS
  - The AHC Health-Related Social Needs Screening Tool (cms.gov)
- The Better Care Playbook
  - Community Engagement Interventions to Improve Health Equity | Playbook (bettercareplaybook.org)
- Center for Healthcare Strategies
  - Shifting the Power Balance: Creating Health System Accountability through Trusted Community Partnerships (chcs.org)

Resources:

- Social Determinants of Health Literature Summaries - Healthy People 2030 | health.gov
- Reports - Gravity Project (thegravityproject.net)
- Community Health Assessment Toolkit | ACHI (healthycommunities.org)
- Foundations of Health Equity Self-Guided Training Plan Domains and Competencies | Health Equity | CDC
- How to improve screening for social determinants of health | American Medical Association (ama-assn.org)
- Investing in the Power of Teams to Address Social Needs | AHA
- Community Health Worker Integration with and Effectiveness in Health Care and Public Health in the United States | Annual Reviews

AHA Health Equity Roadmap

[The Health Equity Roadmap | Equity (aha.org)]

The Continuum

Hospitals and health systems can be in any of the following positions along the continuum.

Exploring

Exploring the values and resources needed to publicly **commit** to embarking upon a journey toward health equity.

Committing

Committing the resources to listen, learn, train and **implement policies and practices** that establish equity as the standard practice.

Immersing

Immersing the leadership and system into **accountability** for implementing policies, procedures and cultural structures that support diversity, equity and inclusion.

Affirming

Affirming a just, equitable system culture with **continuous equity self-assessments** of policies and practices that remove structural barriers to equity.

Transforming

Transforming beyond the system toward **supporting a sustainable and equitable ecosystem** of health care within the community.

USING SDOH Z CODES

Can Enhance Your Quality Improvement Initiatives

Health Care Administrators

Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals

Follow the ICD-10-CM coding guidelines.[3]

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.[4]
- Coding team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code Categories

- **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

This list is subject to revisions and additions to improve alignment with SDOH data elements.

[3] cms.gov/medicare/icd-10/2021-icd-10-cm
[4] cdc.gov/nchs/icd/icd10cm.htm

Revision Date: February 2021

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented in an individual's health care record by any member of the care team.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] cms.gov/medicare/icd-10/2021-icd-10-cm

[2] aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

IMPROVING THE COLLECTION OF

Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

What Are Z Codes?

- 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

What Are SDOH & Why Collect Them?

- 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]

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

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

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

Shrink the Goal – Camden Coalition

Camden Coalition

[Blueprint-for-Complex-Care_UPDATED_030119-2.pdf (camdenhealth.org)]

Shrinking the Goal