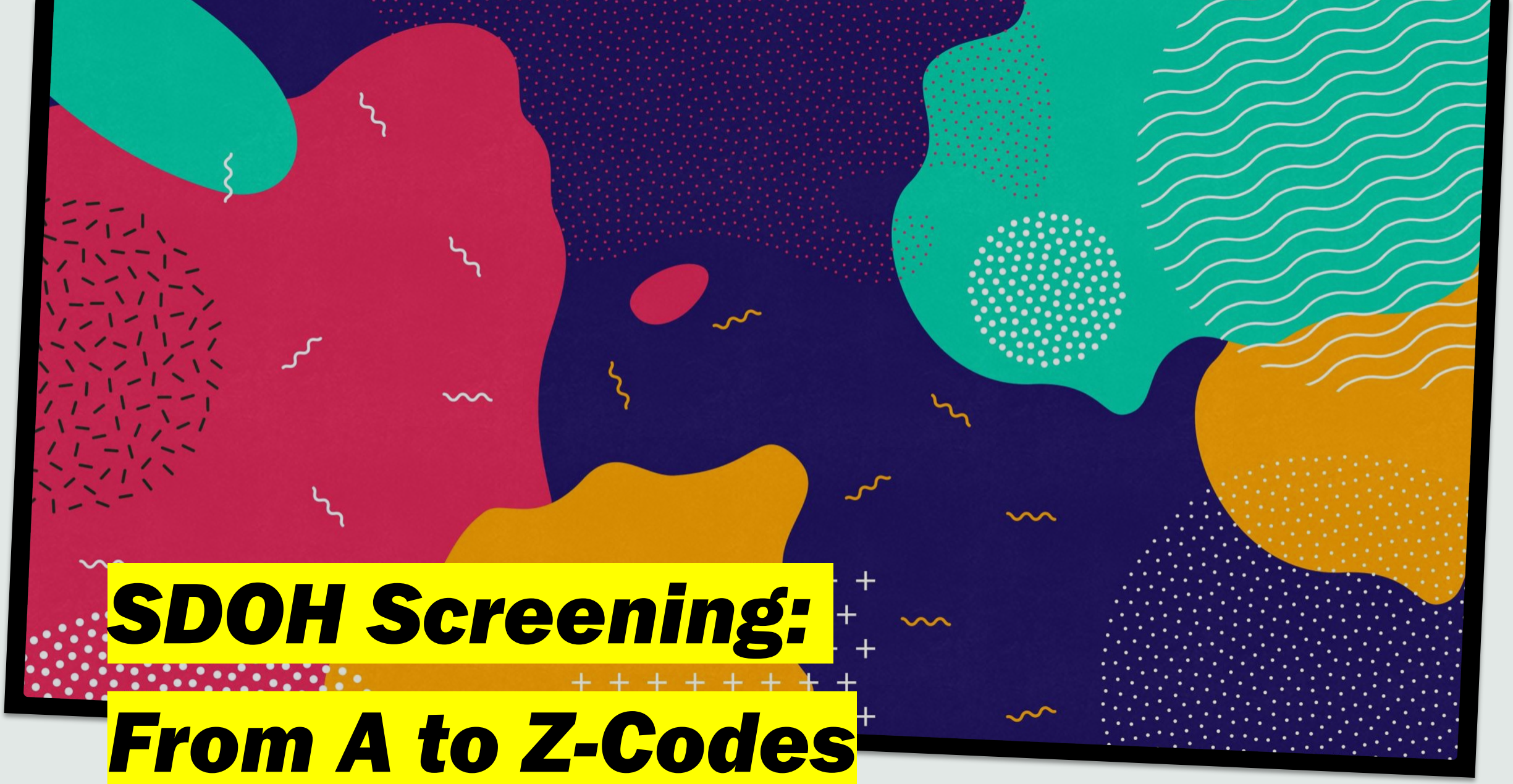


SDOH Screening: From A to Z-Codes

July 25, 2023 | 2:30 ET

Goals for Today – Your Questions

- Why should we use Z codes?
- How can we identify and document Z codes?
- What is the relationship to SDOH screening?
- How can we use Z codes to guide improvement?

Refresher – CMS Health Equity Measures

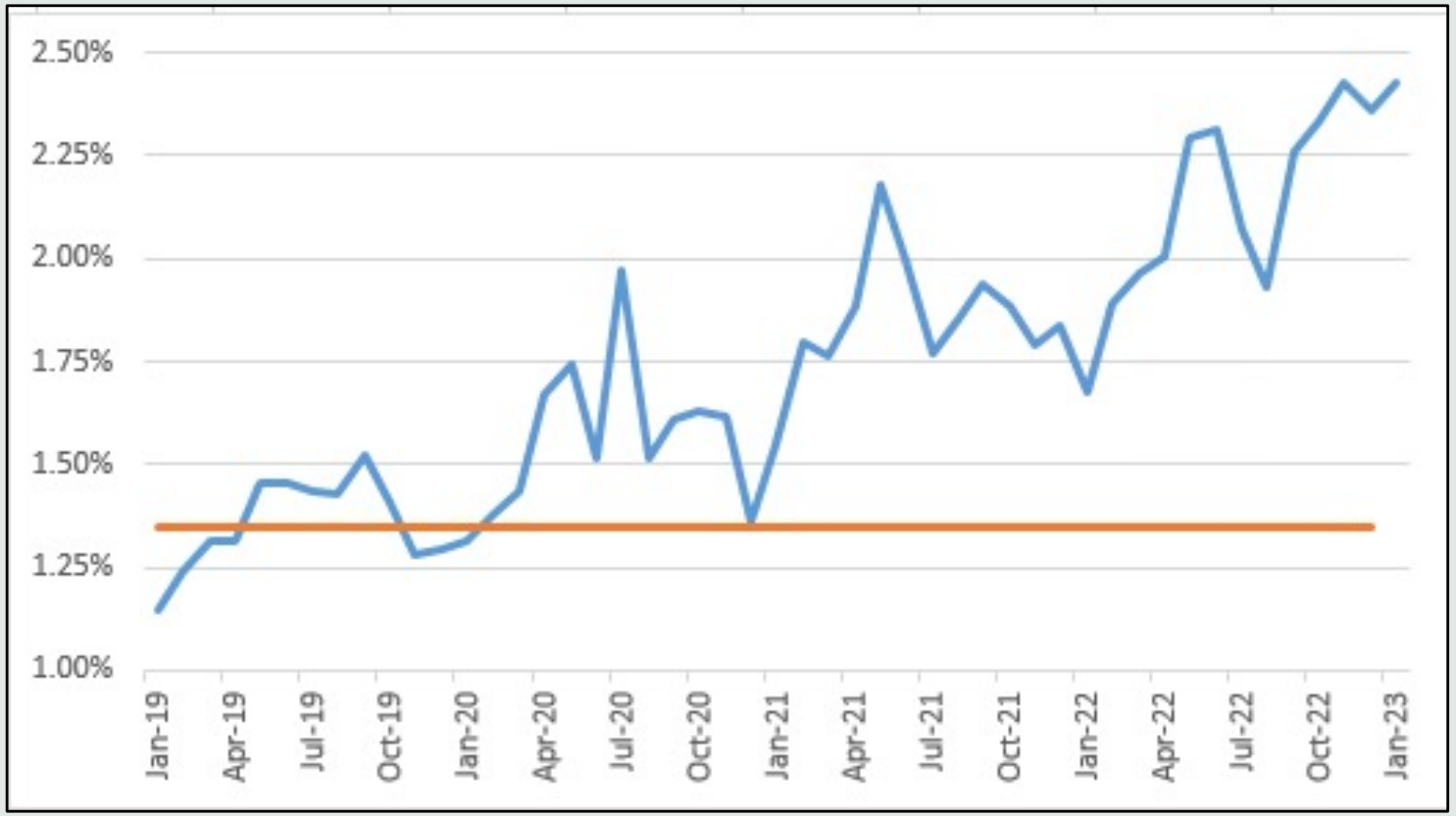
Hospital Commitment to Health Equity – 5 domains, including data collection, analysis, and QI activities to reduce health disparities

Social Drivers of Health Screening – screening rate and screen positive rate for 5 domains (housing instability, transportation needs, food insecurity, difficulty paying utilities, interpersonal violence)

	HCHE	SDOH-1 and SDOH-2
Reporting Process	Inpatient Quality Reporting program: https://qualitynet.cms.gov/inpatient/iqr	
Optional Reporting Period	N/A	CY2023
Mandatory Reporting Period	CY2023	CY2024
Publicly Reported?	Yes	No
IQR Guidance Docs/FAQ	https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf	https://qualitynet.cms.gov/files/643473d9a484cd0017883d92?filename=SDOH_Measure_FAQs_April2023.pdf
IQR Specifications	https://qualitynet.cms.gov/files/6481de2304f753001cd056d1?filename=HCHEStrctMeasSpecs_v2.1.pdf	https://qualitynet.cms.gov/files/643473c59920e9001651eddf?filename=ScrnSocDrvrs_Scrn_Pos_Specs.pdf
Resources	https://blog.medisolv.com/articles/a-guide-to-cms-new-health-equity-measure	https://blog.medisolv.com/articles/intro-cms-sdoh-measures

More info here: https://www.cms.gov/files/document/zcodes-infographic.pdf

Percent of Medicare FFS Discharges with SDOH-Related ICD-10 Code, January 2019-October 2022, Cynosure HQIC Hospitals (N=300)



What's the capture rate?

Note: Data not for public distribution. Data has been estimated and has not been verified by CMS.

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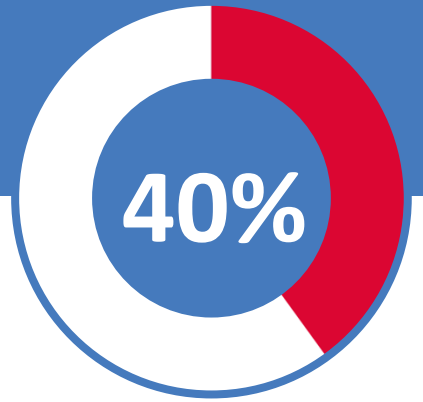
SDOH Screening: From A to Z Codes

July 25, 2023

Julia Resnick, Director, Strategic Initiatives
American Hospital Association
jresnick@aha.org

Health is More Than Health Care

Societal factors impact an individual's health regardless of age, gender, race or ethnicity.

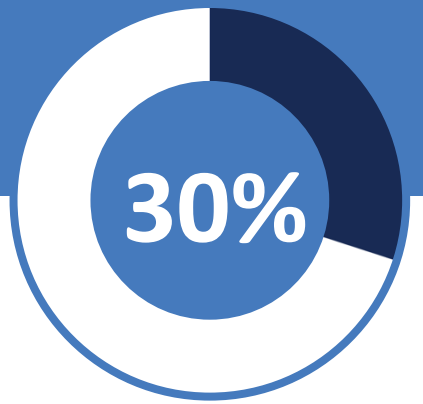


Socioeconomic Factors

- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

- Environment



Health Behaviors

- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care

- Access to Quality Care

Source: http://www.countyhealthrankings.org/county-health-rankings-model

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Current Environment

1.48 million individuals are **homeless**

3.6 million people cannot access medical care due to lack of **transportation**

42 million Americans face **hunger**

12.7% of households are **food insecure**

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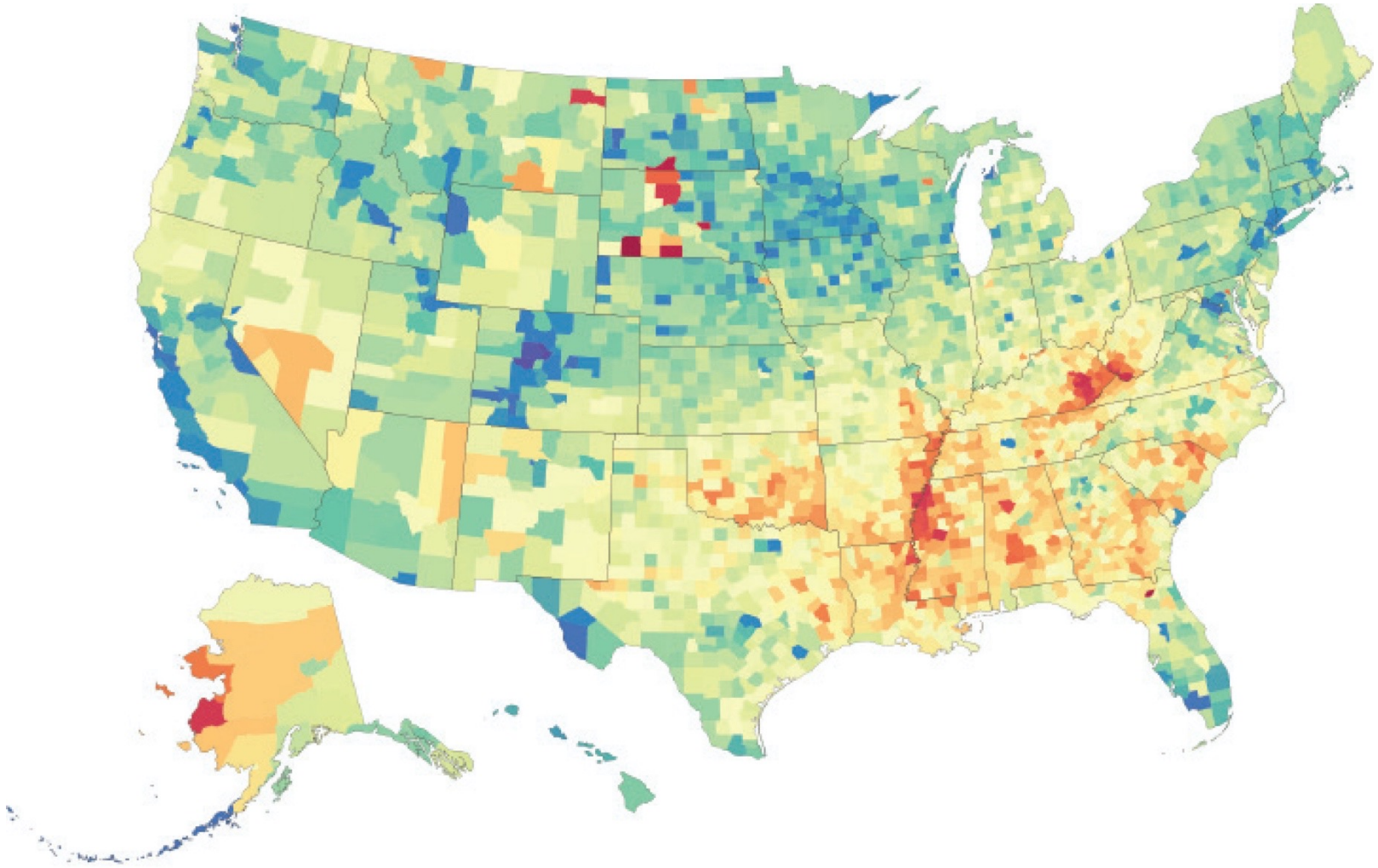
Inequities in Life Expectancy



Life expectancy at birth (years):

66 69 72 75 78 81 84 87

Source: Institute for Health Metrics and Evaluation, University of Washington, 2019.

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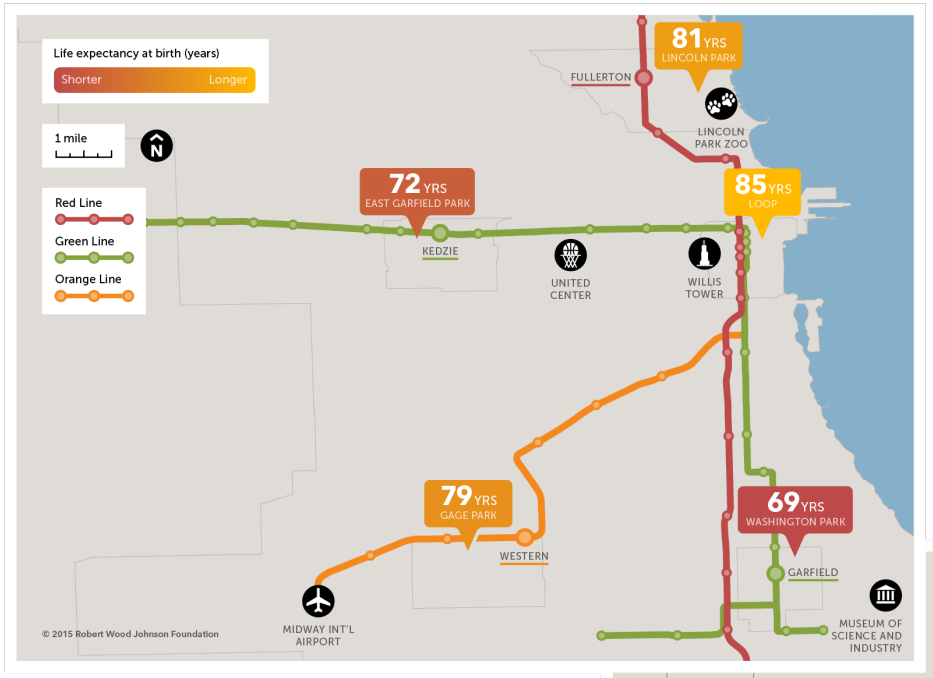
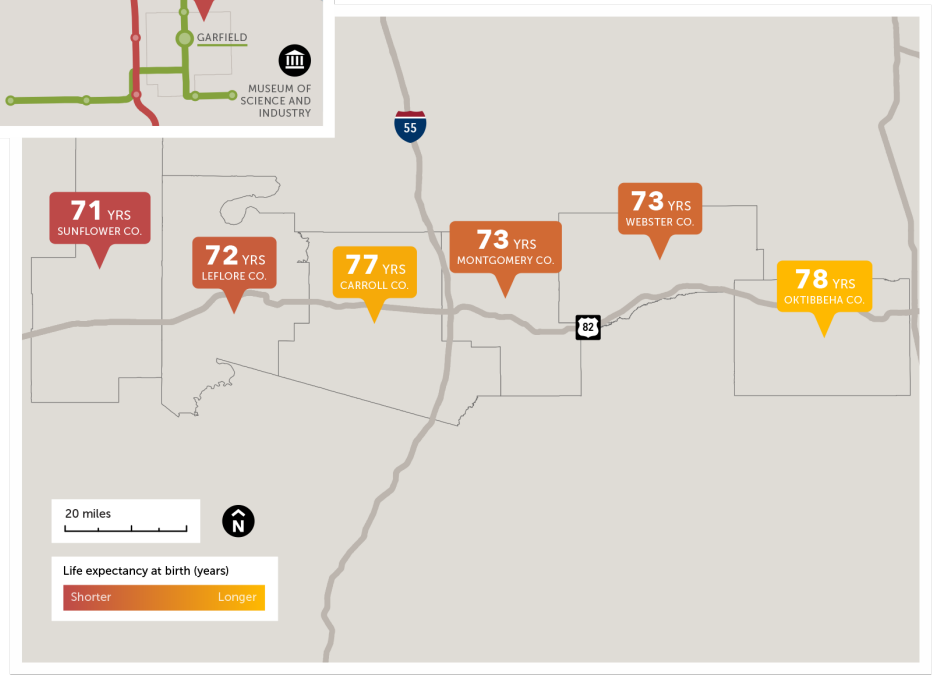
INEQUITIES IN LIFE EXPECTANCY

Short Distances Between Large Gaps
in Health



▲ Chicago, Illinois

Mississippi ▼

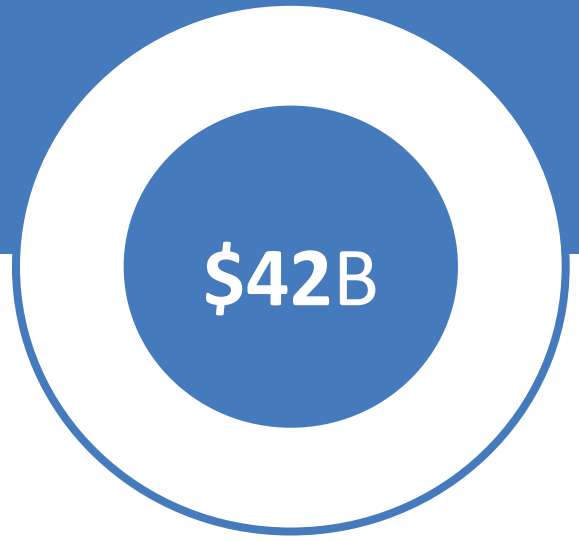


Source: VCU Center on Society and Health.

The Cost of Health Inequities

Racial health inequities are associated with substantial annual economic losses nationally, including:

in excess health care expenditures



in illness-related lost productivity

Source: LaVeist, 2011, Estimating the economic burden of racial health inequalities in the United States.

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SOCIETY BENEFITS FROM IMPROVING HEALTH EQUITY

Economic Benefits of Closing the Racial Equity Gap

Source: Turner, Ani. "The Business Case for Racial Equity: A Strategy for Growth," W.K. Kellogg Foundation and Altarum, July 24, 2018.

$8 TRILLION

Gain in GDP by 2050 if the United States eliminated racial disparities in health, education, incarceration and employment.

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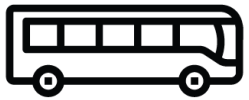
Societal Factors are a Pathway to Address Health Inequities – and health care organizations have a key role to play

Food and Nutrition

Housing



Transportation

Utilities

Education

Environmental exposures

Economic Stability

Community and Household Safety

Digital Access and Literacy

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Societal Factors that Influence Health

A Framework for Hospitals

Social Needs

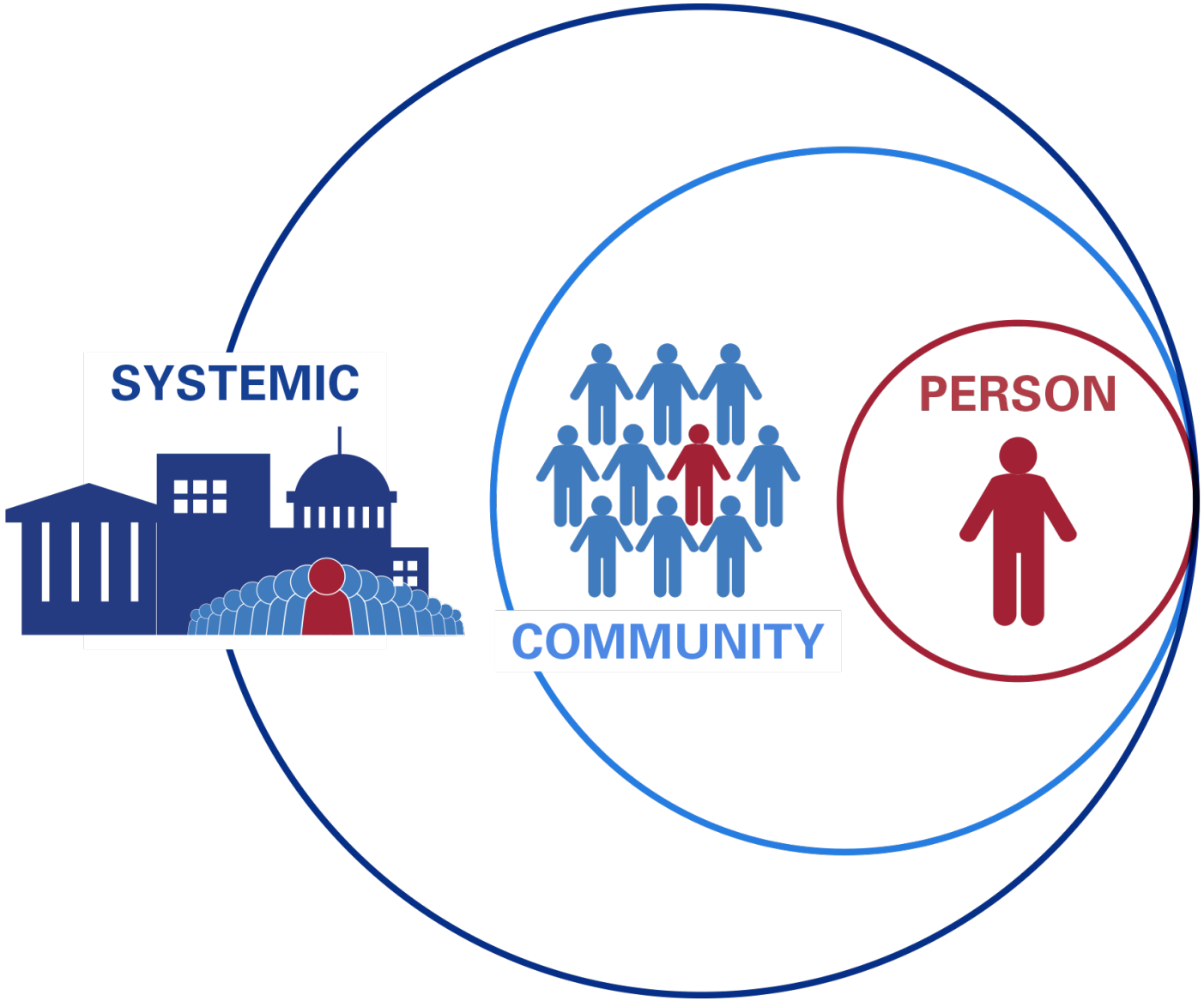
Individuals' non-medical, social or economic circumstances that hinder their ability to stay healthy and/or recover from illness.

Social Determinants of Health

Underlying social and economic conditions that influence people's ability to be healthy.

Systemic Causes

The fundamental causes of the social inequities that lead to poor health.



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SOCIETAL FACTORS THAT INFLUENCE HEALTH

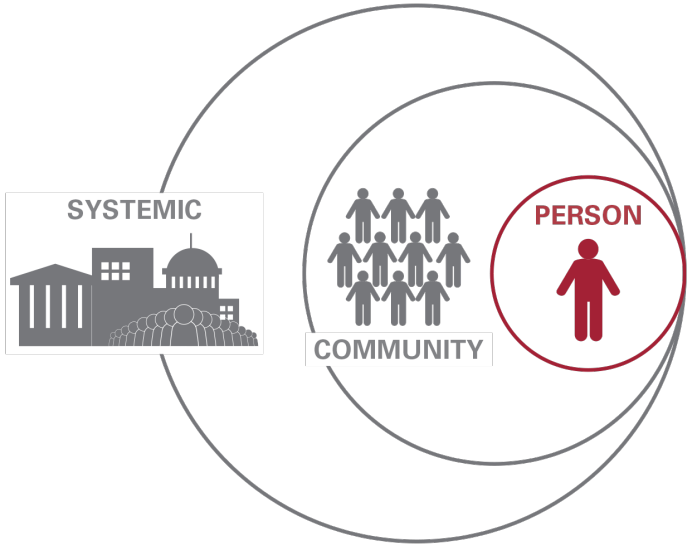
Social Needs

Who: Individuals who present for health care services

Setting: Patient encounter at a point of care.

Examples: Lack of stable housing, limited access to healthy food, loneliness, unsafe home, lack of access to internet.

Strategies: Screening and documenting, referrals, food pharmacies, temporary supportive housing, signing up for benefits.



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SOCIETAL FACTORS THAT INFLUENCE HEALTH

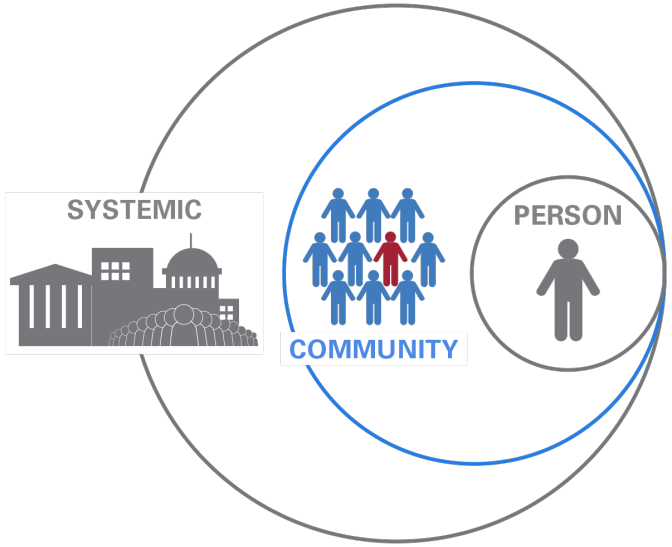
Social Determinants of Health

Who: The community served by a hospital

Setting: In the community

Examples: Food deserts, lack of affordable housing, community violence

Strategies: Partner with community-based organizations and multi-sector stakeholders, support food banks, build grocery stores, invest in affordable housing, create employment opportunities.



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SOCIETAL FACTORS THAT INFLUENCE HEALTH

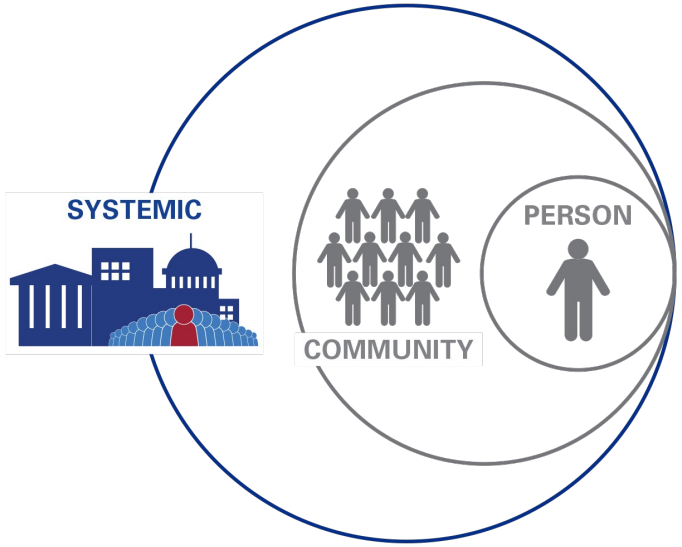
Systemic Causes

Who: Anchor organizations such as hospitals and health systems, community leaders, legislators or policy makers

Setting: Community, state or national

Examples: Systemic inequities such as racism, sexism, generational poverty, redlining, environmental injustice

Strategies: Support and affect policy, system and environmental changes, incentivize investments, support higher wages, advocate for child tax credits.



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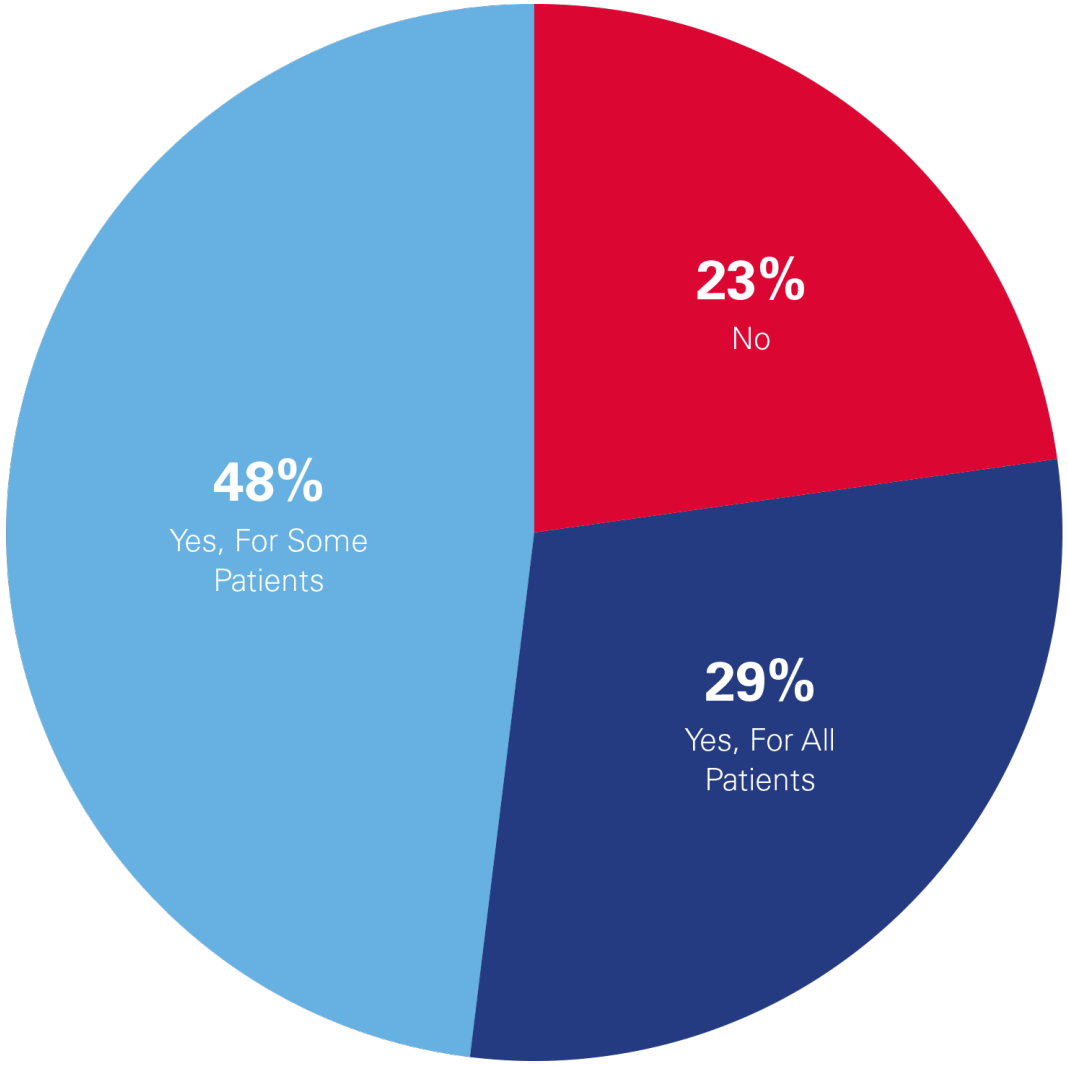
Hospitals are Screening for Social Needs



Source: *AHA 2018 Population Health, Equity and Diversity in Health Care Survey*

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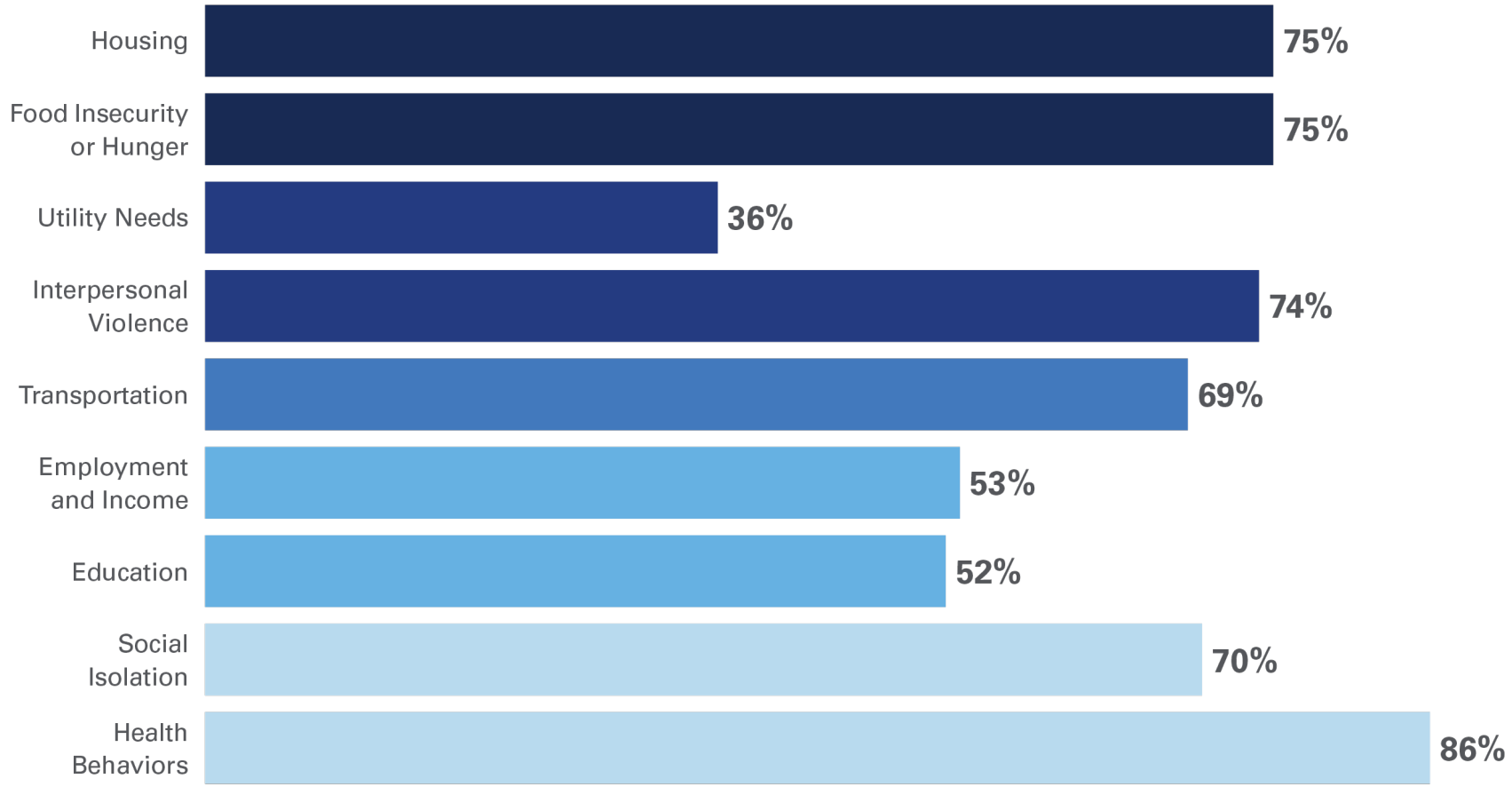
Social Needs Screening Questions



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Source: *AHA 2018 Population Health, Equity and Diversity in Health Care Survey*

Social Determinants of Health ICD-10-CM Z Codes

- Z codes are a subset of ICD-10-CM diagnosis codes that represent factors influencing health status and contact with health services that may be recorded as diagnoses.
  - ICD-10-CM categories Z55-Z65 are a more specialized group of codes to identify social determinants of 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*
- *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*

Barriers to using Z Codes

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

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Lack of Definitions and Lack of Incentives

- Neither the ICD-10-CM classification nor the guidelines provide definitions for SDOH terms
  - There are national efforts like the Gravity Project to help
  - In the interim, hospitals may consider incorporating terms/definitions into internal coding guidelines
- Lack of incentives
  - There is interest among commercial and government payors to identify SDOH for reimbursement, quality adjustments, etc.
  - Without the data, payers cannot recognize SDOH factors for reimbursement

Productivity Challenges

- Coding is important and needs to be done on a timely basis.
- Coding for SDOHs needs to be made a priority
- Coding managers and supervisors giving the coder permission to take the time to capture these additional codes.

Benefits of Using Z-Codes

- **Identify** social needs that impact patients and connect with community resources
- **Aggregate** data across patients to focus a social determinants strategy

- **Track** trends or risks in the community
- **Guide** community partnerships and CHNAs

- **Enable** system-wide research at the national level to understand the social needs of communities
- **Tailor** state and federal programs to meet those needs
- **Support** policy and payment reforms

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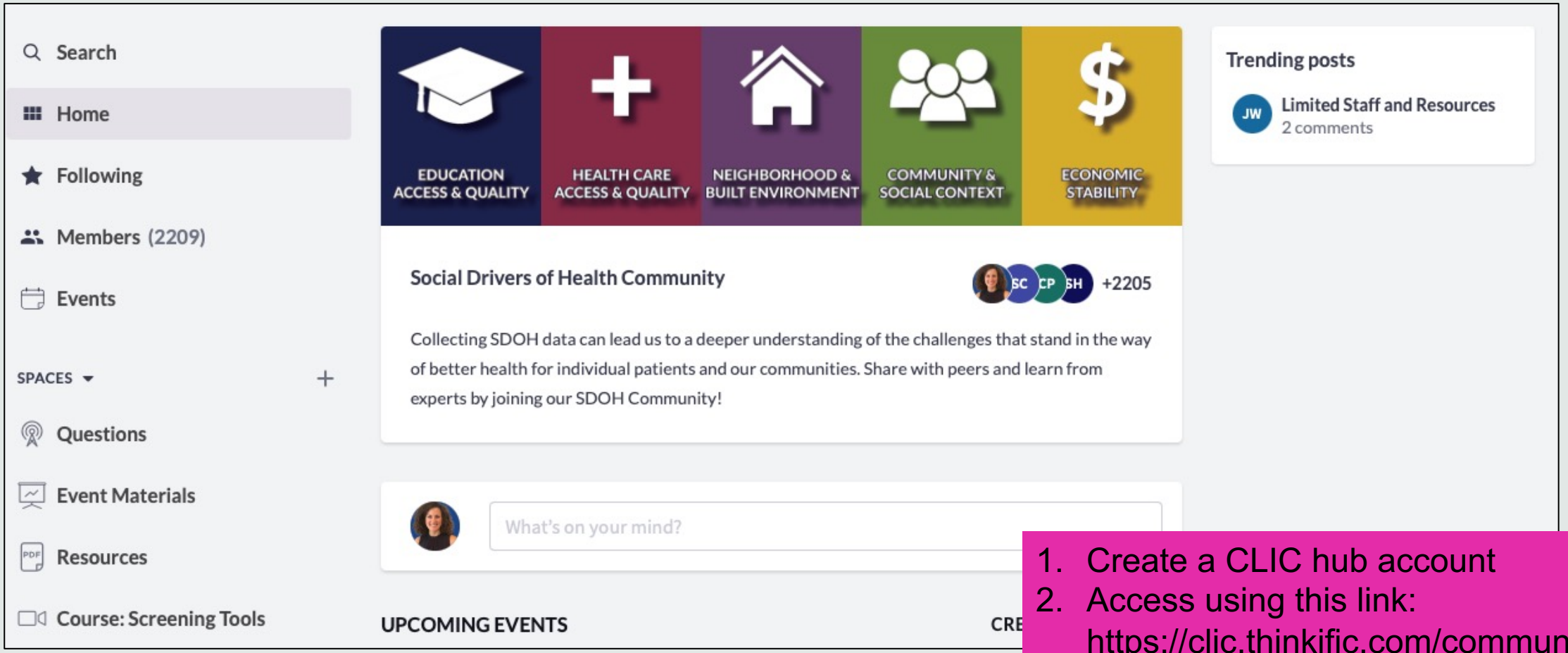
Questions?

Join Our SDOH Online Community!



1. Create a CLIC hub account
2. Access using this link: https://clic.thinkific.com/communities/Q29tbXVuaXR5LTMxODc5

Resources

- ICD-10 Z Codes (from Blue Cross Blue Shield of Illinois): https://www.bcbsil.com/pdf/clinical/ICD-10_Z_codes_flier.pdf
- Using Z Codes (from Centers for Medicare and Medicaid Services): https://www.cms.gov/files/document/zcodes-infographic.pdf
- ICD-10-CM Coding for Social Determinants of Health (from the American Hospital Association): https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Thank You!

Natalie Graves

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