Health Equity and SDOH: What's Next? Moving Beyond the Data

2024 OOA Winter CME Seminar

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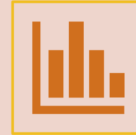
DISCLOSURE

- I have no financial relationships or other conflicts of interest to disclose.

LEARNING OBJECTIVES

Define Health Equity, SDOH and ADI



Review health related data on SDOH

Discuss common SDOH screening methods and strategies

Develop tactics to address SDOH based on your screening data

DEFINITIONS & DATA

WHAT IS HEALTH EQUITY?

- Two Common Definitions

CMS –

"Health Equity is 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."

Robert Wood Johnson Foundation-

"Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

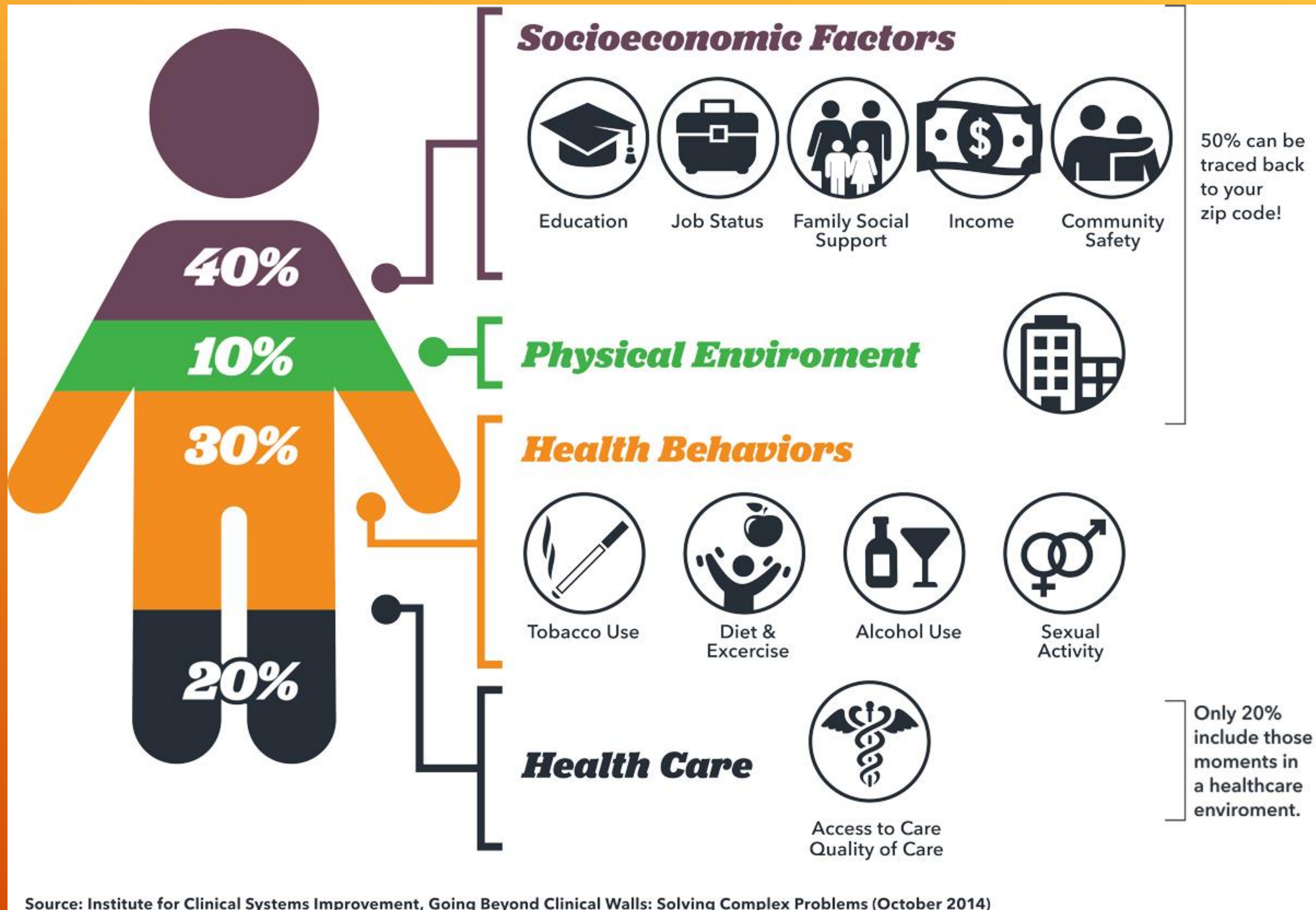
WHAT ARE SOCIAL DETERMINATES OF HEALTH?

Social determinates of health are the conditions in the environments 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

Social determinants of health can be grouped into 5 domains. The domains and examples of those include:

- **Economic Stability**
  - job opportunities, income, and childcare availability/quality
- **Education Access and Quality**
  - graduation rates, reading skills, and school readiness
- **Health Care Access and Quality**
  - health insurance, preventative care, and access to a primary care provider
- **Neighborhood and Built Environment**
  - violence, clean water and air, and physical activity opportunities
- **Social and Community Context**
  - discrimination, relationships, and social support

WHAT ARE SOCIAL DETERMINATES OF HEALTH?



CMS FRAMEWORK FOR HEALTH EQUITY PRIORITIES 2022-2032

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**.

WHAT THE RESEARCH SAYS - HE AND SDOH

10/2019: The Feasibility of Screening for Social Determinants of Health: Seven Lessons Learned (https://www.aafp.org/pubs/fpm/issues/2019/0900/p13.html)

- Social factors such as low education, racial segregation, and low social support can have an effect on mortality that is similar to medical conditions such as acute myocardial infarction, cerebrovascular disease, and lung cancer.

5/23/2023: Loneliness poses risks as deadly as smoking: surgeon general (https://apnews.com/article/surgeon-general-loneliness-334450f7bb5a77e88d8085b178340e19)

- Widespread loneliness in the U.S. poses health risks as deadly as smoking up to 15 cigarettes daily, costing the health industry billions of dollars annually, the U.S. surgeon general said Tuesday in declaring the latest public health epidemic.
- Loneliness increases the risk of premature death by nearly 30%, with the report revealing that those with poor social relationships also had a greater risk of stroke and heart disease. Isolation also elevates a person's likelihood for experiencing depression, anxiety and dementia, according to the research.

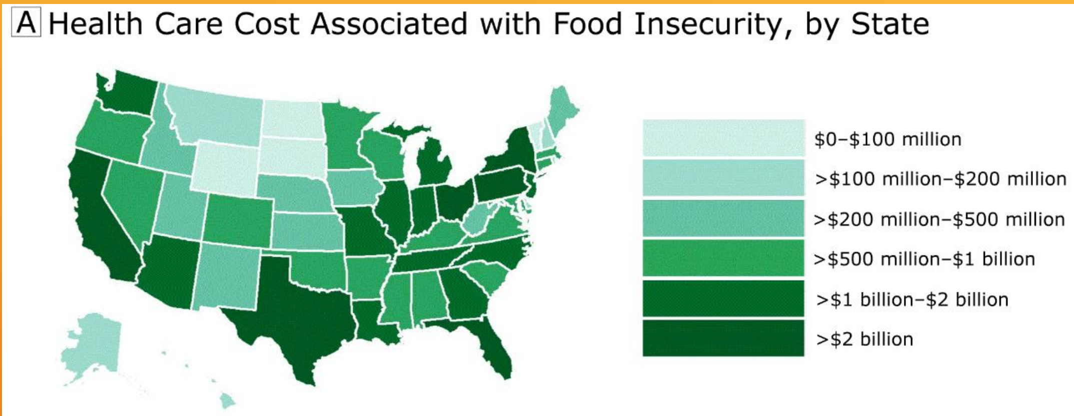
4/24/2023: Which Social Determinants of Health Lead to Low Care Quality? (https://patientengagementhit.com/news/which-social-determinants-of-health-lead-to-low-care-quality)

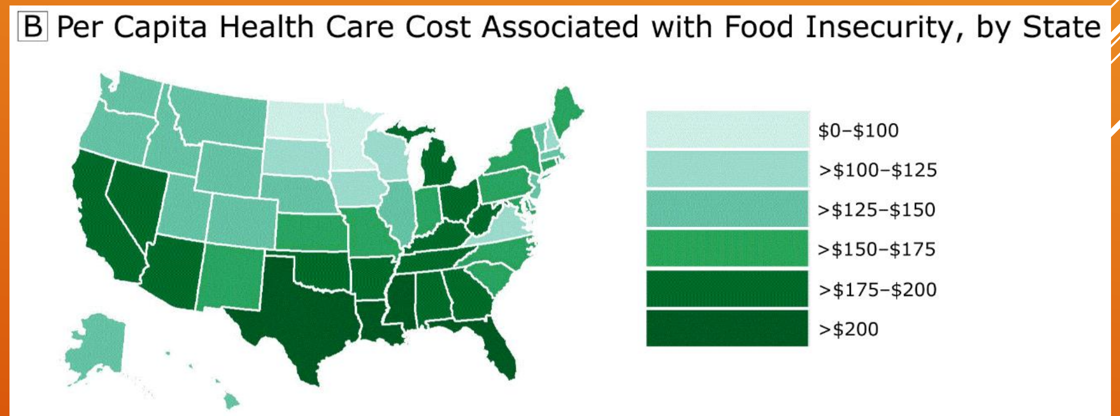
- Those in the type 2 diabetes population are more likely to experience SDOH.
- Experiences of loneliness, lack of transportation, utility insecurity, and housing insecurity were all linked to lower diabetes medication adherence, a key element of clinical quality.
- Loneliness and lack of transportation were also linked to higher acute care utilization, like increased emergency room visits.

WHAT THE RESEARCH SAYS - HE AND SDOH

7/11/2019 State-Level and County-Level Estimates of Health Care Costs Associated with Food Insecurity

- Adults who were food insecure had annual health care expenditures that were **$1,834 higher** than adults who were food secure
- Estimates of the excess cost associated with food insecurity translates to approximately **$51.8 billion** in excess health care expenditures associated with food insecurity in 2016
- Food insecurity was associated with higher health care spending in adults and that this spending varied substantially across locality.





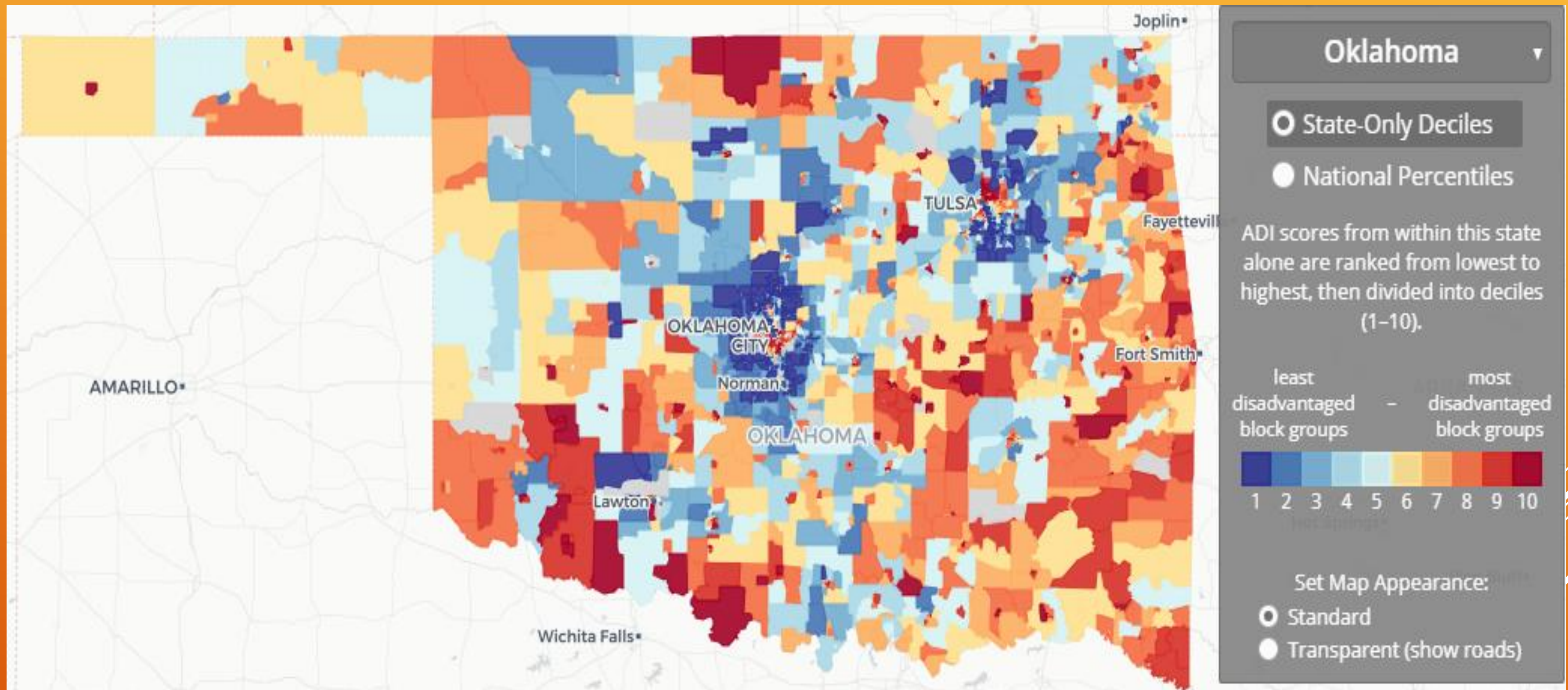
https://www.cdc.gov/pcd/issues/2019/18_0549.htm#F1_down

AREA DEPRIVATION INDEX (ADI)

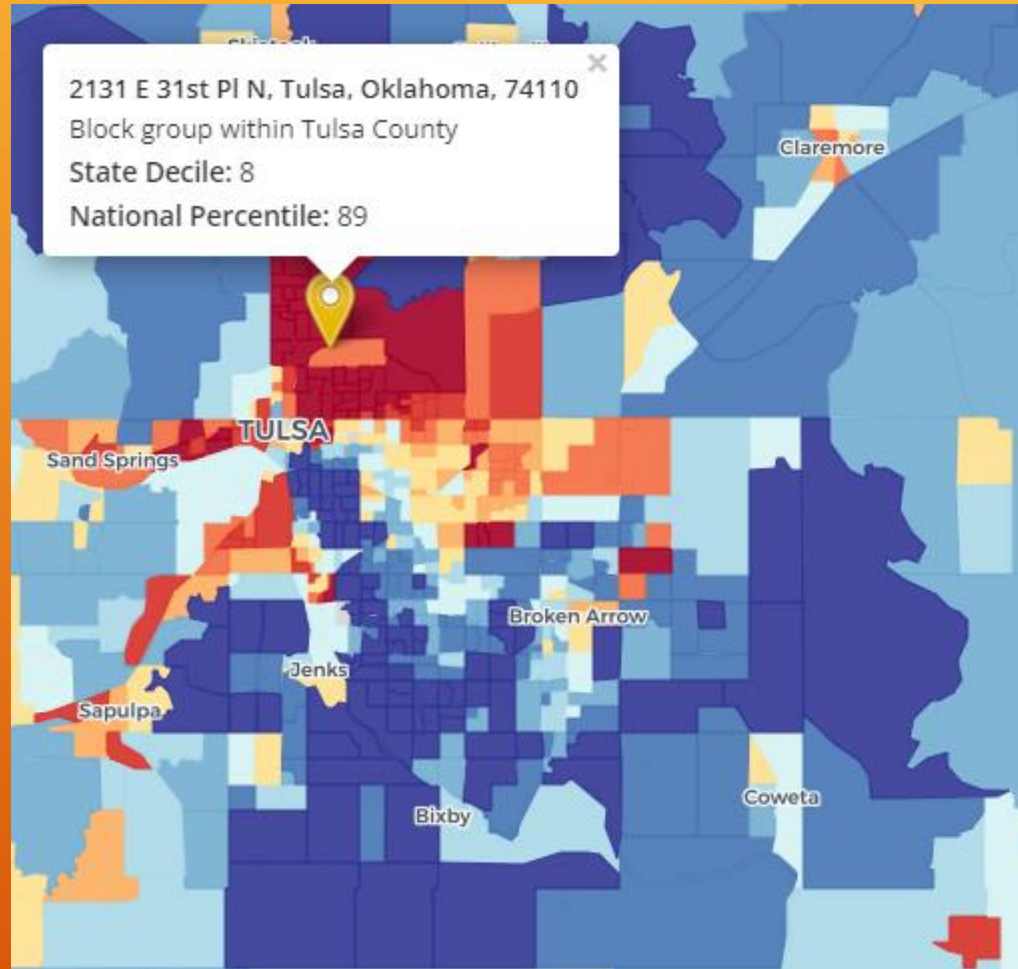
- What is it?
  - ADI allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest (e.g., at the state or national level).
  - It includes factors for the theoretical domains of income, education, employment, and housing quality.
  - It can be used to inform health delivery and policy, especially for the most disadvantaged neighborhood groups.

https://www.neighborhoodatlas.medicine.wisc.edu/

NEIGHBORHOOD ATLAS



NEIGHBORHOOD ATLAS



ADI AND READMISSION RISK

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NIHMSID: NIHMS932043
PMID: 29357679

Area Deprivation Index (ADI) Predicts Readmission Risk at an Urban Teaching Hospital

Jianhui Hu, Ph.D., Amy J.H. Kind, M.D., Ph.D., and David Nerenz, Ph.D.

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Abstract Go to: ▸

A growing body of evidence has shown that neighborhood characteristics have significant effects on quality metrics evaluating health plans or health care providers. Using a data set of an urban teaching hospital patient discharges, this study aimed to determine whether a significant effect of neighborhood characteristics, measured by the Area Deprivation Index, could be observed on patients' readmission risk, independent of patient-level clinical and demographic factors. We found that patients residing in the more disadvantaged neighborhoods had significantly higher 30-day readmission risks, compared to those living in the less disadvantaged neighborhoods, even after accounting for individual-level factors. Those living in the most extremely socioeconomically challenged neighborhoods were 70 percent more likely to be readmitted than their counterparts who lived in the less disadvantaged neighborhoods. Our findings suggest that neighborhood-level factors should be considered along with individual-level factors in future work on adjustment of quality metrics for social risk factors.

SCREENINGS AND STRATEGY

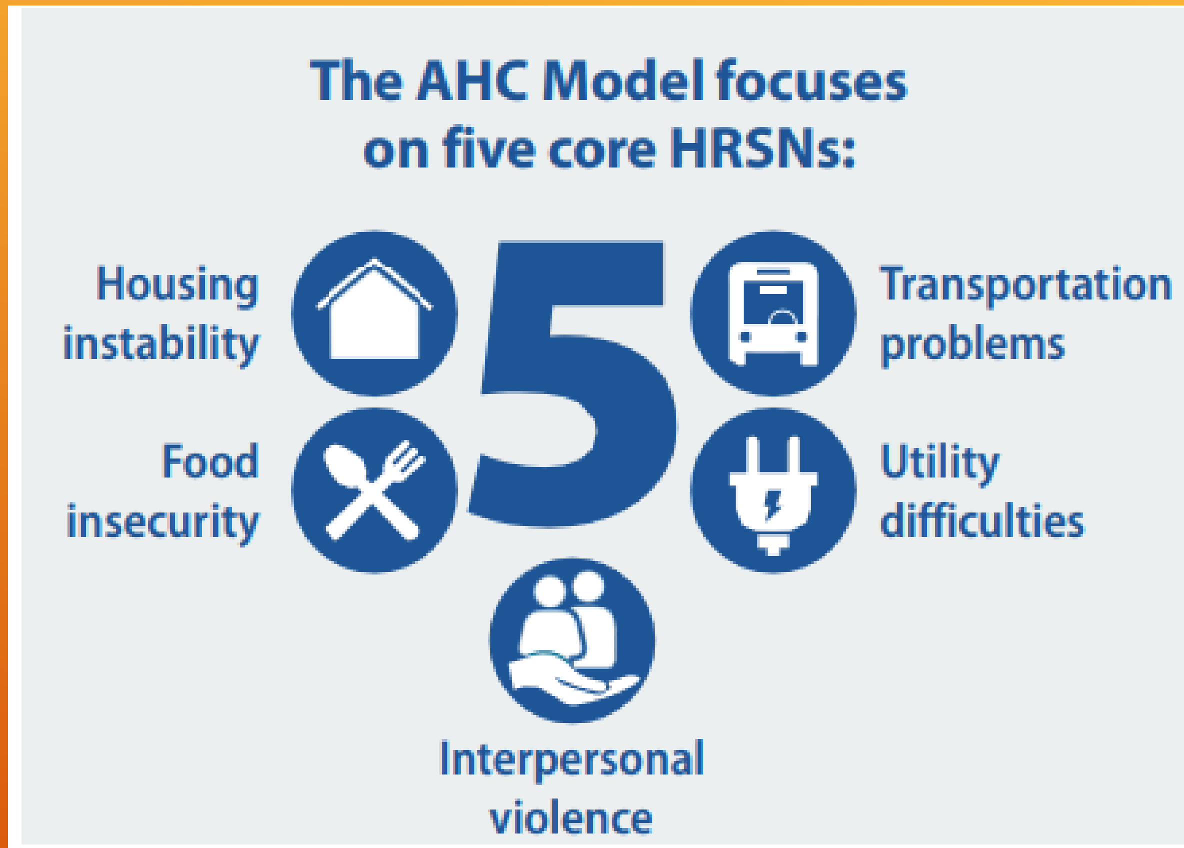
COMMON SCREENING TOOLS

- HealthBegins Upstream Risk Screening Tool.
- PRAPARE.
- Structural Vulnerability Assessment Tool.
- WellRx Toolkit.
- Kaiser Permanente's Your Current Life Situation Survey.
- American Academy of Family Physicians (AAFP) Social Needs Screening Tool.
- Health-Related Social Needs Screening Tool. (HRSN)

QUICK POLL

- Menti.com POLL

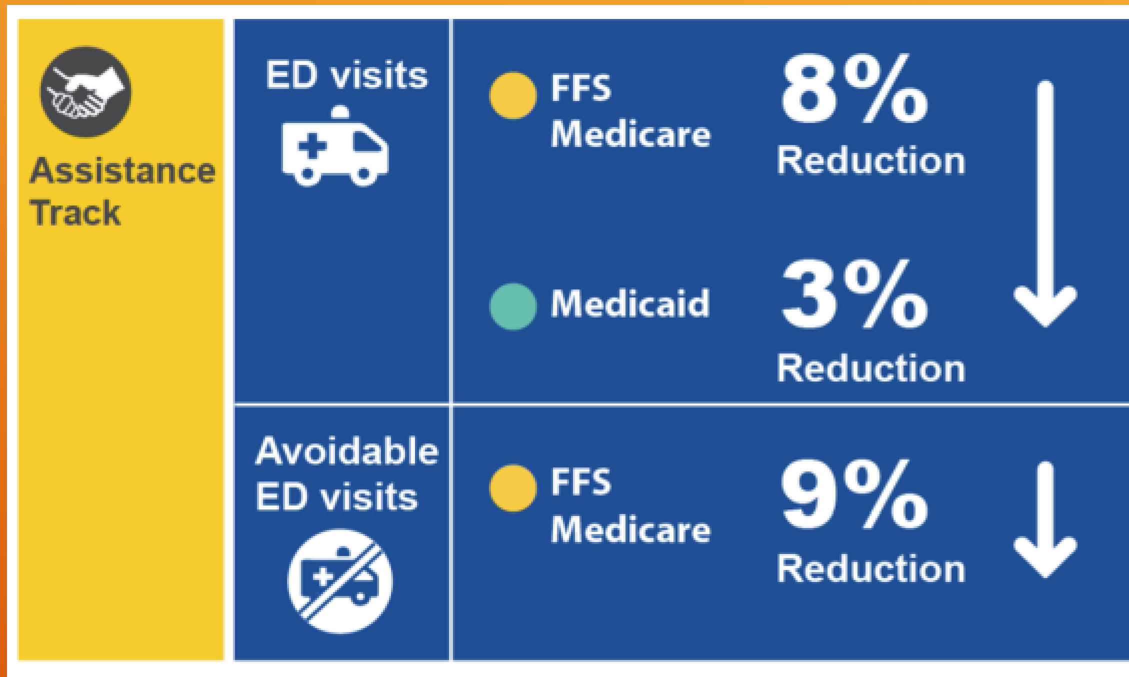
ACCOUNTABLE HEALTH COMMUNITIES MODEL



https://www.cms.gov/priorities/innovation/data-and-reports/2023/ahc-second-eval-rpt-fg

CMS AHC SDOH FINDINGS

The AHC Model reduced ED visits among Medicaid and fee-for-service (FFS) Medicare beneficiaries in the Assistance Track.

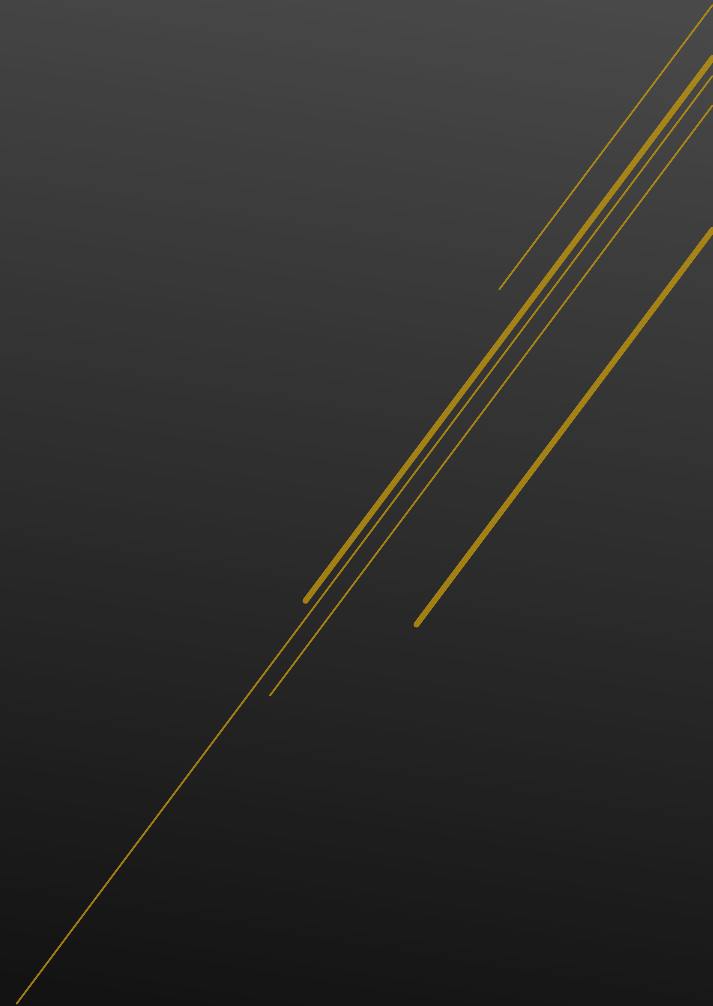


STRATEGY

- Regardless of tool used, focus on these 5 strategies to address SDOH
  - Awareness
  - Adjustment
  - Assistance
  - Alignment
  - Advocacy

https://www.healthleadersmedia.com/clinical-care/5-ways-healthcare-organizations-can-address-social-determinants-health#:~:text=Partnerships%20are%20a%20crucial%20component,Sciences%2C%20Engineering%2C%20and%20Medicine.

DEVELOP A TACTICAL PLAN



HEALTHY PEOPLE 2030

- Identify needs and priority populations
- Set you own targets
- Find inspirational and practical tools
- Monitor national progress

https://health.gov/healthypeople/tools-action/use-healthy-people-2030-your-work

USING YOUR DATA

Crosswalk your SDOH screening results with:

- Chronic disease measures
  - What are your biggest opportunities?
    - DM? CHF? CKD? COPD?
- ADI data
  - Where are your patients with greatest need and the most open care gaps?

How can you address these needs?

- Targeted outreach- meet patients where they are!
- Food prescriptions
- Transportation assistance
- Educational programs/secure housing

Address loneliness

AAFP- NEIGHBORHOOD NAVIGATOR

- Neighborhood Navigator
  - supported in part by a grant from the AAFP Foundation
  - Free to use- connects FPs and their patients with more than 40,000 social services nationwide.
- Searches are conducted via ZIP code
  - Search results can be printed and/or e-mailed for patients in more than 100 languages.
- Can by used by physicians or patients
  - https://www.aafp.org/family-physician/patient-care/the-everyone-project/neighborhood-navigator.html
  - https://familydoctor.org/neighborhood-navigator/

The EveryONE Project™ neighborhood navigator

Support Sign Up Log In

ZIP or keyword or program name

Select Language

English

Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost help starts here:

FOOD

HOUSING

GOODS

TRANSIT

HEALTH

MONEY

CARE

EDUCATION

WORK

LEGAL

2,052 programs

in the tulsa, ok 74128 area

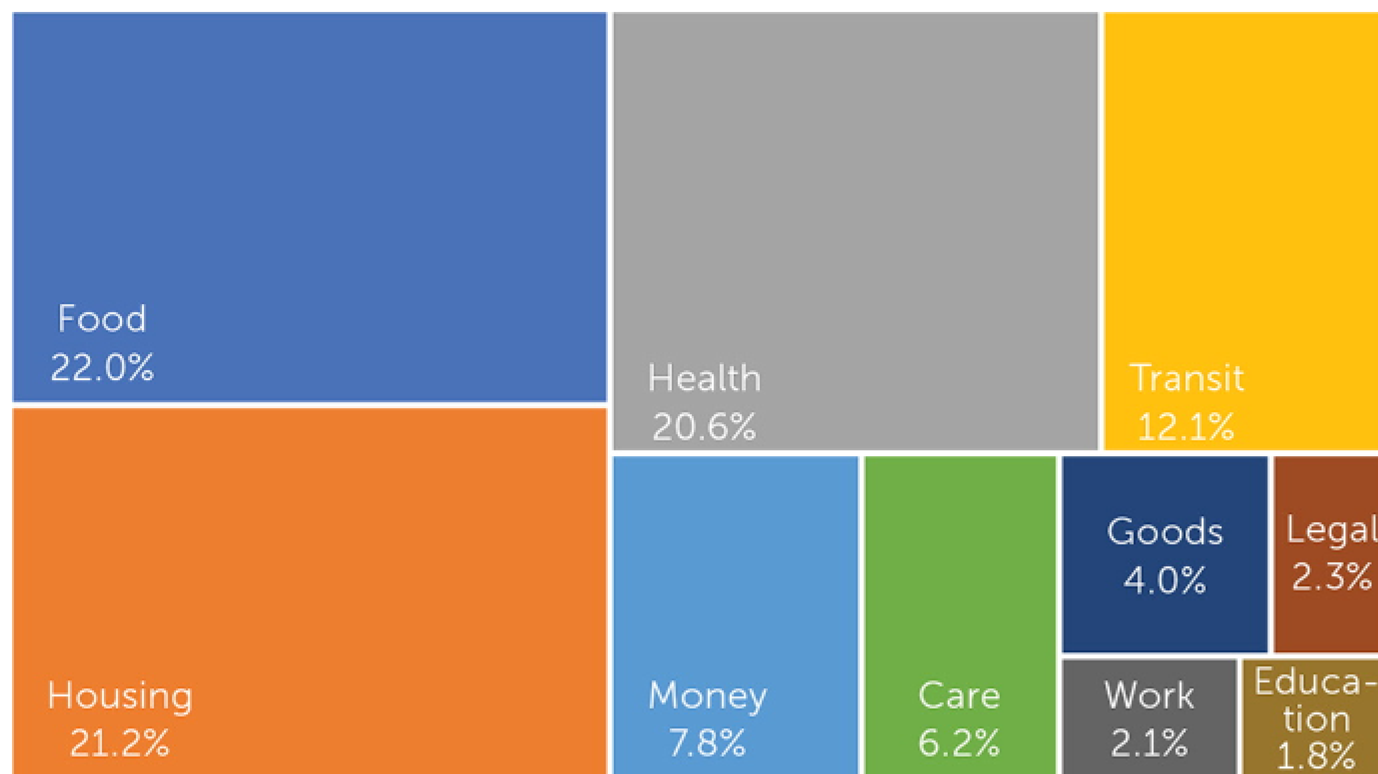
Choose from the categories above and browse local programs

The EveryONE Project™

Advancing health equity in every community

neighborhood navigator

Use of Neighborhood Navigator by Family Physicians



Percentage of searches per social determinants of health category (N = 168,135).

The most common Neighborhood Navigator searches were for food, housing, and health care referral (*Figure 1*). Seasonal analysis revealed 22% more searches in the winter than in the spring, potentially due to the increased need for housing assistance during colder months in some areas. The average number of monthly searches increased by 119% between 2018 and 2022, which was likely attributable to program expansion, dissemination of the tool, and the impact of COVID-19 later in this time frame. Neighborhood Navigator searches increased by 47% during the COVID-19 pandemic. The largest increases were for housing (79%), health (43%), and transportation (40%).

UNITE US

- End-to-End for social support/care
- For Providers, Health Plans, Governmental Entities, and Non-profits
- Screening and predictive analytics at an individual level to help drive change and reduce cost
- Subscription based

https://uniteus.com/solutions/

JULOTA

- A Community Information Platform
  - Enables Critical Community Collaboration Initiatives
- Addressing the Most Challenging and Safety Problems
  - Mental Health | Opioid & Substance Abuse | 911 Super-Utilizers | Emergency Interventions
- Connects the "Helper Community" and Automates Complex Workflows, Referrals, and Tracking
  - Law Enforcement | EMS | Healthcare | Behavioral Health | Social Services
- Also, subscription based

STATE OF OKLAHOMA RESOURCES

- **OKLAHOMA 2-1-1**
  - **DIVIDED INTO WESTERN AND EASTERN OK RESOURCES**
    - Crises/Helplines & Support Groups
    - Mental Health/Addiction Services
    - Financial Assistance
    - Housing/Shelter
    - Food/Meals
    - Clothing
    - Health/Dental
    - Legal/Law Assistance
    - Family/Parent Support
    - Transportation
    - School/Adult Education

https://211eok.org/

SHORT ANSWER…

- Menti.com POLL

Z-CODES

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]

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

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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** Special thanks to Jennifer Faries, MBA, MA, LPC, PMP for assistance in putting this presentation together

MOST COMMON QUESTION!

- How do you accomplish the work of screening for SDOH AND providing resources within the context of a busy primary care practice??

WANT TO CONTINUE THE CONVERSATION?

- Connect with me via LinkedIn
  - https://www.linkedin.com/in/dustincupp-do/