Emerging Trends in Social Determinants of Health

Presented By
Cindy Edgerton, MHA, MEd, RHIA
Charter Oak State College

Created in Collaboration with:

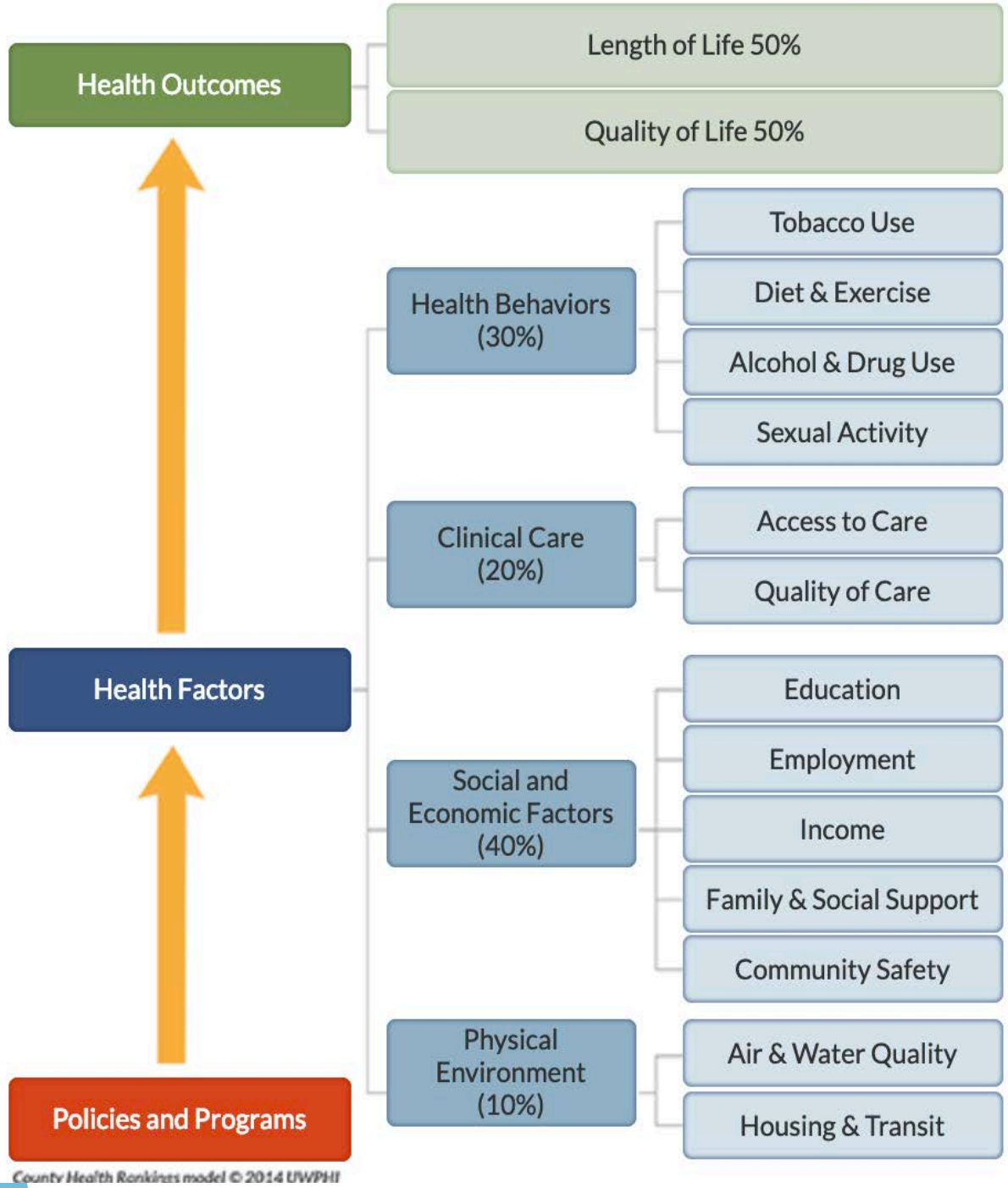
Brooke Palkie, Ed.D, RHIA, FAHIMA

Charter Oak State College

Brittney Dahlin, MS, RHIA, CPHQ
Minnesota Association of Community Health Centers

What are social determinants of heatlh (SDOH)?

- Conditions in which people are born, grow, live, work and age
  - Affect a persons health and access to healthcare
  - Shaped by the distribution of money, power, and resources



SOCIAL DETERMINANTS OF HEALTH

(SDOH)


What We See in the Provider's Office
Housing Instability
Legal Issues
Social Isolation
Unemployment
Adverse Childhood Experiences
Lack of Transportation
Education
Support Systems
Stress
Access to Health Care
Health Literacy
Food Instability
Health Insurance
Language
Unsafe Neighborhoods

Background

- World Health Organization (WHO) created the Commission on Social Determinants of Health in 2005
  - To promote health equity
  - To foster a global movement to achieve it

- 2008 “Closing the gap in a generation; Health equity through action on the social determinants of health”
  - Recommended:
    - improving daily living conditions
    - Tackling the distribution of power, money, and resources
    - Measuring and understanding the problem
    - Assessing the impact of action

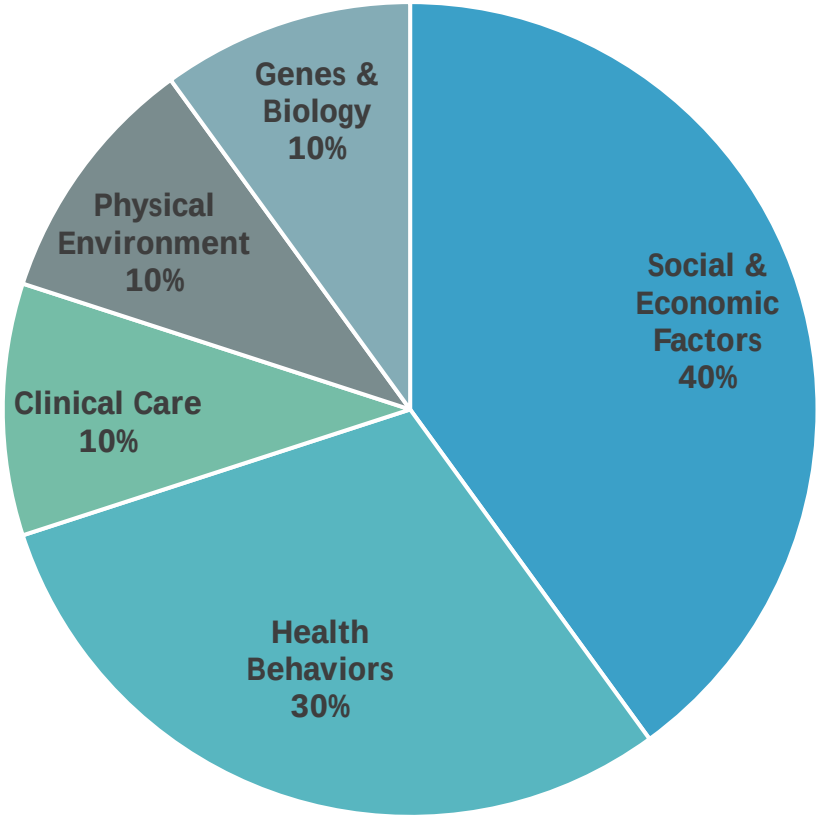
More Recently

- Office of the National Coordinator for Health IT (ONC) prioritized the integration of health and social services data
  - Draft 2020-2025 Health IT Strategic Plan
    - Using health IT to assess and address unmet health and social needs of individuals and communities
    - Capturing and integrating SDOH data into EHR's to use in care delivery and clinical decision support
    - Addressing health disparities ethically

National Initiatives

- The Gravity Project
- CMS' CMMI Accountable Health Communities (AHC) Model
- HHS Office for Civil Rights Notice or Proposed Rulemaking

WHY COLLECT SDOH?



DETERMINANTS OF HEALTH

- Improve health outcomes
- Decrease health disparities
- Better target needed enabling services and community partnerships.
- Demonstrate the complexity of our patients and the resource intensity required to treat them to payers, legislators, community stakeholders, etc.

(Artiga & Hinton, 2018)

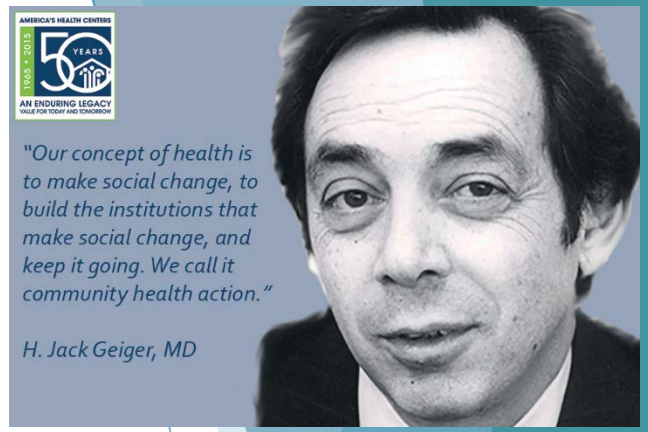
What Can We Do?

- “Upstream” interventions outside of traditional clinical care can lead to overall improvements in health and reduce health disparities and inequities

- Housing
- Neighborhood conditions
- Increased socioeconomic status

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

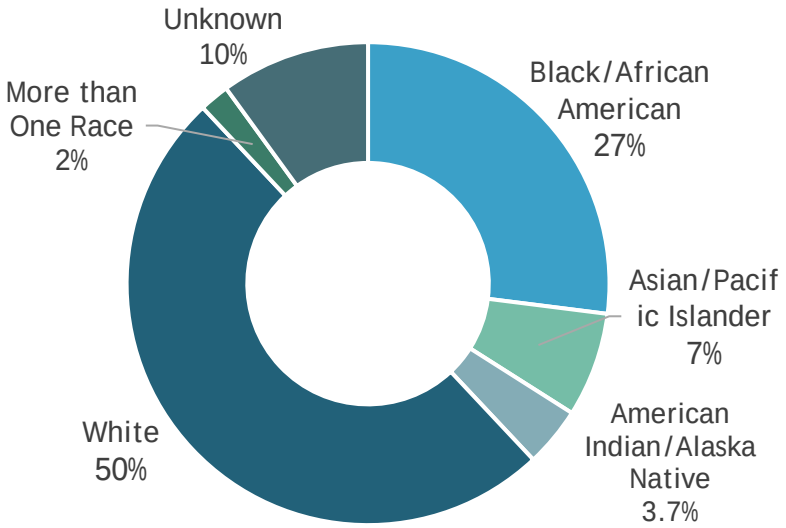
Community Health Centers



- Born out of the Civil Rights Movement – eliminating health disparities is central to our work
- Medical, Dental, Behavioral Health services all under one roof – Some health centers offer additional services like chiropractic, pharmacy, vision care, and Substance Use Disorder treatment.
- We serve **EVERYONE** regardless of their ability to pay (sliding fee scale for uninsured). We receive federal funding from HRSA help with these costs.
- The majority (at least 51%) of our governing boards are CHC patients.
- Located in medically underserved areas.
- Offer culturally sensitive care.
- Provide enabling services - services that help patients overcome barriers to care (e.g., transportation, care coordination, locating affordable medications, assistance with housing, interpretation, health insurance eligibility screening, etc.)

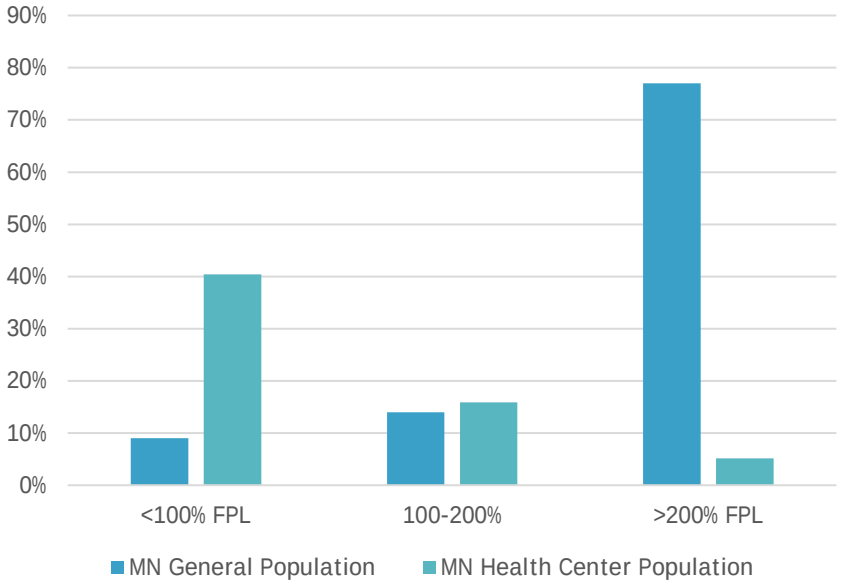
WHO DO THEY SERVE?

Race & Ethnicity

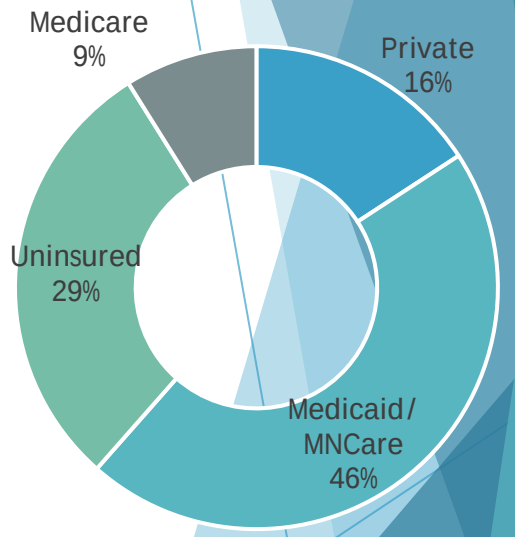


LatinX 26.3%

Income



Insurance Type



WHAT ELSE CAN AND SHOULD WE DO?

Telehealth

- Reimbursement methodologies that make virtual services financially sustainable (e.g., telephone visits)
- Keep technology literacy and access in mind.

Food

- Food banks on site.
- Collaboration with community partners (use connection tools like NowPow)

Transportation

- Assisting with transportation or bringing the services to the patients (e.g., swab squads, mobile vaccine teams).

WHAT ELSE CAN AND SHOULD WE DO?

Housing

- Assist with identifying housing solutions.
- Isolation can be magnified during a pandemic.

Employment

- Identify opportunities for patients to be seen outside of work hours as many do not have paid time off.
- Pipeline programs (e.g., medical assistants)

WHAT ELSE CAN AND SHOULD WE DO?

Partnerships!!!!

Example Case Study:

- Unite Us
  - https://nccare360.org/
- About NCCARE360
- **NCCARE360 is the first statewide coordinated care network to better connect individuals to local services and resources.**
  - NCCARE360 is the first statewide network that unites health care and human services organizations with a shared technology that enables a coordinated, community-oriented, person-centered approach for delivering care in North Carolina. NCCARE360 helps providers electronically connect those with identified needs to community resources and allow for feedback and follow up. This solution ensures accountability for services delivered, provides a “no wrong door” approach, closes the loop on every referral made, and reports outcomes of that connection. NCCARE360 is available in all 100 counties across North Carolina.

COVID: Proactively identifying at-risk populations

- Population health data is key to recognize vulnerable populations; CDC's Social Vulnerability Index and zip-code level SDOH data can be used to connect with members at the high level. State health departments are tracking COVID disparities as well.

SAFETY NET RESIDUAL IMPLICATIONS FROM COVID-19

Health Inequities

- Not only do populations who are considered vulnerable experience disproportionality of higher infection rates and worse health outcomes, there is also an imbalance in the distribution of and access to the necessary resources.
- HIMSS
  - "A deeply embedded structural inequity, producing further health inequity (higher rates of COVID-19 infections), through existing social determinants of health (low socioeconomic status), is the formula that we see consistently playing out throughout this public health crisis."
- Telehealth can help support sustained equitable access.

A CLOSER LOOK AT TELEHEALTH DURING COVID-19

How do lives change during a pandemic; beyond just the clinical needs to service the patient holistically?

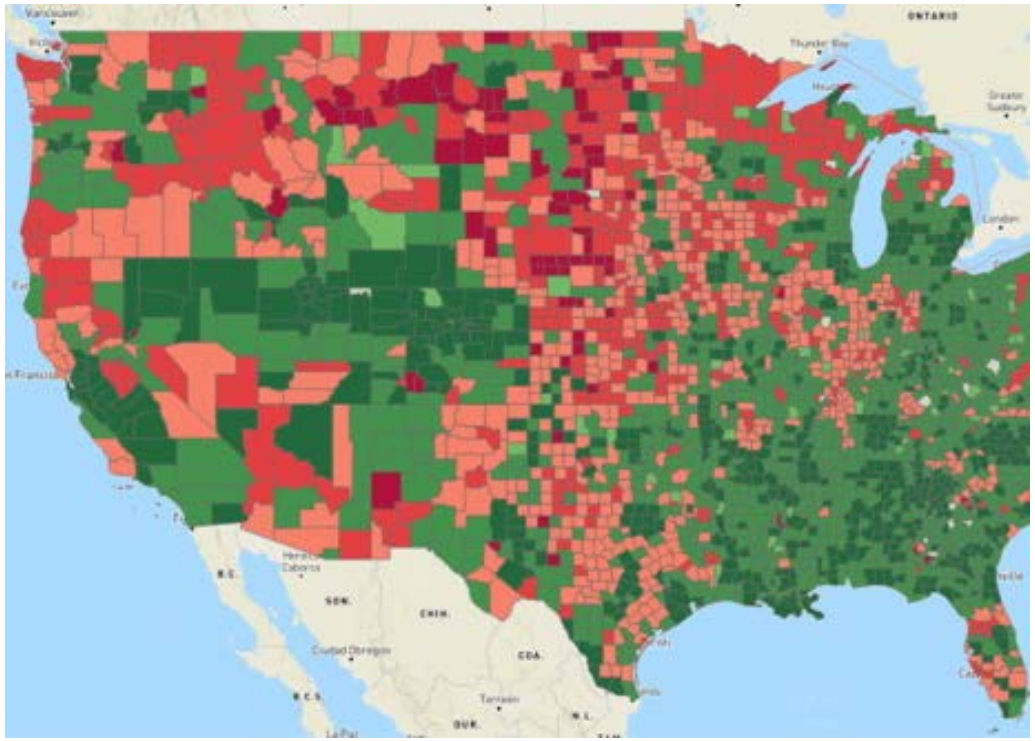
- Reframe services and communication
- Continue coverage of telehealth services into the future through multipronged efforts to:
  - Reduce patient and provider exposure (including conserve PPE)
  - Maintain patient access
  - Ensure continuity of care of patients

HOW TO ACQUIRE THE DATA

Gravity Project – developing structured data standards to reduce barriers to exchange of SDOH data across settings and providers

- Insecurities: Food, housing, stability, transportation access
- Intent: Standardize definitions at the discrete data field level
- EHR needed for consistency in SDOH data: House in the same part of the chart, index the same way (not in notes or different areas such as progress, nursing or case management notes).
- Identify high-risk patients

SOCIAL RISK GROUPER



- Carrothealth.com Carrot Health Social Risk GrouperTM (SRG)
  - Use consumer data and predictive analytics to develop a risk scoring tool that assigns social risk to every patient
  - Useful in targeting interventions, predicting cost, improving health outcomes.
  - Intent is for health plans, Accountable Care Organizations (ACOs) and providers to all utilize these types of groupers.

RISK STRATIFICATION AND PREDICTIVE ANALYTICS

- Health centers are looking at their data in ways they hadn't before…
  - Diagnosis groups (e/g. diabetes, depression, hypertension)
  - Special/Vulnerable Populations (homeless, veterans, LGBTQ)
  - Demographics (insurance status, age, race/ethnicity)
  - Health Center Site
- Create lists of patients who need intervention

Enhanced High Risk Stratification

Chronic Disease Score

- Diabetes
- Hypertension
- Asthma
- COPD
- IVD

Mental Score

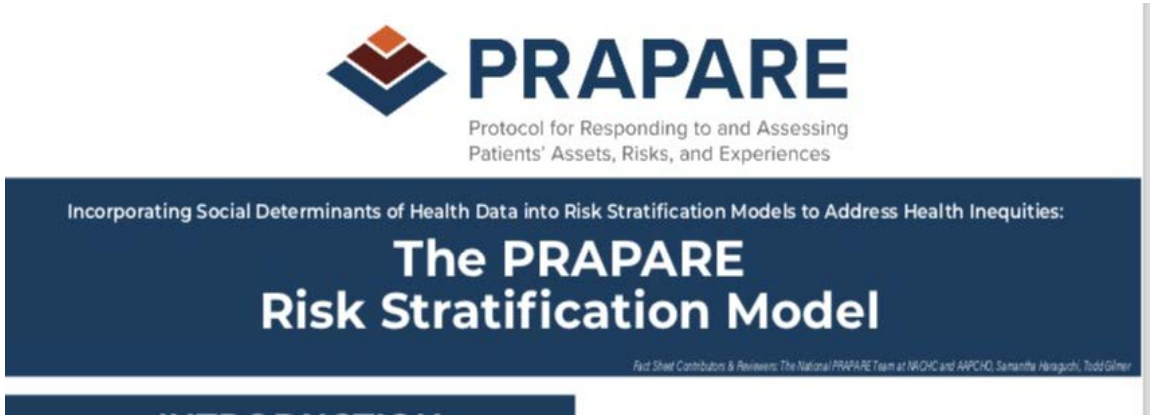
- Mental Disease Diagnosis
- Substance Abuse Diagnosis

Social Score

- Homelessness
- Income at or below 200% of federal poverty level – Sliding Fee Scale
- **PRAPARE SCORE – 1 point given for each positive answer**

Cost Score

- Frequency of visits (MD, Pharmacist, BH, etc)
- Number of Medications
- Number of referrals
- Number of Labs
- Number of No Shows
- Number of Canceled and Rescheduled Appointments
- Number of Medications
- Number of Hospital Admissions



Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

With national standardization of a risk algorithm across clinics and stratification based on population characteristics, the national model can be used for benchmarking and standardization of patient risk across all participating health centers.

https://www.nachc.org/wp-content/uploads/2021/03/PRAPARE-RS-Fact-Sheet-3.30.21.pdf

How to make data actionable

It is not realistic to capture and code SDOH data with Z Codes alone (88 categories and subcategories). Knowledge of various classification and terminology systems are needed.

- ICD-10-CM (Dx & Z Codes), SNOMED-CT (Collection of findings related to social needs i.e. Food insecurity (finding) Homeless (finding), and LOINC (Screening Tools)

Coding Professionals

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

- Follow the ICD-10-CM coding guidelines
- 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
- Coding team managers should review codes for consistency and quality
- Assign all relevant SDOH Z codes to support quality improvement initiatives

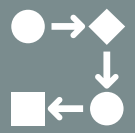
Z Codes

- Z Codes Categories
  - Z55.0 – Z65.8
  - Z55 Problems related to education and literacy
  - Z56 Problems related to education 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

How to make data Actionable

Real time alerts reminding clinicians to collect SDOH

Real time alerts that identify needs – such as referral to a food bank or free transportation service to healthcare appointments. Connect these to the providers order system.



Incorporate a feedback loop! Did the patient use the service? How did it impact their health?

Opportunities

- AHIMA advocates for SDOH data to be collected, accessed, managed, and shared to support whole person healthcare
- Establishing a data governance framework for SDOH is important
- AHIMA members / HIM professionals have a long history of advocating for and expertise in implementing strong health data governance practices to support the data lifecycle
  - New jobs?

Challenges

- Most organizations don’t have a formal data governance committee to address SDOH data collection and usage
- Resource constraints
- Privacy
- Lack of sufficient work force education
- Lack of standardization
- Lake of organizational policy

Sharing……

- What is your organization doing?
- Does your patient record have SDOH collection fields?
- Is your organization coding SDOH?
- Any initiatives at your organization, that you know of, that focus on SDOH?

References

AHIMA. (2021) *Social determinants of health: Improving Capture and Use by Applying Data Governance and Strategies.*

Artiga, S., & Hinton, E. (2018, May 10). *Beyond health care: The role of social determinants in promoting health and health equity.* Retrieved from https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Bresnick, Jennifer. "ICD-10 Allows Non-Physician Documentation of Social Determinants." *ICD-10 Allows Non-Physician Documentation of Social Determinants*, 13 June 2018, healthitanalytics.com/news/icd-10-allows-non-physician-documentation-of-social-determinants.

Federally qualified health centers. (n.d.). Retrieved from https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html

Hyde, Linda (April 2020). *Beyond Z Codes.*. Retrieved from https://journal.ahima.org/beyond-z-codes/

Krohn, Rick. *Addressing social determinants of health with data interoperability.* (April 2020). Retrieved from https://www.healthcareitnews.com/blog/addressing-social-determinants-health-data-interoperability?mkt_tok=eyJpIjoiTVRnek9EQXdZMll5WkdReSIsInQiOiJCZUFhT2IrRnZFcFRJTnVDUFhRekll
cElHSU5pcndBaDIxK1A5Z0FoNk5cL3haZDg3NE5PRGgxR1JJMXJtYTB2R2FCeFFreVc1WWcra0RFeFwvNG1H

References

PRAPARE Risk Stratification Model:

https://www.nachc.org/wp-content/uploads/2021/03/PRAPARE-RS-Fact-Sheet-3.30.21.pdf

U.S. Department of Health and Human Services. 2016. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Retried from https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf

Vreenman, Danial J. Advancing the interoperability of social and behavioral determinants of health. Retrieved from https://loinc.org/sdh/webinar/

What and Why We Rank. (n.d.). Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank

Whole-Person Healthcare. (March 2020). Retrieved from https://journal.ahima.org/whole-person-healthcare/

https://carrothealth.com/wp-content/uploads/2019/11/SRG-Brochure-Oct-2019.pdf