HQIC Community of Practice Call

Addressing Social Determinates of Health to Improve Patient Outcomes: Coding Optimization

July 14, 2022

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Introduction

Welcome!

Shaterra Smith
Social Science Research Analyst -
Division of Quality Improvement
Innovation Models Testing
iQuality Improvement and Innovations Group
Center for Clinical Standards and Quality
CMS

Agenda

- Introduction
- Today's topic
  - Addressing Social Determinates of Health to Improve Patient Outcomes: Coding Optimization

    Presenters:

    - Pooja Kothari, Health Equity SME, IPRO HQIC
    - Karen Scott, Director of Education & Training, TruCode Owner, Karen Scott Seminars & Consulting
    - Athena G. Minor, Chief Nursing and Clinical Officer, Ohio County HealthCare, Hartford, Kentucky
- Open discussion
- Closing remarks

As You Listen, Ponder…

- What information can you leverage to help expand opportunities in your facilities and communities?
- What impactful actions can you take as a result of the information shared today?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- What activities do you have underway that will allow for you to expand and push forward in action over the next 30, 60 or 90 days?

Meet Your Speakers

Pooja Kothari, RN, MPH
Health Equity SME
IPRO HQIC

Karen Scott MEd, RHIA, CCS-P, CPC, FAHIMA
Director of Education & Training, TruCode
Owner, Karen Scott Seminars & Consulting

Athena G. Minor, MSN, RN, CNCO
Chief Nursing and Clinical Officer
Ohio County HealthCare

Addressing Social Determinates of Health to Improve Patient Outcomes

Pooja Kothari, RN, MPH

Health Equity SME - Qsource

IPRO HQIC

IPRO HQIC
Healthcentric Advisors ■ Qlarant
Kentucky Hospital Association
Q3 Health Innovation Partners
Superior Health Quality Alliance
HQIC
Hospital Quality Improvement Contractors
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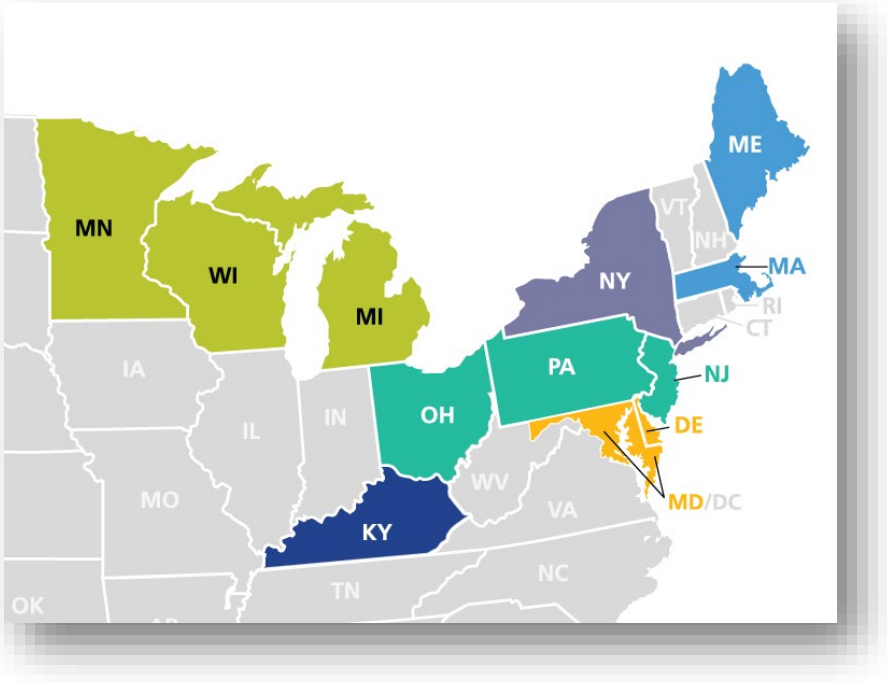
The IPRO HQIC

A federally funded Medicare Hospital Quality Improvement Contractor (HQIC) in 12 states:

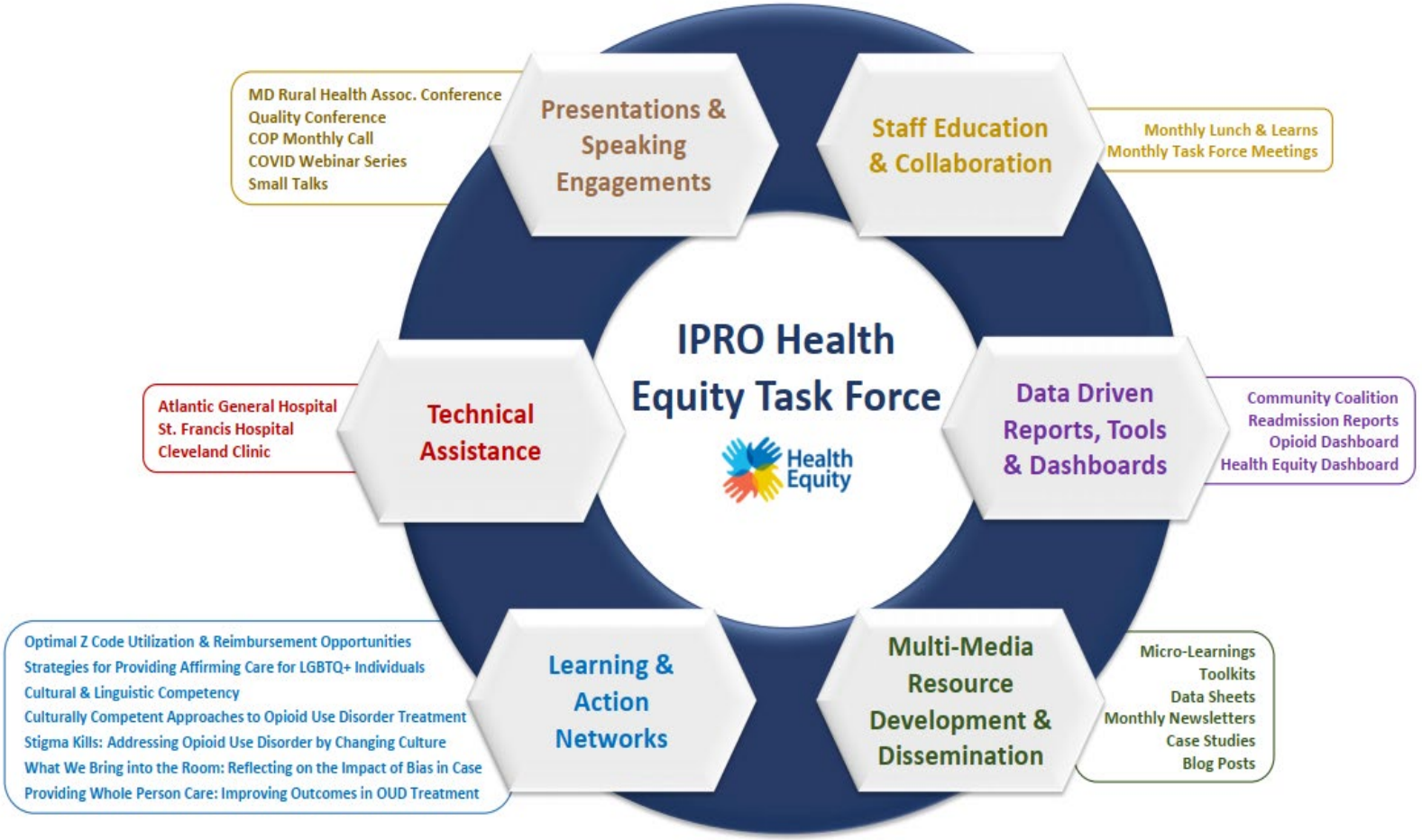
- **IPRO**
- **Healthcentric Advisors**
- **Kentucky Hospital Association**
- **Qlarant**
- **Q3 Health Innovation Partners**
- **Superior Health Quality Alliance**

American Institutes for Research (AIR)

Qsource



IPRO's Cross Task Health Equity Initiative



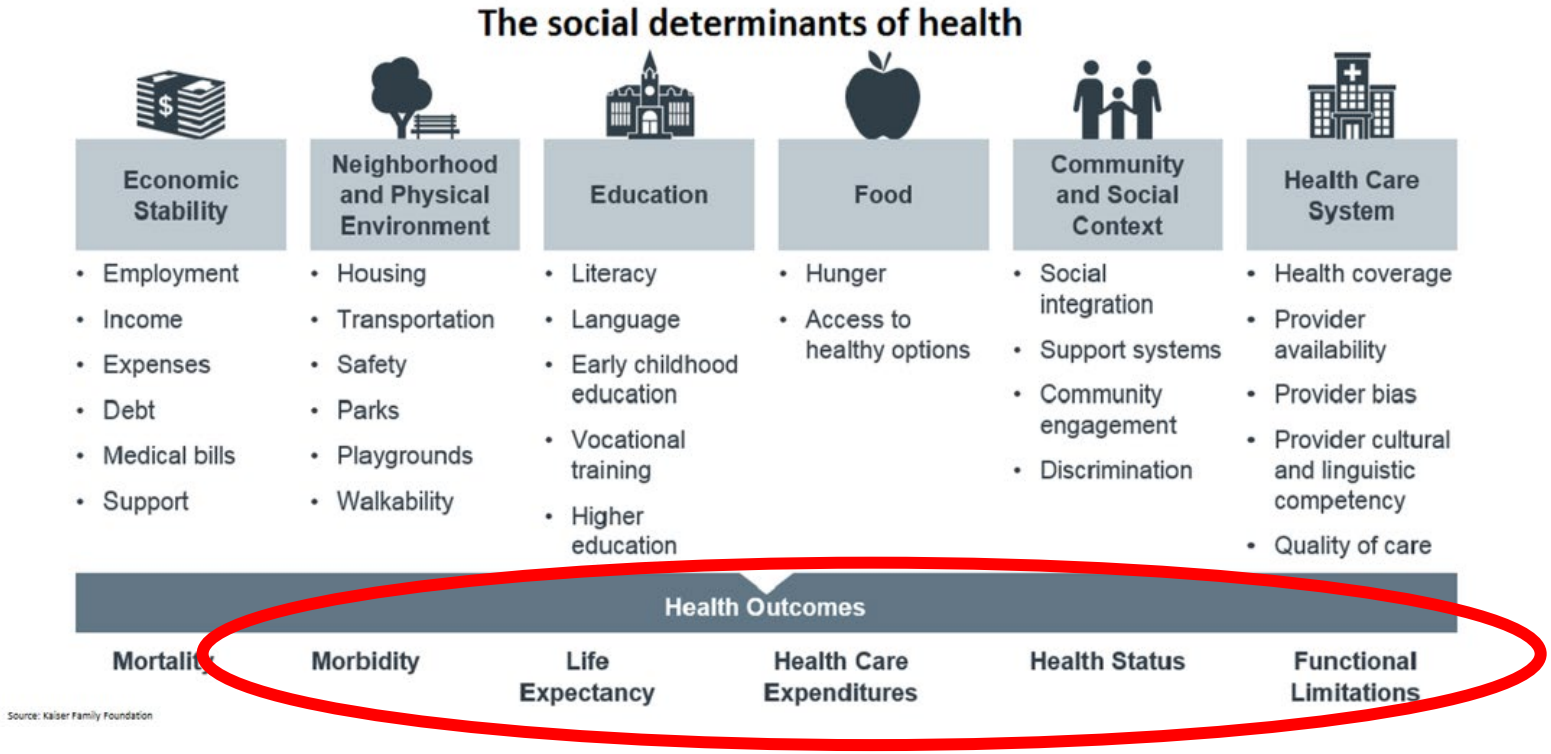
Historical Perspective on Social Determinants of Health

"The improvement of medicine would eventually prolong human life, but improvement of social conditions could achieve this result even more rapidly and successfully."

Rudolf Virchow, Mittheilungen über die in Oberschlesien herrschende Typhus-Epidemie, G. Reimer, Berlin (1848)

Defining Social Determinants of Health (SDOH)

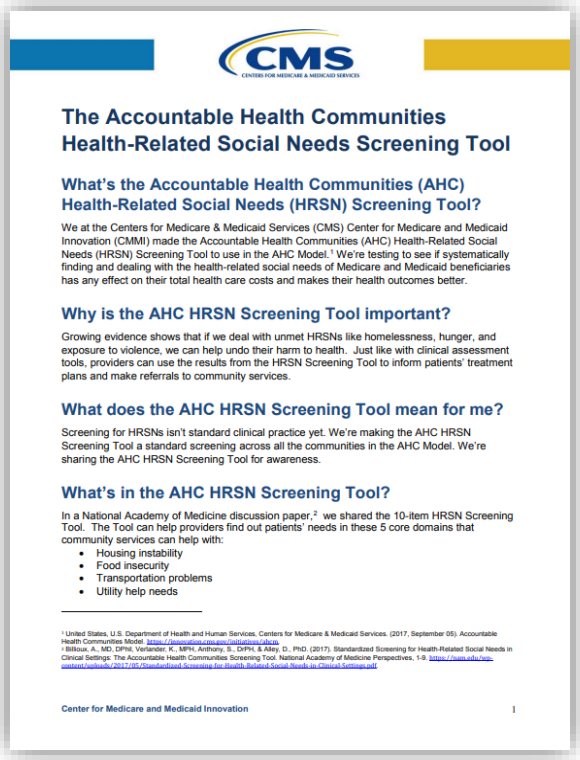
Social determinants of health (SDOH) are the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."



Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

UIC Center. Retrieved from https://www.center4healthandsdc.org/the-social-determinants-of-health.html.

Screening Tools for SDOH



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, DPhil, 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

What Does PRAPARE Measure?

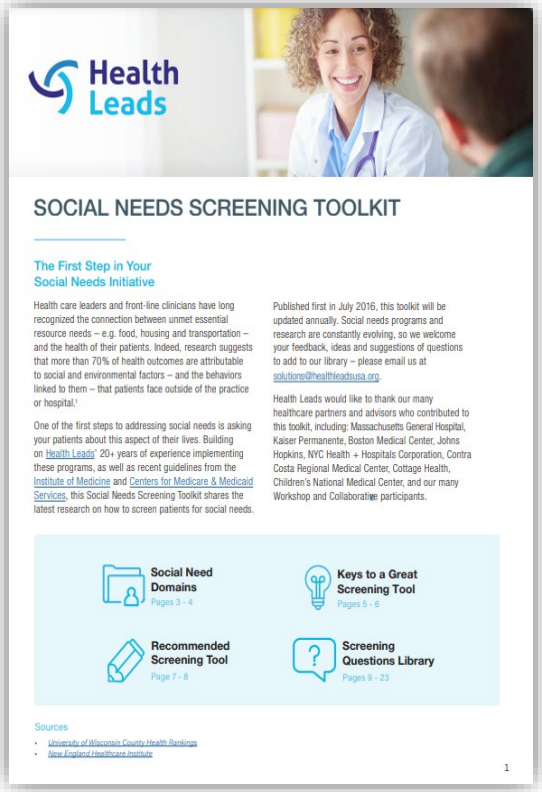
The PRAPARE tool is both evidence-based and stakeholder driven. It was informed by research on social determinant of health domains that predict poor outcomes and high cost, the experience of existing social risk assessments, and the advice and feedback from key stakeholders including patients, providers, clinical leadership, non-clinical staff, and payers. It aligns with national initiatives prioritizing the social determinants of health (e.g., Institute of Medicine's recommendations, Healthy People 2020 goals), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10 Z codes, and health centers' current federal reporting requirements (i.e., Uniform Data System). PRAPARE emphasizes measures, listed below, that are actionable.

Core Measures in PRAPARE

PERSONAL CHARACTERISTICS	• Race • Ethnicity • Farmworker Status	• Language Preference • Veteran Status
FAMILY AND HOME	• Housing Status and Stability • Neighborhood	
MONEY AND RESOURCES	• Education • Employment • Insurance Status	• Income • Material Security • Transportation Needs
SOCIAL AND EMOTIONAL HEALTH	• Social Integration and Support • Stress	
OTHER MEASURES IN PRAPARE	• Incarceration History • Refugee Status	• Safety • Domestic Violence

PRAPARE measures are mapped to ICD-10 Z codes, LOINC codes, and SNOMED codes in our PRAPARE Data Documentation and Codification file to further standardize data for aggregation and analysis. Many of the PRAPARE EHR templates automatically map to the ICD-10 Z codes so that they can be easily added to the diagnostic/problem list.

CHAPTER 1: Understand the PRAPARE Project 3



Health Leads

SOCIAL NEEDS SCREENING TOOLKIT

The First Step in Your Social Needs Initiative

Health care leaders and front-line clinicians have long recognized the connection between unmet essential resource needs – e.g. food, housing and transportation – and the health of their patients. Indeed, research suggests that more than 70% of health outcomes are attributable to social and environmental factors – and the behaviors linked to them – that patients face outside of the practice or hospital.[1]

One of the first steps to addressing social needs is asking your patients about this aspect of their lives. Building on Health Leads' 20+ years of experience implementing these programs, as well as recent guidelines from the Institute of Medicine and Centers for Medicare & Medicaid Services, this Social Needs Screening Toolkit shares the latest research on how to screen patients for social needs.

Published first in July 2016, this toolkit will be updated annually. Social needs programs and research are constantly evolving, so we welcome your feedback, ideas and suggestions of questions to add to our library – please email us at solutions@healthleadsusa.org.

Health Leads would like to thank our many healthcare partners and advisors who contributed to this toolkit, including: Massachusetts General Hospital, Kaiser Permanente, Boston Medical Center, Johns Hopkins, NYC Health + Hospitals Corporation, Contra Costa Regional Medical Center, Cottage Health, Children's National Medical Center, and our many Workshop and Collaborative participants.

Sources

- University of Wisconsin County Health Rankings
- New England Healthcare Institute

1

CMS, The Accountable Health Communities Health-Related Social Needs Screening Tool. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

NACHC. PRAPARE Screening Tool. https://prapare.org/the-prapare-screening-tool/

Health Leads. The Health Leads Screening Toolkit. https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

Case Study: Quality Improvement with a SDOH Focus

- Primary care patients in urban practices were screened for basic unmet needs e.g., food and housing as part of the Health Leads program to understand if helping patients meet their needs improved outcomes.
- Patients with unmet needs were connected with an advocate who prioritized needs, identified community resources, and helped them obtain the resources.
- Screening for and attempting to address unmet basic resource needs in primary care was associated with modest improvements in blood pressure and lipid, but not blood glucose, levels.

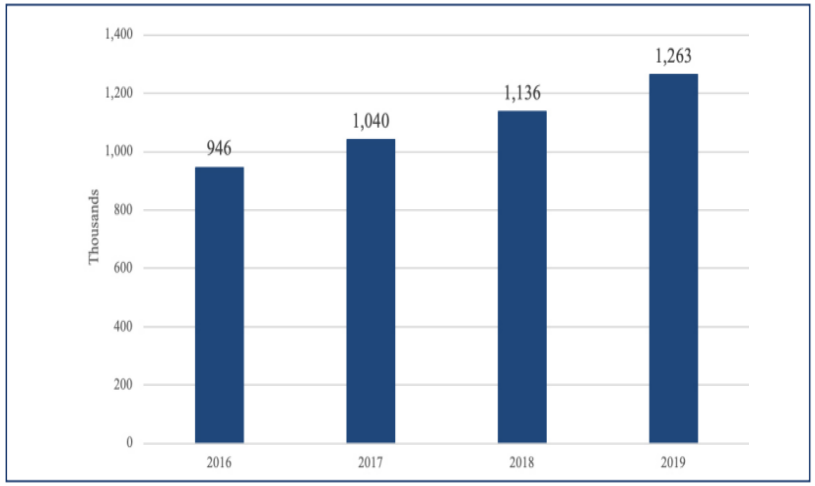
"Quality improvement efforts must start to focus on the environments in which humans are "born, grow, live, work, and age."

Kaveh Shojania. "Making the social determinants of health the focus for healthcare improvement efforts," *BMJ Opinion,* November 20, 2020. https://blogs.bmj.com/bmj/2020/11/20/making-social-determinants-of-health-the-focus-for-healthcare-improvement-efforts/
Berkowitz SA, Hulberg AC, Standish S, Reznor G, Atlas SJ. Addressing Unmet Basic Resource Needs as Part of Chronic Cardiometabolic Disease Management. *JAMA Intern Med.* 2017;177(2):244–252. doi:10.1001/jamainternmed.2016.7691

Using Z Codes to Track SDOH

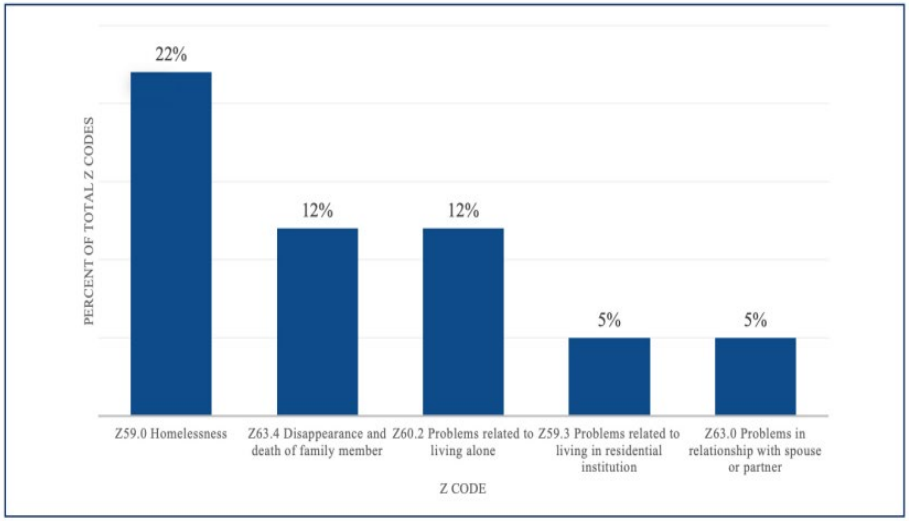
Z Codes are psychosocial risk and economic determinant-related codes used in the International Classification of Diseases; 10th Revision Clinical Modification (ICD-10-CM) used to capture SDOH.

Figure 1. Change in Total Number of Z Code Claims, 2016 to 2019.



The total number of Z code claims was 945,755 in 2016, 1,039,790 in 2017, and 1,135,642 in 2018.

Figure 3. The Top Five Z Codes Representing the Largest Shares of All Z Code Claims, 2019.



CMS, Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019, September 2021. https://www.cms.gov/files/document/z-codes-data-highlight.pdf

Social Determinants of Health (SDOH) Their Impact on Your Community

Karen S. Scott, MEd, RHIA, CCS-P, CPC, FAHIMA
Director of Education and Training, TruCode

Physician SDOH Resources

American Academy of Family Physicians

- The EveryONE Project™
  SDOH Guide to Social Needs Screening
  https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

Journal of AHIMA

- Improving ICD-10-CM Coding for SDOH
  https://journal.ahima.org/improving-icd-10-cm-coding-for-social-determinants-of-health/

From AHIMA

- Currently, a tremendous amount of healthcare data is captured electronically. The data is used by local, state, and federal agencies for population health reporting, trending, research, and more.
- The clinical documentation from sources other than the provider will assist in the accurate capture of data on social determinants of health. The data provided from the code categories Z55-Z65 may be very important information to collect.
- Any of these social determinants can impact an individual's health; for example, not taking prescribed medications as ordered, lack of follow-up care, or exacerbations of chronic illness.

Official Coding Guidelines

- For social determinants of health, such as information found in categories Z55-Z65, 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.
- **Patient self-reported documentation may also 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 health record by either a clinician or provider.**

Z55-59

- Persons with potential health hazards related to socioeconomic and psychosocial circumstances (Z55-Z65)
- Z55Problems related to education and literacy
- Z56Problems related to employment and unemployment
- Z57Occupational exposure to risk factors
- Z59Problems related to housing and economic circumstances

Z60-65

- 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

National Healthcare for the Homeless Council

- "Consistent use of the codes… can increase opportunities to compare data across systems and raise providers' attention to a high-risk acuity factor as patients (and their medical records) move within and across systems.
- For health centers, standardizing data coding and reporting helps document patient complexity compared to other providers and can help demonstrate the value of the health center model of care by showing good outcomes for a complex patient population.
- Regular coding also helps ensure providers are not penalized for serving a high-needs, complex population.
- New payment methodologies that include social determinants of health, patient acuity, and other risk factors will become more important to ensure reimbursements and performance metrics accurately reflect the breadth and depth of patient need, services delivered, and actual health outcomes."

https://nhchc.org/wp-content/uploads/2019/08/ask-code-documenting-homelessness-throughout-the-healthcare-system.pdf

MDM E&M Codes Risk Level

- Social determinants of health:
  - Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.
  - ICD-10-CM Z55-65

Risk Levels

Level	Risk
Straightforward	Minimal risk of morbidity from additional testing/tx
Low	Low risk morbidity
Moderate	Moderate risk of morbidity Examples: Prescription Drug Management Decision regarding minor surgery with id pt or procedure risk factors Decision regarding elective major surgery without id pt/procedure risk factors Diagnosis/treatment significantly limited by social determinants of health (SDOH)

Examples

- Category Z56 Problems related employment and unemployment, subcategory Z56.3
  - Stressful work schedule: A stressful work schedule can certainly impact the health of an individual.
- Category Z59 Problems related to housing and economic circumstances, subcategory Z59.1
  - Inadequate housing: This may impact an individual's ability to prepare and eat healthy meals, get proper rest, and practice good personal hygiene.
- Category Z63 Other problems related to primary support group, including family circumstances, subcategory Z63.6
  - Dependent relative needing care at home: This situation can be very stressful for the caregiver, and oftentimes the caregiver may neglect their own health due to the responsibilities of caring for a relative.

Code the SDOH

- New patient
- CHF; COPD, severe HTN
- Extensive history taken, physical exam
- Counseling on diet, smoking cessation
- Reviewed current meds and dosages and discussed need to take all meds as prescribed.
- He had a job loss and this will lead to loss of insurance after the first of the year; he is worried this will have a serious impact on his healthcare.

Possible SDOH Codes

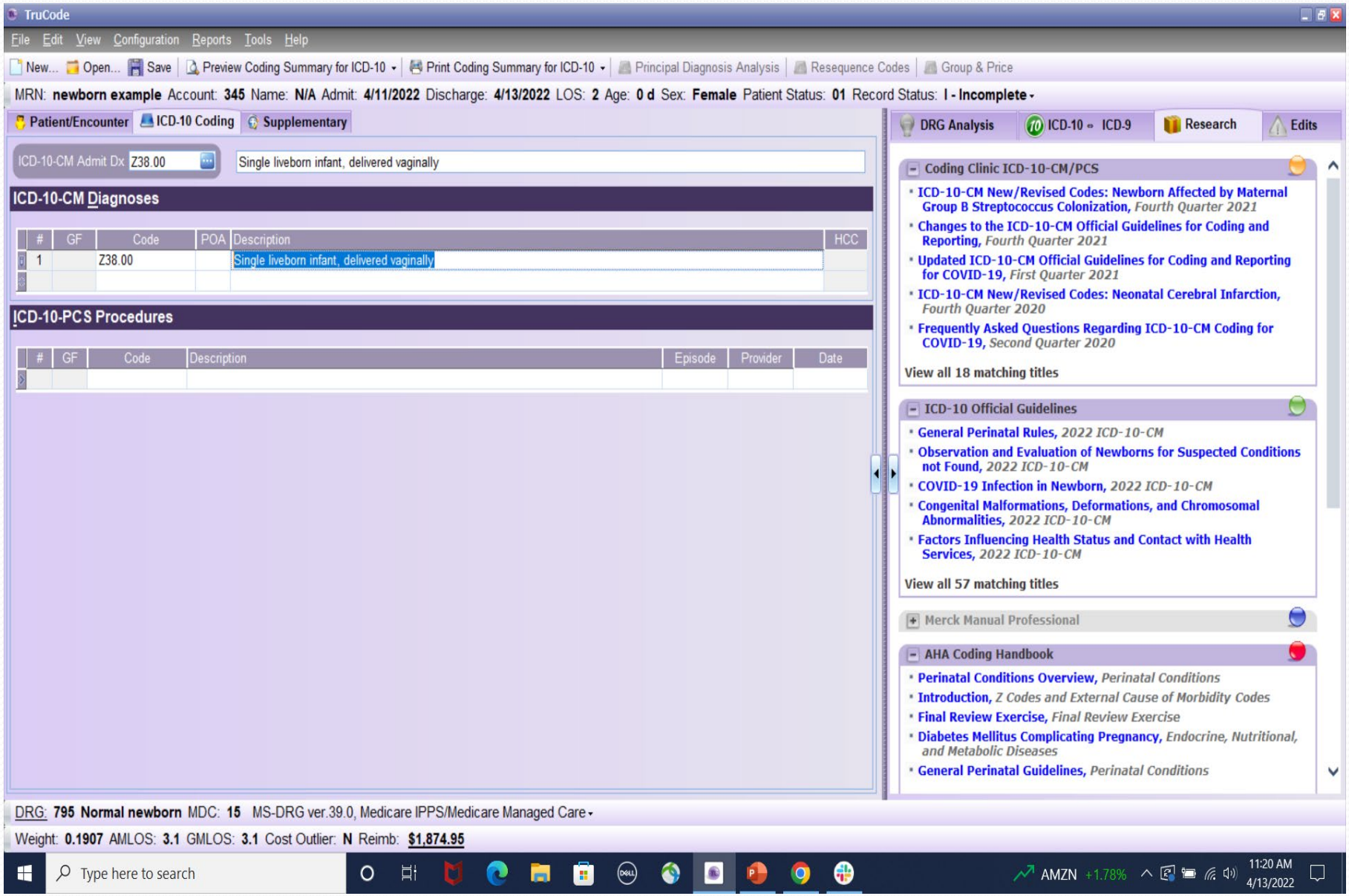
- Z56.0 Unemployment
- Z59.7 Insufficient social insurance and welfare support

Example

- An elderly patient new to your practice is underweight and not thriving. After talking with the caregiver and asking about food intake, you determine the patient has food insecurity.
- The appropriate diagnosis codes are:
  - R63.6 Underweight
  - R62.7 Failure to thrive (adult)
  - Z68.1 Body mass index (BMI)19.9 or less, adult
  - Z59.41 Food Insecurity

DRG Example

- Some SDOH Codes impact reimbursement
- Normal Newborn
- Use an SDOH code such as
  - Child in welfare custody
  - Z62.21


TruCode
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MRN: newborn example Account: 345 Name: N/A Admit: 4/11/2022 Discharge: 4/13/2022 LOS: 2 Age: 0 d Sex: Female Patient Status: 01 Record Status: I - Incomplete
Patient/Encounter ICD-10 Coding Supplementary
ICD-10-CM Admit Dx Z38.00
Single liveborn infant, delivered vaginally
ICD-10-CM Diagnoses
GF Code POA Description HCC
1 Z38.00 Single liveborn infant, delivered vaginally
ICD-10-PCS Procedures
GF Code Description Episode Provider Date
DRG Analysis ICD-10 ⇔ ICD-9 Research Edits
Coding Clinic ICD-10-CM/PCS
ICD-10-CM New/Revised Codes: Newborn Affected by Maternal Group B Streptococcus Colonization, Fourth Quarter 2021
Changes to the ICD-10-CM Official Guidelines for Coding and Reporting, Fourth Quarter 2021
Updated ICD-10-CM Official Guidelines for Coding and Reporting for COVID-19, First Quarter 2021
ICD-10-CM New/Revised Codes: Neonatal Cerebral Infarction, Fourth Quarter 2020
Frequently Asked Questions Regarding ICD-10-CM Coding for COVID-19, Second Quarter 2020
View all 18 matching titles
ICD-10 Official Guidelines
General Perinatal Rules, 2022 ICD-10-CM
Observation and Evaluation of Newborns for Suspected Conditions not Found, 2022 ICD-10-CM
COVID-19 Infection in Newborn, 2022 ICD-10-CM
Congenital Malformations, Deformations, and Chromosomal Abnormalities, 2022 ICD-10-CM
Factors Influencing Health Status and Contact with Health Services, 2022 ICD-10-CM
View all 57 matching titles
Merck Manual Professional
AHA Coding Handbook
Perinatal Conditions Overview, Perinatal Conditions
Introduction, Z Codes and External Cause of Morbidity Codes
Final Review Exercise, Final Review Exercise
Diabetes Mellitus Complicating Pregnancy, Endocrine, Nutritional, and Metabolic Diseases
General Perinatal Guidelines, Perinatal Conditions
DRG: 795 Normal newborn MDC: 15 MS-DRG ver.39.0, Medicare IPPS/Medicare Managed Care
Weight: 0.1907 AMLOS: 3.1 GMLOS: 3.1 Cost Outlier: N Reimb: $1,874.95
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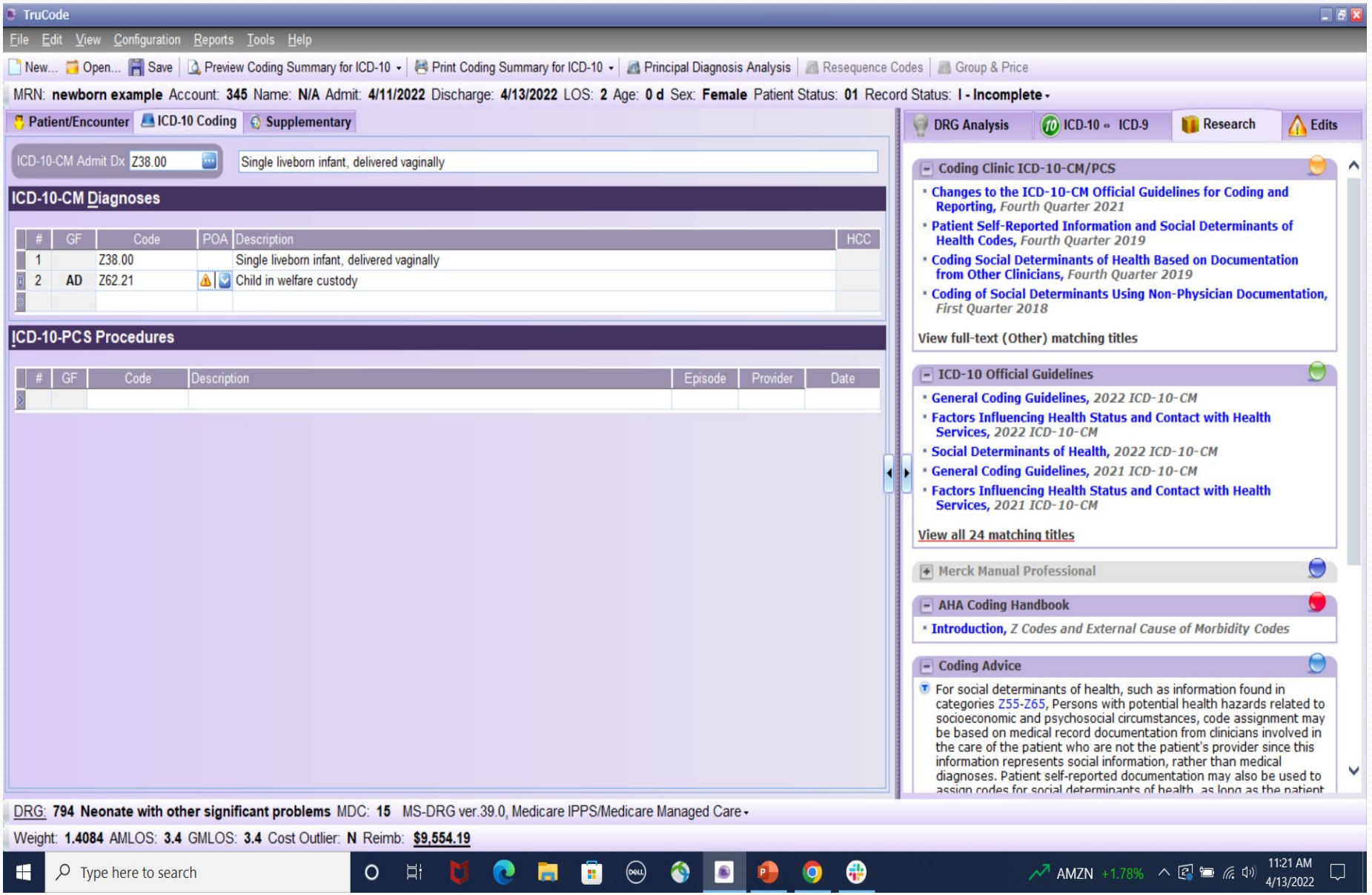
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Coding Clinic ICD-10-CM/PCS
Changes to the ICD-10-CM Official Guidelines for Coding and Reporting, Fourth Quarter 2021
Patient Self-Reported Information and Social Determinants of Health Codes, Fourth Quarter 2019
Coding Social Determinants of Health Based on Documentation from Other Clinicians, Fourth Quarter 2019
Coding of Social Determinants Using Non-Physician Documentation, First Quarter 2018
View full-text (Other) matching titles
ICD-10 Official Guidelines
General Coding Guidelines, 2022 ICD-10-CM
Factors Influencing Health Status and Contact with Health Services, 2022 ICD-10-CM
Social Determinants of Health, 2022 ICD-10-CM
General Coding Guidelines, 2021 ICD-10-CM
Factors Influencing Health Status and Contact with Health Services, 2021 ICD-10-CM
View all 24 matching titles
Merck Manual Professional
AHA Coding Handbook
Introduction, Z Codes and External Cause of Morbidity Codes
Coding Advice
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DRG: 794 Neonate with other significant problems MDC: 15 MS-DRG ver.39.0, Medicare IPPS/Medicare Managed Care
Weight: 1.4084 AMLOS: 3.4 GMLOS: 3.4 Cost Outlier: N Reimb: $9,554.19
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Coding Tip Sheet

From American Academy of Pediatrics
https://downloads.aap.org/AAP/PDF/SDOH.pdf

- Discussion of addition of SDOH to risk table:

  "If the patient has a documented SDOH that fits this criteria it could potentially lead to a higher level code. This is appropriate as patients with one or more SDOHs may have higher risk for morbidity. This was an important addition to the MDM table for 2021. However, it is strongly advised to not only document how the identified SDOH may impact the diagnosis or treatment, but to also code for it using the many ICD-10-CM codes available for reporting."

What Can We Do?

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

- Need a standardized approach screening for, documenting and coding social needs
- Track social needs that impact 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
- Identify population health trends and guide community partnerships

AHIMA Steps to SDOH Coding

- Examples of internal guidelines include:
  - In accordance with the AHA 4th Quarter 2019 issue of *Coding Clinic*, identifying the categories of clinicians, such as, community health workers, social workers and case managers whose health record documentation may be used for SDOH code assignment.
  - Identifying documentation that would justify the assignment of an SDOH-related ICD-10-CM code. For example, documentation of "Tent City" resident or "Lives in vehicle" would justify the reporting of code Z59.0, Homelessness. Code Z56.6, Other physical and mental strain related to work, is to be assigned for documentation of patient being furloughed, underemployed, or reporting reduced work hours.
  - Reporting SDOH-related codes on readmission records to support the healthcare organization's readmission reduction program.
  - Requiring the reporting of SDOH-related codes on all well child visits to meet a state Medicaid requirement that this information be included on the claim.
  - Requiring that SDOH-related ICD-10-CM codes be reported in the top 25 diagnosis fields to ensure that the information is included on claims submitted to payers."

https://journal.ahima.org/improving-icd-10-cm-coding-for-social-determinants-of-health/

White Paper from AHIMA

- AHIMA-SDOH-White-Paper-July-2021.pdf
- Discussion on how HIM professionals can help collect this data from an information governance perspective
- Coding productivity standards is key
- Challenges
  - Privacy
  - Organization commitment
  - Lack of manpower
  - Process development/restructure
- Recommendations to address these

Utilize Tools and Education

- Tools that screen for SDOH
  - Your EHR
  - Specialty societies
  - Vendors
- Educate providers
  - Start with CPT office visit discussions
  - Checks to make sure coding of dx codes occurs
  - Consistency

More Resources

- **CMS Office of Minority Health**
  - Utilization of Z Codes for SDOH among Medicare Fee-For-Service Beneficiaries, 2019
    https://www.cms.gov/files/document/z-codes-data-highlight.pdf
  - Using Z Codes: The SDOH Data Journey to Better Outcomes
    https://www.cms.gov/files/document/zcodes-infographic.pdf
- **National Health Care for the Homeless Council**
  - Ask & Code: Documenting Homelessness Throughout the Health Care System
    https://nhchc.org/wp-content/uploads/2019/08/ask-code-documenting-homelessness-throughout-the-healthcare-system.pdf
- **The Gravity Project**
  - https://thegravityproject.net/
- **The Centers for Disease Control and Prevention**
  - National Center for Health Statistics ICD-10-CM Browser Tool
    https://icd10cmtool.cdc.gov/?fy=FY2022

Asking about Homelessness

The Health Resources and Services Administration (HRSA), which funds the health center program [including Health Care for the Homeless (HCH) grantees], noted in 1999 guidance that "a recognition of the instability of an individual's living arrangements is critical to the definition of homelessness."[6] While there is no requirement for all health centers to ask about housing status, HCH grantees are required to report annually on the numbers of patients who stay in six types of housing categories: homeless shelters, transitional programs, doubled up, on the street, other, and unknown.[7] In HCH settings, conducting a more thorough screening for housing status may have the added benefit of ensuring eligibility for services, especially when the capacity for new patients may be limited.

ICD-10-CM Z Series:

Factors influencing health status & contact with health services

Z55-Z65 Series: *Persons with potential health hazards related to socioeconomic & psychosocial circumstances*

Z59 Series: *Problems related to housing & economic circumstances*

Current "asking" practices: Directly asking "Are you homeless?" does not effectively identify homelessness. People without homes may not identify themselves as "homeless" due to stigma, shame, or the thought that a temporary and tenuous living arrangement is "home." When asked for an address, people without homes of their own often provide one that belongs to a friend, relative, shelter, or church, or is a previous residence. Places where people stay might change daily as individuals and families move between shelter, street, and/or temporary stays with friends or family. It is also possible that bad experiences seeking health care in the past will prevent someone from self-disclosing homelessness for fear of being treated poorly.

There is no common or required methodology for asking about housing status in health care settings, and different organizations have adopted various practices to determine homelessness. These usually involve a short series of questions or multiple-choice questions about the patient's current living situation. Appendix A includes examples of screening tools used to make housing-related inquiries. These examples represent tools used by several institutions:

- **HCH grantees:** Questions from the intake forms of seven HCH projects that ask detailed questions about living situations.
- **Health centers:** A tool called *Protocol for Responding to and Assessing Patients' Assets, Risks and*

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Quick Reference for Social Determinants of Health (SDOH) Coding

Determining SDOH Risk Factors

Via Standardized Instrument

If SDOH risk factors are determined by use of a standardized instrument, CPT code 96160 or 96161 can be reported:

96160 *Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument*

96161 *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*

CPT defines "standardized instruments" as follows: Used in the performance of these services. Standardized instruments are validated tests that are administered and scored in a consistent or "standard" manner consistent with their validation.

Codes 96160-96161 are reported in addition to the evaluation and management (E/M) code (eg, 99213).

Via Non-Standardized Instrument or Assessment

If SDOH risk factors are determined by use of a non-standardized instrument or assessment, CPT codes 96160 or 96161 cannot be reported.

patients:

Social Determinant	ICD-10-CM Code/Description
Abuse (history of)	Z62.810 Personal history of physical and sexual abuse in childhood Z62.811 psychological abuse in childhood Z62.812 neglect in childhood Z62.819 unspecified abuse in childhood
Economic difficulties	Z59.5 Extreme poverty Z59.6 Low income Z59.7 Insufficient social insurance and welfare support Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
Education	Z55.0 Illiteracy and low-level literacy Z55.1 Schooling unavailable and unattainable Z55.2 Failed school examinations Z55.3 Underachievement in school Z55.4 Educational maladjustment and discord with teachers and classmates Z55.8 Other problems related to education and literacy Z55.9 Problems related to education and literacy, unspecified
Environmentally-compromised housing (eg, Lead)	Z77.011 Contact with and (suspected) exposure to lead Z77.1 to other environmental pollution

Issues (Relationship)	Z63.32 Other absence of family member Z63.4 Disappearance and death of family member Z63.5 Disruption of family by separation and divorce Z63.71 Stress on family due to return of family member from military deployment Z63.79 Other stressful life events affecting family and household Z63.0 Problems in relationship with spouse or partner Z63.6 Dependent relative needing care at home Z63.8 Other specified problems related to primary support group Z63.9 Problem related to primary support group, unspecified
Food insecurity	Z59.4 Lack of adequate food and
Housing issues	Z59.0 Lack of housing (homeless) Z59.1 Inadequate housing Z59.8 Other problems related to housing and economic circumstances Z59.3 Problems related to living in residential institution
Nutrition	Z71.3 Dietary counseling and surveillance Z59.4 Lack of adequate food and safe drinking water
Parent/Sibling-Child Issues	Z62.0 Inadequate parental supervision and control Z62.1 Parental overprotection Z62.3 Hostility towards and scapegoating of child Z62.6 Inappropriate (excessive) parental pressure Z62.820 Parent-biological child conflict Z62.821 Parent-adopted child conflict Z62.822 Parent-foster child conflict Z62.890 Parent-child estrangement NEC Z62.891 Sibling rivalry
Psychosocial Issues	Z64.0 Problems related to unwanted pregnancy Z64.4 Discord with counselors Z65.1 Imprisonment and other incarceration Z65.2 Problems related to release from prison

The EveryONE Project™

Advancing health equity in every community

Social Determinants of Health

GUIDE TO SOCIAL NEEDS SCREENING

"Why treat people and send them back to the conditions that made them sick in the first place?"[1]

– Sir Michael Marmot

INTRODUCTION

Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual's health outcomes. For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls. Effectively implementing programs to identify and attend to these social factors depends on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.

SDOH, as defined by the American Academy of Family Physicians (AAFP), are the conditions under which people are born, grow, live, work, and age. Factors that strongly influence health outcomes include a person's:

- Access to medical care
- Access to nutritious foods

Family physicians understand that it is important to identify and address SDOH for individuals and families to achieve optimal health outcomes and whole-person care. The challenge is operationalizing and implementing a large task with many factors into a busy practice environment in a manner that is actionable and practical.

The movement toward value-based payment models is structured around health outcomes rather than processes. Under these models, physicians are paid based on those health outcomes. Empowering family physicians to address SDOH allows them to discuss behaviors and social factors that influence those health outcomes.

The AAFP is committed to helping you and your patients with a series of tools to use at the point of care by the practice team to quickly and efficiently screen your patients, act when needed, and link to community resources. All SDOH do not need to be addressed at one time, nor should this all be done by the family physician alone.

To help get you started, the AAFP is providing resources that you can customize to your individual practice, population, and community needs. These tools are intended to be useful to

Receptionists/medical assistants

- Distribute the SDOH screening tool to patient upon arrival
- Make educational materials and resources available in waiting areas and exam rooms

Nurses, physician assistants, and/or health educators

- Review the completed SDOH screening tool and determine patient needs
- Determine resources available in your community and complete action plan prior to the visit
- Counsel patient during the visit and assist with documentation and follow up

Family physician

- Review the completed SDOH screening tool and action plan prior to the visit, and incorporate into the plan of care for the patient
- Consider action at each visit with information available
- Refer patients to additional team members for education, as needed

Administrators

- Ensure adequate resources and staffing to screen and provide action plan
- Communicate to each staff member his or her responsibilities
- Provide training and education about responsibilities to staff, assuring new staff are also trained

Social workers and/or community health workers (if available)

- Determine resources available in your community and complete action plan prior to the visit
- Facilitate referrals to community resources based on

Social determinants of health are interrelated. A positive screen could indicate the need for an in-depth conversation about needs and challenges outside of a specific social need. Increased stress due to multiple social determinants further impacts health.

The long-form version of the screening tool is intended for practices that choose to screen for additional needs. It includes the five core health-related needs in the short-form version, as well as screening for the additional needs of employment, education, child care, and financial strain.

Screening for SDOH does not need to be administered by a physician, and it can be performed upon check in or while rooming so that it does not disrupt the flow of the visit while promoting more comprehensive care.[2] The screening tool can be self-administered or given via an in-person interview. However, individuals may be more likely to disclose sensitive information, such as interpersonal violence, when self-administered.[3]

The following SDOH screening tools and patient action plan provides a starting point to make it easy and efficient to integrate into your busy clinic.

- SDOH Short-form Screening Tool
- SDOH Long-form Screening Tool
- SDOH Patient Action Plan

CORE SOCIAL NEEDS*

Underlined answer options indicate a positive response for a social need for the housing, food, transportation, utilities, child care, employment, education, and finances categories.

Using Z Codes in Quality Improvement: One Hospital's Journey

Athena G. Minor, MSN, RN, CNCO
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Ohio County HealthCare
Hartford, Kentucky

Ohio County HEALTHCARE

Ohio County Healthcare is a non-profit Joint Commissioned accredited health system which provides a wide range of hospital, primary care and specialty physician services.

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Discussion

- What information can you leverage to help expand opportunities in your facilities and communities?
- What impactful actions can you take as a result of the information shared today?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- What activities do you have underway that will allow for you to expand and push forward in action over the next 30, 60 or 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on August 11, 2022
from 1:00 – 2:00 PM ET

We invite you to register at the following link:
https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post event assessment.

We will use the information you provide to improve future events.