# Progress not Perfection:
# A Discussion of SDOH Data Collection and Coding

**Monthly HQIC Health Equity Office Hours**

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ALLIANT HEALTH SOLUTIONS | HQIC Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

# Polling Question

**Do you currently utilize Z-codes in your hospital's data and reporting systems to track and address health inequities or SDOH in your patients?**

1. Yes, we actively use health equity Z-codes in our data and reporting systems.
2. No, we are not currently using health equity Z-codes, but we are considering implementing them in the future.
3. We are aware of health equity Z-codes, but we haven't incorporated them into our data practices yet.
4. Not sure/Don't know.

# Polling Question

Do you currently add Health Equity Z-Codes as part of the patient's encounter?

1. Yes, we currently have processes in place to screen for and utilize Z-Codes.
2. No, we do not currently screen for SDOH or utilize Z-Codes but we are discussing doing so.
3. No, we do not currently screen for SDOH or utilize Z-Codes and have not discussed doing so.
4. Not sure/Don't know.

# Rhonda Spellmeier, KONZA National Network

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*Rhonda earned a BSN in 1996 and has been an RN for over 27 years working in critical access health systems in various roles. Those roles have included bedside nursing in med-surg, ER, OB, outpatient, cardiopulmonary rehab, swing bed, and case management. Additionally, she has served as a nurse manager, clinical IT analyst, and chief nursing officer. Ultimately, after earning an MBA, she began to focus on bridging the gap between clinicians and health IT in hopes of improving patient outcomes and clinician and patient satisfaction. Rhonda has been actively involved in many successful quality improvement initiatives throughout her career with a recurrent theme of workflow analysis and the impact it has on outcome success.*

**Implementing system-wide programs can be overwhelming and often results in focus on perfection of the end product rather than making step-wise, intentional, long-term progress. During today's webinar, we will briefly review the components of an HRSN/SDOH program and provide guidance and resources for the data collection and mapping portion of the HRSN/SDOH program. Actionable steps and vetted resources will be included so you can take this information back to your team and utilize what is relevant for your SDOH journey.**

# Understanding HRSN and SDOH

**The term "health-related social needs" is sometimes used interchangeably with Social Determinants of Health (SDOH).**

**SDOH** refers to the conditions in which people are born, grow, work, live, and age that are shaped by the distribution of money, power and resources and impacted by factors such as institutional bias, discrimination, racism, and more.

**HRSN** refers to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They include things such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more.

**HRSN is a result of the SDOH. An unequal distribution of SDOH is the root cause of HRSNs at the individual level.**

**We can't always fix the SDOH but we CAN take steps to address the resulting health-related social needs.**

# Components of a HRSN Program

Equity

- Strategic Planning
- Data Collection/Validation
- Data Analysis
- Quality Improvement
- Leadership Engagement

# Health Equity Gap Assessment as part of Strategic Planning

## AKA: We don't know what we don't know.

This is the time to engage <u>all</u> your internal stakeholders to answer these questions.
*This is not the time to design or implement solutions.*









**DATA Collection**:

- Does your hospital use a self-reporting methodology to collect demographic data from the patient and/or caregiver? Examples include REaL, SOGI, and SDOH data
    - Consider running reports out of your EHR to determine if codes Z55-65 are being used
    - Consider manual chart abstraction if reporting tools not available within your EHR to review "notes" for documentation
    - Consider partnering with your Health Information Exchange for a data review of SDOH elements
    - Consider evaluating claims data for presence of Z-Codes

# Z-Codes as an SDOH Tool

## Using a standardized approach to SDOH data is important for:

- ❑ Meeting the needs of patients by appropriately screening for the right services and referrals
- ❑ Allows for streamlined Z-Code assignment
- ❑ Identifying population health-related trends that may be tackled through nontraditional, system-wide relationships beyond the hospital and clinic
- ❑ Aggregate data across patient populations to determine how to focus an SDOH strategy
- ❑ Match program scope and staffing based on population needs
- ❑ Supporting policy/payment reforms that include appropriate adjustments for SDH
- ❑ Enabling system-wide research and evaluating outcomes of interventions

## Why Z-Codes?

- ❑ Have been available since 2015-16
- ❑ Allows a structured format for mapping documentation to a problem
- ❑ Supports automated analysis and reporting for quality programs
- ❑ Analysis can be used in Community Needs Assessments
- ❑ Allows for implementation without an EHR build (unlike Snomed or LOINC mapping)
- ❑ Can be used by coding professionals without physician approval if supporting documentation is present (Since 2018)
- ❑ Are Interoperable and shareable across multiple organizations, including your Health Information Exchange

## Barriers to Using Z-Codes

- ❑ Lack of structured, consistent data collection and documentation in patient record
- ❑ Lack of clear organizational goals regarding health equity
- ❑ Lack of workflow development
- ❑ Lack of education, training, understanding by stakeholders
- ❑ Lack of resources to address more data collection requirements
- ❑ Lack of data collection/code mapping in EHR
- ❑ Lack of confidence and organizational authority to assign codes
- ❑ Lack of processes for resolving Z Codes in problem list when appropriate
- ❑ Lack of "solutions" to positive screens
- ❑ Internal and systemic bias

# 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 diagnosis 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, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

### 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 by any member of the care team if their documentation is included in the official medical record.[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.

CMS

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

[1] https://www.cms.gov/medicare/icd-10/2024-icd-10-cm
[2] https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

# Best Practice Considerations

**Data Collection:**

- Determine who, when, what and how screenings will occur
  - Any clinician can perform SDOH assessment
  - Patients can self-report

**Data Documentation:**

- Data may be documented in the problem list, history, provider/nurses/SS notes, structured screening tool to provide support for coders
- Implement an EHR based screening tool (i.e. PRAPARE, ACH HRSN Proprietary)
  - Ideally build with associated SNOMED, LOINC, Z Code and orders
- If no electronic-based tool, use paper forms and scan into EHR.
  - Track completed screenings and positive results for quality reporting

**Map SDOH Data to Z Codes**

- EHR coding modules configured with updated SDOH Z-Codes
- Utilize crosswalk of codes to screening results
- Educate coding staff
- Where to find supporting documentation
- Evaluate usage and provide feedback
- Allow for extra time to code!

# 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.
- Consider 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 and Other 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]
- 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
- **Z58** – Problems related to physical environment
- **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] https://www.cms.gov/medicare/icd-10/2024-icd-10-cm
[4] https://www.cdc.gov/nchs/icd/icd-10-cm.htm

Revision Date: June 2023

go.cms.gov/omh

## *Progress instead of Perfection*

**Administrators**

- GAP Assessment revisited annually with ongoing internal quality programs (i.e. PDSA cycles) more frequently (i.e. monthly or quarterly)
- Ensure resources for education, EHR builds and collaboration with external organizations
- Assess for and address internal and systemic bias
- Educate your community and patients on your HRSN initiatives!!
- Include in your Policies and Procedures

**Health Care Team**

- Keep workflows practical.
  - Can the screening tool be incorporated into existing assessment workflows
  - Consider starting with one area and moving to others as you hone the process
- If you don't have an EHR screening tool, use a paper form
  - Keep a running log of patient's screened and if they have a positive screening. This will help with reporting
- If a Z-code is added to the problem list by a Provider, be aware of it's need to be maintained as a problem

**HIM and Coders**

- Provide feedback to the clinical team leadership about documentation
- Be aware a Z-code program will add time to the coding process
- There may not be an exact Z-code for every scenario

# Screening Tool Resources

## Documentation is required to assign SDOH Z-Codes

### AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

#### Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

#### Food

**Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.** [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

[3] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

[4] Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146



https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

Not sure what to pick? Go to Social Needs Screening Tool Comparison Table | SIREN (ucsf.edu) For access to a table comparing tools

### PRAPARE

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

**PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences**
**Paper Version of PRAPARE® for Implementation as of September 2, 2016**

**Personal Characteristics**

1. Are you Hispanic or Latino?
   ☐ Yes ☐ No ☐ I choose not to answer this question
2. Which race(s) are you? Check all that apply
   ☐ Asian ☐ Native Hawaiian
   ☐ Pacific Islander ☐ Black/African American
   ☐ White ☐ American Indian/Alaskan Native
   ☐ Other (please write):
   ☐ I choose not to answer this question
3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
   ☐ Yes ☐ No ☐ I choose not to answer this question
4. Have you been discharged from the armed forces of the United States?
   ☐ Yes ☐ No ☐ I choose not to answer this question
5. What language are you most comfortable speaking?

**Family & Home**

6. How many family members, including yourself, do you currently live with? ____
   ☐ I choose not to answer this question
7. What is your housing situation today?
   ☐ I have housing
   ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
   ☐ I choose not to answer this question
8. Are you worried about losing your housing?
   ☐ Yes ☐ No ☐ I choose not to answer this question
9. What address do you live at?
   Street:_____
   City, State, Zip code: _____

**Money & Resources**

10. What is the highest level of school that you have finished?
    ☐ Less than high school degree ☐ High school diploma or GED
    ☐ More than high school ☐ I choose not to answer this question
11. What is your current work situation?
    ☐ Unemployed ☐ Part-time or temporary work ☐ Full-time work
    ☐ Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:
    ☐ I choose not to answer this question
12. What is your main insurance?
    ☐ None/uninsured ☐ Medicaid
    ☐ CHIP Medicaid ☐ Medicare
    ☐ Other public insurance (not CHIP) ☐ Other Public Insurance (CHIP)
    ☐ Private Insurance
13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.
    _____
    ☐ I choose not to answer this question

PRAPARE-English.pdf

# Guiding Principles for Social Needs Screenings

**Table 1. Guiding Principles for Social Needs Screenings**

| | |
|---|---|
| **Empathy.** The ability to understand and share the feelings of another. | Empathy builds connections between clinicians and their patients to better understand their life circumstances and emotions. It allows the clinician to listen and react nonjudgmentally to the patient's challenges. |
| **Respect.** Regard for the feelings, wishes, rights or traditions of others. | Demonstrate respect by considering patients' willingness to share their challenges related to socioeconomic risk factors. Asking patients about their priorities demonstrates respect for their wishes and goals. |
| **Autonomy.** The right of patients to make independent decisions about their care. | Respect individual autonomy to make decisions about what social support they want to accept. The patient's choice is critical in seeking his or her buy-in for the screening process and any subsequent actions. |
| **Trust.** The reassuring feeling of confidence in the clinician. | Build trust with patients to reduce the barriers discussed above; this enables a clinician to gain insight into a patient's life circumstances and priorities, and elicit their on-going input on their health status and social needs. Key traits related to trust include competence, compassion, privacy, confidentiality, reliability and communication.[10] |
| **Dignity.** Sense of self-respect. | Recognize patients as an equal, value their needs, inform them about their medical diagnoses and social risk, recommend treatment, but give them the right to make decisions. |
| **Collaboration.** Working with someone to create an outcome. | Partner and foster relationships with community stakeholders to develop strategies that meet the unique social needs of patients and community members. |
| **Support.** The act of helping or assisting someone. | Show support by valuing patients' priorities, giving them time to comprehend their health and social needs, and respecting their decision to seek help, based on their preferences. |
| **Sensitivity.** An appreciation of others' feelings. | Recognize the sensitivities associated with individuals being asked to share their deepest concerns. Build a safe environment for patients to share their life circumstances. |
| **Cultural Competence.** Being respectful and responsive to the health beliefs and practices of diverse population groups. | Recognize the diversity of the community and establish a culture where clinicians acknowledge that societal norms and attitudes towards health are grounded in culture. Leverage this openness to empower individuals to address their health and social needs in a culturally appropriate manner. |
| **Community-engaged.** The process of working collaboratively with community groups and members to address issues that impact the well-being of those groups. | Prioritize engaging patients and the community the hospital services by partnering with community organizations and listening to the life experiences of community members to gain insight on community needs as well as assets. |

**Source:** American Hospital Association, 2019.

**Table 2. Skills for Engaging in Sensitive Conversations**

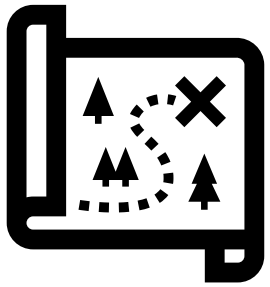
| Approach | Description |
|---|---|
| **Cultural Competency.** The ability to interact effectively with people from different cultures. | Cultural competency training helps care team members increase their sensitivity to cultural diversity, reduce language barriers and build understanding for life experiences that shape a person's identity.[12] |
| **Motivational Interviewing.** Counseling method that helps people resolve challenges and find the internal motivation to change their behavior. | Motivational interviewing empowers patients to take control of their own health and behaviors by setting goals based on their wishes and current circumstances.[13] |
| **Active Listening.** Technique where the listener fully concentrates, understands, responds and remembers what is being said. | Active listening teaches providers how to properly listen to what patients are saying, identify any underlying hesitance and in return ask leading, open-ended, closed-ended and reflective questions related to their challenges. |
| **Empathic Inquiry.** The technique that integrates motivational interviewing and trauma-informed care to facilitate collaboration and emotional support. | Empathic inquiry trains care team members to connect with patients, increase relatability and suggest nonjudgmental approaches to improve health. |
| **Asset-based.** An approach to care that focuses on the individual's strengths and potentials. | Recognize that, alongside having needs, patients and communities have many assets that can be leveraged to address their social needs. An asset-based approach allows the provider-patient conversation to be reframed from a focus on deficits to connecting with their strengths, interests and areas the patient fiends meaningful. At the community level, an asset-based approach helps identify, partner with and leverage resourceful organizations such as schools, community-based or faith-based organizations, government, local businesses, etc., and people in the community to collectively build on existing resources and form new community connections. |
| **Trauma-informed.** A framework that involves understanding and responding to behaviors/actions and needs as a result of trauma. | Trauma-informed care is a holistic approach of treating a patient, where it is assumed that each individual has a history of trauma and coping mechanisms. Integrate questions and practices that are trauma-sensitive to increase resiliency and build a culture that supports personalized patient care.[14] |

**Source:** American Hospital Association, 2019.

screening-for-social-needs-tool-value-initiative-rev-9-26-2019.pdf (aha.org)

# Z-Code Mapping

| Housing Instability | | | | |
|---|---|---|---|---|
| **AHC Question (and LOINC code)** | **Answer** | **ICD-10-CM** | **SNOMED CT** | **Exact Q-A** |
| What is your living situation today? (71802-3) | I have a place to live today, but I am worried about losing it in the future | Z59.819 Housing instability, housed unspecified | 1156191002 \|Housing instability (finding) | Yes |
| | **With more questioning…** | | | |
| | | Z59.819 Housing instability, housed unspecified | 1156193004 \|Housing instability due to frequent change in place of residence (finding) | No |
| | | Z59.819 Housing instability, housed unspecified | 1156195006 \|Housing instability due to being behind on payments for place of residence (finding) | No |
| | | Z59.819 Housing instability, housed unspecified | 1187272007 \|Housing instability due to housing cost burden (finding) | No |
| | | Z59.819 Housing instability, housed unspecified | 1156196007 \|Housing instability due to threat of eviction (finding) | No |
| | | Z59.811 Housing instability, housed, with risk of homelessness | 1156192009 \|Housing instability due to imminent risk of homelessness (finding) | No |
| | | Z59.812 Housing instability, | 1156194005 \|Housing | No |



| PRAPARE Question | PRAPARE Response | ICD-10 z-code |
|---|---|---|
| What is your housing situation today? | I have housing | |
| | I do not have housing (staying with others, in a hotel, on the street, in a shelter) | **Z59.0 Homelessness** |
| What is the highest level of school that you have finished? | Less than high school degree | **Z55.3 Underachievement in school** |
| | High school diploma or GED | |
| | More than high school | |
| What is your current work situation? | Unemployed and seeking work | **Z56.0 Unemployment, unspecified** |
| | Part-time work | |
| | Full-time work | |
| | Otherwise unemployed but not seeking work | |
| Percent of federal poverty level (FPL) | 100% or below | **Z59.5 Extreme poverty** |
| | 101-150% | **Z59.6 Low-income** |

| | Social Risk Factors | ICD-10-CM |
|---|---|---|
| What is your current housing situation? | Sheltered homelessness | Z59.01 |
| | Unsheltered homelessness | Z59.02 |
| | Risk of homelessness (imminent) | Z59.811 |
| | Housed, homeless in past 12 mos. | Z59.812 |
| | Other housing problems (e.g., financial) | Z59.89 |
| What is your education level? | Less than high school diploma | Z55.5 |
| What is your employment situation? | Change of job | Z56.1 |
| | Threat of job loss | Z56.2 |
| | Stressful work schedule | Z56.3 |
| | Discord with boss and co-workers | Z56.4 |
| | Uncongenial work environment | Z56.5 |
| | Physical and mental strain | Z56.6 |
| | Sexual harassment on the job | Z56.81 |
| What is your household income level?* | Extreme poverty | Z59.5 |
| | Low income | Z59.6 |
| Are you able to afford food? | Food insecurity | Z59.41 |

Resources for Social Risk Coding in Care Settings - Gravity Project - Confluence (hl7.org)

ICD-10 Z-Codes for Social Determinants of Health (healthleadsusa.org)

Coding SDOH Takes Practice - AAPC Knowledge Center

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**

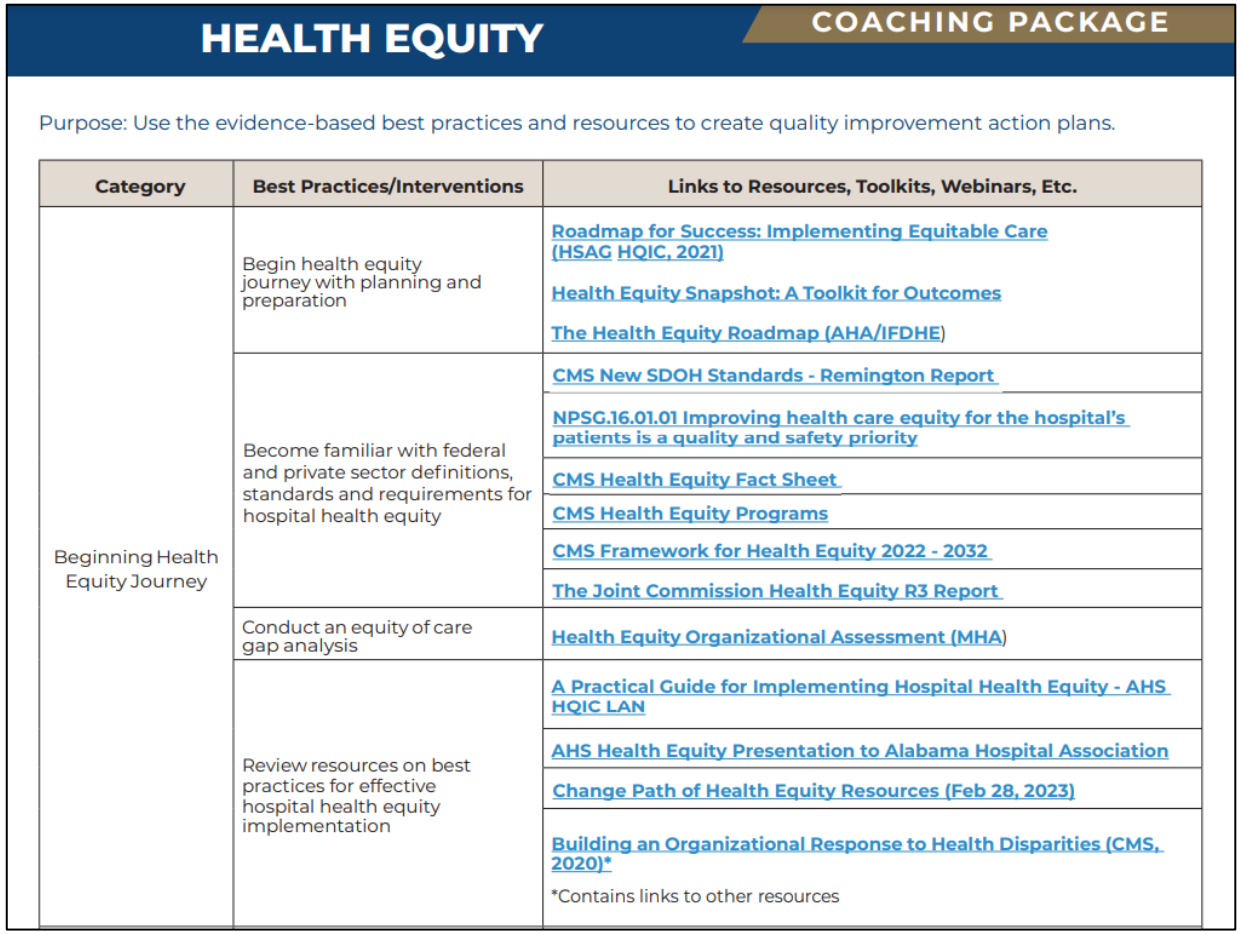
ICD-10 codes are updated every April and October

- Educate staff on newly added codes
- Evaluate updated codes for inclusion in your EHR
- Update Crosswalks
- Discuss updates with clinical team to determine if screens need updated as well

# Resources Cited

- USING Z CODES (cms.gov) CMS Z-Code Road Map
- Resources For Implementation - Gravity Project - Confluence (hl7.org) Confluence Resources for Implementation
- value-initiative-icd-10-code-sdoh-0418.pdf (codingclinicadvisor.com) AHA ICD-10 Coding for SDOH
- Quick Start Guide (hqin.org) Health Quality Innovation Network to address Health Equity Measure
- Disparities Impact Statement (cms.gov) Tool for taking action after Gap Assessment
- Coding SDOH Takes Practice - AAPC Knowledge Center
- ifdhe_real_data_toolkit_1.pdf (aha.org) With links to many other resources

# Alliant Health Solutions Health Equity Coaching Package



**HEALTH EQUITY** COACHING PACKAGE

Purpose: Use the evidence-based best practices and resources to create quality improvement action plans.

| Category | Best Practices/Interventions | Links to Resources, Toolkits, Webinars, Etc. |
|---|---|---|
| Beginning Health Equity Journey | Begin health equity journey with planning and preparation | Roadmap for Success: Implementing Equitable Care (HSAG HQIC, 2021)<br>Health Equity Snapshot: A Toolkit for Outcomes<br>The Health Equity Roadmap (AHA/IFDHE) |
| | Become familiar with federal and private sector definitions, standards and requirements for hospital health equity | CMS New SDOH Standards - Remington Report |
| | | NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority |
| | | CMS Health Equity Fact Sheet |
| | | CMS Health Equity Programs |
| | | CMS Framework for Health Equity 2022 - 2032 |
| | | The Joint Commission Health Equity R3 Report |
| | Conduct an equity of care gap analysis | Health Equity Organizational Assessment (MHA) |
| | Review resources on best practices for effective hospital health equity implementation | A Practical Guide for Implementing Hospital Health Equity - AHS HQIC LAN |
| | | AHS Health Equity Presentation to Alabama Hospital Association |
| | | Change Path of Health Equity Resources (Feb 28, 2023) |
| | | Building an Organizational Response to Health Disparities (CMS, 2020)*<br>*Contains links to other resources |

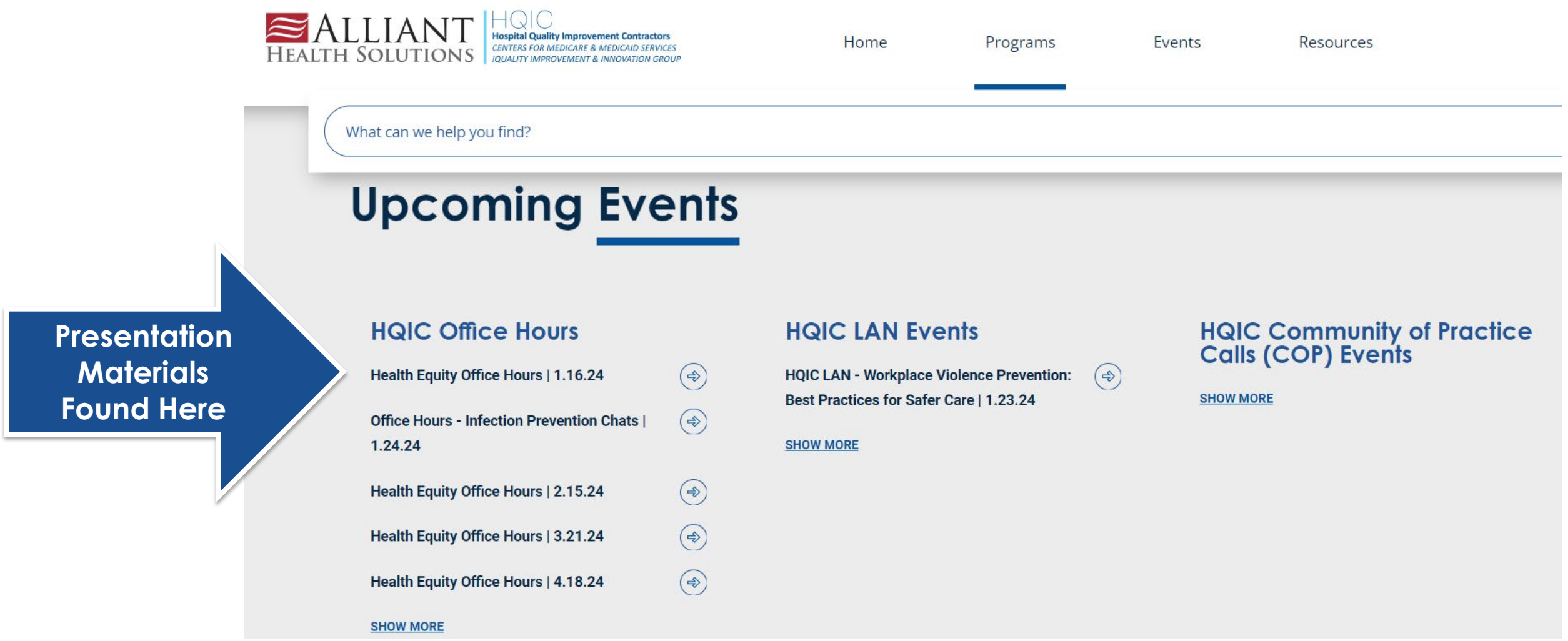
https://quality.allianthealth.org/wp-content/uploads/2023/04/2023-Coaching-Package-Health-Equity_508.pdf

# Join Us for Monthly Hospital Health Equity Office Hours

**February - August 2024 Registration:**
https://bit.ly/AHS_HealthEquityOfficeHour_Registration

SCAN ME

# Alliant Health Solutions HQIC Health Equity Office Hour Materials




**Presentation Materials Found Here**

https://quality.allianthealth.org/nqiic/hqic/

# Questions?

Email me at Rosa.Abraha@allianthealth.org

or call us at 678-527-3681.

# Making Health Care Better *Together*

**COLLABORATORS:**

Alabama Hospital Association
Alliant Health Solutions
Comagine Health
Georgia Hospital Association
KFMC Health Improvement Partners
Konza

# Hospital Quality Improvement

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## Thank you for joining us!
## How did we do today?

**Alliant Health Solutions**

**AlliantQIO**

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