ICD-10 Coordination and Maintenance Committee Meeting
Social Determinants of Health

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What are Social Determinants of Health?

Social determinants are the environmental factors that impact health outcomes, utilization and cost, including financial stability, physical safety, education, housing, transportation, nutrition, community support, and access to care

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: Henry J Kaiser Family Foundation, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*

By the Numbers: Social Determinants and Health

20%
of health outcomes can be directly attributed to clinical care

15 year
life expectancy difference between the most advantaged and disadvantaged Americans

85%
of physicians report that unmet social needs lead to poorer health outcomes

80%
of health and well being is tied to social and economic factors, physical environment and health behaviors

162,000
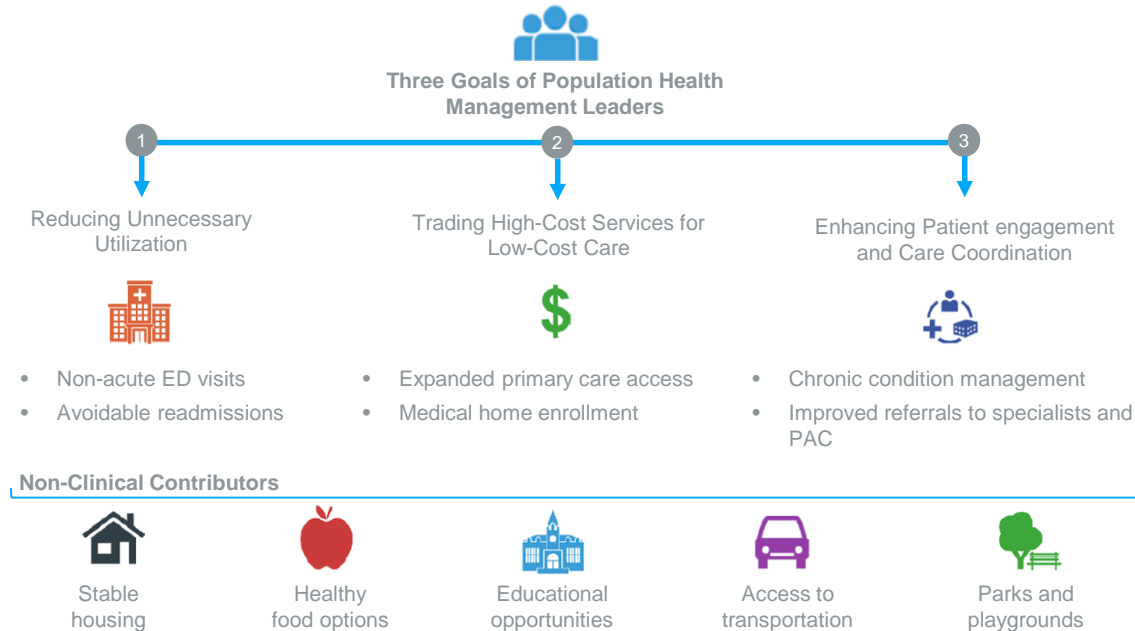**deaths annually due to low social support**

20%
of physicians are confident in their ability to address unmet social needs

Sources: Robert Wood Johnson Foundation, Kaiser Family Foundation, New England Journal of Medicine, American College of Physicians

Improving the System by Addressing Social Determinants

The Advisory Board: *Socioeconomic factors are far stronger determinants of health outcomes than medical care, and addressing Social Determinates of Health has been shown to be effective in improving outcomes.[1]*

Three Goals of Population Health Management Leaders

1 — Reducing Unnecessary Utilization
- Non-acute ED visits
- Avoidable readmissions

2 — Trading High-Cost Services for Low-Cost Care
- Expanded primary care access
- Medical home enrollment

3 — Enhancing Patient engagement and Care Coordination
- Chronic condition management
- Improved referrals to specialists and PAC

Non-Clinical Contributors

- Stable housing
- Healthy food options
- Educational opportunities
- Access to transportation
- Parks and playgrounds

Figure 2 – Three Goals of Population Health Management Leaders[2]

Addressing Non-clinical Barriers to Care

25% — Missed appointments or rescheduling needs due to transportation problems

$8K — Annual per-person health care savings as a result of offering housing and supportive services to high-cost homeless individuals

39% — Increased likelihood of a Medicaid-enrolled child visiting an ED more than once in a year if living in un-renovated public housing

Source: Silver D, et al, "Transportation to clinic," Journal of Immigrant and Minority Health, 14, no. 2 (2012), 350–355; Kersten EE et al., "San Francisco Children Living in Redeveloped Public Housing Used Acute Services Less than Children in Older Public Housing, Health Affairs, 33, no. 12 (2014), 2230-2237; Corporation for Supportive Housing, "FAQ's About Supportive Housing Research, http://www.csh.org/wp-content/uploads/2011/11/Cost-Effectiveness-FAQ.pdf; Population Health Advisor research and analysis.

Creating a Consistent Infrastructure

Where We Started

- Began SDOH collection with 18 existing ICD-10 Z codes

- Developed standardized data collection model and added placeholder codes

- Leveraged the PRAPARE tool in data collection expansion (National Association of Community Health Centers-NACHC endorsed)

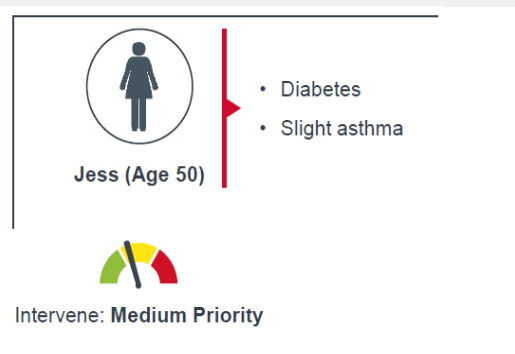- Creates industry model that can be used consistently across payers and providers

Results in 2018

500K Members served

700K Social referrals

Enabling Whole Person Diagnosis through Social Determinants

Typical risk stratification

Jess (Age 50)

- Diabetes
- Slight asthma

Intervene: **Medium Priority**
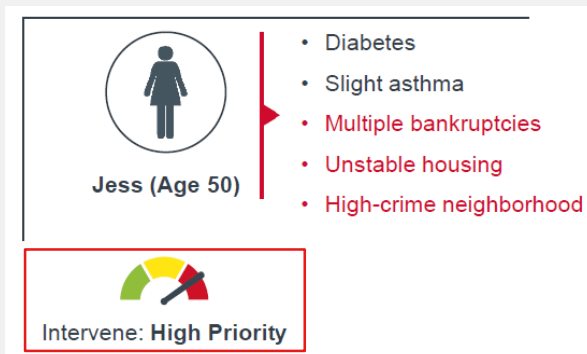
It is unlikely Jess will be identified for intervention until a likely unnecessary ED or inpatient event occurs.

Risk stratification inclusive of SDoH

Jess (Age 50)

- Diabetes
- Slight asthma
- Multiple bankruptcies
- Unstable housing
- High-crime neighborhood

Intervene: **High Priority**

After SDoH is added to risk stratification model, Jess is identified as a High Priority for intervention.

[1]Advisory Board interviews and analysis. "Social Determinates of Health Data, Educational Briefing for Non-IT Executives"
[2]Deloitte Insights **"Social determinants of health and Medicaid payments"** By Jim Jones, Sima Muller

Our Recommendation

The What

- Expand existing code categories to capture, analyze, and act on SDOH data

The Why

- Social Determinant data provides a more complete, holistic picture of a patient's health and potential risk factors
- ICD-10-CM codes are the standard language between care providers and payers
- Building on existing ICD-10 Social Determinant codes significantly expands a physician's ability to capture information relevant to a patient's overall condition, improves the ability for comprehensive diagnosis, and promote more coordinated services and care

The How

- ***Create new ICD-10-CM attribution codes that better capture the need for social-related services***

Social

Medical

Behavioral

Sample: High Volume SDoH Codes and Referrals

Current Code	Code Description	Requested ICD-10 Code	Sample Referral Agencies
ZTRAN1	Unable to get or pay for transportation for Medical Appointments or Prescriptions	Z59.641	• Birmingham-Jefferson County Transit Authority, Birmingham, AL • Neighborly Care Network, Clearwater, FL • Paratransit Operations, Miami, FL
ZCARE	Unable to pay for medical care	Z59.63	• American Lung Association • Walgreen Co. • Hadley Vision Center

Data Use and Capture:
Integration with Provider Workflows

Will these codes be used? **Yes**

- Providers already utilize existing ICD-10 Z codes. As represented by UnitedHealthcare, which has received more than **5 million c**laims for social barriers using existing ICD-10 Z codes, demonstrating providers do submit codes when available

- Much of this data **exists in a physician's electronic medical records** as a result of health risk assessments, but without additional ICD-10-CM codes, cannot be coded or captured

- These proposed codes are not payer-specific and would **integrate** into ICD-10-CM standard language between care providers and payers

Your Questions

Thank you