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ICD-10-CM Codes for Social Determinants of Health

July 8, 2020

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Faculty

Nelly Leon-Chisen, RHIA
Executive Editor *Coding Clinic*
Publications
Director of Coding and Classification
American Hospital Association

Julia Resnick, MPH
Senior Program Manager
The Value Initiative
American Hospital Association

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What You Will Learn

- Background on the societal factors that influence health – and their importance for health and equity.
- The role of hospitals in addressing Social Determinants of Health (SDOH) and Social Needs (SNs)
- How hospitals are collecting social needs data.
- ICD-10-CM categories for SDOH.
- ICD-10-CM Official Coding Guidelines affecting SDOH codes.
- Documentation issues related to SDOH coding.
- Why code for social determinants – for patients, for communities, for national advocacy.
- AHA resources to support coding for SDOH.

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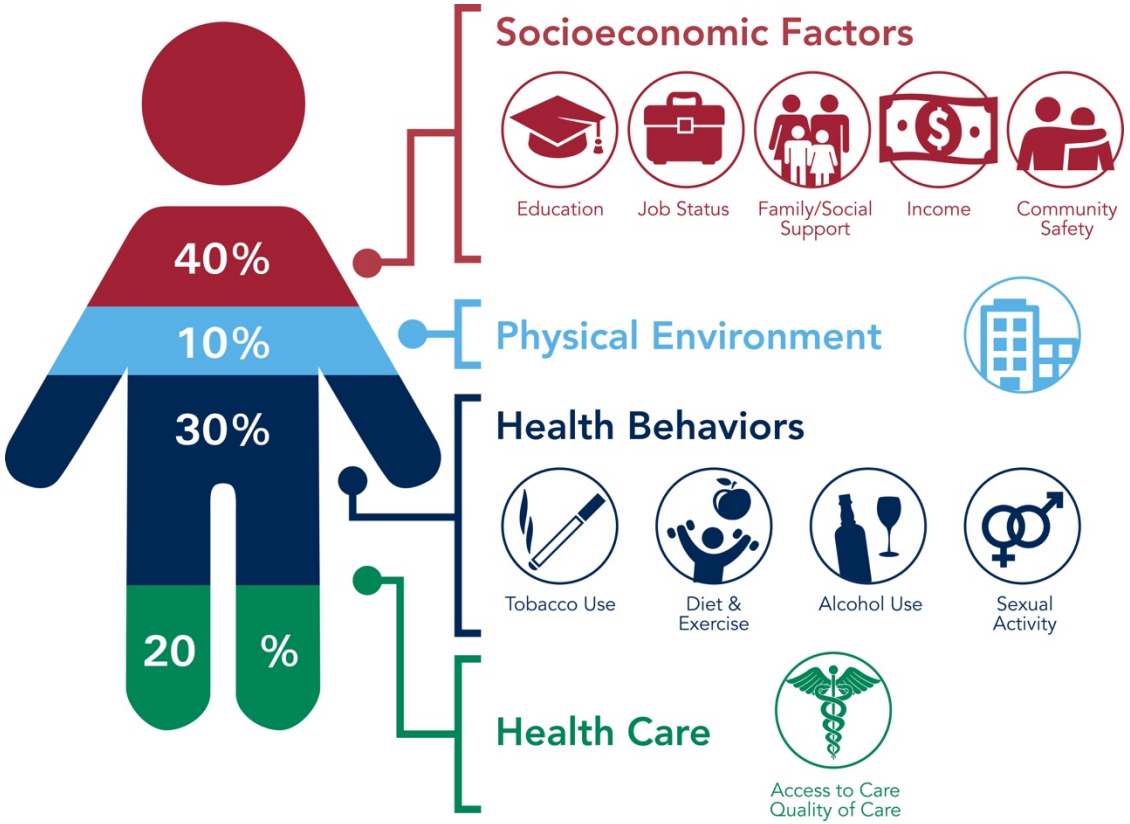
Why all the buzz about social determinants?

	Today		Future
Focus	Individual patient	→	Community health
Care	Fragmented, episodic treatment	→	Coordinated, longitudinal care
Goal	Treating sick	→	Achieving wellness
Rewards	Volume driven (FFS)	→	Value, outcome driven
Setting	Institutional base; hospital oriented	→	Community based; range of settings
Leadership	Managing departments/divisions	→	Systems thinking/integrated processes

Impact of Societal Factors on Health



- **20%** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment, social determinants** and **behavioral factors** drive **80%** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

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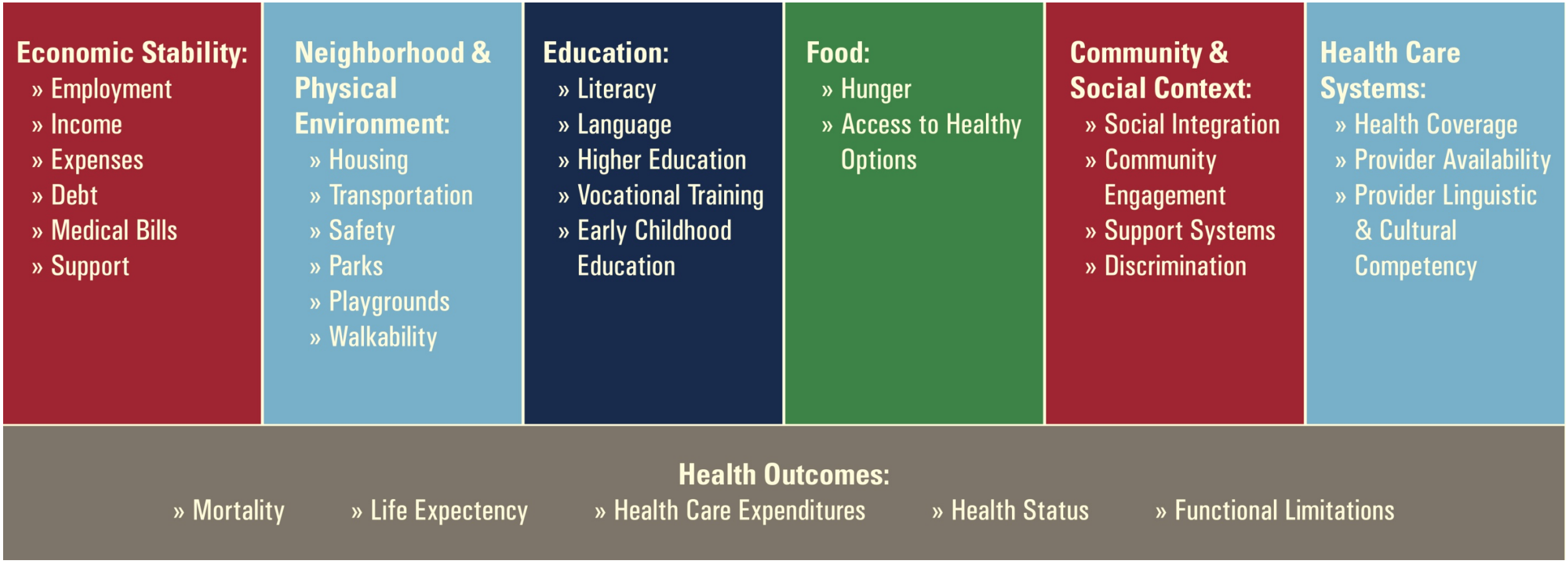
Impact of Social Determinants of Health



Source: Adapted from Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. November 2015.

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Current Environment

1.48 million individuals are **homeless**

3.6 million people cannot access medical care due to lack of **transportation**

42 million Americans face **hunger**

12.7% of households are **food insecure**

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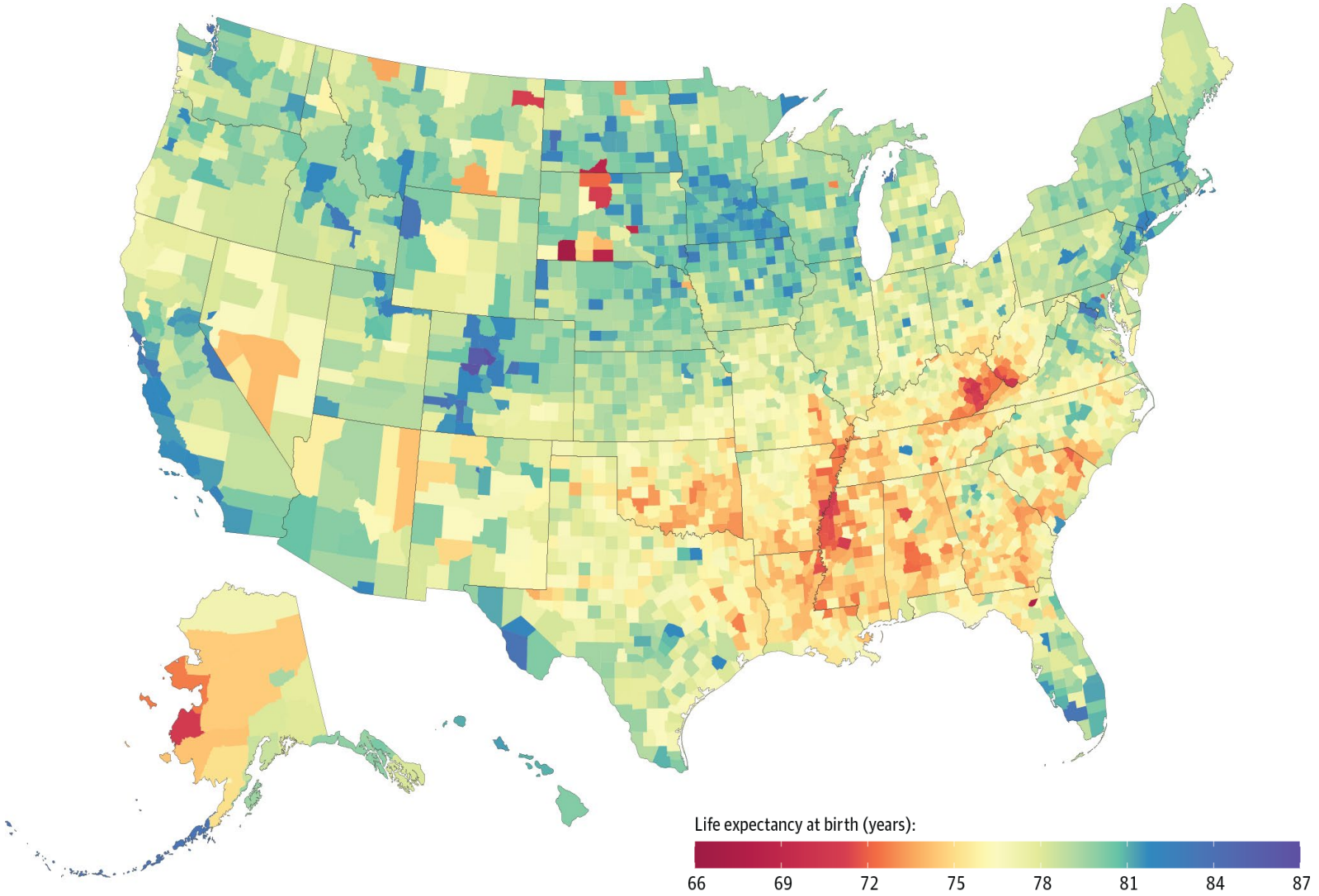
COVID-19 Health Disparities

- African Americans account for 33% of confirmed COVID-19 cases and Latino Americans account for 23% of confirmed cases.
- The hospitalization rate for Black Americans is 5 times the rate of white Americans and Hispanic or Latinx individuals have a rate of hospitalization 4 times that of white Americans.
- Black and Latinx Americans are three times more likely than white people to contract COVID-19, and those who contract it are more than twice as likely to die than their white counterparts.
- Two Native American pueblos in New Mexico have the highest infection rates of any U.S. county.

Life Expectancy Varies by Where you Live



Source: Institute for Health Metrics and Evaluation, University of Washington, 2014

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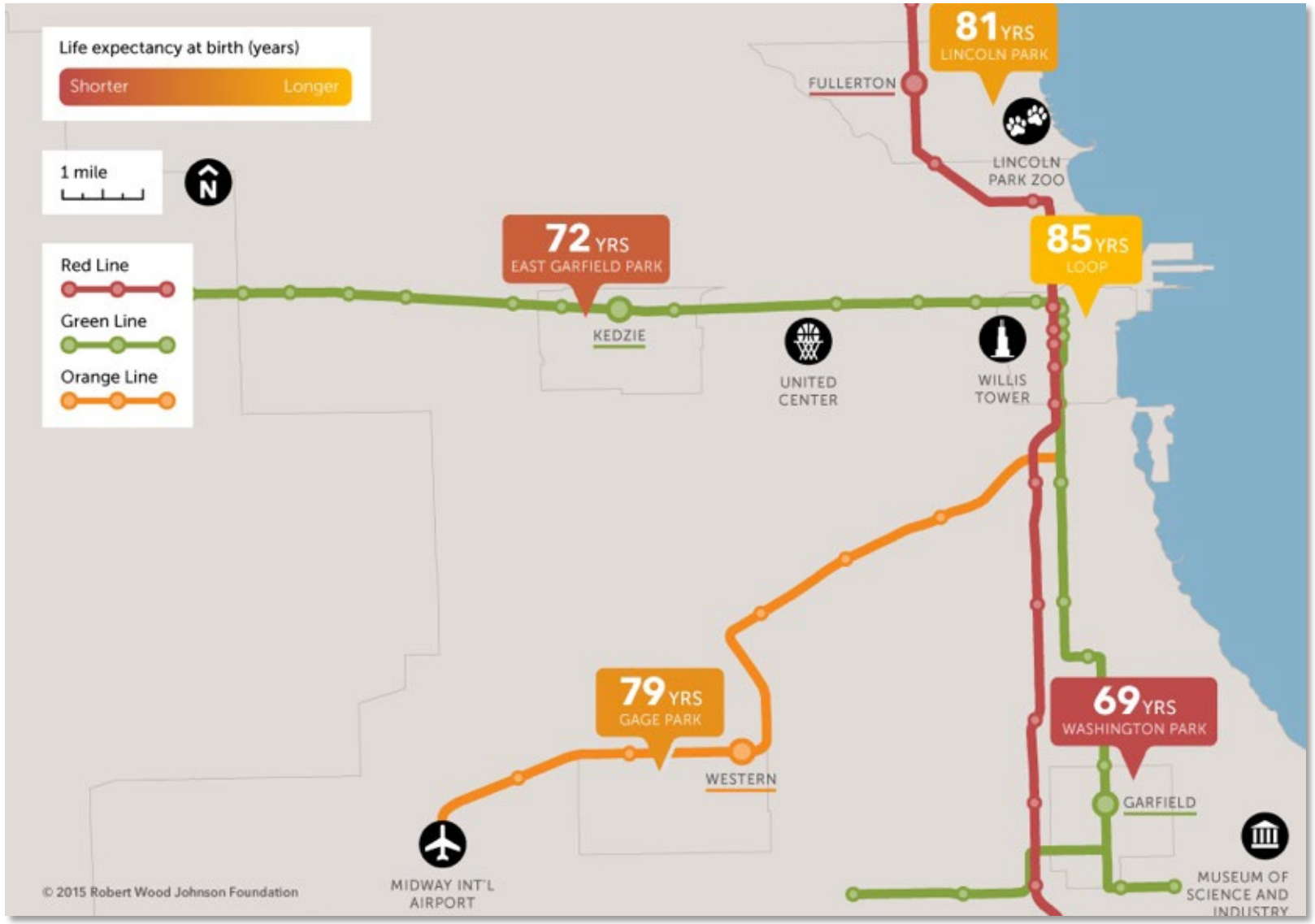
Where You Live Matters – Life Expectancy in Chicago



Source: Reprinted with permission from the VCU Center on Society and Health.

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Societal Factors that Influence Health

Social Needs: individuals' non-medical social or economic circumstances that hinder their ability to stay healthy and/or recover from illness.

Social Determinants of Health: the underlying social and economic conditions that influence people's ability to be healthy.

Systemic Causes: the fundamental causes of the social inequities that lead to poor health

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Societal Factors and COVID-19

- Housing Insecurity
  - Inability to pay rent, mortgage or utilities due to job loss, putting individuals and families at risk of eviction or homelessness
  - Individuals living in high-density homes or homeless shelters are unable to social distance or self-quarantine
- Food Insecurity
  - Struggles to keep food in the home due to lost jobs or lost school meals
- Unconscious Bias
  - Minorities tested for the coronavirus at a lower rate
  - Ensure patients' linguistic and cultural needs are met
- Screening for Social Needs
  - How COVID-19 spreads makes it important to understand patients' social circumstances

Screening for Social Needs During COVID-19

- **Allina Health**
  - digitized their approach for screening and addressing patients' social needs.
  - integrate their social needs screening tool into the patient portal
  - Providers can virtually collect patient information and make connections with community-based services.
  - Links patient responses back to the electronic medical record where care navigators can track the outcomes of the referral.

- **University of Arkansas for Medical Sciences**
  - Developed a self-quarantine capacity screening tool to determine whether patients who tested positive were able to self-quarantine.
  - Individuals who could not self-quarantine due to homelessness are connected with housing

Members in Action:

University of Illinois Hospital and Health Sciences System

Better Health Through Housing

- Identify chronically homeless individuals who frequently visit the ED
- Move them directly to permanent housing
- Provide a support system to keep them healthy and integrate back into the community
- Reduced health care costs by more than 50%
- After two years, 90% continue to be in stable housing
- Similar savings for courts, jails and social services

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Members in Action:

Sharp Healthcare

Care Transitions Interventions

- Team of nurses, social workers, and financial service advisors provide care transition coaching and community resources for vulnerable patients
- Team includes those from community organizations, including 2-1-1 San Diego
- Significant reduction in readmission rates and length of stay

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Housing and Food Insecurity During COVID-19

- **Alameda Health System**
  - partnering with Abode, a supportive housing and homeless services provider, and other community partners to launch two housing initiatives.
  - Operation Comfort provides isolation housing for symptomatic or COVID-19-infected people experiencing homelessness
  - Operation Safer Ground provides safe housing for high-risk people experiencing homelessness.

- **Henry Ford Health System**
  - Partnering with the United Way of Southeastern Michigan and the BET COVID-19 Relief Fund to launch *At Your Door: Food & More*
  - Community outreach program to address African American health disparities exacerbated by COVID-19
  - Promotes health and wellbeing by providing contact-free deliveries of food boxes, PPE, diapers, culturally informed education, and equipment for virtual support, allowing vulnerable populations to reduce risk of exposure.

Members in Action:

Nationwide Children's Hospital

Healthy Neighborhoods Healthy Families

- Provide small grants to low-income residents
- Build or gut and rehab homes on neglected properties
- Develop affordable rental homes
- Aligned with ACO
- Improved graduation rates and reduced violent crime; property value starting to rise
- Declines in the cost of care and ED utilization in the neighborhood

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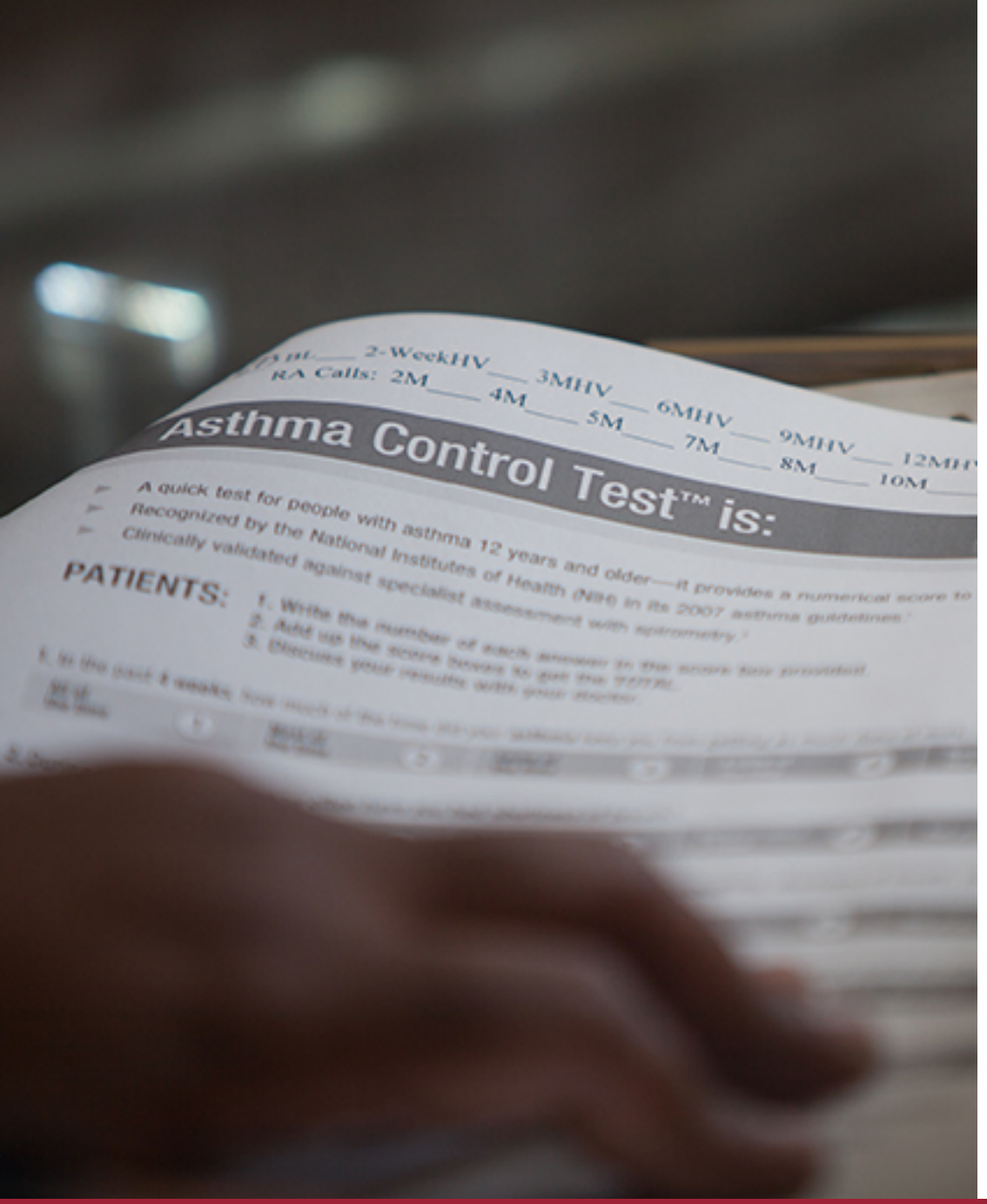

Members in Action:

Sinai Health System

Asthma Care Partners

- Community health worker model to educate, support and guide patients
- 59-62% reduction in asthma symptoms
- Reduced ED visits by 75%
- Hospital visits reduced by 80%
- $3-8 averted for every $1 spent on the program

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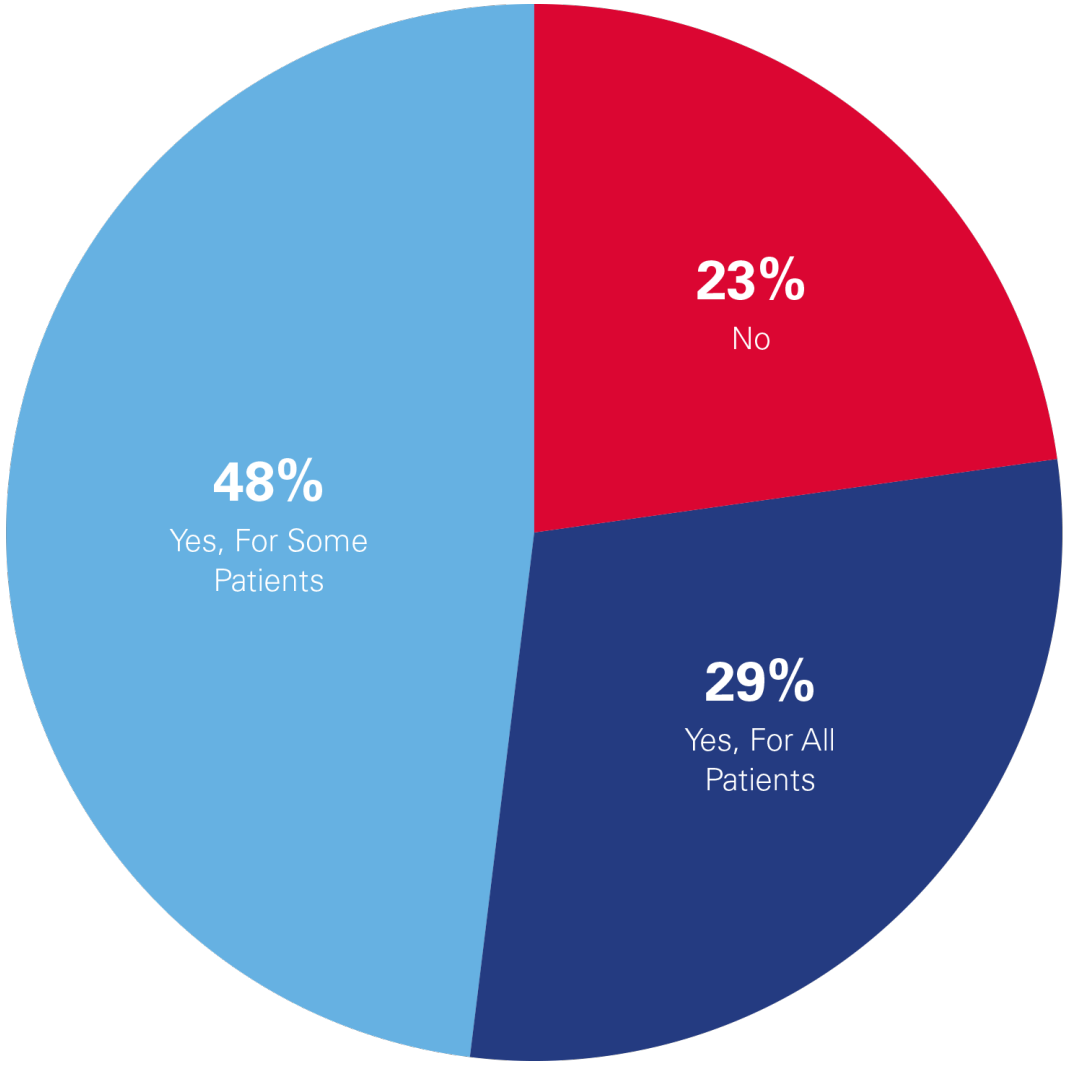
Hospitals are Screening for Social Needs



Source: *AHA 2018 Population Health, Equity and Diversity in Health Care Survey*

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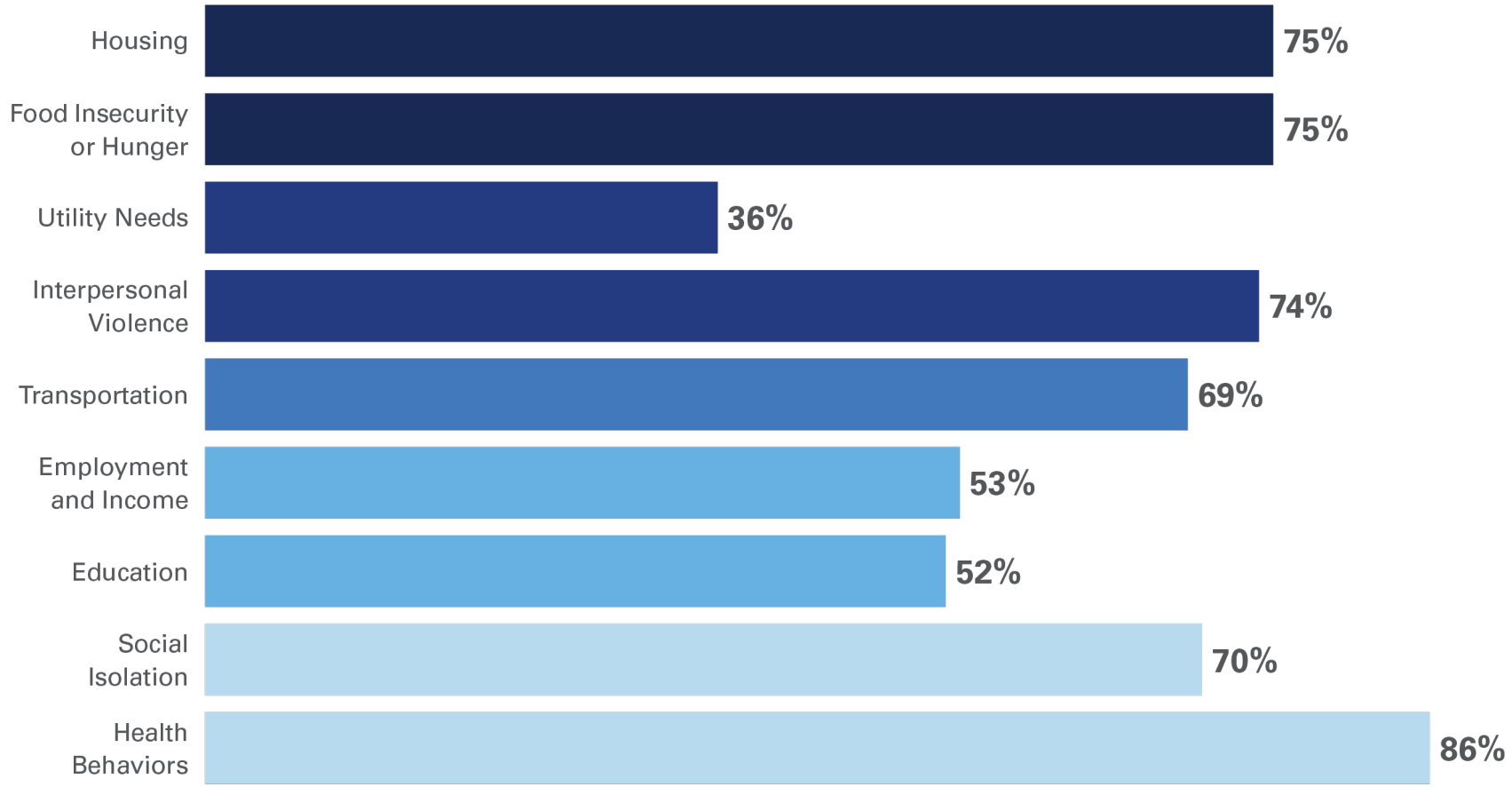
Social Needs Screening Questions



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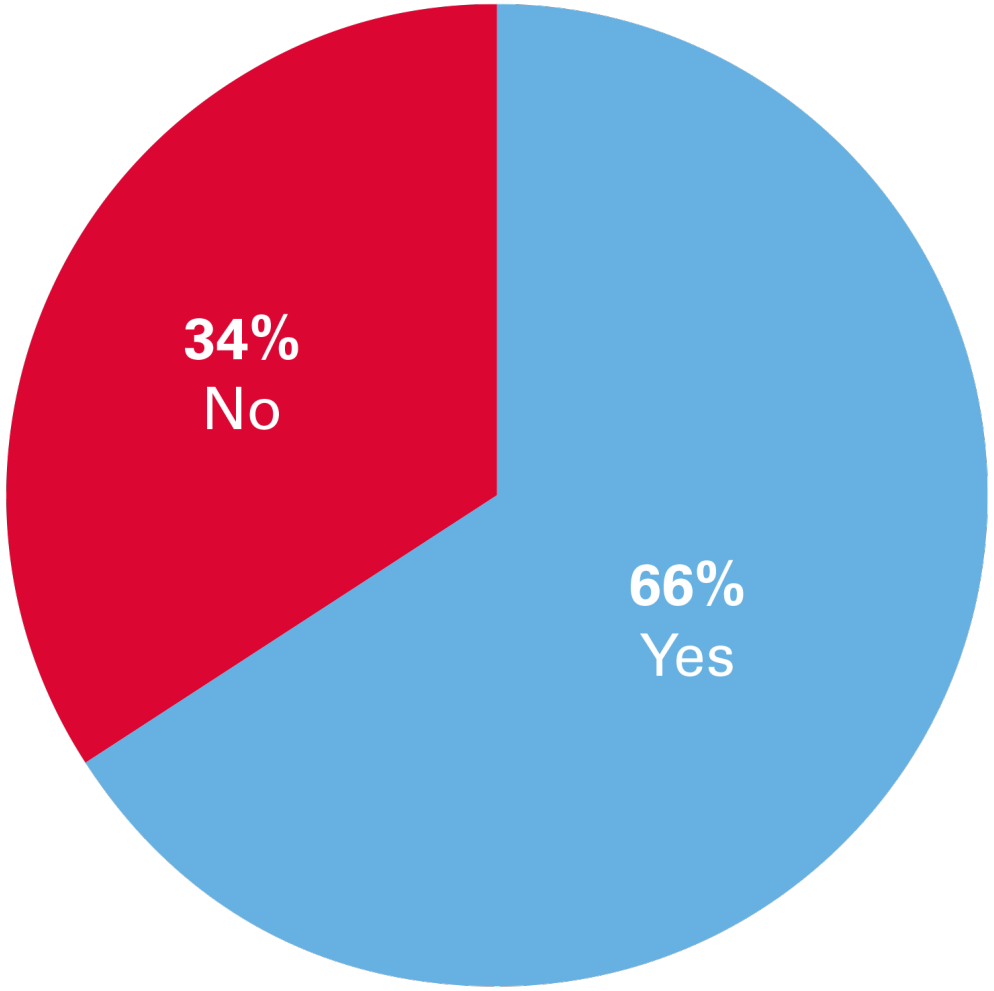
Source: *AHA 2018 Population Health, Equity and Diversity in Health Care Survey*

Documentation of Social Need Screening in EHRs



Source: *AHA 2018 Population Health, Equity and Diversity in Health Care Survey*

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Social Determinants of Health ICD-10-CM Z Codes

- Z codes are a subset of ICD-10-CM diagnosis codes that represent factors influencing health status and contact with health services that may be recorded as diagnoses.
  - ICD-10-CM categories Z55-Z65 are a more specialized group of codes to identify social determinants of health.

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ICD-10-CM SDOH Categories

- *Z55 – Problems related to education and literacy*
- *Z56 – Problems related to employment 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*

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ICD-10-CM SDOH Categories (cont.)

- *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*

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Barriers to using Z Codes

- Lack of definitions for SDOH terms
- Unfamiliarity with social needs
  - Providers and coders
- Perceived priority/lack of incentives
- Operational processes
  - EHR-based screening tool
  - Standard documenting process
  - Coding processes
- Lack of clarity about who can screen and document
- Productivity challenges

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Documentation and SDOH Coding

- Code assignment is based on the documentation by the patient's provider (i.e., the physician or other qualified healthcare practitioner legally responsible for establishing the patient's diagnosis)
  - Exception: For SDOH, such as information found in categories Z55-Z65, 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.

Official Guidelines for Coding and Reporting, Section I.B.14

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Documentation and SDOH Coding

- "The ICD-10-CM Official Guidelines for Coding and Reporting do not have a unique definition of the term 'clinicians.' In the context of code assignment for social determinants of health Z codes, documentation deemed meeting the requirements for inclusion in the patient's official medical record based on regulatory or accreditation requirements or internal hospital policies, could be utilized since the information pertains to social rather than medical information."

Coding Clinic, Fourth Quarter 2019, pages 52-53

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Documentation and SDOH Coding (cont.)

- "If the patient self-reported information is signed-off and incorporated into the health record by either a clinician or provider, it would be appropriate to assign codes from categories Z55-Z65, describing social determinants of health."

Coding Clinic, Fourth Quarter 2019, pages 52-53

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Productivity Challenges

- Coding is important and needs to be done on a timely basis.
- Coding for SDOHs needs to be made a priority
- Coding managers and supervisors giving the coder permission to take the time to capture these additional codes.

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Lack of Definitions and Lack of Incentives

- Neither the ICD-10-CM classification nor the guidelines provide definitions for SDOH terms
  - There are national efforts like the Gravity Project to help
  - In the interim, hospitals may consider incorporating terms/definitions into internal coding guidelines
- Lack of incentives
  - There is interest among commercial and government payors to identify SDOH for reimbursement, quality adjustments, etc.
  - Without the data, payers cannot recognize SDOH factors for reimbursement

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Coding Example #1

- Long history of diastolic congestive heart failure under medication control. Patient fails to take maintenance beta blocker resulting in acute decompensated heart failure requiring readmission. Patient has been having problems managing living alone since his wife recently passed away. He also has trouble with his medication co-pays because of his low income and he has been skipping doses.
  - I50.33, Acute on chronic diastolic (congestive) heart failure
  - T44.7X6A, Underdosing of beta-adrenoreceptor antagonists, initial encounter
  - Z60.2, Problems related to living alone
  - Z63.4, Disappearance and death of family member
  - Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
  - Z59.6, Low income

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Coding Example #2

- Patient brought into the emergency department after he was found wandering the streets confused. He complaining of dizziness, nausea and indicated that he's a diabetic. He has been living in his car since his wife kicked him out. He has had problems managing his diet because he doesn't have access to healthy food. His diagnosis was uncontrolled diabetes and he was referred for community services.
  - E11.65, Type 2 diabetes mellitus with hyperglycemia
  - Z59.0, Homelessness
  - Z59.4, Lack of adequate food and safe drinking water
  - Z63.0, Problems in relationship with spouse or partner

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Benefits of Using Z Codes

identify social needs that impact patients and connect with community resources

aggregate data across patients to focus a social determinants strategy

track trends or risks in the community

guide community partnerships and CHNAs

enable system-wide research at the national level to understand the social needs of communities

tailor federal programs to meet those needs

support policy and payment reforms

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- **Issue Briefs:** Start the conversation
- **Executive Forums:** Perspectives and strategies
- **Innovative Activities:** Real solutions that promote value
- **Members in Action Series:** Success stories from the field
- **Voices on Value:** Expert insights from outside the field
- **Data:** Trends and support for federal policy solutions

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AHA Resources on Social Determinants

[Access at: https://www.aha.org/guidesreports/2019-05-15-social-determinants-health-and-value](https://www.aha.org/guidesreports/2019-05-15-social-determinants-health-and-value)

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