Social Determinants of Health – Where Are We Now?

Linda Hyde, RHIA

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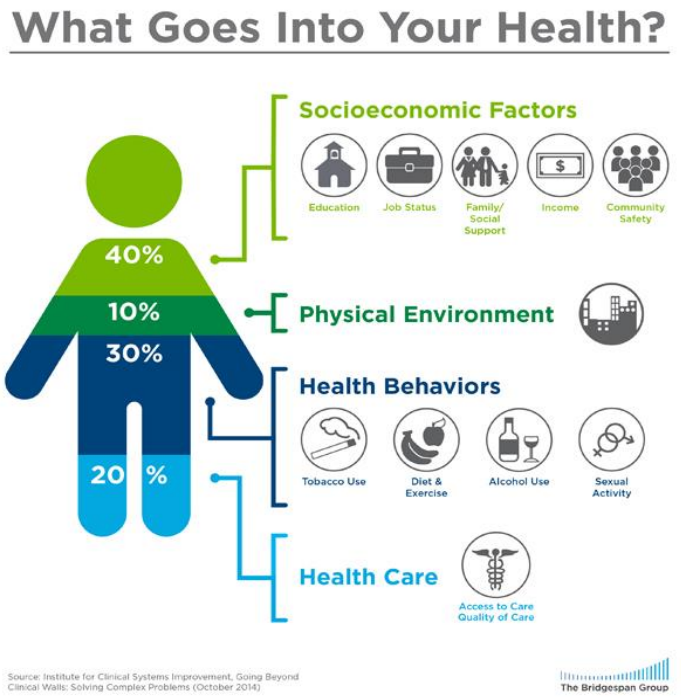
Why Social Determinants of Health (SDOH) are Important

The role of social, environmental risks in health and health outcomes are well known

- **Food insecurity** correlates with Hypertension, Coronary heart disease, Stroke, Cancer, Asthma, Diabetes, Arthritis, Chronic obstructive pulmonary disease (COPD), Chronic kidney disease, Depression
- **Housing Instability** poor neonatal growth, maternal depression
- **Transportation barriers** correlates with missed appointments, delayed care, and lower medication adherence



https://www.bridgespan.org/insights/library/public-health/the-community-cure-for-health-care-(1)

SDOH

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Origins

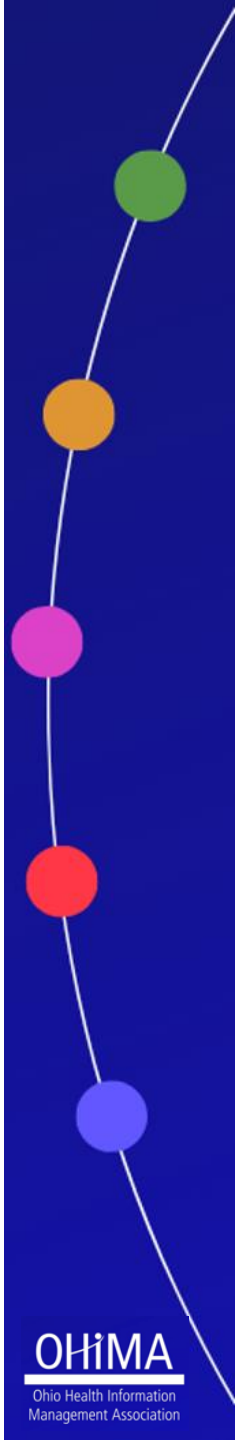
- There are a number of organizations that have contributed to recognizing the importance and need to identify the impact of social risk factors in health care.
- Today's podcast will focus on the work of the Gravity Project in this area. https://thegravityproject.net/
- Evolved from the work of SIREN (Social Interventions Research and Evolution) https://sirenetwork.ucsf.edu/about-us
  - Develop compendium of medical terminology codes for social risk factors in 2018

Gravity Structure

- Collaborative public-private initiative launched in 2019
- Develop consensus-driven data standards to support the collection, use and exchange of social risk data
- Two workstreams; terminology and technology
- Terminology team focus is to identify data elements needed by social risk domain (e.g. Food insecurity) and creating a gap analysis for needed codes
- Technology team focus on methods to exchange social risk data

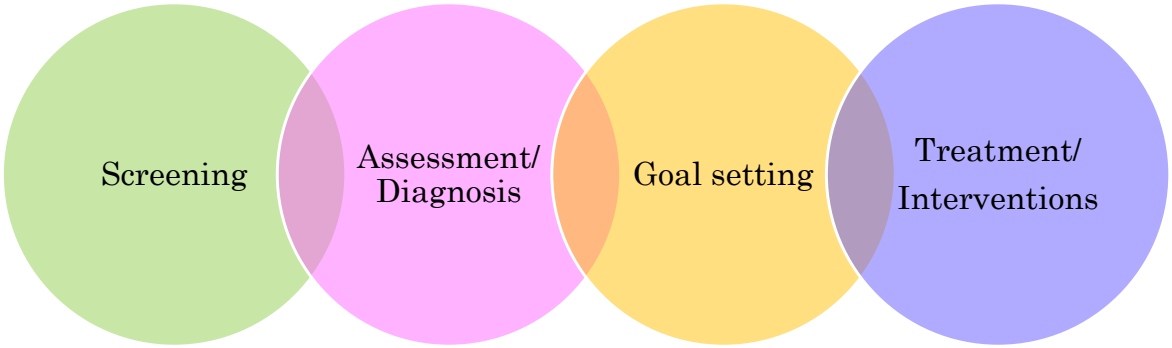
gravity PROJECT

https://confluence.hl7.org/display/GRAV/The+Gravity+Project



Gravity Scope

- Develop data standards to represent and exchange patient level social risk data across four clinical activities



- Test and validate standardized social risk data for use in patient care, care coordination between health and human services sectors, population health management, public health, reimbursement, value-based payment, quality measurement and clinical research

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Social Risk Data Uses

Identify and document social risks during patient encounters

Communicate social risk needs across clinical and community settings

Aggregate social risk data for uses beyond point of care

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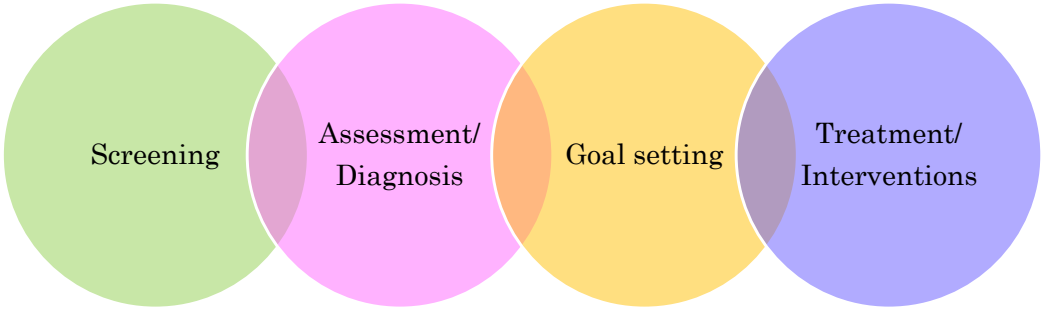
Terminology

- For each activity there are one or more terminologies that support the capture of coded data.
- Screening – LOINC
  - Identify presence of social risk factors through patient or provider completed assessment (Hunger Vital Signs – food insecurity status)
- Assessment/Diagnosis – ICD-10-CM and SNOMED CT
  - ICD-10-CM identifies social risk data supporting in many aspects of patient care, reimbursement and quality measurement
  - SNOMED CT supports structured data in EHRs and for exchange of data



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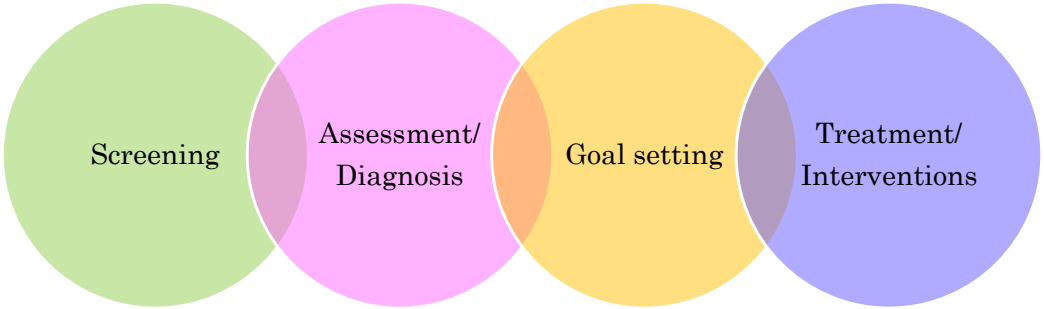
Terminology cont.

- Goal Setting – SNOMED CT
  - Structured data for patient goals

- Treatment/Interventions – CPT, HCPCS, SNOMED CT
  - CPT/HCPCS primary focus is claims, value based payment
  - SNOMED CT – similar to diagnosis data, supports structured data in EHRs and data exchange



Contrasting ICD-10-CM and SNOMED CT Diagnoses

- SNOMED CT will generally contain more specificity and granularity than ICD-10-CM
- SNOMED CT will include normal states (food security)
- SNOMED CT does include a mapping to ICD-10-CM
- Example ICD-10-CM Food insecurity code maps to three SNOMED CT codes for mild, moderate and severe food insecurity

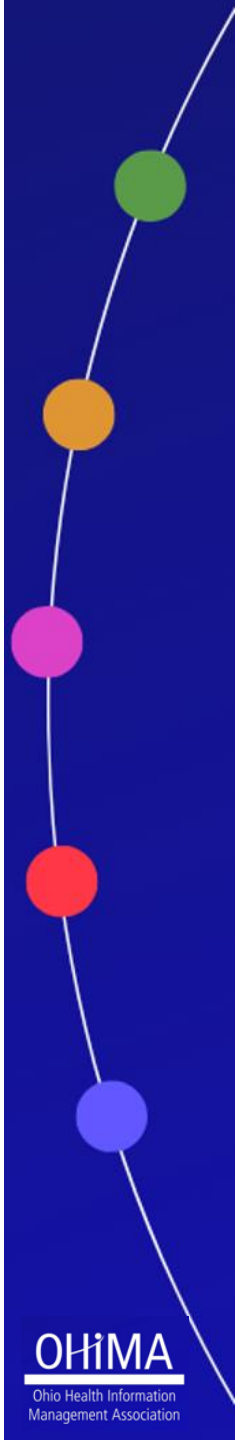
Identifying Social Risk Factors using ICD-10-CM

The Gravity Project has been submitting requests for new or revised ICD-10-CM social risk codes since its inception.

FY 2022 (10/1/2021)
Food insecurity, housing instability, sheltered and unsheltered homelessness, high school degree

FY 2023 (10/1/2022)
Transportation insecurity, financial insecurity, material hardship, inability to comply with dietary, medication or treatment due to financial hardship

FY 2023 (4/1/2023)
Financial abuse, additional abuse perpetrator codes, specific types of inadequate housing, healthy literacy problems



Social Risk Value Sets

- Gravity maintains value sets through the Value Set Authority Center (VSAC) for all of the terminologies containing social risk data.
- Value sets are organized by terminology, activity and domain (e.g. Food Insecurity ICD-10-CM Diagnoses)
- VSAC is free (only need to set up login/password) and value sets can be exported to be used as needed

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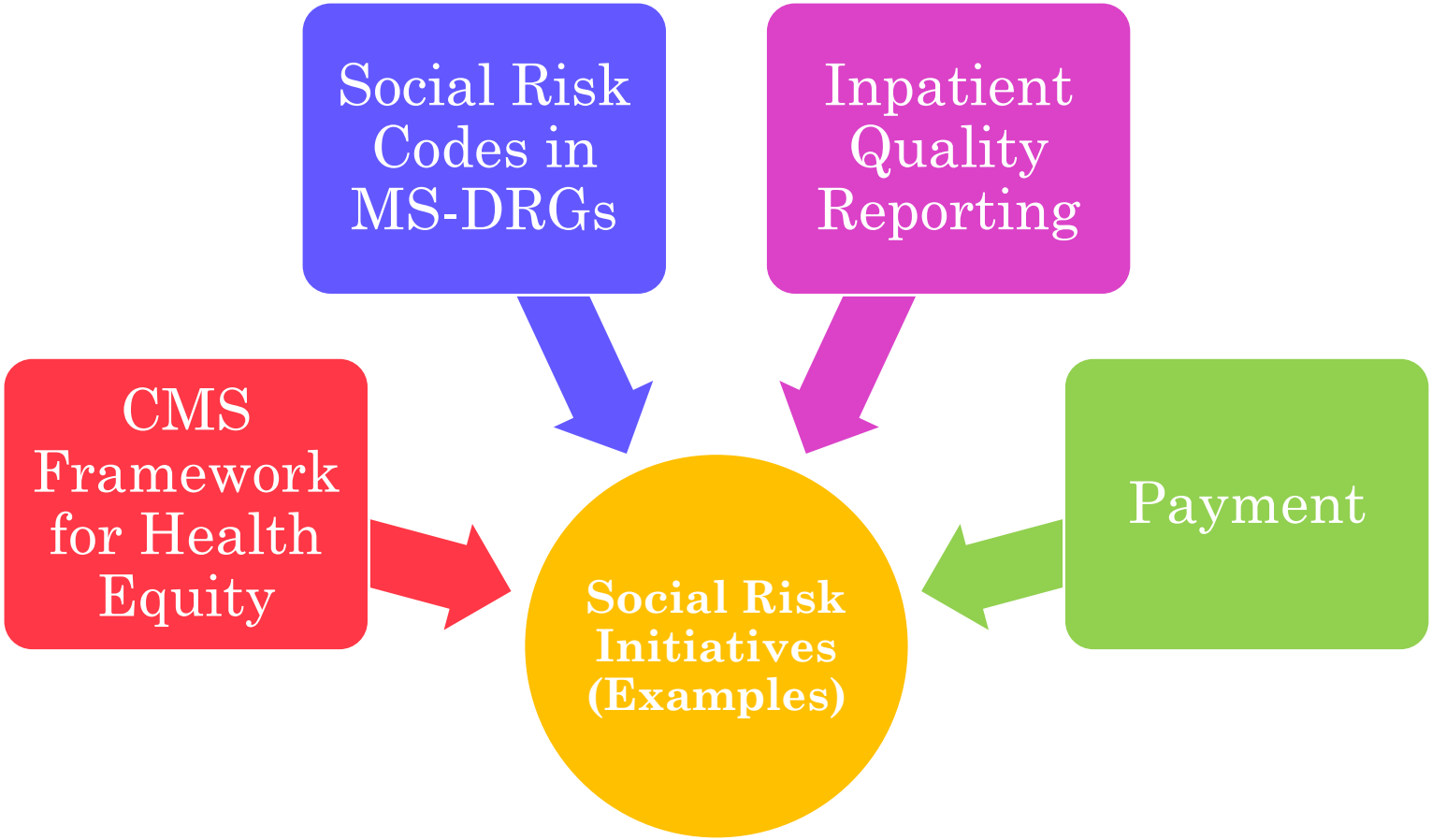
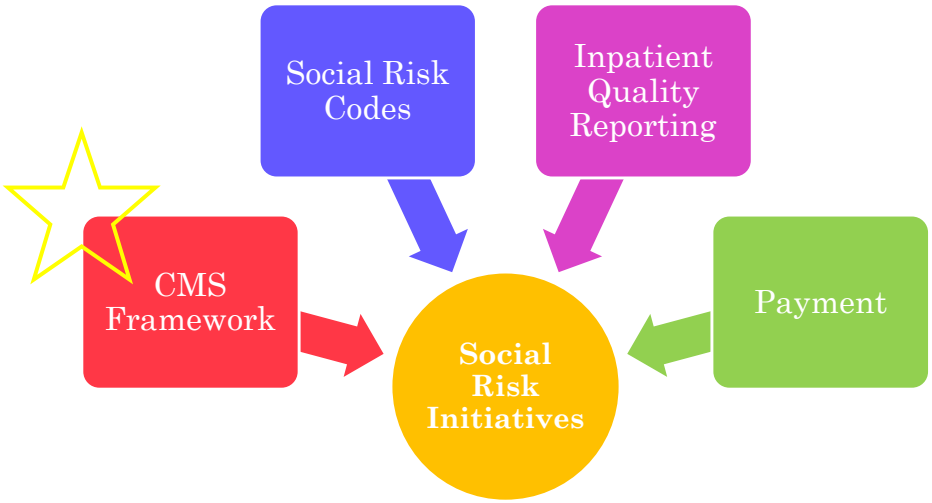
Social Risk Initiative Examples



CMS Framework for Health Equity

- Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data
- CMS strives to improve our collection and use of comprehensive, interoperable, standardized individual-level demographic and social determinants of health (SDOH) data, including race, ethnicity, language, gender identity, sex, sexual orientation, disability status, and SDOH. By increasing our understanding of the needs of those we serve, including social risk factors and changes in communities' needs over time, CMS can leverage quality improvement and other tools to ensure all individuals have access to equitable care and coverage.



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Social Risk Codes and MS-DRGs

- CMS solicited comments as part of the FY 2023 Inpatient Prospective Payment rule on how the use of social risk codes could improve their ability to recognize severity of illness, complexity of service, and/or utilization of resources under the MS-DRGs
- Feedback submitted that supported the need to find ways to improve the documentation of social risk factors.
- Homelessness was an example of a factor that was considered similar to other conditions that are considered complications/comorbidities
- CMS will be considering these comments for future use.

IPPS Quality Reporting

- CMS is adopting two measures
  - Screening for Social Drivers of Health
  - Screen Positive for Social Drivers of Health

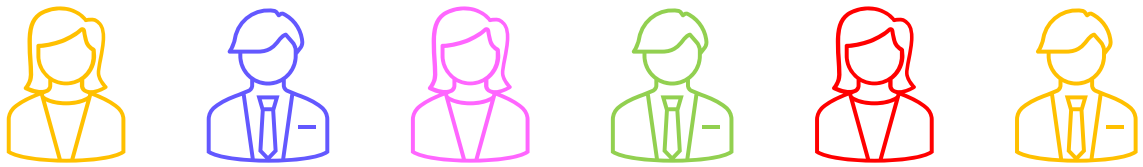
- Initially adopted for voluntary reporting in the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination.

Payment

- The Millbank report identifies key takeaways regarding the development and implementation of payment plans that are including social risk factors.
- Health care value-based payment reforms that fail to target nonmedical needs may be less effective in improving population health, advancing health equity, and lowering health care costs.
- Value-based payment models can provide the financial flexibility and accountability that allow health care organizations to more easily address social determinants of health at the population level.

Careers

- Virtually all aspects of health information will include aspects social risk factors. Understanding the impact these factors have on health care will be important in all of these areas
- Specialization in social risk data will be crucial in a number of areas including
  - Public Policy – identifying the local, state and federal areas where collection, reporting and using social risk data is needed
  - Terminology –representing social risk data in a variety of terminologies.
  - Analytics
    - Determining what social risk factors are needed to screen, diagnosis, intervene and set goals for addressing these factors
    - Evaluating how these factors should be utilized to insure equitable reimbursement
  - Education – promoting the importance of social risk data across health care, community and payer settings



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THANK YOU FOR JOINING!

Linda Hyde, RHIA

hydela@charter.net

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