ICD-10-CM Codes for Social Determinants of Health

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What You Will Learn

- Background on social determinants of health and social needs – 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.
- 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.

Why all the buzz about social determinants?

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

Impact of Social Determinants of Health

- **Economic Stability:**
  - Employment
  - Income
  - Expenses
  - Debt
  - Medical Bills
  - Support

- **Neighborhood & Physical Environment:**
  - Housing
  - Transportation
  - Safety
  - Parks
  - Playgrounds
  - Walkability

- **Education:**
  - Literacy
  - Language
  - Higher Education
  - Vocational Training
  - Early Childhood Education

- **Food:**
  - Hunger
  - Access to Healthy Options

- **Community & Social Context:**
  - Social Integration
  - Community Engagement
  - Support Systems
  - Discrimination

- **Health Care Systems:**
  - Health Coverage
  - Provider Availability
  - Provider Linguistic & Cultural Competency

**Health Outcomes:**

- Mortality
- Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations

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

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

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

Life Expectancy Varies by Where you Live

Source: Institute for Health Metrics and Evaluation, University of Washington, 2014
Where You Live Matters – Life Expectancy in Chicago

Social Needs, Social Determinants & Systemic Causes

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

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

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
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

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
Hospitals are Screening for Social Needs

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

Social Needs Screening Questions

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

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
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

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
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

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
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.

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
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 copays 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

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
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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AHA Resources on Social Determinants

Access at:
Please fill out evaluation at:

https://www.surveymonkey.com/r/march122020

CEU Certificate will be available upon completion for self-reporting.
March 2020

Registrant name: ________________________________________
Title: ________________________________________
Organization: ________________________________________
Address: ________________________________________
City, State, ZIP: ________________________________________

This serves as verification for your Continuing Education for the AHA Coding Clinic’s webinar ICD-10-CM Codes for the Social Determinants of Health by Nelly Leon-Chisen, RHIA - Director, Coding & Classification, American Hospital Association and Julia Resnick, MPH - Senior Program Manager, The Value Initiative, American Hospital Association. The webinar was held on March 12, 2020 (and available for on-demand viewing after the live date) and was one hour in length.

Please use this form for self-reporting to AHIMA.

Retain this verification in your personal file for audit purposes.

Thank you for your interest and participation.

Chabre Ross
Program Chairperson
American Hospital Association