Taking the Next Step: Social Determinants of Health Action Toolkit

Quality Insights

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Pennsylvania Focus: Social Determinants of Health

Health disparities persist throughout Pennsylvania and the nation. The 2022 Pennsylvania Health Assessment demonstrates many ways the health of Pennsylvanians has been impacted by social determinants of health (SDOH), including education, socioeconomic status, social supports, access to services, systemic racism and oppression, racial segregation, and housing.

Below are a small number of selected examples of disparities found in the report:

- Black Pennsylvanians were more likely to have financial difficulty paying their mortgage, rent, or utility bills, buying food, eating a balanced diet, seeing a doctor due to cost, and are more likely to be uninsured.
- Compared to non-Hispanic Whites, Hispanic residents were more likely to be uninsured, not have a health care provider, be unable to see a doctor due to cost, and to have greater health literacy challenges.
- Those with lower educational levels were more likely to have financial difficulty paying mortgage, rent, or utility bills, eating a balanced diet, having a personal health care provider, visiting a dentist, and receiving care due to cost.

There are many resources and areas of support within Pennsylvania that strengthen the health care community's position to address gaps and barriers to health. This toolkit from Quality Insights offers Pennsylvania's clinicians evidence-based education, actionable tools, workflows, and real-time examples of care teams who are effectively working to address SDOH amongst their patient populations.

Health Disparities

A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, disability (cognitive, sensory, or physical), sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion.

Source: Healthy People 2030

Health Equity

The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Source: Healthy People 2030

Social Determinants of Health (SDOH)

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.

Source: Healthy People 2030

Ten Tips to Reduce Health Disparities in Practice Settings

To best address patients' social needs, care teams must first identify the social determinants their patients are experiencing. Screening tools, like the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE), have been developed to assess the needs of individuals seeking care. But as with any new process, workflow challenges can arise that may potentially impede progress in collecting and using SDOH data to decrease disparities.

Use the ten tips below to get started with adopting the PRAPARE tool, utilizing ICD-10-CM (Z Codes), and reducing health disparities.

1. Assess your electronic health record's (EHR's) capability of running reports based on clinical quality measures.
2. Determine ability to collect and report race, ethnicity, and preferred language data.
3. Explore your EHR's ability to integrate with the PRAPARE tool. Review Chapter 4 of the PRAPARE tool for guidance.
4. Use the PRAPARE tool or implement a paper form to identify your patients' social needs.
5. Develop and implement a standardized SDOH screening workflow (see page 6).
6. Plan a communication strategy to help patients understand why they are being asked about SDOH and ways they can benefit from the assessment.
7. Review common challenges to SDOH data collection and suggestions for resolution in primary care settings.
8. Refer patients to local and/or online social resources:
    - Unite Us Pennsylvania
    - Findhelp.org (Aunt Bertha)
    - 211 Helpline Center (United Way)
    - Supplemental Nutrition Assistance Education Program (PA SNAP-Ed)
    - Expanded Food and Nutrition Education Program (EFNEP)
    - Pennsylvania Department of Transportation
    - Pennsylvania Department of Human Services
    - Pennsylvania Department of Aging
9. Implement structured data fields to track referrals and feedback; referrals and feedback are essential to continuity of care. If your practice is participating in the Centers for Medicare & Medicaid Services (CMS) Quality Payment Program (QPP), consider monitoring the following Clinical Quality Measure (CQM), *Closing the Referral Loop*: *Receipt of Specialist Report.*
    - **Definition:** The percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.
        - Electronic clinical quality measures (eCQMs): CMS50v9

- MIPS clinical quality measures (MIPS CQMs): CMS 374

10. Go to page 7 to review Quality Insights' *Quick Guide to Social Determinants of Health* as a starting point to utilize ICD-10 Z codes to link SDOH and diagnoses/problem lists.

SDOH Screening: Taking a Closer Look at PRAPARE

The National Association of Community Health Centers' (NACHC) PRAPARE tool is both a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing the social determinants at both the patient and population levels. By using PRAPARE, providers can better target clinical and non-clinical care (often in partnership with other community-based organizations) to drive care transformation, delivery system integration, as well as improved health and cost reductions.

PRAPARE Implementation and Action Toolkit

Click on the chapter links below to view resources and best practices on that implementation step.

- Introduction to the PRAPARE Implementation and Action Toolkit
- Preparing to Gather Data on the SDOH
  - Chapter 1: Understand the PRAPARE Project
  - Chapter 2: Engage Key Stakeholders
  - Chapter 3: Strategize the Implementation Process
- Assessing Social Determinants of Health Data
  - Chapter 4: Technical Implementation with PRAPARE Electronic Health Record Templates
  - Sign an End User License Agreement to access free EHR templates for Epic, eClinicalWorks, athenaPractice (formerly GE Centricity), Greenway Intergy, NextGen, Athena, and Cerner
  - Chapter 5: Workflow Implementation
  - Chapter 6: Develop a Data Strategy
  - Chapter 7: Understand and Evaluate Your Data

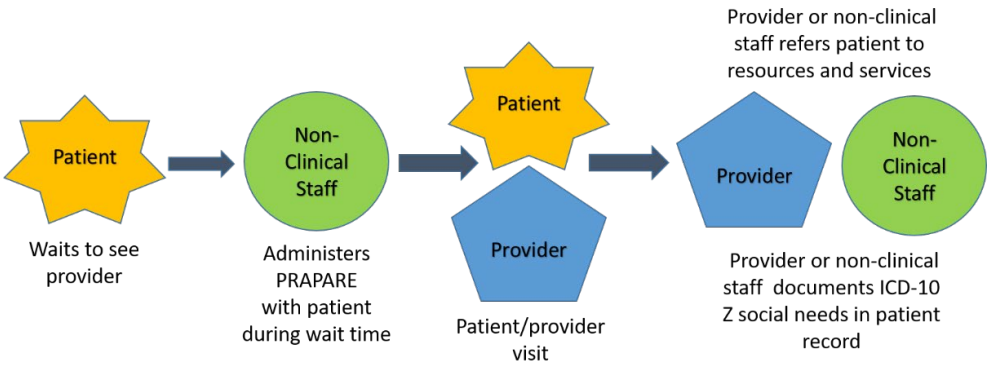
  Note: **Athena users (not athenaPractice) must contact their customer success managers to implement PRAPARE in their EHR.*
- Responding to Social Determinants of Health Data
  - Chapter 8: Building Capacity to Respond to Your Data
  - Chapter 9: Act on Your Data
  - Chapter 10: Track Enabling Services

Podcast: Social Determinants of Health and Utilizing the PRAPARE Tool

Join Quality Insights Practice Transformation Specialists, Joe Pinto and Danielle Nugent, as they explore the topic of SDOH and discuss how care teams can overcome barriers in implementing the PRAPARE tool. Scan this QR code to access the podcast.

Sample Care Team Workflows to Address SDOH

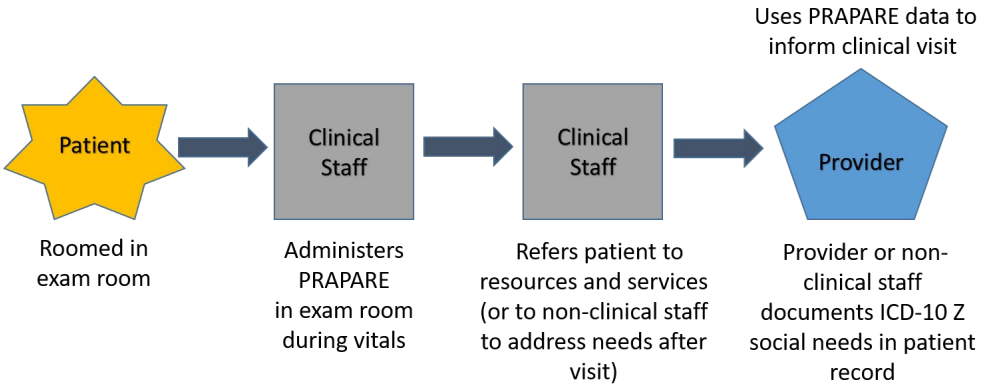
Option 1: Using Non-Clinical Staff Before the Clinical Visit



Option 1 Advantages:

- PRAPARE data informs clinical visit to ensure appropriate treatment plan developed.
- Uses "value-added" time when patient would otherwise be waiting.

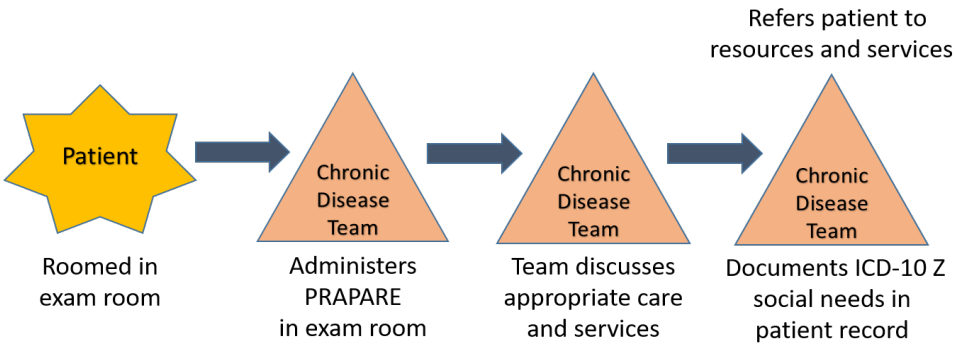
Option 2: Using Clinical Staff During Clinical Visit



Option 2 Advantages:

- Administering PRAPARE in exam room ensures privacy.
- Use PRAPARE data to inform clinical visit with provider to ensure appropriate treatment plan developed.

Option 3: Using Chronic Disease Management Team



Option 3 Advantages:

- Comprehensive team to assess and address patient's social determinant needs and use data for care planning.
- Eases burden on staff who conduct other screenings.

Quick Guide to Social Determinants of Health ICD-10 Codes

What are Z Codes?

- ICD-10-CM Z codes represent factors influencing health status and contact with health services that may be recorded as diagnoses.
- Codes Z-55 through Z-65 identify non-medical factors that may influence a patient's health status.

Benefits of Using Z Codes:

- Identify social needs that impact patients and connect with community resources.
- Aggregate data across patients to determine a social determinants strategy.
- Track trends or risks in the community.
- Guide community partnerships.
- Connect social needs to claims for future financial incentives from private and government payers.

Addressing Common Barriers to Use of Z Codes

Lack of definitions for social determinants of health (SDoH) terms	The national Gravity Project is underway to lay groundwork for national standardization of definitions and data. Consider developing internal definitions for coding guidelines until national standards established.
Lack of incentives	Commercial and government payers have strong interest in identification of SDOH for reimbursement, risk adjustment, etc. Documenting Z codes in claims now develops data for future incentives.
Operational processes for screening and documenting	Consider using The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences, or PRAPARE tool, a standardized SDOH assessment that can be integrated into the EHR and adapted to individual workflows. PRAPARE can automatically link to appropriate ICD-10 Z codes that can be added to the diagnosis or problem list.
Lack of clarity about who can document Z codes	According to the American Hospital Association (AHA) Coding Clinic, for SDOH information such as found in Z codes 55-65, 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** because this information represents social documentation rather than medical diagnoses.
Questions about documenting patient self-reported information	The 2019 AHA Coding Clinic notes that "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."
Productivity challenges	AHA recommends training coders to understand the value of documenting Z codes.

Source: American Hospital Association ICD-10-CM Coding for Social Determinants of Health

Provider's Quick Guide to Social Determinants of Health ICD-10 Z Codes

ICD-10 Code Category	Problems/Risk Factors Included in Category
Z55 – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, educational maladjustment and discord with teachers and classmates.
Z56 – Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
Z57 – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
Z59 – Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance and welfare support.
Z60 – Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.
Z62 – Problems related to upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility towards and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, personal history of unspecified abuse in childhood, parent-child conflict, and sibling rivalry.
Z63 – Other problems related to primary support group, including family circumstances	Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, alcoholism and drug addiction in family.
Z64 – Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiparity, and discord with counselors.
Z65 – Problems related to other psychosocial circumstances	Conviction in civil and criminal proceedings without imprisonment, imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war and other hostilities

As of 2022, there are nine categories of Z codes related to SDoH and several sub-codes (CMS, 2022).

Adapted from: ICD-10-CM Coding for Social Determinants of Health (AHA)

References: ICD-10Data.com, ICD-10coded.com

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Quality Insights Health Care Spotlight

Joining Forces: Teaming Up to Reduce Health Disparities in Philadelphia

Ten organizations in the Philadelphia area have teamed up to launch Accelerate Health Equity. This initiative, spearheaded by health insurers, hospital systems, and medical schools looks to improve Philadelphia residents' overall health through pilot programs across the city. The 2021 edition of the University of Wisconsin-Madison's Population Health Institute's County Health Rankings, placed Philadelphia as having the worst overall health outcomes in the state. The proposed programs are aimed at areas of concern, including heart disease, colorectal cancer, and obesity and diabetes. After the pilot phase of the programs, successful programs will be expanded to assist larger portions of the population.

Interested in learning more? Explore the initiatives areas of interest and the program as a whole on the Philadelphia Health Equity Dashboard.

Addressing SDOH by Lending a Hand in Hermitage: Fresenius Kidney Care

When staff at Fresenius Kidney Care in Hermitage, PA noticed a growing concern with patients accessing nutritious food, they decided to address the challenge directly. The result has become a community-wide effort known as the "Lend a Hand Stand" and it's making positive changes for people in Hermitage.

It all started about seven years ago when one of the facility's nurses encountered a few patients who would come to treatment and talk about lack of access to food. The nurse happened to have a mother-in-law who was the director of a local food bank. Each time a patient would express this type of food insecurity, the nurse would contact her mother-in-law and get food for the patient from the food bank. The food bank would always end up bringing a couple of boxes of food to patients in need.

In 2016, staff at the facility decided to host a food drive as a way to say "thank you" to the food bank for helping patients. Everything collected during that initial food drive was donated back to the food bank.

The food drive was so successful that the facility decided to continue hosting one each November. Food collected during the first few years was stored on a shelf in the dialysis facility. Even the facility's patients got involved. Staff encouraged participation by putting food items out on a counter in the treatment area so patients could see and be inspired to bring in items.

"The food drives get bigger every year," Sonya Conti, Clinical Manager at the facility, said. "During one of the first years, our entire conference room was filled with food. That year, our staff divided into

teams and made it a competition to see which team could bring in more food. Teams were bringing in food by the cases!"

In 2018, after a couple of years of food drive success, staff at the facility had an idea to construct an actual food cupboard at the facility. The facility's charge nurse, Chad Park, offered to design and construct the free-standing structure, which included doors and shingles. Other staff members helped paint the structure before placing it behind the facility. It's now called the "Lend a Hand Stand."

Fresenius Kidney Care of Hermitage's "Lend a Hand Stand"

The food drives usually take care of stocking the Stand for most of the year. If supplies get low, staff at the facility contribute food to keep everything stocked until the next food drive. There are no requirements about the type of food donated. Staff always make sure there are diabetic-friendly food items available.

Patients as well as other community members have free access to the Stand when needed.

"All of the patients know that it's there and the whole community knows it," Conti said. "Some people from the community donate food items, as do some of our patients. It's sort of become like a pantry for the community as well."

In addition to the food drive each year, the facility also collects mittens, hats, and winter clothes for the community. These items are donated to women's shelters and schools. Staff have also started making meal boxes for some patients before Easter each year.

"The patients are always very appreciative," Conti said. "There have been a couple of times when a patient has been emotional and talked about how much it meant to them."

The facility is located in a rural business park in the Shenango Valley area. The door to the Stand is left unlocked so people can drive around the back of the building and pick up a few items at their own discretion, allowing for more convenience and privacy. The Stand operates on the honor system and the facility has never had issues with people taking advantage of the offering.

"We've had no issues with anyone cleaning us out," Conti said. "It's a pretty tight community. Our rural location has also helped. Not every dialysis clinic location would be conducive to something like this."

News of the food cupboard has spread mostly by word of mouth and social media. Although the facility has never officially promoted the cupboard, some community members have posted about it on their Facebook accounts.

"We will keep it going as long as we're able," Conti said. "As long as we can contribute enough. Anything that can benefit our patients and the community as well – it's just kind of a given now."

For more information about the Lend a Hand Stand or Fresenius Kidney Care of Hermitage, PA, please visit the facility's website at www.freseniuskidneycare.com or contact Sonja Conti, Clinical Manager, at (724) 981-1328 or sonya.conti@fmc-na.com.