Bright HealthCare

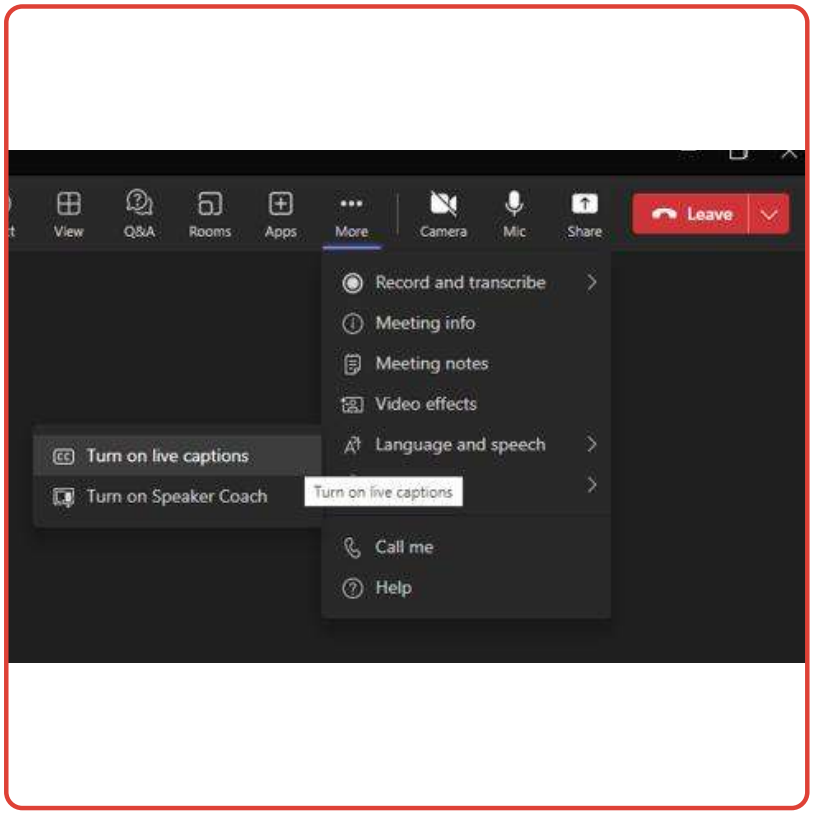
Welcome! We will get started shortly.

Each month's webinar slide deck & recording will be posted to **Healthcare Provider Home | Brand New Day HMO (bndhmo.com)** for on-demand access!

AAPC CEU certificates will be shared after the webinar via email.

Webinar Live-Captioning

Microsoft Teams provides live captioning with speaker attribution in 28 languages.



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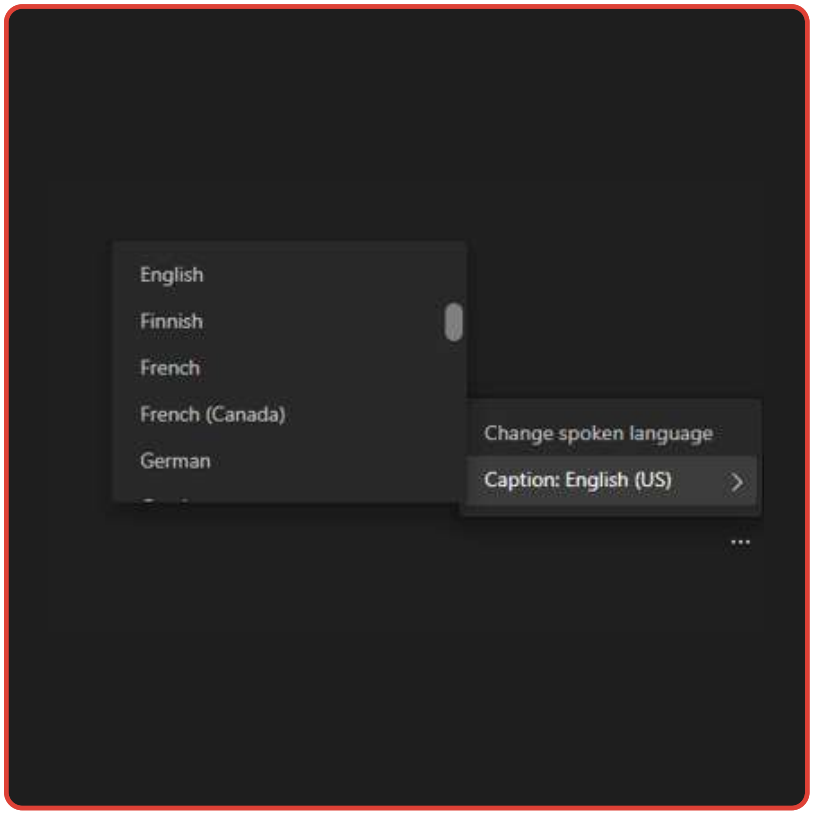

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Social Determinants of Health (SDoH) and Health Equity

Agenda

1. What are SDoH and Health Equity?
2. What is the Impact to Providers & Patients?
3. SDoH Quick Guide

Social Determinants of Health (SDoH) and Health Equity

Social determinants of health (SDoH) are the conditions in which people are born, grow, live, work, and age.

Health equity is the goal of achieving the highest level of health for all people. It requires removing barriers that prevent people from achieving their full health potential.

Social Determinants of Health & Health Equity

Housing Instability

Food Insecurity

Transportation Problems

Utility Help Needs

Interpersonal Safety

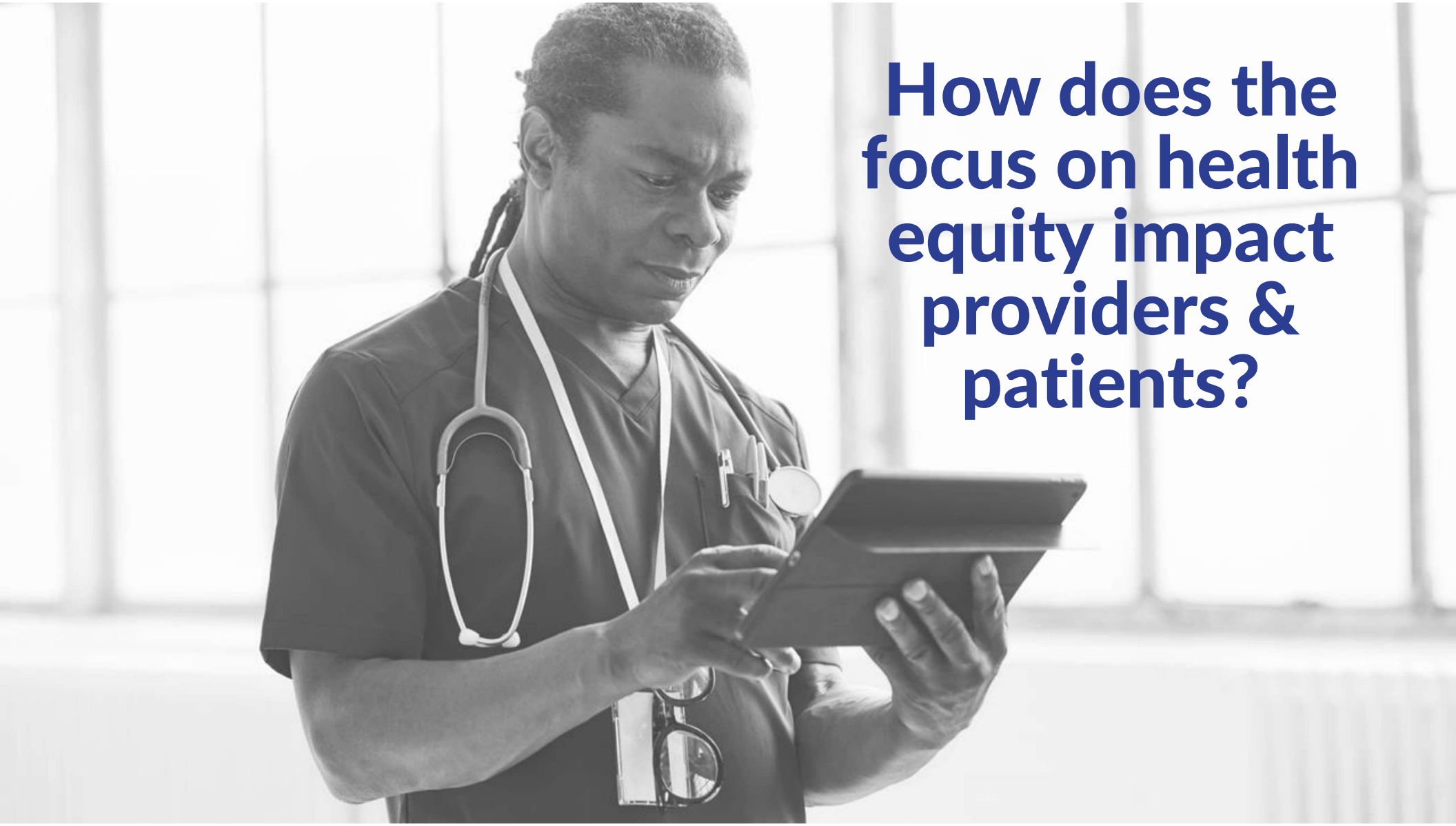
How does health equity relate to risk adjustment?

The movement toward value-based payment models is structured around health outcomes, rather than processes. Empowering providers to address SDoH supports **high quality patient-provider connections.**

Discussing behaviors and social factors that influence health outcomes and **documenting the true health status** of your patients is integral to value-based care.

Our Mission: Making healthcare right, together.

Our Vision:
Collaborating with Care Partners to make healthcare simpler, personal, and more affordable.



How does the focus on health equity impact providers & patients?

Poll Question #1

What percentage of Americans say they want to die at home?

A 10%

B 30%

C 50%

D 70%

E 90%

Poll Question #2

What percentage of Americans die in the hospital?

- A 10%
- B 30%
- C 50%
- D 70%
- E 90%

Goals of Care

After your ICP conversation is complete, say to the member... I have one more question for you...

"Please don't be scared by this question, I must ask everyone this question. Remember, YOU are the captain of your care, and YOU get to decide the care you receive. All of us naturally have our heart stop someday. When your heart naturally stops beating someday, do you want to have a natural death? Or do you want CPR? Hooked up to machines to breathe for you? Hooked up to machines to feed you?"

1 in 3 adults
completes any type of advance directive for end of life care

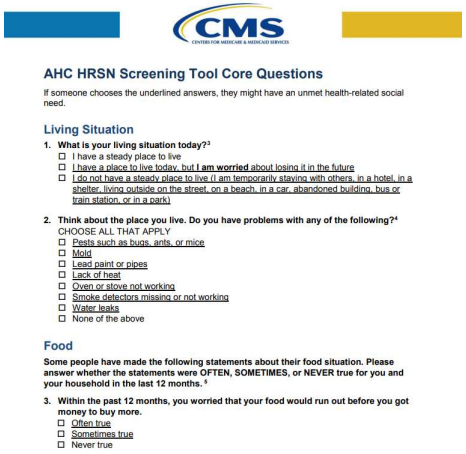
1 in 4 indicators
in the HEDIS *Care for Older Adults* (COA) measure, advanced care planning targets members 65 and older

Reminder → It is not the job of the care managers, UM nurses, DC planners, or social workers to fill out the POLST. However, it ***is*** our job to FACILITATE these goals of care conversations.

- Document your conversation in **Advance Care Planning** assessment in panorama which ask the following questions:
  - Have you started planning ahead for your healthcare?
  - Have you completed any advance care planning documents?
  - Who has a copy of your advance care planning documents?
    - If the member does not have any form of advance care planning in place, you will ask if the member is interested in talking about goals of care
    - Inquire if the member needs assistance with completing the document(s). If so, discuss, document, and facilitate talking with their PCP.

Screening

Consider utilizing SDoH screening tools in your practice.



AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

SDoH Tools & Resources

AAFP & CMS both have great SDoH resources that include screening tools.

AAFP: The EveryONE Project | AAFP

CMS: The AHC Health-Related Social Needs Screening Tool (cms.gov)

Why this Matters

Among U.S. adults…

11%

DID NOT fill a prescription due to high cost.

1.8%

Cited transportation as a barrier for a DELAY IN MEDICAL CARE.

12%

SKIPPED medication doses to save money.

Impact to Patient

Incorporate any identified social needs into the plan of care for the patient.

Resources for Social Needs

AAFP's "Neighborhood Navigator" is an interactive tool at the point of care to connect patients with supportive services in their neighborhoods. It lists more than 40,000 social services by zip code.

Neighborhood Navigator | AAFP

Documentation Tips

Consistently document non-medical social needs in the EHR.

Coding Insights

Coders can assign SDoH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.

Top Ten SDoH Z Codes

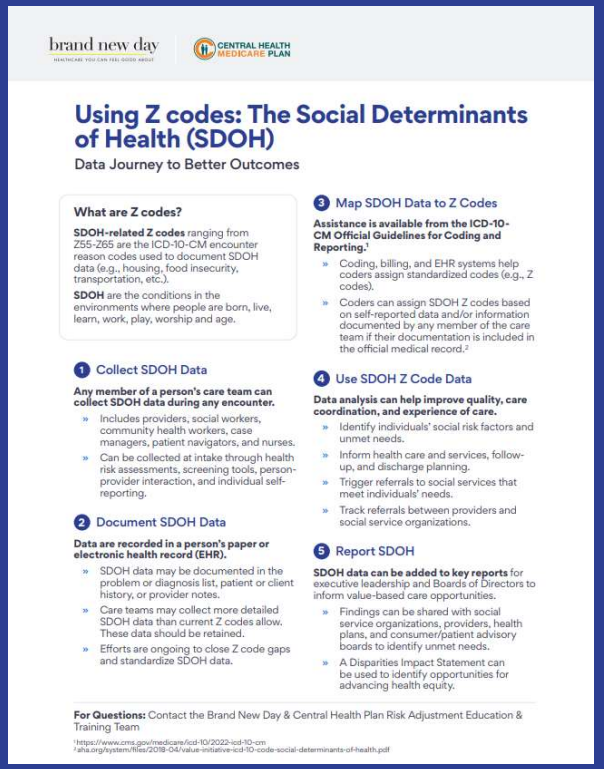
Ranking	ICD-10 Code	ICD-10 Description
1	Z59.0	Homelessness
2	Z63.0	Problems in relationship with spouse or partner
3	Z63.4	Disappearance and death of family member
4	Z62.820	Parent-biological child conflict
5	Z62.810	Personal history of physical and sexual abuse in childhood
6	Z56.0	Unemployment, unspecified
7	Z63.8	Other specified problems related to primary support group
8	Z60.2	Problems related to living alone
9	Z65.8	Other specified problems related to psychosocial circumstances
10	Z63.5	Disruption of family by separation and divorce

*Definitive Healthcare, November 2022.

Social Determinants of Health Quick Guide

Understand how to collect & document SDoH Data, assign the appropriate ICD-10 Z Codes, and utilize the collected information.

Additionally, recognize your role in the integration of SDoH data into primary care workflows to help achieve health equity for all of your patients.



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CENTRAL HEALTH MEDICARE PLAN

Using Z codes: The Social Determinants of Health (SDOH)

Data Journey to Better Outcomes

What are Z codes?

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age.

1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.[2]

4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

5 Report SDOH

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

For Questions: Contact the Brand New Day & Central Health Plan Risk Adjustment Education & Training Team

[1] https://www.cms.gov/medicare/icd-10/2022-icd-10-cm
[2] aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Coming soon: Brand New Day Authorization Portal Training Webinar!

Join us for the Brand New Day Authorization Portal Training Webinar on **Thursday, August 10th at noon!**

Please email Natasha Koermer, at nkoermer@brighthealthgroup.com, if you would like an invitation. Invites will be sent out soon!

Thank you!

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HEALTHCARE YOU CAN FEEL GOOD ABOUT

For additional resources & information, visit our risk adjustment education websites:

BND: www.bndhmo.com/providers

CHP: www.centralhealthplan.com/cpa

For questions, contact: Elise Depew, Risk Adjustment Senior Manager; edepew@brighthealthcare.com