


Care Coordination Quickinar Series: Health Equity/Disparities: Health Area Deprivation Index (API)

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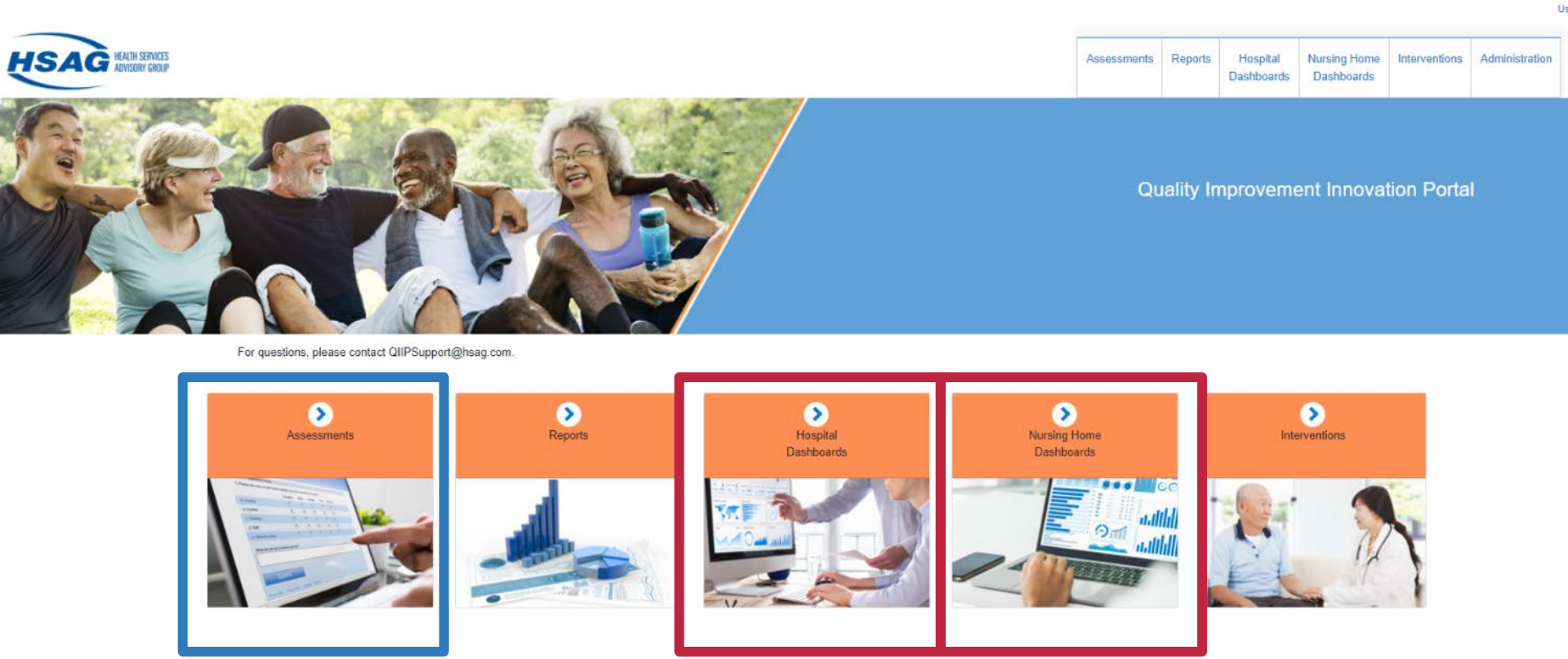
OBJECTIVES

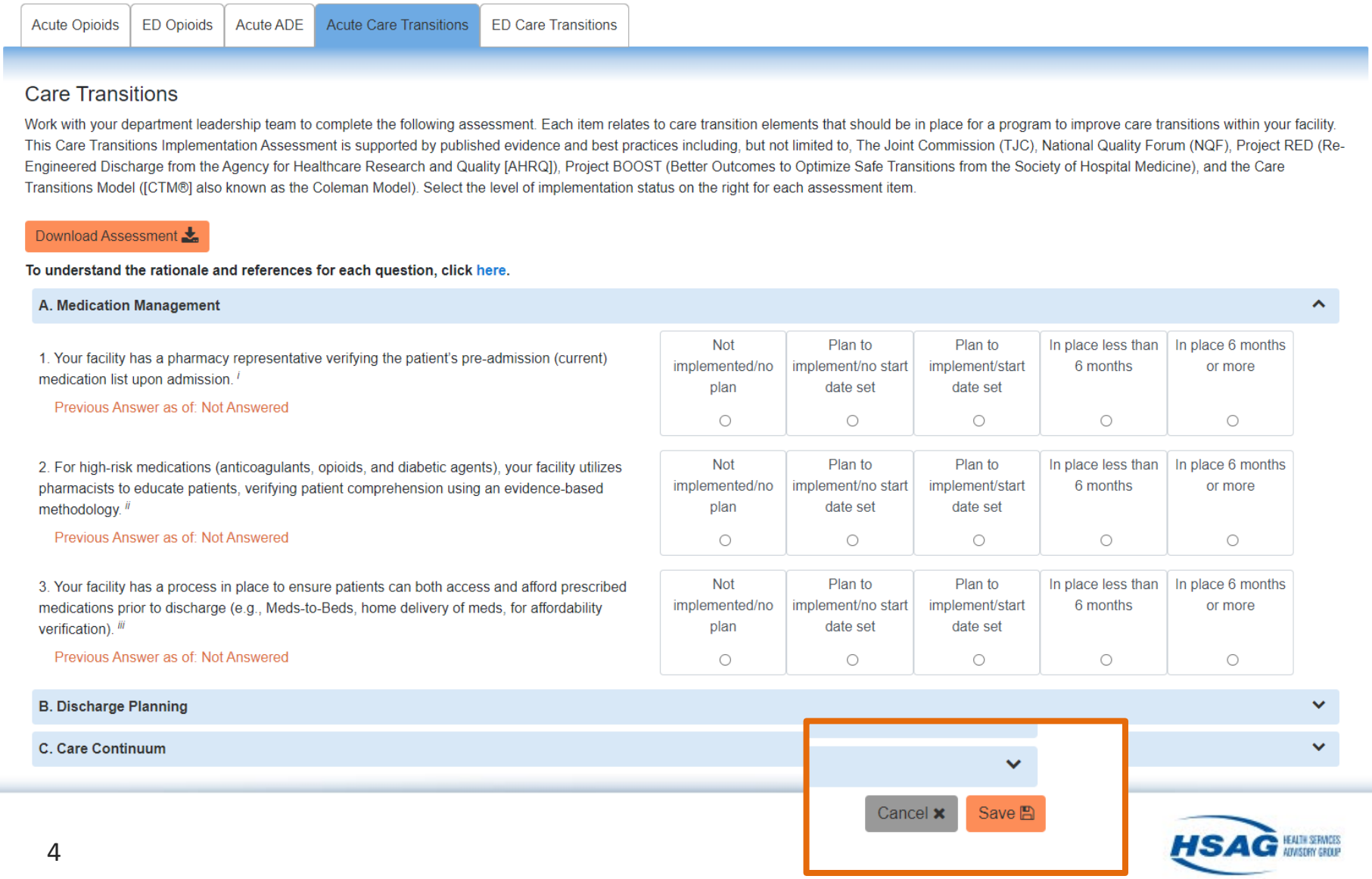
- Use ADI to visualize your community's level of social need.
- Examine the various social need screening tools available to collect patient-level social determinants of health (SDOH) data.
- Discuss how to use Z Codes to document SDOH in the medical record.
- Review HSAG tools and resources for addressing health equity.

Quality Improvement Innovation Portal (QIIP)— Assessments and Data



www.hsag.com/qiip-start

QIIP Care Transitions Assessment



Care Coordination Website

www.hsag.com/cc-resources

What Are Social Determinants?

- Healthy People 2030 describes SDOH as 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."

Healthy People 2023. Social Determinants of Health. Available at https://health.gov/healthypeople/priority-areas/social-determinants-health.

What Are Social Determinants? (cont.)

- SDOH can be grouped into 5 primary categories:
  - Economic issues
  - Education access and quality
  - Healthcare access and quality
  - Neighborhood and built environment
  - Social and community context
- SDOH contribute significantly to health outcomes.
  - 80%–90% of modifiable contributors to health outcomes are social factors.
- SDOH contribute to health disparities and inequities.
  - Social factors can contribute to poor health outcomes and lower life expectancies.

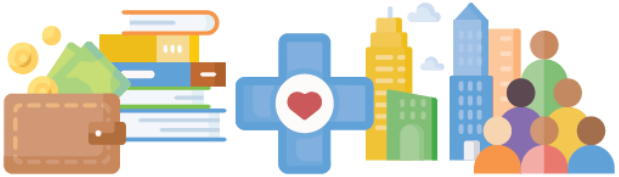
Healthy People 2023. Social Determinants of Health. Available at https://health.gov/healthypeople/priority-areas/social-determinants-health.

A Business Case for Health Equity

Consider The Impact of Health Disparities

Health disparities can lead to poor patient outcomes and significant excess financial cost.

Social determinants of health include: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community contexts.[1]



1 in 10 Americans live in poverty with the inability to afford healthcare, healthy food, and housing.[1]

Health Outcome Contributors

80%-90% social determinants

10%-20% medical care[3]

Yet, an estimated **95%** of health expenditures are on medical costs.[4]

In the United States:

Health disparities have amounted to **$93 billion** in excess medical cost annually.[5]

Dual Eligible Individuals

1.5 times higher hospital utilization

70% higher use of high-risk drugs

18% higher avoidable hospital readmissions

as opposed to non-dual eligible individuals[2]

Patient outcomes and hospital finances are significantly impacted by health disparities.

Health outcomes are greatly impacted by social determinants.

You cannot improve outcomes without addressing heath disparities.

www.hsag.com/globalassets/hqic/hqic-healthequity-bizcase.pdf

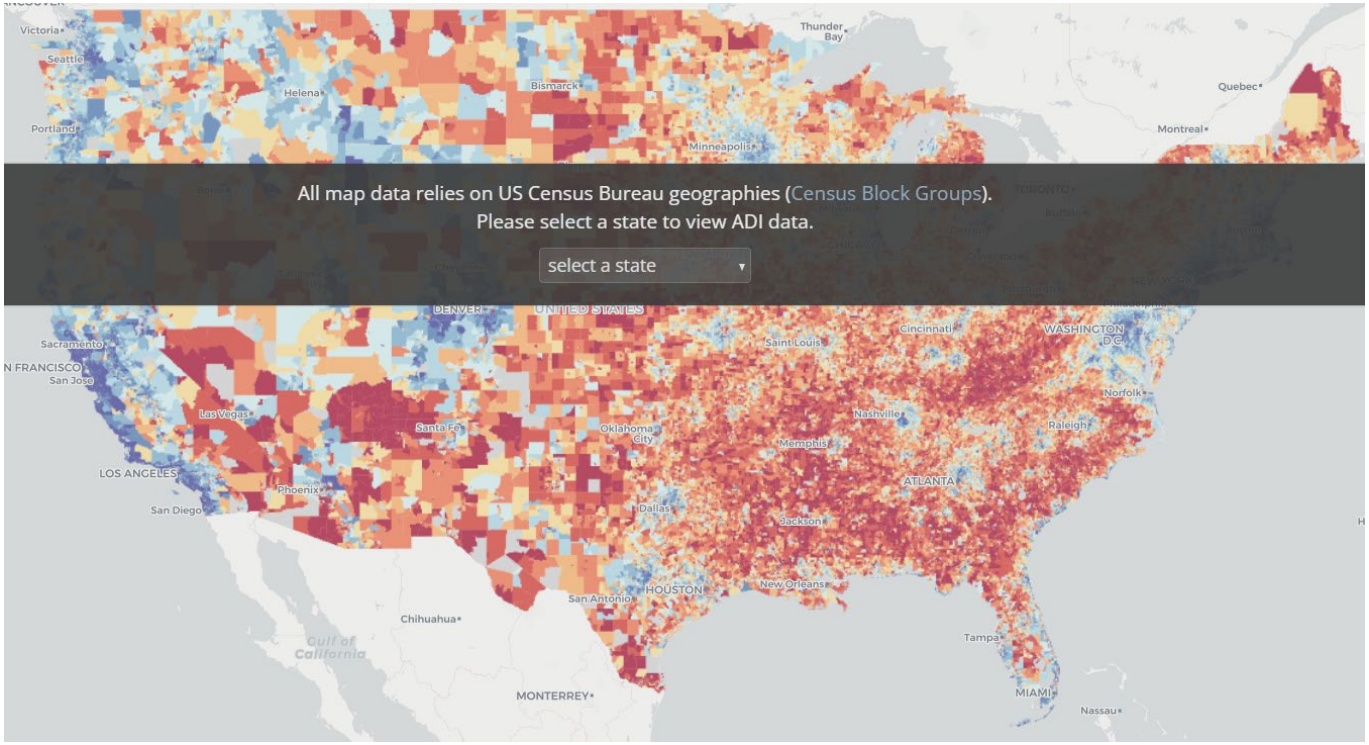
ADI

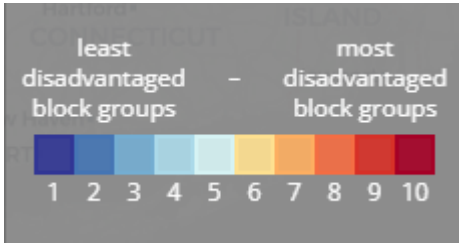
"An ADI is a multidimensional evaluation of a region's socioeconomic conditions, which have been linked to outcomes." – *Maroko, et. al.*

- Neighborhood Atlas®
- Created by Health Resources & Services Administration (HRSA)
- Through University of Wisconsin
- In existence for 30 plus years
- Uses census block groups to define "neighborhoods"
- Identifies most "disadvantaged neighborhoods"
- Factors in:
  - ✓ Income
  - ✓ Education
  - ✓ Employment
  - ✓ Housing

Maroko AR, Doan TM, et al. Integrating Social Determinants of Health With Treatment and Prevention: A New Tool to Assess Local Area Deprivation. Prev Chronic Dis . 2016. 13: 160221. https://www.cdc.gov/pcd/issues/2016/16_0221.htm#:~:text=An%20area%20deprivation%20index%20(ADI)%20is%20a%20multidimensional%20evaluation%20of,outcomes%20at%20various%20geographic%20levels.

ADI Mapping Tool





Neighborhood Atlas. Available at: https://www.neighborhoodatlas.medicine.wisc.edu/mapping

Social Needs Screening Tools

- Screening for individual social needs is important, too.
  - Dependent on patient circumstances
  - Can be impacted by community factors
  - Social needs are fluid, so regular screening can be helpful
- Multiple options for screening tools are available:
  - PRAPARE tool (https://prapare.org/)
  - CMS tool (https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf)
  - HSAG Social Work Assessment (https://www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf)
  - Screening tool comparison (https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison)

PRAPARE = Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
CMS = The Centers for Medicare & Medicaid Services

PRAPARE Social Needs Screening Tool

- Standardized risk-assessment tool for SDOH
- Evidence-based
- Well-established
- Questionnaire
- Z code mapping tool
- Implementation and Action Tool Kit

National Association of Community Health Centers

National Association of Community Health Centers, Inc. (NACHC). Association of Asian Pacific Community Health Organizations (AAPCHO). Oregon Primary Care Association. PRAPARE. Available at https://prapare.org/.

PRAPARE Webinar: July 22, 2021
www.hsag.com/hqic-events

PAST EVENT

Using PRAPARE to Collect SDOH Data

Thursday, July 22, 2021, 2:00 p.m. to 3:00 p.m. ET.

11:00 a.m. Pacific | 12 noon Mountain | 1:00 p.m. Central

Access the Recording

The Health Services Advisory Group (HSAG) Hospital Quality Improvement Contract (HQIC) Offers an overview on how to use the protocol for responding to and assessing patients' assets, risks, and experiences (PRAPARE) assessment tool to collect and document data on the social determinants of health (SDOH).

Objectives

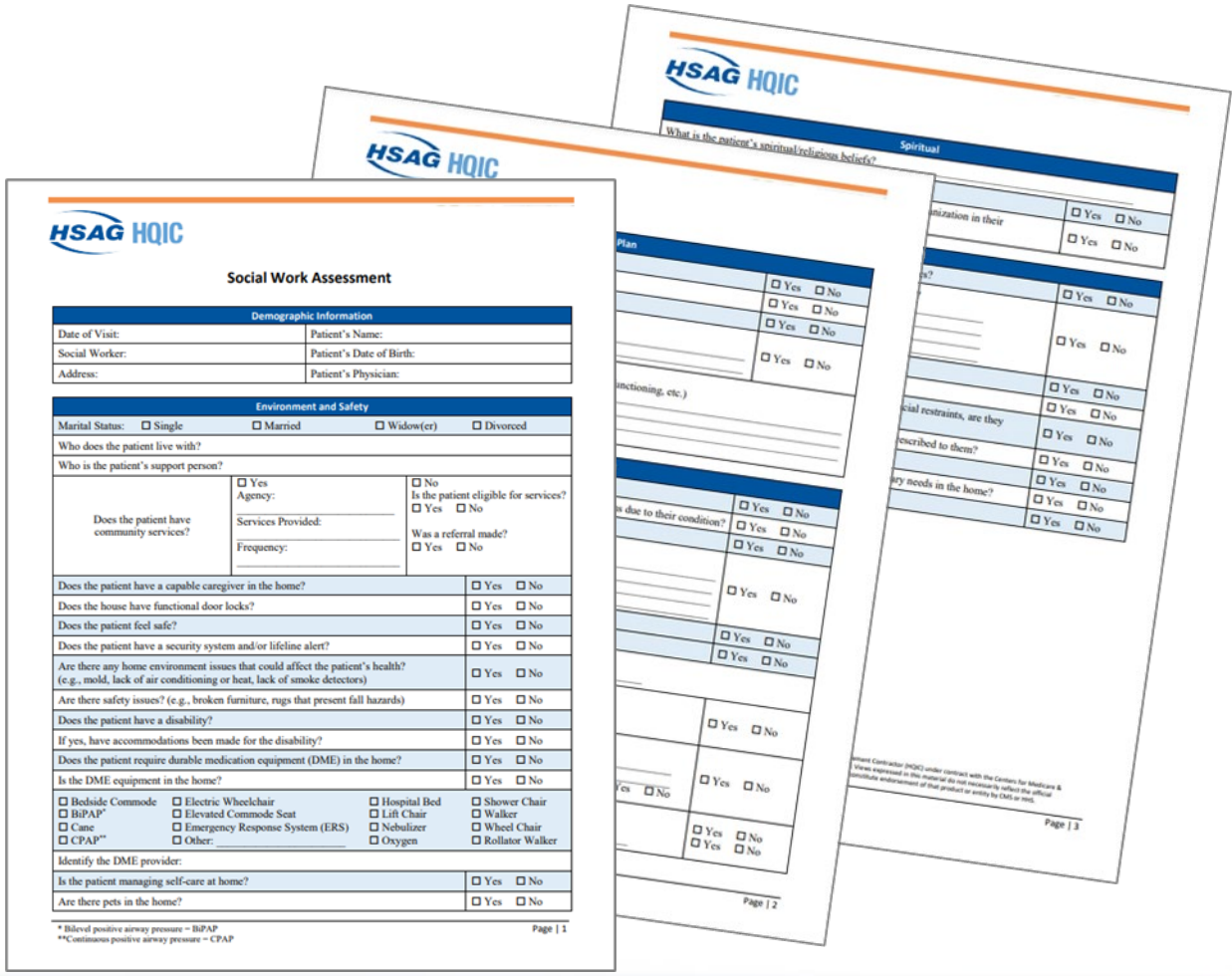
- Discover how PRAPARE enables hospitals to better understand patient complexity, address social risks, and demonstrate value.
- Identify workflows, tips, and strategies for effectively implementing PRAPARE.
- Explore examples of how PRAPARE has led to changes at the patient, organization, and community levels.

- Direct link: https://www.hsag.com/en/hqic/hqic-events/2021/july-2021/using-prapare-to-collect-sdoh-data/?date=7/1/2021.

HSAG. Using PRAPARE to Collect SDOH Data. July 22, 2021. Available at webpage: https://www.hsag.com/hqic/hqic-events/2021/july-2021/using-prapare-to-collect-sdoh-data/.

HSAG HQIC Social Work Assessment

HSAG has developed a Social Work Assessment that includes screening questions for common social needs.



HSAG HQIC

Social Work Assessment

Demographic Information	
Date of Visit:	Patient's Name:
Social Worker:	Patient's Date of Birth:
Address:	Patient's Physician:

Environment and Safety		
Marital Status: ☐ Single ☐ Married ☐ Widow(er) ☐ Divorced		
Who does the patient live with?		
Who is the patient's support person?		
Does the patient have community services?	☐ Yes Agency: Services Provided: Frequency:	☐ No Is the patient eligible for services? ☐ Yes ☐ No Was a referral made? ☐ Yes ☐ No
Does the patient have a capable caregiver in the home?	☐ Yes ☐ No	
Does the house have functional door locks?	☐ Yes ☐ No	
Does the patient feel safe?	☐ Yes ☐ No	
Does the patient have a security system and/or lifeline alert?	☐ Yes ☐ No	
Are there any home environment issues that could affect the patient's health? (e.g., mold, lack of air conditioning or heat, lack of smoke detectors)	☐ Yes ☐ No	
Are there safety issues? (e.g., broken furniture, rugs that present fall hazards)	☐ Yes ☐ No	
Does the patient have a disability?	☐ Yes ☐ No	
If yes, have accommodations been made for the disability?	☐ Yes ☐ No	
Does the patient require durable medication equipment (DME) in the home?	☐ Yes ☐ No	
Is the DME equipment in the home?	☐ Yes ☐ No	
☐ Bedside Commode ☐ BiPAP* ☐ Cane ☐ CPAP** ☐ Electric Wheelchair ☐ Elevated Commode Seat ☐ Emergency Response System (ERS) ☐ Other: ☐ Hospital Bed ☐ Lift Chair ☐ Nebulizer ☐ Oxygen ☐ Shower Chair ☐ Walker ☐ Wheel Chair ☐ Rollator Walker		
Identify the DME provider:		
Is the patient managing self-care at home?	☐ Yes ☐ No	
Are there pets in the home?	☐ Yes ☐ No	

* Bilevel positive airway pressure = BiPAP
**Continuous positive airway pressure = CPAP

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HSAG HQIC

Spiritual

What is the patient's spiritual/religious beliefs?

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HSAG HQIC

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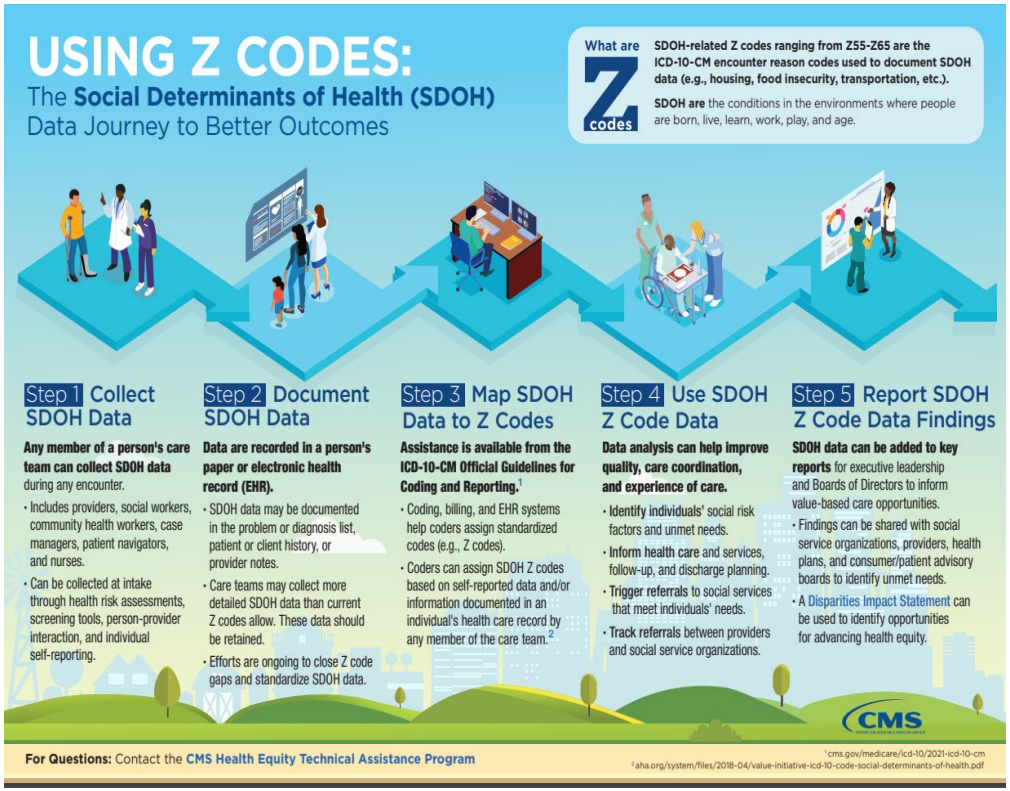
HSAG. Social Work Assessment. Available at https://www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf

HSAG HEALTH SERVICES ADVISORY GROUP

Measuring SDOH: Z Codes



Z codes are a group of ICD-10 codes used to report factors influencing health status.

Assist in capturing social needs of patients, such as SDOH.

Can be used to enhance discharge planning.

Can be used to stratify outcomes based on SDOH.

ICD-10 = International Classification of Diseases, 10th Edition

CMS. Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes. Available at https://www.cms.gov/files/document/zcodes-infographic.pdf.

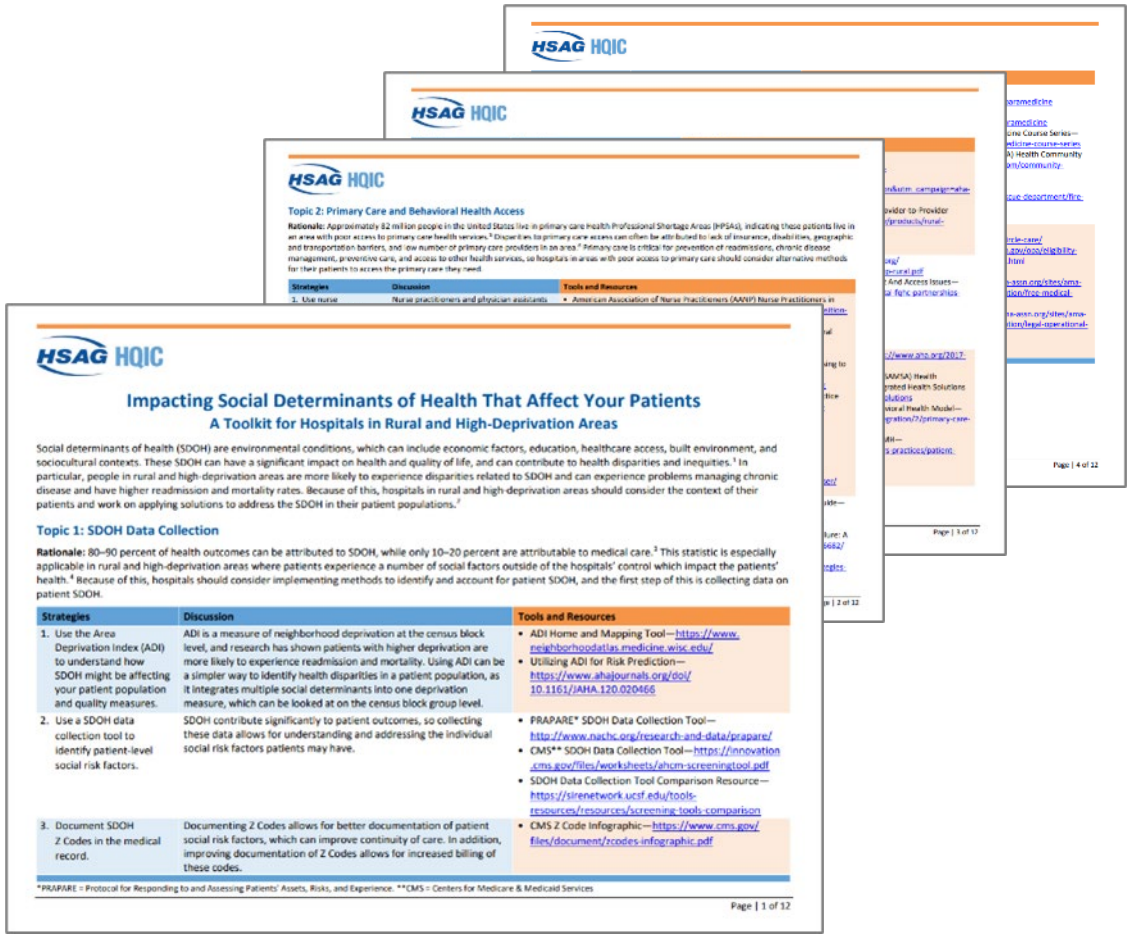
SDOH ICD-10 Z Codes

SDOH ICD-10 Z-Codes	Description	Number of Sub-Codes
Z55	Problems related to education and literacy	7
Z56	Problems related to employment and unemployment	12
Z57	Occupational exposure to risk factors	12
Z59	Problems related to housing and economic circumstances	10
Z60	Problems related to social environment	7
Z62	Problems related to upbringing	24
Z63	Other problems related to primary support group, including family circumstances	14
Z64	Problems related to certain psychosocial circumstances	3
Z65	Problems related to other psychosocial circumstances	8

CMS. Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes. Available at https://www.cms.gov/files/document/zcodes-infographic.pdf.

HSAG SDOH Toolkit

- HSAG developed a SDOH toolkit for hospitals in rural and high-deprivation areas.
  - Focuses on common SDOH
  - Provides strategies, tools, and resources to assist hospitals in addressing community-level drivers, as well as individual social needs


HSAG HQIC

Topic 2: Primary Care and Behavioral Health Access

HSAG HQIC

HSAG HQIC

Impacting Social Determinants of Health That Affect Your Patients

A Toolkit for Hospitals in Rural and High-Deprivation Areas

Social determinants of health (SDOH) are environmental conditions, which can include economic factors, education, healthcare access, built environment, and sociocultural contexts. These SDOH can have a significant impact on health and quality of life, and can contribute to health disparities and inequities.[1] In particular, people in rural and high-deprivation areas are more likely to experience disparities related to SDOH and can experience problems managing chronic disease and have higher readmission and mortality rates. Because of this, hospitals in rural and high-deprivation areas should consider the context of their patients and work on applying solutions to address the SDOH in their patient populations.[2]

Topic 1: SDOH Data Collection

Rationale: 80–90 percent of health outcomes can be attributed to SDOH, while only 10–20 percent are attributable to medical care.[3] This statistic is especially applicable in rural and high-deprivation areas where patients experience a number of social factors outside of the hospitals' control which impact the patients' health.[4] Because of this, hospitals should consider implementing methods to identify and account for patient SDOH, and the first step of this is collecting data on patient SDOH.

Strategies	Discussion	Tools and Resources
1. Use the Area Deprivation Index (ADI) to understand how SDOH might be affecting your patient population and quality measures.	ADI is a measure of neighborhood deprivation at the census block level, and research has shown patients with higher deprivation are more likely to experience readmission and mortality. Using ADI can be a simpler way to identify health disparities in a patient population, as it integrates multiple social determinants into one deprivation measure, which can be looked at on the census block group level.	• ADI Home and Mapping Tool—https://www.neighborhoodatlas.medicine.wisc.edu/ • Utilizing ADI for Risk Prediction—https://www.ahajournals.org/doi/10.1161/JAHA.120.020466
2. Use a SDOH data collection tool to identify patient-level social risk factors.	SDOH contribute significantly to patient outcomes, so collecting these data allows for understanding and addressing the individual social risk factors patients may have.	• PRAPARE* SDOH Data Collection Tool—http://www.nachc.org/research-and-data/prapare/ • CMS** SDOH Data Collection Tool—https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf • SDOH Data Collection Tool Comparison Resource—https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison
3. Document SDOH Z Codes in the medical record.	Documenting Z Codes allows for better documentation of patient social risk factors, which can improve continuity of care. In addition, improving documentation of Z Codes allows for increased billing of these codes.	• CMS Z Code Infographic—https://www.cms.gov/files/document/zcodes-infographic.pdf

*PRAPARE = Protocol for Responding to and Assessing Patients' Assets, Risks, and Experience. **CMS = Centers for Medicare & Medicaid Services

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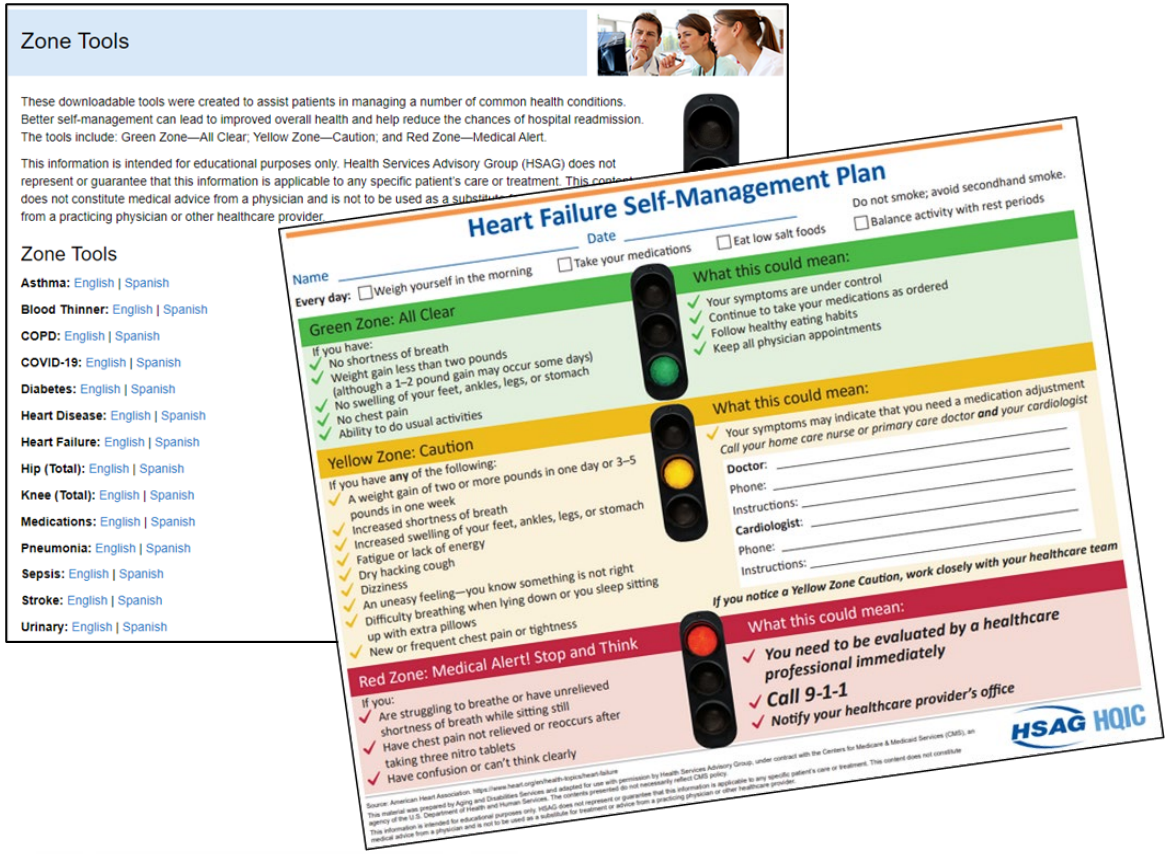
HSAG. Impacting Social Determinants of Health That Affect Your Patients. Available at https://www.hsag.com/globalassets/hqic/hqic_sdoh_toolkit_508.pdf

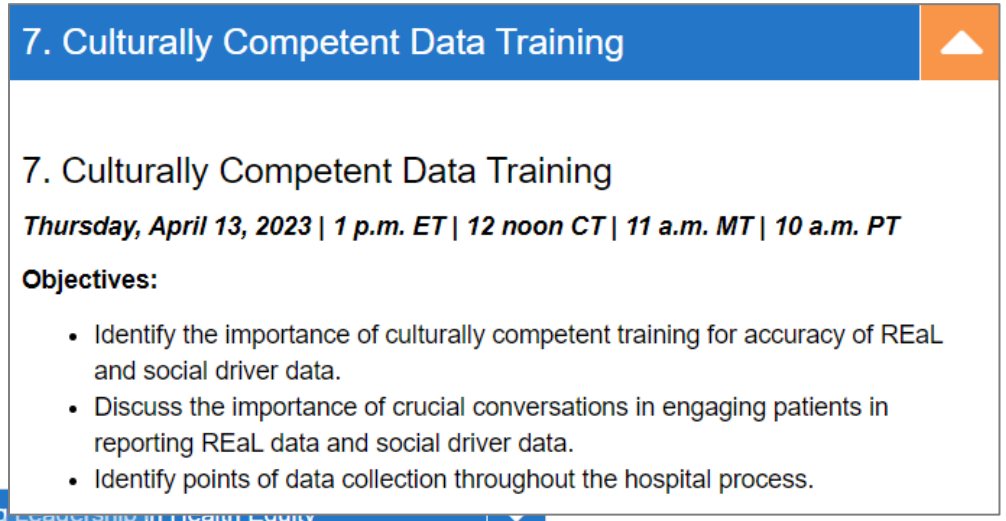
HSAG Zone Tools

- Patients in rural areas often have lower health literacy.
- Education tools, such as Zone Tools, can help patients understand and manage their own care.



Join Us for the Entire Health Equity Quickinar Series: 2nd and 4th Thursdays

Recordings, slides, and resource links are posted for on-demand access after every session.



1. Health Equity, Hospitals, and CMS Reporting
2. Engaging Leadership in Health Equity
3. Health Equity as a Strategic Priority
4. Collection and Validating REaL Data
5. Social Determinants and Social Drivers of Health
6. Screening for Social Drivers
7. Culturally Competent Data Training
8. Analysis and Stratification of Health Equity Data
9. Health Equity Interventions
10. Best Practices in Health Equity Interventions
11. Community Paramedicine
12. Identifying Community Health Disparities
13. Community Engagement—Health Equity

www.hsag.com/health-equity-quickinars

HSAG Health Services Advisory Group

Our Next Care Coordination Quickinar

Health Literacy, Part 2

Tuesday, May 2, 2023 | 11 a.m. PT

bit.ly/cc-quickinars2

www.hsag.com/cc-quickinars

Questions?

Please Take 5 Seconds and Let Us Know

We want this call to be meaningful to you, so we need your input.

At the end of the webinar, you will be asked **one question** to determine if this call equipped your organization to begin implementing care coordination practices.

Thank you!

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