



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



Assessments	Reports	Hospital Dashboards	Nursing Home Dashboards	Interventions	Administration
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Quality Improvement Innovation Portal

For questions, please contact QIIPSupport@hsag.com.

Assessments

Reports

Hospital Dashboards

Nursing Home Dashboards

Interventions

www.hsag.com/qiip-start



QIIP Care Transitions Assessment

Acute Opioids ED Opioids Acute ADE **Acute Care Transitions** ED Care Transitions

Care Transitions

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, The Joint Commission (TJC), National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item.

Download Assessment 

To understand the rationale and references for each question, click [here](#).

A. Medication Management

1. Your facility has a pharmacy representative verifying the patient's pre-admission (current) medication list upon admission. ⁱ

Previous Answer as of: Not Answered

Not implemented/no plan <input type="radio"/>	Plan to implement/no start date set <input type="radio"/>	Plan to implement/start date set <input type="radio"/>	In place less than 6 months <input type="radio"/>	In place 6 months or more <input type="radio"/>
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2. For high-risk medications (anticoagulants, opioids, and diabetic agents), your facility utilizes pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology. ⁱⁱ

Previous Answer as of: Not Answered

Not implemented/no plan <input type="radio"/>	Plan to implement/no start date set <input type="radio"/>	Plan to implement/start date set <input type="radio"/>	In place less than 6 months <input type="radio"/>	In place 6 months or more <input type="radio"/>
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3. Your facility has a process in place to ensure patients can both access and afford prescribed medications prior to discharge (e.g., Meds-to-Beds, home delivery of meds, for affordability verification). ⁱⁱⁱ

Previous Answer as of: Not Answered

Not implemented/no plan <input type="radio"/>	Plan to implement/no start date set <input type="radio"/>	Plan to implement/start date set <input type="radio"/>	In place less than 6 months <input type="radio"/>	In place 6 months or more <input type="radio"/>
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B. Discharge Planning

C. Care Continuum



Care Coordination Website

Care Coordination



Care coordination is a key priority for the Centers for Medicare & Medicaid (CMS) to improve quality and achieve safer and more effective care. However, gaps in care, such as poor communication and ineffective discharge processes, remain a challenge. To address these gaps, HSAG provides evidence-based tools, strategies, resources, and training needed to improve care coordination.



Hospital Care Coordination Toolkit



Nursing Home Care Coordination Toolkit



Access the QIIP

Care Coordination Assessments

Download PDF versions:

- Acute Care Transitions Assessment
- ED Care Transitions Assessment
- SNF Care Transitions Assessment



Care Coordination Quickinars

Care Coordination Resources

- Medication Management
- Health Equity
- Patient Engagement
- Care Coordination Collaboration
- Quality Improvement Tools
- Care Coordination Evidence-Based Models

- ### Hospitals
- Care Coordination
 - Hospital Care Coordination Toolkit
 - Emergency Preparedness
 - Infection Prevention
 - Opioid Stewardship
 - QIO Events

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.”



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.

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
care³

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



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 health disparities.

Dual Eligible Individuals



1.5 times higher hospital utilization



70% higher use of high-risk drugs



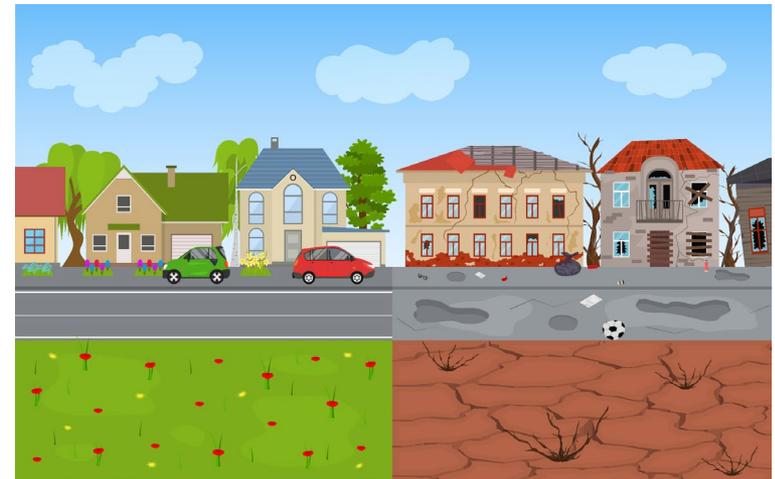
18% higher avoidable hospital readmissions

as opposed to non-dual eligible individuals²

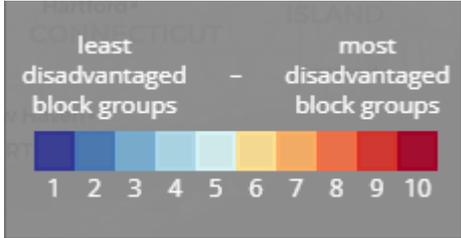
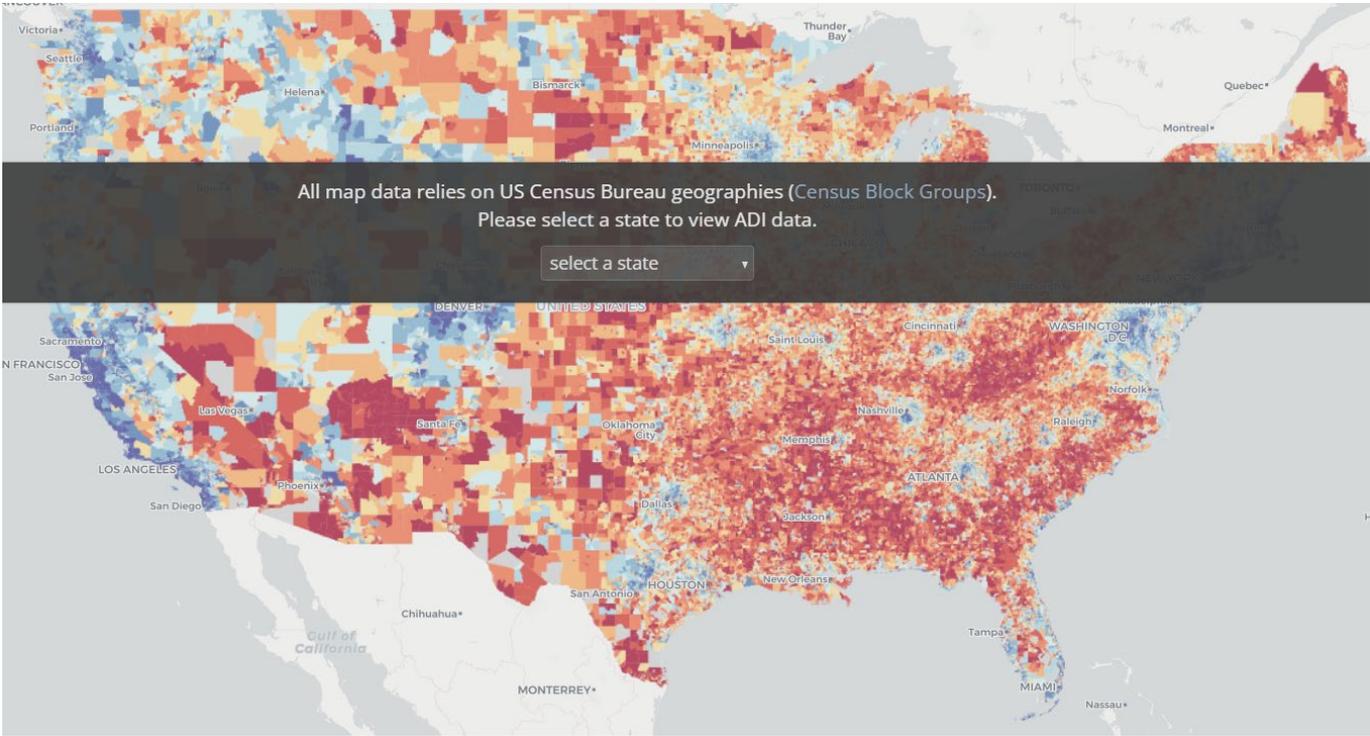
ADI

“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
 - ✓ Employment
 - ✓ Education
 - ✓ Housing



ADI Mapping Tool



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 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



PRAPARE Webinar: July 22, 2021

www.hsag.com/hqic-events



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?	<input type="checkbox"/> Yes Agency: _____ Services Provided: _____ Frequency: _____	<input type="checkbox"/> No Is the patient eligible for services? <input type="checkbox"/> Yes <input type="checkbox"/> No Was a referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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

<input type="checkbox"/> Bedside Commode	<input type="checkbox"/> Electric Wheelchair	<input type="checkbox"/> Hospital Bed	<input type="checkbox"/> Shower Chair
<input type="checkbox"/> BiPAP*	<input type="checkbox"/> Elevated Commode Seat	<input type="checkbox"/> Lift Chair	<input type="checkbox"/> Walker
<input type="checkbox"/> Cane	<input type="checkbox"/> Emergency Response System (ERS)	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Wheel Chair
<input type="checkbox"/> CPAP**	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Oxygen	<input type="checkbox"/> 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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Measuring SDOH: Z Codes

USING Z CODES: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes

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, and age.



Step 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.

Step 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.

Step 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 in an individual's health care record by any member of the care team.²

Step 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.

Step 5 Report SDOH Z Code Data Findings

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 CMS Health Equity Technical Assistance Program

¹cms.gov/medicare/icd-10/2021-icd-10-cm

²aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

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.

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

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

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.	<ul style="list-style-type: none"> • ADI Home and Mapping Tool—https://www.neighborhooddataasmedicine.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.	<ul style="list-style-type: none"> • PRAPARE* SDOH Data Collection Tool—http://www.nachc.org/research-and-data/prapare/ • CMS** SDOH Data Collection Tool—https://innovation.cms.gov/files/worksheets/ahum-screeningtool.pdf • SDOH Data Collection Tool Comparison Resource—https://stirenetwork.ucsf.edu/tools-resources/resource/screening-tools-comparison • CMS Z Code Infographic—https://www.cms.gov/files/document/zcodes-infographic.pdf
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.	

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

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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.

Zone Tools

These downloadable tools were created to assist patients in managing a number of common health conditions. Better self-management can lead to improved overall health and help reduce the chances of hospital readmission. The tools include: Green Zone—All Clear, Yellow Zone—Caution, and Red Zone—Medical Alert.

This information is intended for educational purposes only. Health Services Advisory Group (HSAG) does not represent or guarantee that this information is applicable to any specific patient's care or treatment. This content does not constitute medical advice from a physician and is not to be used as a substitute for medical advice from a practicing physician or other healthcare provider.

Zone Tools

- Asthma:** [English](#) | [Spanish](#)
- Blood Thinner:** [English](#) | [Spanish](#)
- COPD:** [English](#) | [Spanish](#)
- COVID-19:** [English](#) | [Spanish](#)
- Diabetes:** [English](#) | [Spanish](#)
- Heart Disease:** [English](#) | [Spanish](#)
- Heart Failure:** [English](#) | [Spanish](#)
- Hip (Total):** [English](#) | [Spanish](#)
- Knee (Total):** [English](#) | [Spanish](#)
- Medications:** [English](#) | [Spanish](#)
- Pneumonia:** [English](#) | [Spanish](#)
- Sepsis:** [English](#) | [Spanish](#)
- Stroke:** [English](#) | [Spanish](#)
- Urinary:** [English](#) | [Spanish](#)

Heart Failure Self-Management Plan

Name _____ Date _____

Every day: Weigh yourself in the morning Take your medications Eat low salt foods Balance activity with rest periods

Green Zone: All Clear

If you have:

- ✓ No shortness of breath
- ✓ Weight gain less than two pounds (although a 1-2 pound gain may occur some days)
- ✓ No swelling of your feet, ankles, legs, or stomach
- ✓ No chest pain
- ✓ Ability to do usual activities

Yellow Zone: Caution

If you have **any** of the following:

- ✓ A weight gain of two or more pounds in one day or 3-5 pounds in one week
- ✓ Increased shortness of breath
- ✓ Increased swelling of your feet, ankles, legs, or stomach
- ✓ Fatigue or lack of energy
- ✓ Dry hacking cough
- ✓ Dizziness
- ✓ An uneasy feeling—you know something is not right
- ✓ Difficulty breathing when lying down or you sleep sitting up with extra pillows
- ✓ New or frequent chest pain or tightness

Red Zone: Medical Alert! Stop and Think

If you:

- ✓ Are struggling to breathe or have unrelieved shortness of breath while sitting still
- ✓ Have chest pain not relieved or reoccurs after taking three nitro tablets
- ✓ Have confusion or can't think clearly

What this could mean:

- ✓ Your symptoms are under control
- ✓ Continue to take your medications as ordered
- ✓ Follow healthy eating habits
- ✓ Keep all physician appointments

What this could mean:

- ✓ Your symptoms may indicate that you need a medication adjustment

Call your home care nurse or primary care doctor **and** your cardiologist

Doctor: _____
 Phone: _____
 Instructions: _____

Cardiologist: _____
 Phone: _____
 Instructions: _____

If you notice a Yellow Zone Caution, work closely with your healthcare team

What this could mean:

- ✓ You need to be evaluated by a healthcare professional immediately
- ✓ Call 9-1-1
- ✓ Notify your healthcare provider's office

Source: American Heart Association. <https://www.heart.org/health-topics/heart-failure>
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HSAG HQIC
HEALTH SERVICES ADVISORY GROUP

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
- 3. Health Equity as a Strategic Priority
- 5. Social Determinants and Social Drivers of Health
- 7. Culturally Competent Data Training
- 9. Health Equity Interventions
- 11. Community Paramedicine
- 13. Community Engagement—Health Equity

- 2. Engaging Leadership in Health Equity
- 4. Collection and Validating REaL Data
- 6. Screening for Social Drivers
- 8. Analysis and Stratification of Health Equity Data
- 10. Best Practices in Health Equity Interventions
- 12. Identifying Community Health Disparities

7. Culturally Competent Data Training

7. Culturally Competent Data Training

Thursday, April 13, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT

Objectives:

- Identify the importance of culturally competent training for accuracy of REaL and social driver data.
- Discuss the importance of crucial conversations in engaging patients in reporting REaL data and social driver data.
- Identify points of data collection throughout the hospital process.

Our Next Care Coordination Quickinar

Health Literacy, Part 2

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

bit.ly/cc-quickinars2



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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