VETERANS HEALTH ADMINISTRATION

Office of Health Equity

Focus on Health Equity in Action Cyberseminar

The WHO's Greatest ICD-10 Hits for Fiscal Year 2022: Social Determinants of Health

Shannon M. Jordan, MPH

Engagement Lead

Office of Health Equity

Shannon.Jordan2@gov

March 9, 2022

OFFICE OF HEALTH EQUITY

Established in 2012
Ernest Moy, MD, Executive Director

Vision is to champion the advancement of health equity and reduction of health disparities and to ensure appropriate individualized care to each Veteran

OHE collaborates w/the Health Equity Coalition to establish operational plans and achieve goals guided by a Health Equity Action Plan (HEAP) to achieve health equity for Veterans

HEAP plans and goals are updated annually around 5 aims: Awareness; Leadership; Health Outcomes; Cultural Competency and Diversity; and Data, Research, and Evaluation

OFFICE OF HEALTH EQUITY

https://www.va.gov/healthequity

OUR PRESENTERS

Alicia Cohen, MD, MSc, FAAFP

Research Investigator and Primary Care Physician, VA Providence Healthcare System; Assistant Professor of Family Medicine, Warren Alpert Medical School of Brown University; Assistant Professor of Health Services, Policy, and Practice; Brown University School of Public Health

Maria Bruton, CPC

Certified Professional Coder
Dallas VA Medical Center

Dina Hooshyar, MD, MPH

Director, National Center on Homelessness Among Veterans, VACO Homeless Programs; Associate Professor, Department of Psychiatry, University of Texas Southwestern Medical Center

The WHO's Greatest ICD-10 Hits for Fiscal Year 2022:
Social Determinants of Health

The views expressed in this presentation are those of the presenters and do not necessarily reflect the position or policy of VA or the US government.

THE WHO'S GREATEST ICD-10 HITS FOR FISCAL YEAR 2022: *SOCIAL DETERMINANTS OF HEALTH*

CYBERSEMINAR SERIES
OFFICE OF HEALTH EQUITY

MARCH 9, 2022

Maria Bruton
Certified Professional Coder
Health Information Management Service
VA North Texas Health Care System

Alicia Cohen, MD, MSc, FAAFP
Primary Care Physician
Research Investigator, Center of Innovation in Long Term Services and Supports
VA Providence Healthcare System

Dina Hooshyar, MD, MPH
Director, National Center on Homelessness among Veterans
VHA Homeless Programs Office

VA | U.S. Department of Veterans Affairs

DISCLOSURES

- No financial disclosures of conflicts of interest
- Accessing Circumstances and Offering Resources for Needs (ACORN) is funded by VHA Office of Health Equity
- Views expressed are our own and do not necessarily reflect the views of the U.S. Government or Department of Veterans Affairs

OBJECTIVES

- Develop an understanding of social determinants of health (SDOH) and why we should address them in healthcare settings
- Discuss how clinical documentation and coding can capture SDOH and why this is important
- Learn about a current initiative to better identify and address SDOH with VHA

SOCIAL DETERMINANTS OF HEALTH (SDOH)

"The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems."

– World Health Organization Commission on Social Determinants of Health

SOCIAL DETERMINANTS OF HEALTH (SDOH)

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education			
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Artiga et al. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. Henry J Kaiser Family Foundation. 2018.

Social determinants

The conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.

Social risk factors

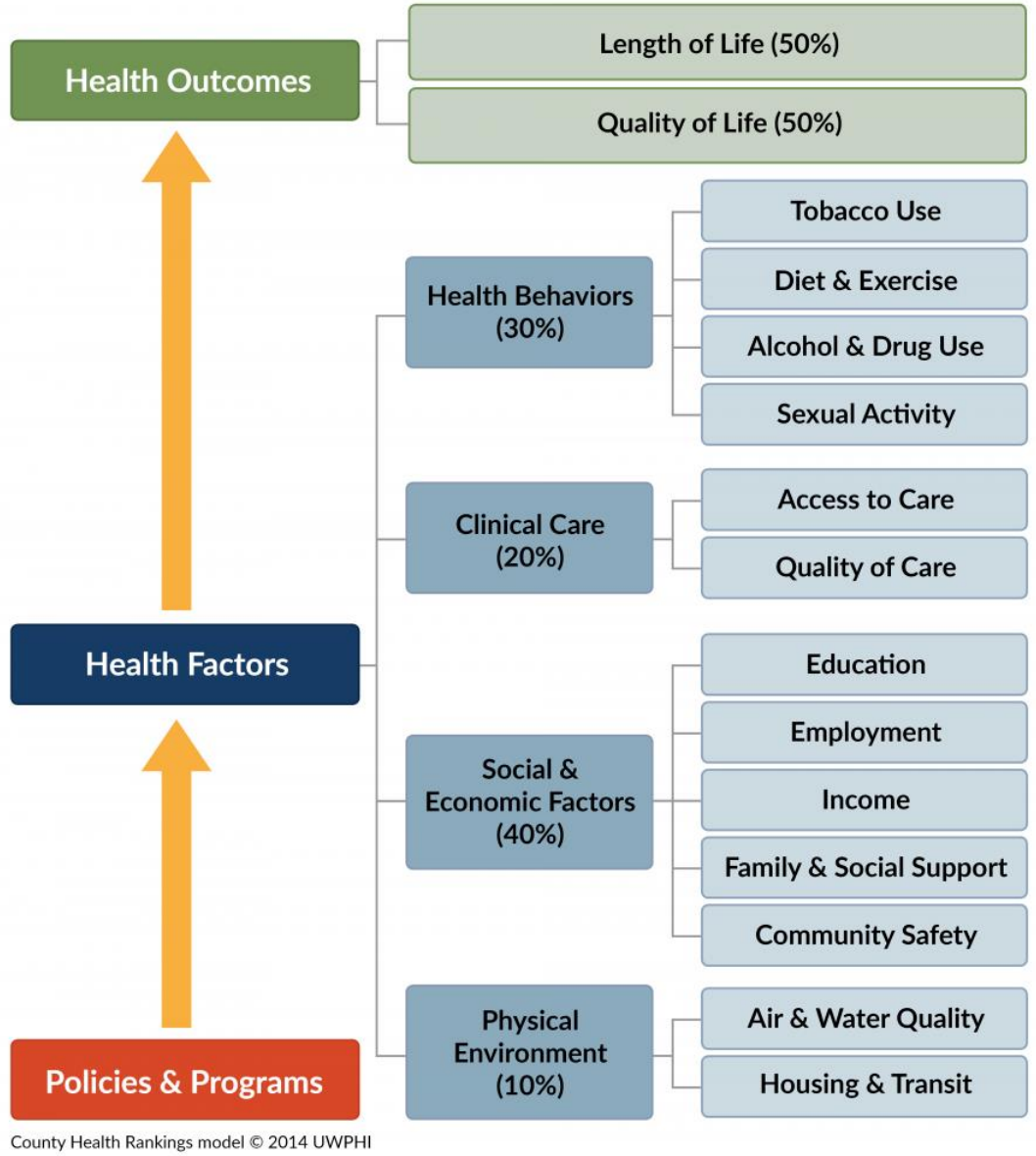
Specific adverse social conditions associated with poor health, such as food insecurity and housing instability.

Social needs

A patient-centered concept that incorporates a person's perception of his or her own health-related needs.

- Alderwick H, Gottlieb LM. *Milbank Q.* 2019;97(2):407.
- Green K, Zook M. *Health Affairs Blog.* 2019
- National Academies of Sciences, Engineering, and Medicine 2019.
- World Health Organization (WHO). 2010.

SOCIAL DETERMINANTS HAVE A GREATER IMPACT ON HEALTH OUTCOMES THAN CLINICAL CARE



Remington et al. *Popul Health Metr.* 2015;13:11.

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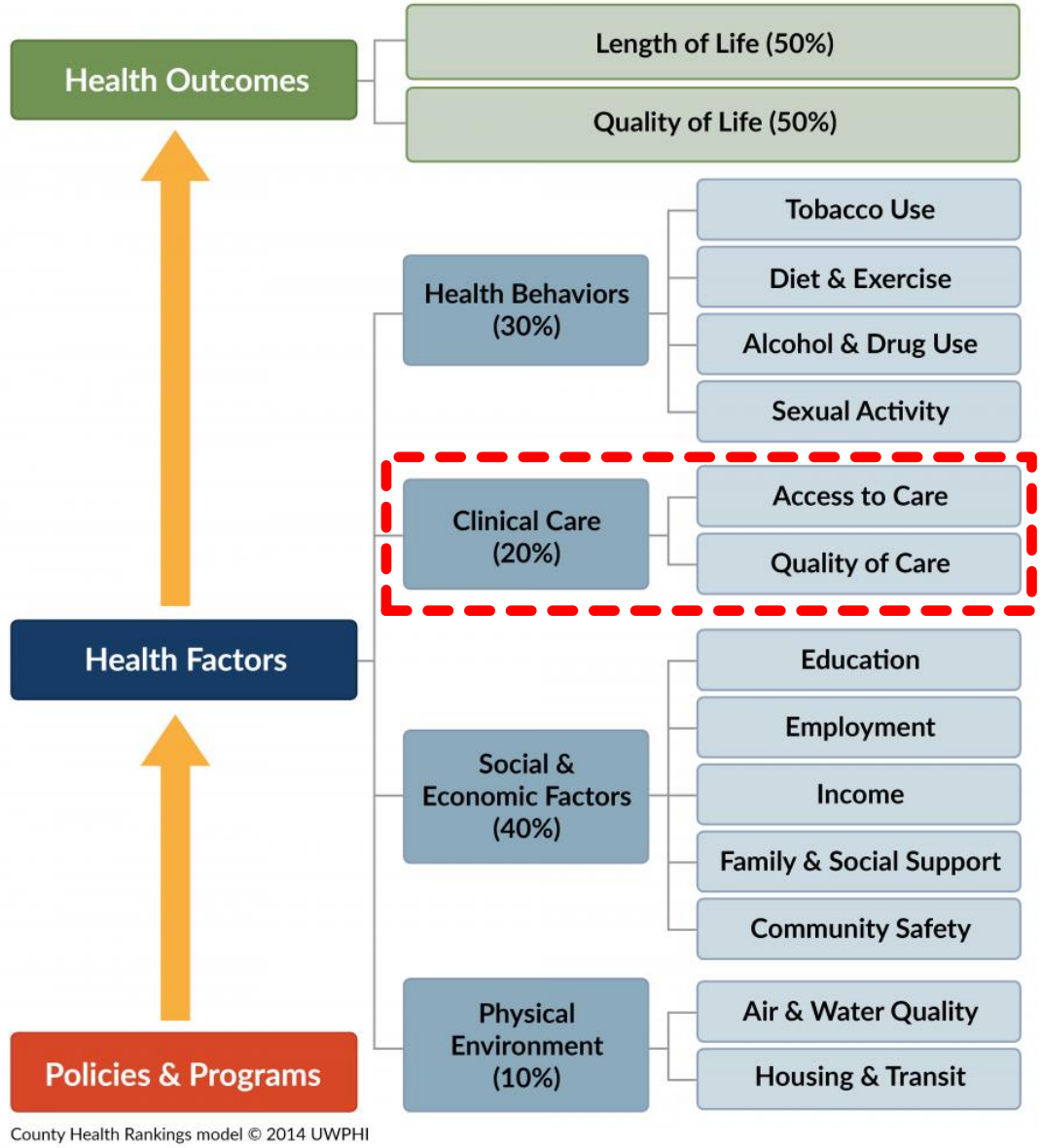
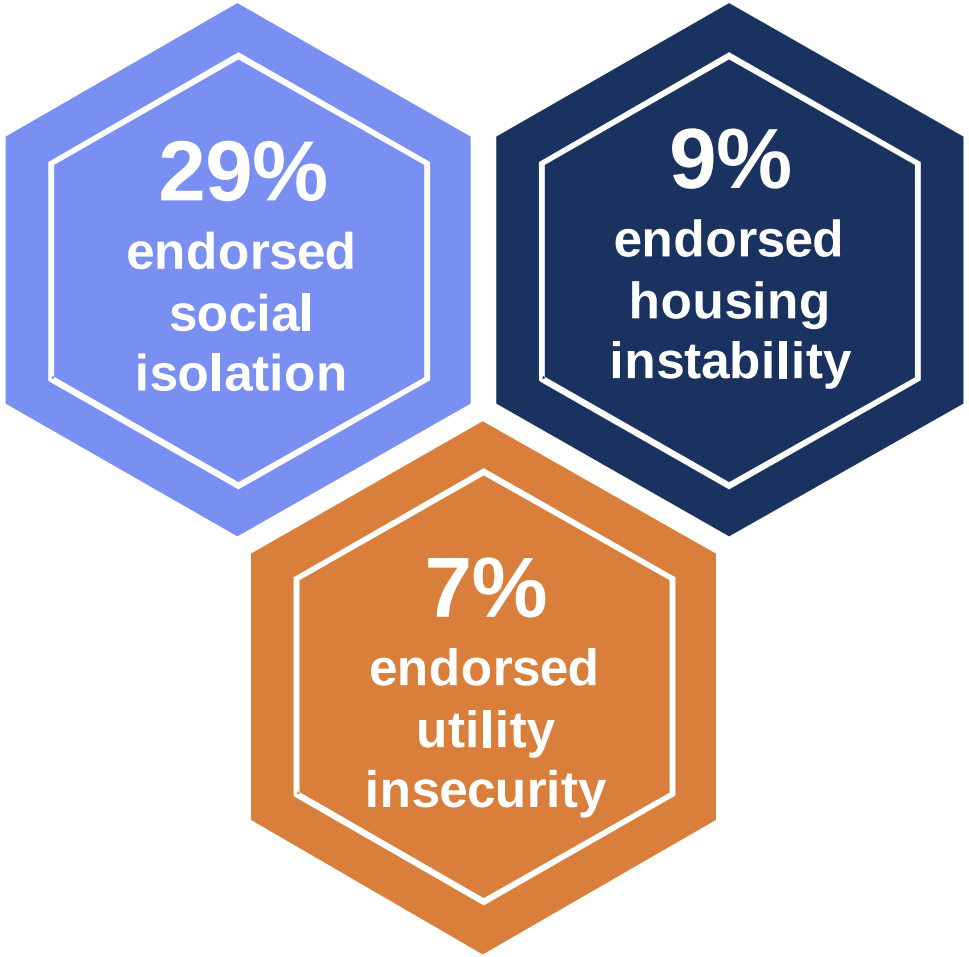


Remington et al. *Popul Health Metr.* 2015;13:11.

SOCIAL RISK FACTORS HAVE A SIGNIFICANT IMPACT ON VETERANS



In a recent QI initiative (ACORN) at two primary care clinics in VISN 1, **40%** of Veterans screened positive for at least one social risk

Cohen AJ, Lehmann LS, Russell LE. "Systematic Screening of Veterans for Health-Related Social Needs: An Ethical Imperative." Office of Health Equity/HSR&D Cyberseminar, U.S. Department of Veterans Affairs, Nov 2020.

What do clinical documentation and coding have to do with identifying SDOH?

Why is it important for clinical documentation and coding to capture SDOH?

depositphotos

INTERNATIONAL CLASSIFICATION OF DISEASES (ICD)

- 1762 *Nosologia Methodica*: first attempt to classify diseases systematically
- 1891 International Statistical Institute: committee to classify causes of death
- 1898 American Public Health Association: recommended adoption of the Bertillon Classification in Canada, Mexico, and USA & revised every 10 years
- 1900 First International Conference for the Revision of the Bertillon or International List of Causes of Death
- 1923 Health Organization of the League of Nations: interest in vital statistics
- 1944 US Public Health Service & US Bureau of Census: expanded diagnoses to capture morbidity not just mortality. Used by hospital insurance plans
- 1946 Interim Commission of World Health Organization (WHO): *International Classification of Diseases, Injuries, and Causes of Death*
- 1948 WHO Constitution: guides Member States in compiling morbidity and mortality statistics in accordance with the International Statistical Classification

World Health Organization. History of the Development of the ICD.

IMPACT OF ICD CODES

Individual Patient Level Care

- Continuity of clinical care

Hospital Level Interventions

- VA Strategic Analytics for Improvement and Learning (SAIL)

Payments/Hospital Resources

- Veterans Equitable Resource Allocation (VERA)

Health Organization's Reputation/Patient's Perception

- VA Hospital Compare Data

Research

Policy

WHO ARE YOU?

WHO, WHO, WHO, WHO !!

We don’t own the rights to this song.

WHO MAINTAINS THE ICD-10-CM?

World Health Organization

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CDC
Centers for Disease Control and Prevention
National Center for Health Statistics

WHAT IS THE DIFFERENCE BETWEEN INPATIENT AND OUTPATIENT CODING?

Physician/Outpatient Coding	Facility/Inpatient Coding
ICD-10-CM for diagnoses	ICD-10-CM for diagnoses
Coding for "probable," "suspected," or "rule-out" conditions is NOT allowed	Coding for "probable," "suspected," or "rule-out" conditions is allowed
Medical/surgical procedures: CPT® and HCPCS Level II	Medical/surgical procedures: ICD-10-PCS
Reimbursement primarily based on physician fee, insurance contracted rates, ambulatory surgical center rates, etc.	Reimbursement primarily based on the diagnosis-related group (DRG)
Does not require hospital stay	Requires a hospital stay (usually with two-day minimum)
Code assignment is based on the encounter/visit	Code assignment is based on the entire admission (length of stay)
Services are billed on CMS-1500 form	Services are billed on UB-04 form

REVOLUTIONARY CHANGE

Starting in Fiscal Year 2022, ICD-10 permits SDOH to be coded as the primary diagnosis for outpatient visits.

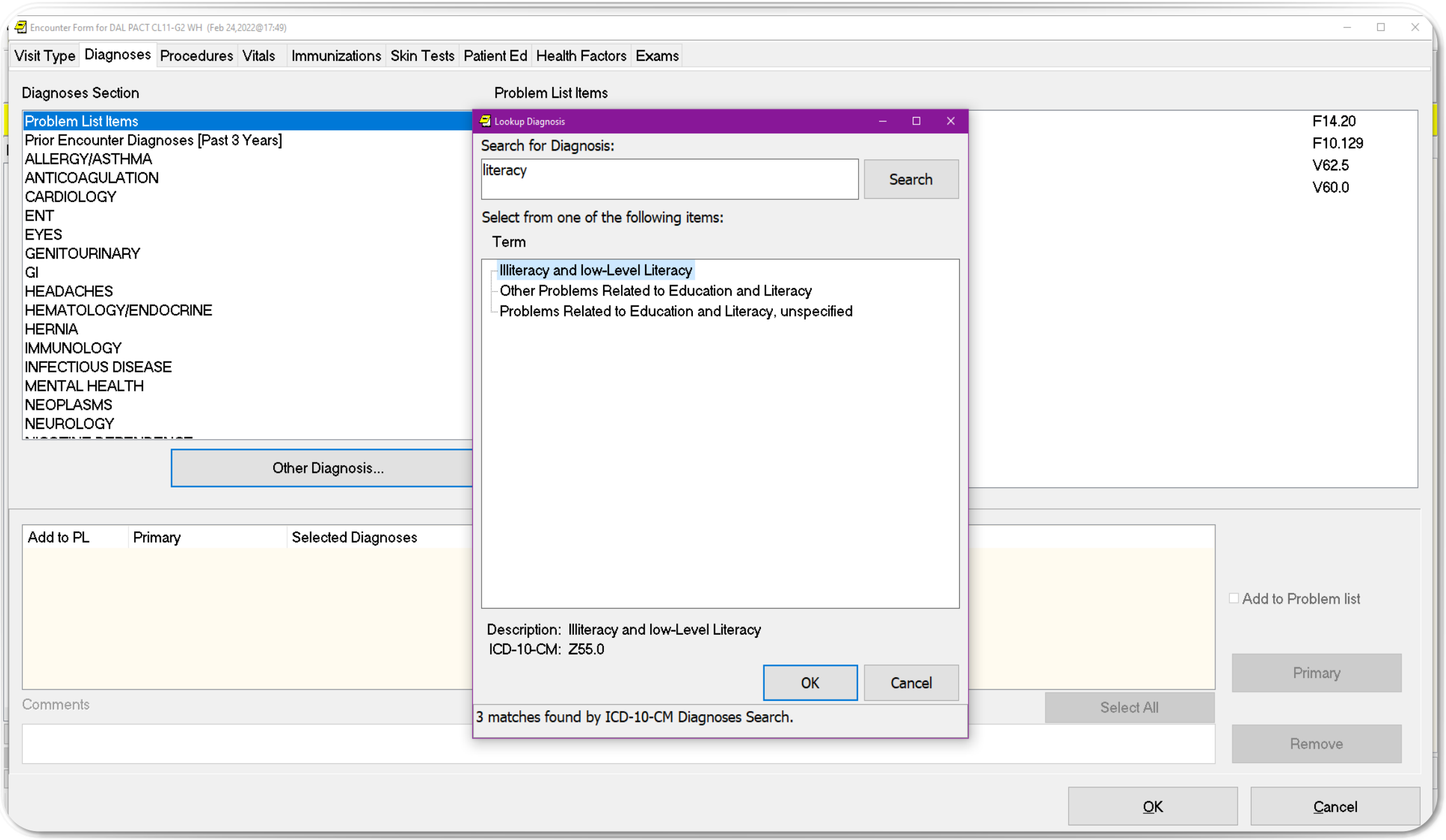
SOCIAL DETERMINANTS OF HEALTH ICD-10-CM CODING GUIDELINES

Social Determinants of Health Codes describing social determinants of health (SDOH) should be assigned when this information is documented. For social determinants of health, such as information found in categories Z55-Z65.

Persons with potential health hazards related to socioeconomic and psychosocial circumstances, 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.

For example, coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record.

Economic Stability	Education	Social and Community Context	Health and Healthcare	Neighborhood and Built Environment
Z59.4- Lack of adequate food and safe drinking water	Z55.0- Illiteracy and low-level literacy	Z60.2- Problems related to living alone	Z75.3- Unavailable and inaccessibility of health care facilities	Z59.0- Homelessness
Z59.5- Extreme poverty	Z55.1- Schooling unavailable and unattainable	Z60.4- Social exclusion and rejection	Z75.4- Unavailability and inaccessibility of other helping agencies.	Z59.1- Inadequate housing
Z59.6- Low income	Z55.2- Failed school examinations	Z60.8- Other problems related to social environment	Z77.010- Contact with and suspected exposure to arsenic	Z59.2- Discord with neighbors, lodgers and landlord
Z59.7- Insufficient social insurance and welfare support	Z55.3- Underachievement in school	Z60.9- Problems related to social environment, unspecified	Z77.011- Contact with and suspected exposure to lead	Z59.8- Other problems related to housing and economic circumstances
Z59.8- Other problems related to housing and economic circumstances	Z55.4- Education maladjustment and discord with teachers and classmates	Z62.21- Child in welfare custody	Z77.090- Contact with and suspected exposure to asbestos	Z65.0- Conviction in civil or criminal proceedings with out imprisonment
Z59.9- Problems related to housing and economic circumstances, unspecified	Z55.8- Other problems related to education and literacy	Z62.810- Personal history of physical and sexual abuse in childhood		Z65.1- Imprisonment and other incarceration
Z56.0- Unemployment, unspecified	Z55.9- Problems related to education and literacy, unspecified	Z62.820- Parent-biological child conflict		Z65.2- Problems related to release from prison
Z56.1- Change of job		Z62.822- Parent- foster child conflict		Z71.3- Dietary counseling and surveillance
Z56.2- Threat of job loss		Z63.4- Disappearance and death of a family member		Z71.6- Tobacco abuse counseling
Z56.4- Discord with boss and workmates		Z63.8- Other specified problems related to primary support group		Z71.82- Exercise counseling
Z56.89- Other problems related to employment				Z71.89- Other specified counseling


Encounter Form for DAL PACT CL11-G2 WH (Feb 24,2022@17:49)
Visit Type
Diagnoses
Procedures
Vitals
Immunizations
Skin Tests
Patient Ed
Health Factors
Exams
Diagnoses Section
Problem List Items
Problem List Items
Prior Encounter Diagnoses [Past 3 Years]
ALLERGY/ASTHMA
ANTICOAGULATION
CARDIOLOGY
ENT
EYES
GENITOURINARY
GI
HEADACHES
HEMATOLOGY/ENDOCRINE
HERNIA
IMMUNOLOGY
INFECTIOUS DISEASE
MENTAL HEALTH
NEOPLASMS
NEUROLOGY
F14.20
F10.129
V62.5
V60.0
Other Diagnosis...
Add to PL
Primary
Selected Diagnoses
Comments
Add to Problem list
Primary
Select All
Remove
OK
Cancel
Lookup Diagnosis
Search for Diagnosis:
literacy
Search
Select from one of the following items:
Term
Illiteracy and low-Level Literacy
Other Problems Related to Education and Literacy
Problems Related to Education and Literacy, unspecified
Description: Illiteracy and low-Level Literacy
ICD-10-CM: Z55.0
OK
Cancel
3 matches found by ICD-10-CM Diagnoses Search.

SDOH IMPACT ON MEDICAL DECISION MAKING

We have assessed the patient's SDOH

We have documented the patient's SDOH

We now have to tie the SDOH to the status of the patient's current health conditions.

Moderate	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

DOCUMENTING THE ASSESSMENT AND PLAN: TAKE 1

HLD

- discussed starting with dietary modification/exercise, referral sent to RD
- f/u with repeat labs in 3 months, if not adequate improvement may consider statin

HTN

- well-controlled, cont current meds

financial hardship/food insecurity

- referred to SW

WHAT PRIMARY DIAGNOSIS CODE DOES THIS A/P SUPPORT?

HLD complicated by food insecurity

- discussed starting with dietary modification/exercise
- recent job loss and resulting food insecurity making it difficult to afford healthful foods and complicating dietary changes
- referred to SW for financial/food assistance resources
- referred to RD for heart-healthy dietary counseling in context of limited budget/food pantry use
- f/u with repeat labs in 3 months, if not adequate improvement may consider statin

HTN

- well-controlled, cont current meds

WHAT ABOUT THIS A/P DOCUMENTATION?

food insecurity

- recent job loss resulting in food insecurity, making it difficult to afford healthful foods and exacerbating HLD
- referred to SW for financial/food assistance resources
- referred to RD for heart-healthy dietary counseling in context of limited budget/food pantry use

#HLD

- discussed starting with dietary modification/exercise, referred to RD, as above
- f/u with repeat labs in 3 months, if not adequate improvement may consider statin

HTN

- well-controlled, cont current meds

A/P: ONE MORE ITERATION…

food insecurity

- recent job loss, difficulty affording foods exacerbating HLD
- referred to SW and RD

#HLD

- dietary modification/exercise, referred to RD
- f/u with repeat labs in 3 months, if not adequate improvement may consider statin

HTN

- well-controlled, cont current meds

IMPACT OF ICD CODES

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VA SCREENS FOR CERTAIN RISKS AND OFFERS WELL-ESTABLISHED INTERVENTIONS FOR NEEDS

VA Social Risk Screening

- Food security
- Housing stability
- Intimate partner violence

VA Social Needs Interventions

(just a few of the many!)

- Robust integrated Social Work
- Novel housing and vocational programs
- Legal support
- Social groups
- Peer Support

HOWEVER, VA DOES NOT HAVE A SYSTEMATIC SCREENING PROGRAM FOR SOCIAL RISKS MORE BROADLY

VA Social Risk Screening

- Food security
- Housing stability
- Intimate partner violence

VA Social Needs Interventions

(just a few of the many!)

- Robust integrated Social Work
- Novel housing and vocational programs
- Legal support
- Social groups
- Peer Support

How can we better identify social risks and needs systematically, and connect Veterans with existing VA and community resources?

ACORN

SCREENING VETERANS FOR SOCIAL NEEDS

ACORN AIMS TO IDENTIFY AND ADDRESS UNMET SOCIAL NEEDS AMONG ALL VETERANS TO IMPROVE HEALTH OUTCOMES AND PROMOTE HEALTH EQUITY

ACORN
SCREENING VETERANS FOR SOCIAL NEEDS

ACORN Project Co Leads: Alicia Cohen, Meaghan Kennedy, and Lauren Russell, in partnership with Office of Health Equity and National Social Work Program

Contact: VHABEDACORN@va.gov

ACORN (ASSESSING CIRCUMSTANCES & OFFERING RESOURCES FOR NEEDS)

Quality improvement (QI) initiative funded by VA Office of Health Equity that aims to systematically identify and address social risks to promote health equity

Identify Risks in 10 Domains Using ACORN Screening Tool

Address Risks through Resource Guides and Referrals

Domains Screened:

- Food
- Housing
- Utilities
- Transportation
- Education
- Employment
- Legal
- Personal safety
- Social isolation/loneliness
- Digital Divide (added in 2021)

ACORN Assessing Circumstances & Offering Resources for Needs (ACORN) Screening Tool

(1) In the past two months, have you been living in stable housing that you own, rent, or stay in as part of a household?[1]

a. Yes – Living in stable housing

↳ (1.1) Are you worried or concerned that in the next two months you may NOT have stable housing that you own, rent, or stay in as part of a household?[1]

i. Yes – worried about housing near future

↳ (1.2) Where have you lived for MOST of the past two months?[1]

a. Apartment/House/Room (no government subsidy)
b. Apartment/House/Room (with government subsidy)
c. With Friend/Family
d. Motel/Hotel
e. Short-term Institution like Hospital, Rehab Center, Drug Treatment Center
f. Homeless Shelter
g. Anywhere outside (e.g. Street, Vehicle, Abandoned Building)
h. Other

ii. No – Not worried about housing near future

b. No – Not living in stable housing

↳ *Collect answer for the question "Where have you lived for MOST of the past two months?"* [1]

➢ *If respondent endorses either "not living in stable housing" OR "worried about housing near future" for (1):*
(1.3) Are you currently without a place to stay?

a. Yes b. No

(2) I'm going to read you two statements that people have made about their food situation. For each statement, please tell me whether the statement was often true, sometimes true, or never true for your household in the last 12 months.

(2.1) Within the past 12 months, you worried whether your food would run out before you got money to buy more.[2]

a. Often true b. Sometimes true c. Never true

(2.2) Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[2]

a. Often true b. Sometimes true c. Never true

➢ *If respondent endorses "often true" or "sometimes true" for either "food would run out" OR "food didn't last" for (2):*
(2.3) Do you need help getting food for this week?

a. Yes b. No

(3) How often do you have trouble paying for your utilities (i.e., electric, gas, oil, water, or phone)?[3]

a. Often b. Sometimes c. Never

➢ *If respondent endorses "often"or "sometimes" for (3):*
(3.1) Has the electric, gas, oil, or water company threatened to shut off services in your home?[4]

a. Yes b. No c. Already shut off

(4) How often has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?[5]

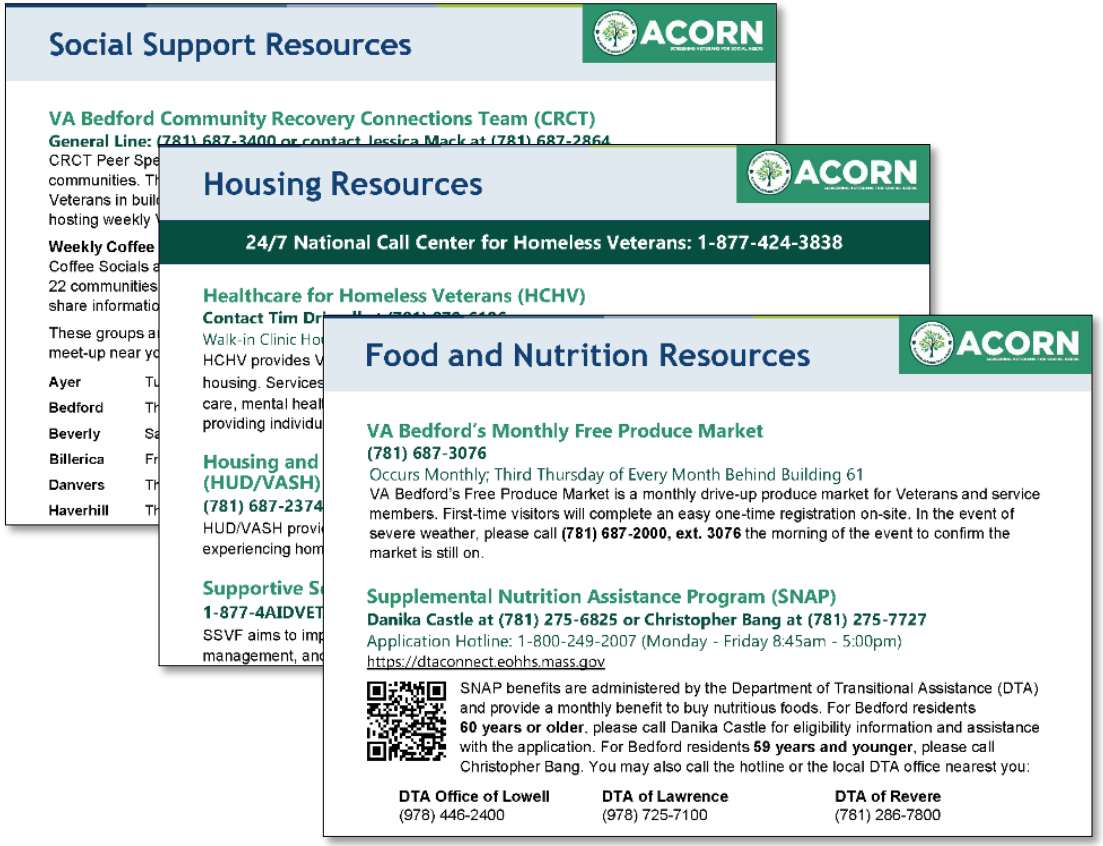
a. Often b. Sometimes c. Never

➢ *If respondent endorses "often"or "sometimes" for (4):*
(4.1) Do you have an upcoming appointment that you need transportation assistance to?

a. Yes b. No

(Continued)

Full Version 8/2021



Veterans who express needs receive geographically-tailored resource guides, support with navigating resources, and/or Social Work assistance.

ACORN
SCREENING VETERANS FOR SOCIAL NEEDS

Modes of Administration Used:

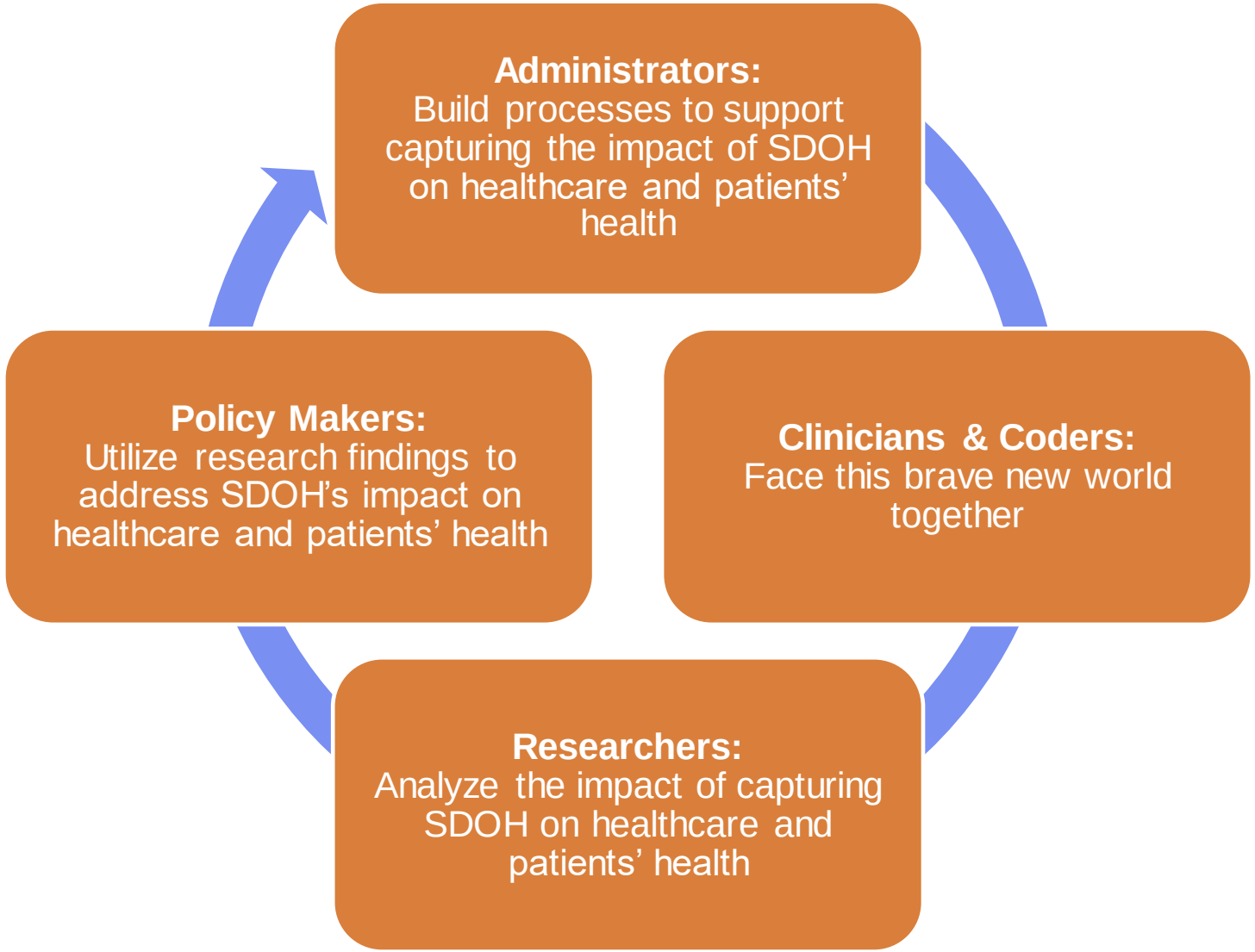
- Veteran-administered via e-tablets or paper-based screening
- Staff-administered via CPRS template – responses linked to Health Factors

Settings for Previous and Ongoing Pilots:

- General Primary Care
- Women's Health
- Homeless PACT
- Mental Health
- Social Work PACTs
- Peer Support

Future Directions: Plans to adapt and expand ACORN to additional clinical settings including: *Geriatrics, advanced directives groups, Whole Health, ED, inpatient*

PARTING THOUGHTS



SEISMIC CHANGE

FOOD IS MEDICINE AND *HOUSING FIRST* CONCEPTS

QUESTIONS?

Maria.Bruton@va.gov

Dina.Hooshyar@va.gov

Alicia.Cohen@va.gov

ACORN TEAM:

VHABEDACORN@va.gov

ACORN Screening Tool

Social Determinants of Health - Office of Health Equity (va.gov)