ICD-10 Coordination and Maintenance Committee Meeting

Social Determinants of Health

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What are Social Determinants of Health?

Social determinants are the environmental factors that impact health outcomes, utilization and cost, including financial stability, physical safety, education, housing, transportation, nutrition, community support, and access to care.

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

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

Source: Henry J Kaiser Family Foundation, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity
By the Numbers: Social Determinants and Health

20% of health outcomes can be directly attributed to clinical care

15 year life expectancy difference between the most advantaged and disadvantaged Americans

85% of physicians report that unmet social needs lead to poorer health outcomes

80% of health and well being is tied to social and economic factors, physical environment and health behaviors

162,000 deaths annually due to low social support

20% of physicians are confident in their ability to address unmet social needs

Sources: Robert Wood Johnson Foundation, Kaiser Family Foundation, New England Journal of Medicine, American College of Physicians
The Advisory Board: Socioeconomic factors are far stronger determinants of health outcomes than medical care, and addressing Social Determinates of Health has been shown to be effective in improving outcomes.¹

Three Goals of Population Health Management Leaders

1. Reducing Unnecessary Utilization
   - Non-acute ED visits
   - Avoidable readmissions

2. Trading High-Cost Services for Low-Cost Care
   - Expanded primary care access
   - Medical home enrollment

3. Enhancing Patient engagement and Care Coordination
   - Chronic condition management
   - Improved referrals to specialists and PAC

Non-Clinical Contributors

- Stable housing
- Healthy food options
- Educational opportunities
- Access to transportation
- Parks and playgrounds

Addressing Non-clinical Barriers to Care

- 25% Missed appointments or rescheduling needs due to transportation problems
- $8K Annual per-person health care savings as a result of offering housing and supportive services to high-cost homeless individuals
- 39% Increased likelihood of a Medicaid-enrolled child visiting an ED more than once in a year if living in un-renovated public housing


¹The Advisory Board – Social Determinates of Health Data. Educational Briefing for Non-IT Executives
²Advisory Board, "Building the Business Case for Community Partnership." December 2016 Adobe PDF Presentation
Creating a Consistent Infrastructure

**Where We Started**
- Began SDOH collection with 18 existing ICD-10 Z codes
- Developed standardized data collection model and added placeholder codes
- Leveraged the PRAPARE tool in data collection expansion (National Association of Community Health Centers-NACHC endorsed)
- Creates industry model that can be used consistently across payers and providers

**Results in 2018**
- 500K Members served
- 700K Social referrals
Enabling Whole Person Diagnosis through Social Determinants

The Advisory Board:

Typical risk stratification
- Jess (Age 50)
  - Diabetes
  - Slight asthma

Intervene: Medium Priority

It is unlikely Jess will be identified for intervention until a likely unnecessary ED or inpatient event occurs.

Risk stratification inclusive of SDoH
- Jess (Age 50)
  - Diabetes
  - Slight asthma
  - Multiple bankruptcies
  - Unstable housing
  - High-crime neighborhood

Intervene: High Priority

After SDoH is added to risk stratification model, Jess is identified as a High Priority for intervention.

1 Advisory Board interviews and analysis. "Social Determinates of Health Data, Educational Briefing for Non-IT Executives"
2 Deloitte Insights "Social determinants of health and Medicaid payments" by Jim Jones, Sima Mulier
Our Recommendation

The What
- Expand existing code categories to capture, analyze, and act on SDOH data

The Why
- Social Determinant data provides a more complete, holistic picture of a patient’s health and potential risk factors
- ICD-10-CM codes are the standard language between care providers and payers
- Building on existing ICD-10 Social Determinant codes significantly expands a physician’s ability to capture information relevant to a patient’s overall condition, improves the ability for comprehensive diagnosis, and promote more coordinated services and care

The How
- *Create new ICD-10-CM attribution codes that better capture the need for social-related services*
## Sample: High Volume SDoH Codes and Referrals

<table>
<thead>
<tr>
<th>Current Code</th>
<th>Code Description</th>
<th>Requested ICD-10 Code</th>
<th>Sample Referral Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZTRAN1</td>
<td>Unable to get or pay for transportation for Medical Appointments or Prescriptions</td>
<td>Z59.641</td>
<td>• Birmingham-Jefferson County Transit Authority, Birmingham, AL</td>
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<td></td>
<td></td>
<td></td>
<td>• Neighborly Care Network, Clearwater, FL</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Paratransit Operations, Miami, FL</td>
</tr>
<tr>
<td>ZCARE</td>
<td>Unable to pay for medical care</td>
<td>Z59.63</td>
<td>• American Lung Association</td>
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<td></td>
<td></td>
<td></td>
<td>• Walgreen Co.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Hadley Vision Center</td>
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</tbody>
</table>
Data Use and Capture: Integration with Provider Workflows

Will these codes be used? **Yes**

- Providers already utilize existing ICD-10 Z codes. As represented by UnitedHealthcare, which has received more than **5 million** claims for social barriers using existing ICD-10 Z codes, demonstrating providers do submit codes when available.

- Much of this data **exists in a physician’s electronic medical records** as a result of health risk assessments, but without additional ICD-10-CM codes, cannot be coded or captured.

- These proposed codes are not payer-specific and would **integrate** into ICD-10-CM standard language between care providers and payers.
Your Questions
Thank you