SDoH Data and Tracking at the Health System Level

Mount Sinai Health System
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Mount Sinai Health Partners

Agenda

- Welcome – 5 minutes
- ACO Introductions – 15 minutes
- Overview of Mount Sinai social needs data journey – 40 minutes
- Discussion/Q&A – 30 minutes

SDoH Tool Development Origins

Objective: Develop SDH tool to be used across a variety of settings by staff with a wide range of direct practice

Nov 2016

- SDH Workgroup charged with developing SDH tool for pilot by Mount Sinai Performing Provider System (PPS) partners

Nov 2016-June 2017

- SDH Workgroup vetted existing SDH tools and interviewed tool authors

Sept 2017

- Mount Sinai PPS SDH tool and CMS Accountable Health Communities screening tool selected

Siren Social Needs Screening Tool Comparison: https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

SDoH Questionnaire

Need	Question	Response
1. Food 	Do you/your immediate family currently have access to enough food each day?	❑ Yes ❑ No
2. Housing 	Do you/your immediate family currently have a safe place to live each day?	❑ Yes ❑ No
3. Income 	Are you/your immediate family able to afford your basic needs most or all of the time? Examples: food, housing, telephone, electric/gas, medications, etc.	❑ Yes ❑ No
4. Literacy 	Are you/someone in your immediate family able to read and understand health care/other important information in your preferred language?	❑ Yes ❑ No
5. Social 	Do you have someone whom you trust and to whom you can go with personal difficulties?	❑ Yes ❑ No
6. Safety 	Do you feel safe? (Not currently being harmed or not concerned of being harmed in any way by someone in your life.) Examples: emotionally, financially, physically, etc.	❑ Yes ❑ No
7. Legal 	Do you need legal assistance? Examples: child and family services, immigration, housing discrimination, domestic issues, etc.	❑ Yes ❑ No
8. Transportation 	Do you have access to transportation to get where you need on a daily basis? Examples: medical appointments, work, school, etc.	❑ Yes ❑ No
9. Healthcare	Do you have a primary medical doctor that you have visited in the past six months?	❑ Yes ❑ No
10. Medication 	Do you have any problems filling prescribed medications?	❑ Yes ❑ No
11. Mental Health	Do you feel down, depressed, hopeless, or anxious?	❑ Yes ❑ No
	Are you in treatment with a psychiatrist or mental health professional?	❑ Yes ❑ No
12. Substance Use 	Has a relative, friend, doctor, or other health care worker been concerned about your drinking or drug use or suggested you cut down?	❑ Yes ❑ No
13. Other 	Is there any other need not mentioned above that you would like assistance with? (If so, please specify to the right). _____	❑ Yes ❑ No

Initial Screening Modalities, Challenges & Limitations

Before Visit: Waiting Room

- Paper screener distributed to patients to fill out while they wait
- Front Desk reviews screener for safety and suicidality for immediate escalation
- Social Worker reviews over next week and enters into Epic flowsheet
- Social Worker performs telephonic outreach to clarify positives and connect patients to appropriate resources

During Visit: Rooming

- MAs screen patients during rooming process
- MA enters data into Epic flowsheet in real time and informs PCPs of safety or suicidality concerns
- PCP refers to social worker to review
- Social Worker performs telephonic outreach to clarify positives and connect patients to appropriate resources

Challenges & Limitations

- Paper-based
- 1 hospital only, select practices at that hospital
- Questions not in Epic EMR
- Paper info not making back to Epic
- Limited SW resources
- Limited or no resource to offer patient
- No place to document outcome

Has your ACO selected a screening tool to assess SDOH needs?

- ❑ Yes, selected an existing tool
- ❑ Yes, developed our own tool
- ❑ No, but considering available tools
- ❑ No, not yet considering tools

Establishing a System Wide SDoH Committee (2019)

Mission

To guide the Mount Sinai Health System strategy in the identification and collection of social determinants information, the creation of tools to gather that information as well as the strategies for closure of social determinants gaps. The SDoH Committee aims to improve the health of the population by encouraging, supporting, and guiding upstream thinking in healthcare.

MSHS Social Determinants of Health Sub-Committee: Assessments

Goal:

Identify a core Social Determinants of Health (SDH) assessment tool that will be implemented system-wide (IP/ED/OP) with adults and children

Benefits of a core SDH assessment:

- Transforms related work across the system into a “Sinai Way”
- Enhances clinical care and collaboration
- Supports “next level” partnerships with CBOs
- Positions MSHS to receive reimbursement for SDoH work via z-codes*
- Deepens our system-level understanding of our patients’ needs

*Z codes are a group of codes provided in ICD-10-CM for the reporting of factors influencing health status and contact with health services

Sub-Committee Workgroup Findings*

Question 1: How similar are the various SDoH tools we use across the health system?
Answer: *Very similar across all tools*

Question 2: How does all of this stack up against the latest and greatest from Epic?
Answer: *Collectively, we are ahead of Epic*. (There is no Epic content for Housing, Legal Concerns or Caregiver Issues)

Questions 3: What is the path to aligning our assessments with the z-codes?
Answer: *We would need to add some questions and strengthen others. We're not far off and it's worth the effort.*

*As of January 2020

Where did we land?

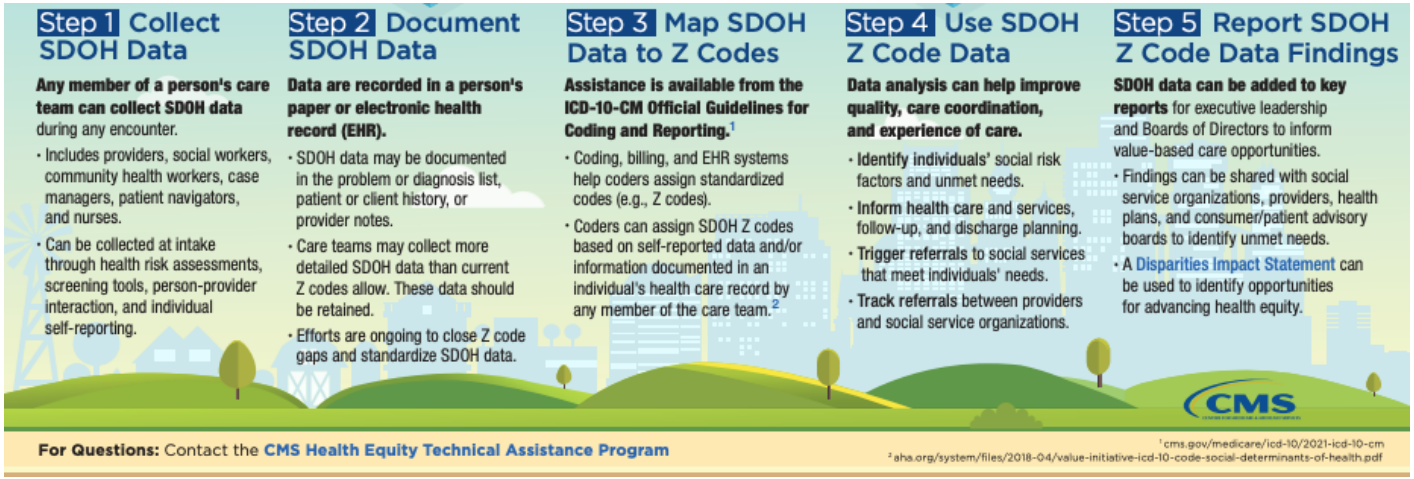
We landed together on a “core assessment” that aligns to the 10 z-code domains

- **Highlights of our core assessment and collaboration:**
  - 34 questions (work with IT to build into Epic)
  - 5 of the 10 z-code domains tie to wedges on the Epic SDH wheel*
  - We also aligned our questions around 4 additional areas (legal, caregiving, housing and literacy) for which there are already requests for new wedges to the wheel
  - Together we strengthened questions around caregiving and housing to make them stronger
  - In z-code areas where we had no questions, we created new ones together: employment, conflict with primary support, discrimination, violence exposure (potential for new Epic wedges)

*As of January 2020

What are Z-codes and why should we care about them?

- 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.).
- Z-codes use could lead to risk adjustment, direct reimbursement and/or more informed care



Source: https://www.cms.gov/files/document/zcodes-infographic.pdf

Who screens for social needs? (Select all that apply)

- ❑ Care Managers
- ❑ Medical Assistants
- ❑ Social Workers
- ❑ Community Health Workers
- ❑ Nurses
- ❑ PCPs

Additional SDoH Data Identification

Standardized SDoH Assessment

(Launched Q1 2020)

Assessment that evaluates and identifies a patient's social needs across 15 categories

Primarily completed by social workers and Care Management

Embedded in Epic electronic medical record

Aligned with Z-codes for potential reimbursement

Vendor SDoH Data

(Launched Q3 2020)

Detailed RFP developed and posted

Vetting and selection of SDoH vendor

Data leveraged to identify aggregate SDoH trends and target patients for outreach

5,000+ unique metrics, 128+ risk and engagement scores

SDoH Questionnaire on MyChart

(Launched Q2 2021)

Questionnaire sent by Care Management to patients via MyChart to better understand their SDoH-related needs

Patients with SDoH needs are connected to Care Management for follow up support and referrals to Community-based organizations

An additional safe space for patients to share their needs

Mount Sinai SDH Core Assessment Components

Epic Foundation Domains

- Housing
- Food Insecurity
- Transportation
- Financial Resource Strain
- Social Supports
- Interpersonal Violence
- Alcohol Use
- Depression
- Physical Activity
- Stress
- Tobacco Use

MS Custom Domains

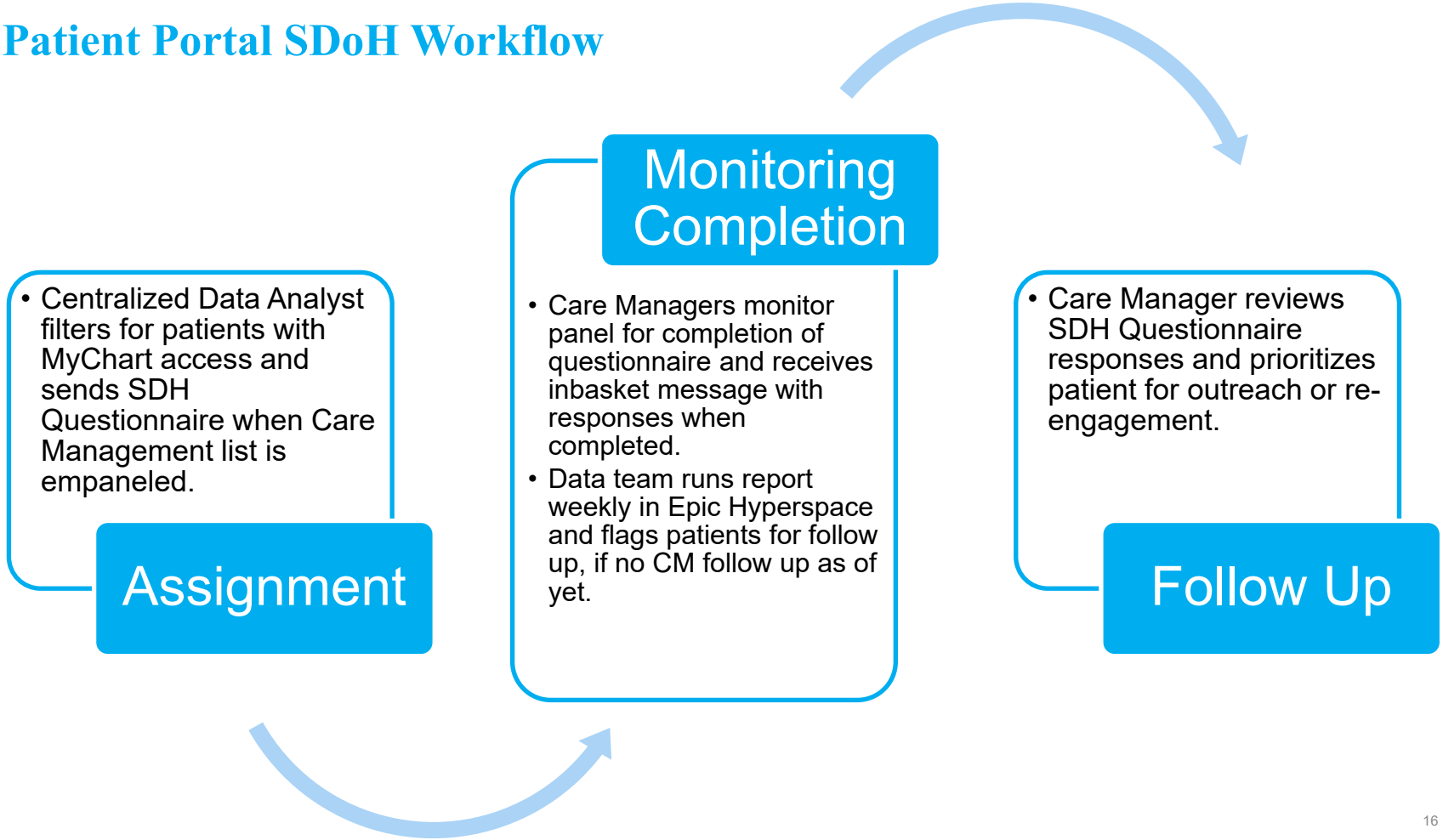
- Education
- Employment
- Caregiving Needs
- Legal Concerns

Patient Portal SDoH Assessment – Reaching the Patient Outside the Clinical Setting

- Creates ability to send Social Determinants of Health (SDoH) Questionnaire* (via MyChart) directly to patient
- SDH Questionnaire capture linked to Epic SDoH Wheel
- Expands Care Management (CM) reach to a larger group of patients without outbound telephone encounter
- Offers patients a pathway to inbound to CM and provides introduction into CM
- **Go Live:** 5/10/2021

*SDH Questionnaire is called Social Factor Questionnaire in Epic

Patient Portal SDoH Workflow



Limitations & Next Steps

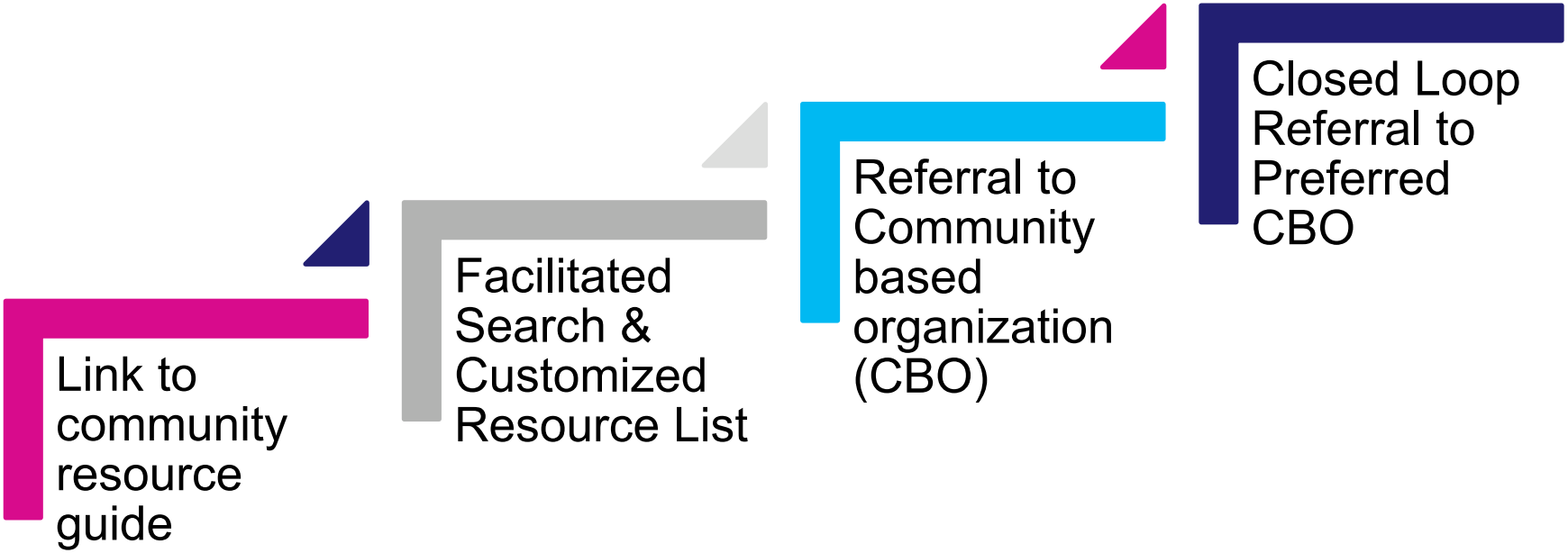
- Limitations:
  - Completion of questionnaire needs to be monitored by Centralized Referral Teams/Administration team or assigned Care Manages
  - Patient must be active on MyChart to receive communication
  - SDoH Questionnaire provided only in English at this time (see next steps)

- Next Steps:
  - Continue to send to newly assigned patients
  - Explore developing SDH Questionnaire in Spanish
    - MSHS Patient Services have completed translation
    - Epic team reviewing for build

Which patients are you screening for SDOH needs?

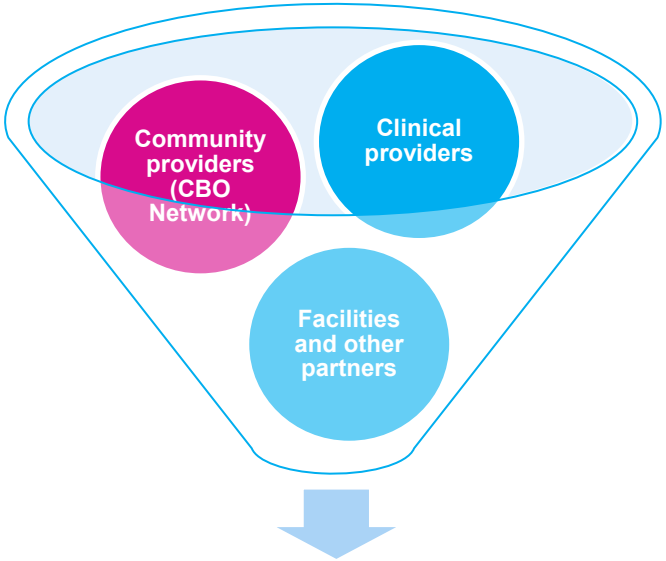
- ❑ All patients
- ❑ Attributed patients
- ❑ Patients in risk-based contracts
- ❑ Patients under care management
- ❑ Patients with select diagnoses
- ❑ Patients in select geographic areas
- ❑ Patients in select provider practices

Levels of Resource Provision



A Preferred CBO Network for Closed Loop Referrals

- Broaden our Clinically Integrated Network from just clinical providers to also include CBOs
- CBOs joining the Network contract with Mount Sinai, complete additional vetting, agree to pre-determined business requirements (e.g. accept Aunt Bertha referrals, respond to referrals within 48 business hours)



Clinically Integrated Network

Together we can more effectively serve our communities and address social needs

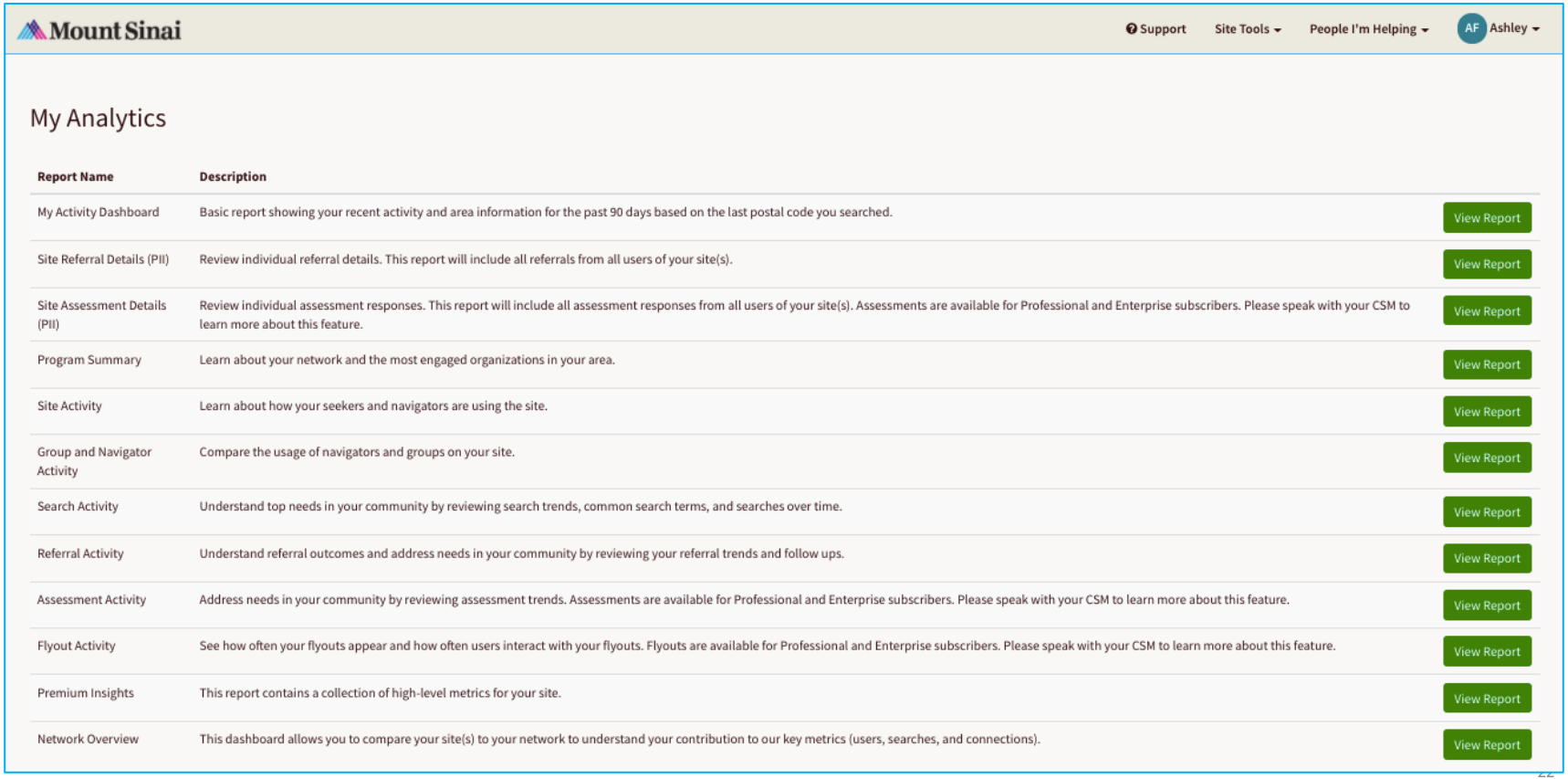
Key Performance Indicators & Data Exchange for CBOs

- KPIs
  - Number of referrals
  - Response time to referrals
    - Designated response time for referrals – 48 business hours
    - Designated follow-up time frame – 72 business hours within receipt of referral
  - Referral acceptance rate
  - Percentage of closed referrals

- Participation
  - Meeting attendance and utilization of the Aunt Bertha platform

- Patient Experience
  - Feedback from patients about the care and experience receiving services

CBO Data Analytics



Are you tracking key performance indicators for referrals to CBOs?

- ❑ Number of referrals
- ❑ Response time to referrals
- ❑ Referral acceptance rate
- ❑ Percentage of closed referrals
- ❑ None of the above

Next Steps for Mount Sinai

- Expand access to core assessment and Epic SDoH wheel
- Select priority domains and subset of questions from core assessment for universal screening
  - Food
  - Legal
  - Housing
  - Transportation
  - Care coordination
- Develop enhanced process for tracking support actions
  - Consider Kaiser Permanente NECTAR model
- Expand CBO preferred network
- Optimize referral platform
- Launch Z-code pilot

What's Next for the Learning Collaborative

- Monday, November 1st: SDoH Lunch & Learn
  - Informal time for us to get to know each other and discuss topics that are top of mind

- Thursday, December 2nd: Session 3 – Community Resources, Referrals & Platforms

Appendix

Social Needs, Health Equity and Race Equity – Recommended Listening

- The Intersection of Racism, Discrimination, and Social Risk Screening in Clinical Settings: https://sirenetwork.ucsf.edu/podcast/intersection-racism-discrimination-and-social-risk-screening-clinical-settings

- Challenging Racist Systems, Processes, and Analyses in Social Care: https://sirenetwork.ucsf.edu/podcast/challenging-racist-systems-processes-and-analyses-social-care

Official Coding Guidance

ICD-10-CM Official Guidelines for Coding and Reporting FY 2021

I.B.14. states:

"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.

Patient self-reported documentation may also be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the health record by either a clinician or provider."

Official Coding Guidance

ICD-10-CM Official Guidelines for Coding and Reporting FY 2021

Chapter 21 Section 14, Miscellaneous Z codes (which include the Z55-Z65 code ranges):

The miscellaneous Z codes capture a number of other health care encounters that do not fall into one of the other categories. Certain of these codes identify the reason for the encounter; others are for use as additional codes that provide useful information on circumstances that may affect a patient's care and treatment.

Official Coding Guidance

AHA Coding Clinic Reference, 1stQtr. 2018, Page 18

Question:

Is it appropriate to utilize non-physician documentation to assign codes that provide information on social determinants of health? For example, codes from categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, provide important information that is typically only found in nurses or social worker documentation.

Answer:

Categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, represent social information, rather than medical diagnoses. As such, it is acceptable to report these codes based on information documented by other clinicians involved in the care of the patient.

Official Coding Guidance

AHA Coding Clinic Reference, 4thQtr. 2019, Pages 66-67

Question:

Is it appropriate to utilize patient self-reported documentation to assign codes for social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances? Currently, the ICD-10-CM Official Guidelines for Coding and Reporting allows code assignment based on medical record documentation from clinician's involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses.

Answer:

Yes. If the patient self-reported information is signed-off and incorporated into the health record by either a clinician or provider, it would be appropriate to assign codes from categories Z55-Z65, describing social determinants of health.