Social determinants of health: How accurately capturing SDoH can positively impact health outcomes

Social determinants, or drivers, of health (SDoH) are the non-medical factors that influence our health outcomes and play a vital role in shaping the well-being and quality of life for individuals and communities. SDoH data covers various dimensions including economic stability, education access and quality, health care access and quality, neighborhood environment, and social and community context. These drivers have an important influence on health inequities, the unfair and avoidable differences in health status seen within and between countries. In countries with all income levels, health and illness outcomes follow a social gradient: **the lower the socioeconomic position, the worse the health**.

In the United States, SDoH has increased pressure on policymakers, hospitals, providers and communities to improve population health and promote equitable health outcomes. We have made good strides in the acute settings, with the coding, clinical documentation integrity (CDI), provider triumvirate. One example is the **Hospital Inpatient Quality Reporting Program**, whereby hospitals are now mandated to report how many patients 18 years or older were screened for SDoH and the percentage of patients who screened positive for one of the drivers of health needs.

This is a screening for the five drivers of health – food security, housing stability, transportation access, utility access and interpersonal safety. Another example is the recent **Centers for Medicare & Medicaid Services (CMS)** change in the severity of three ICD-10-CM diagnosis codes describing homelessness from a non-complication/comorbidity (CC) to a CC designation. This will reflect the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes and will affect reimbursement. There are expanded code sets with each release by CMS. The White House has published the first ever **SDoH Playbook**, a policy guide on working towards integrating social services, public health and the health care system to improve health outcomes in local communities by breaking down federal agency and local system silos.

This increased focus on SDoH is not limited to federal agencies. The largest accreditation organization, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) created a new **National Patient Safety Goal** for improving health care equity with six different performance elements related to a hospital's patients.

The National Committee for Quality Assurance (NCQA) created a **Healthcare Effectiveness Data and Information Set** (HEDIS) measure for Social Need Screening and Intervention. To encourage health plans to assess and address the food, housing and transportation needs of their patient populations, this measure helps health plans identify specific needs and connect members with resources necessary to address these unmet needs. This measure assesses members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and who received a corresponding intervention if they screened positively.

With all this attention given to those in the inpatient setting, what about all the patients who aren't admitted to a hospital? With only **a little more than seven percent of the U.S. population hospitalized each year,** there is a tremendous gap to address within the outpatient or ambulatory setting. As hospitals and other corporations continue to acquire physician practices, there is a chance they will commit to a systemwide focus on SDoH. The outpatient coding realm is significantly different from the inpatient coding realm. Not only are there differences in the code sets used, but also in workflows, whereby codes are assigned by outpatient coders and by providers themselves. The outpatient clinical documentation integrity (CDI) industry and outpatient systems are starting to come into their own but are still immature.

Recent changes in the **Outpatient Prospective Payment System (OPPS) final rule** focus on addressing health inequities. Better documentation and improved coding practices will allow for increased code capture, the foundation for reimbursement and reporting. There have been **updates to the OPPS and ambulatory surgery center (ASC) payment rates** and the establishment of payments for intensive outpatient program services under Medicare which will help to provide services at a lower level of resource use than a patient coming through the emergency department (ED) or being admitted to the hospital.

There are also **changes** to community mental health centers' conditions of participation, which will expand the availability of services to a wider segment of the population, and finalization of changes to the **Hospital Outpatient Quality Reporting, Ambulatory Surgical Center Quality Reporting, and Rural Emergency Hospital Quality Reporting programs** and will impact reimbursement in the future.

Another significant move in the outpatient realm is **CMS establishing a standalone code for the assessment of SDoH in the 2024 Physician Fee Schedule Final Rule**. G0136 is an HCPCS level 2 code for FY24 encouraging provider screening for SDoH. Coding is tied to reimbursement and providers will be offered additional monies when performed.

G0136 has been defined as, "**Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every six months.**" The risk assessment is about the patient's social risk factors that influence the diagnosis and treatment of medical conditions. There are details on when this code can and cannot be used for this assessment, which is separate from a screening, and there are various tools available for this purpose. Possible evidence-based tools include the CMS **Accountable Health Communities (AHC)** tool, the **Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)** tool and instruments identified for **Medicare Advantage Special Needs Population Health Risk Assessment**.

Getting social needs captured and addressed in the outpatient setting before a patient presents to the ED is not only better for the patient, but better for the hospital system and the government.

Non-emergent ED visits cost **$4.4 billion** on an annual basis. These visits happen for a variety of reasons, including waiting until the last minute to see the doctor, having no other alternatives, not having a preventive care or a primary care physician, etc. These visits represent the highest utilization cost for a hospital. Hospital **readmissions within 30 days of discharge occur 1.67 times** more often in patients with limited health literacy than in patients who have reasonable health literacy at an annual cost from **$106 billion to $238 billion**.

Increasing literacy on issues such as obesity or diabetes, with preventive actions like exercise, controlled diet, prescription maintenance and chronic heart failure, with education regarding salt intake and self-care, can help decrease the financial and physical costs to everyone, including the patient. Acknowledging SDoH factors like rural access to care, transportation or financial insecurity, should be considered during whole-patient care.

Where patients receive their care and how well the care received is coordinated from place of service to place of service can also impact outcomes. Are patients in an area that lacks urgent care or walk-in clinics making the hospital ED their first point of contact with the health care system when a problem arises? The ED, where saving lives is the priority, can be less likely to capture SDoH. Will the information captured, or services provided, follow the patient when next they present elsewhere in the health care system?

In addition to improving the health literacy of the patient population, there are several viable solutions to help improve health care inequities and lower costs with personalized, early interventions. A **study by the Robert Wood Johnson Foundation** showed that investing in SDoH programs reduced ED use by 17 percent and spending by 26 percent, while inpatient spending decreased by 53 percent and outpatient spending by 23 percent.

Improving the capture of the patient story is multi-faceted-- including who, when, where and how the data is collected -- and calls for better workflows. An **AHIMA study** revealed disjointed workflows regarding the collection of the patient story: the frontline clinical staff were primarily responsible for collecting SDoH data during a patient or caregiver visit. These frontline SDoH collectors were nurses (24 percent), followed by physicians (15 percent), and then registration or patient financial service representatives or operations staff (12 percent). One in four (26 percent) didn't know who the primary collector of SDoH data was in their organization.

Health care clinicians, including primary care clinicians, specialists and behavioral health clinicians, should consider screening for health-related social needs as well as partnering with community organizations and health entities to perform a more comprehensive assessment, all to meet any needs that are identified. Standardization of data capture, sharing and interoperability should be addressed across the multitude of large electronic health record (EHR) vendors. Standardization of SDoH screening tools and/or assessments by government agencies would also prove extremely helpful to all organizations across the patient continuum.

Some cities, such as Philadelphia, have tried to offer casual walk-in services free of charge for minor complaints such as a cut or a headache, but soon concerns about liabilities arose. What if the cut later became infected? What if the patient was given a dose of aspirin and it was later found they have a gastrointestinal bleed which the aspirin exacerbated?

With a new focus on the outpatient arena for SDoH, and the similar trend in the CDI industry, the time is now to focus on your outpatient programs. Outpatient documentation of physician and ancillary clinical providers should be optimized in the outpatient setting and/or the ED to ensure SDoH code capture.

Adding clinical documentation specialists to outpatient settings would help ensure the documentation to assign the ICD-10-CM diagnosis codes and better capture the presence of SDoH. When performed concurrently, CDI could even help to prompt physicians to inquire about possibly missed factors impacting the patient's care. Improving discharge planning at every level of care could point patients in need to social services and could potentially begin a viable solution to some of these adversities hindering patients' progress and outcomes. A social worker could even be retained on staff for such referrals.

Health inequities don't only exist in the U.S. This is a global issue with different trends by region and country. So, what is the rest of the world doing about social and economic needs? In Europe and Latin America, there are clinical cohorts for population health, including SDoH. In the Middle East, they are looking to keep high cost utilization down and are focused on population health with cardiovascular disease and other chronic conditions, as well as addressing inequitable access to health services.

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