Addressing the Social Determinants of Health through CMS Policies & Programs

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"Working to Achieve Health Equity"

Biography

Jordan Luke is the Director of the Program Alignment and Partner Engagement Group (PAPEG) at the CMS Office of Minority Health (CMS OMH). PAPEG is responsible for working across CMS programs, policies, models, and demonstrations to ensure that the needs of vulnerable populations are met.

Jordan leads the CMS Equity Plan for Improving Quality in Medicare and the Minority Research Grant Program. PAPEG also provides Health Equity Technical Assistance to organizations interested in embedding equity into their policies, programs, and initiatives.

CMS OMH Mission and Vision

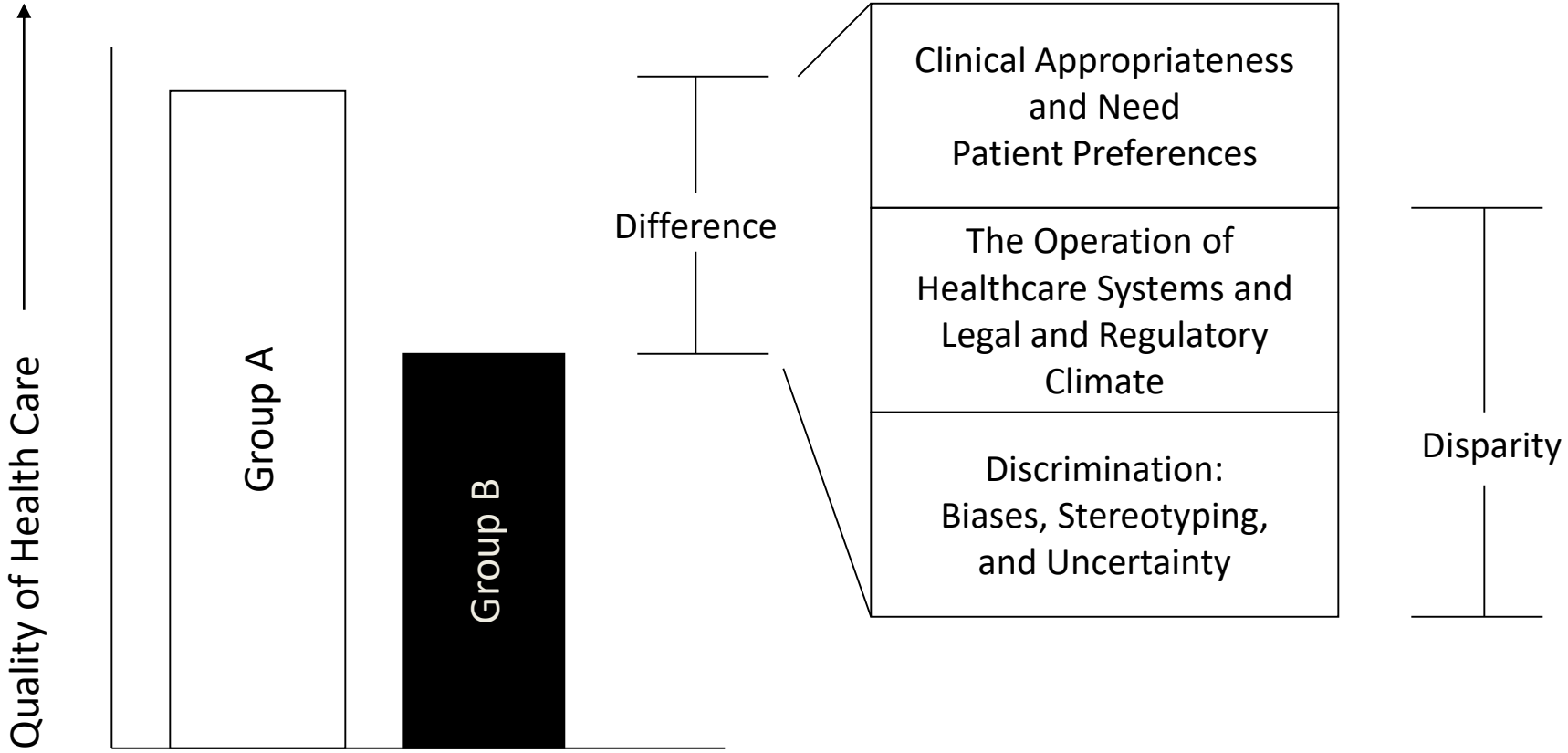
Mission

To ensure that the voices and the needs of the populations we represent (racial and ethnic minorities, sexual and gender minorities, rural populations, and people with disabilities) are present as the Agency is developing, implementing, and evaluating its programs and policies.

Vision

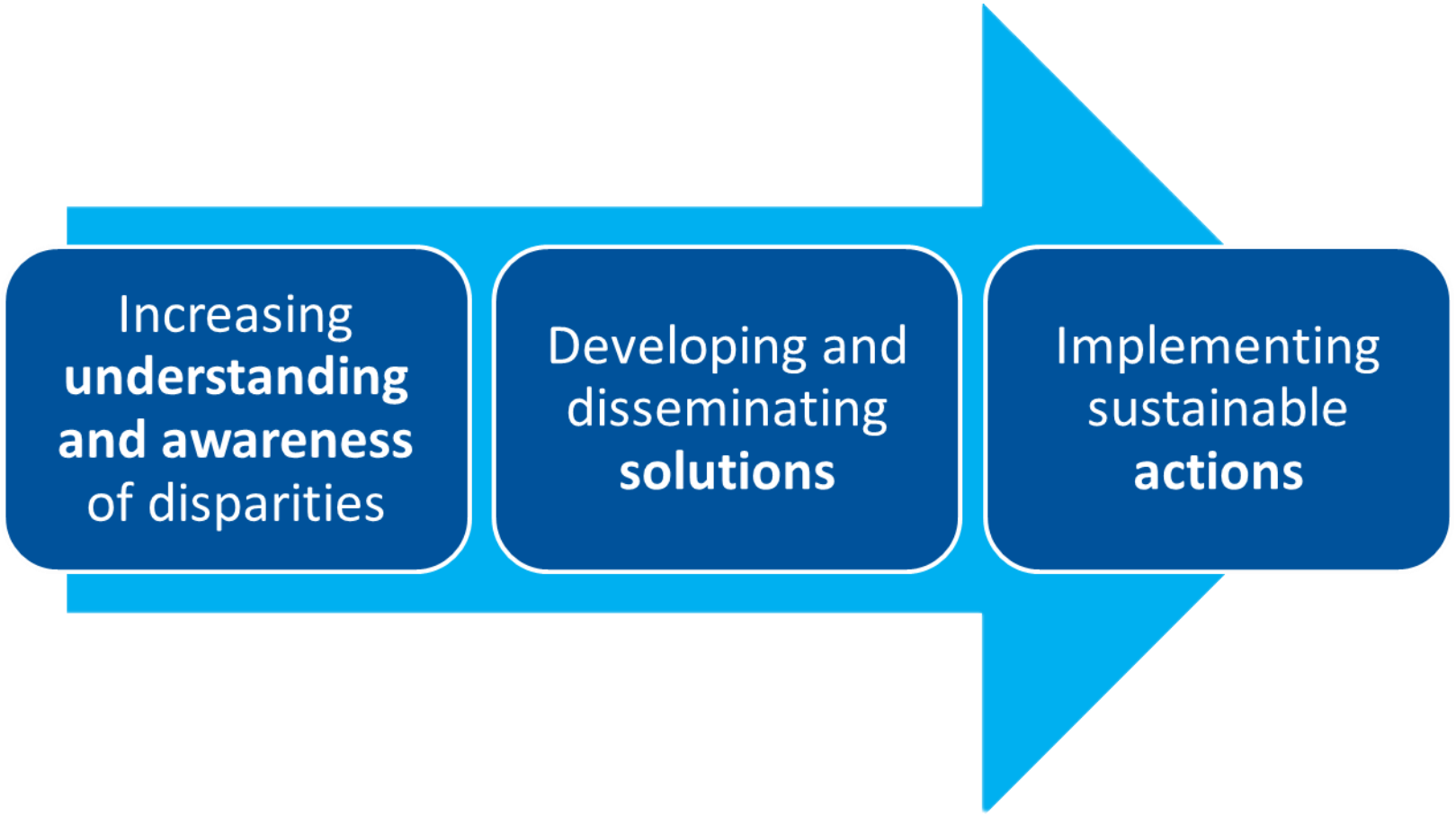
All CMS beneficiaries have achieved their highest level of health, and disparities in health care quality and access have been eliminated.

What is a Health Care Disparity?



SOURCE: Figure 1. Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, Summary*. Brian Smedley, Adrianne Stith, and Alan Nelson, Eds. Washington, DC. Institute of Medicine, 2002.

CMS Path to Equity



Sources of Health Disparities

What Are Z Codes?

- Z-Codes are a subset of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

- The full set of Z codes (Z00-Z99) cover an expansive set of "reasons" for health care encounters, ranging from contact with infections, inoculations and vaccinations, patient history, follow up care, reproductive services, and many others. ICD-10-CM Official Guidelines for Coding and Reporting FY 2019.
  https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf

- Apply to all health care settings.

Z Codes Related to Social Determinants of Health

- Within the Z code set, Z55-65 are used to identify individuals with potential hazards related to **socioeconomic and psychosocial circumstances**, capturing information on social determinants of health (SDOH).

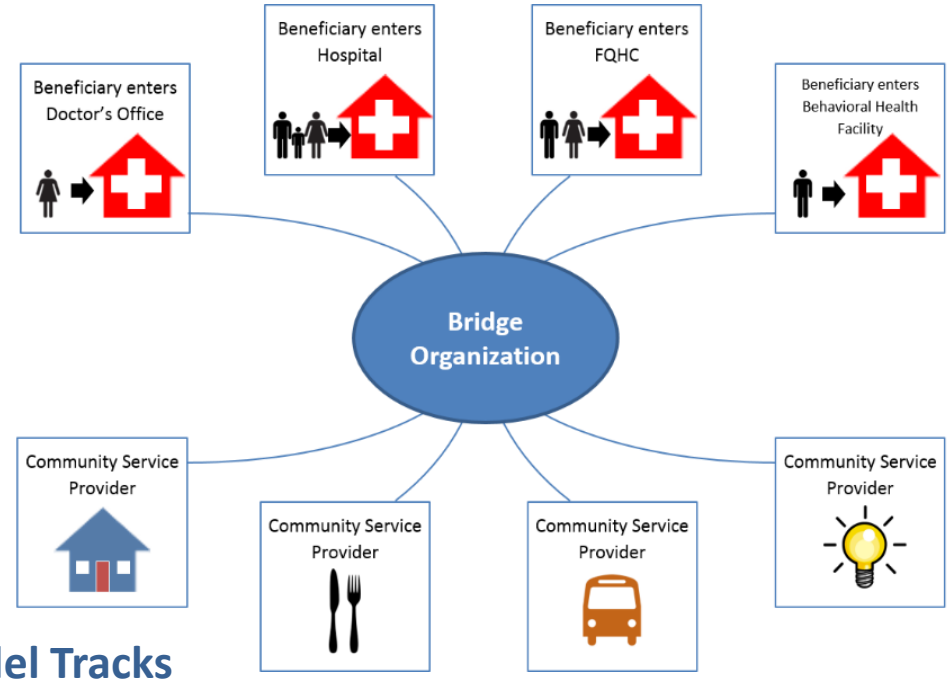
- There are 9 categories of Z codes related to SDOH, each code includes sub-codes resulting in a total of 97 more granular codes

ICD-10	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

Accountable Health Communities (AHC)

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Tests the **effectiveness of referrals and community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs



Model Tracks

Assistance Track

- **Bridge Organizations** in this track provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services to address health-related social needs

Alignment Track

- **Bridge Organizations** in this track encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

SDOH Domains & Indicators

Accountable Health Communities	National Academy of Medicine		Healthy People 2020	
Disabilities (Optional)	Acculturation	Sexual Orientation	Access to Foods that Support Healthy Eating	Housing Instability
Education (Optional)	Dual Eligibility	Social Support	Access to Health Care	Incarceration
Employment (Optional)	Education	Urbanicity/Rurality	Access to Primary Care	Language and Literacy
Family and Community Support (Optional)	Gender Identity	Wealth	Civic Participation	Poverty
Financial Strain (Optional)	Housing		Crime and Violence	Quality of Housing
Food Insecurity	Income		Discrimination	Social Cohesion
Housing Instability	Language		Early Childhood Education and Development	
Interpersonal Safety	Living Alone		Employment	
Mental Health (Optional)	Marital/Partnership Status		Enrollment in Higher Education	
Physical Activity (Optional)	Nativity		Environmental Conditions	
Substance Use (Optional)	Neighborhood Deprivation		Food Insecurity	
Transportation	Environmental Measures		Health Literacy	
Utilities	Race and Ethnicity		High School Graduation	

SDOH Domains & Indicators

ICD-10©	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE©)	Health Leads©
Childhood	Access to Health Care	Behavioral/Mental Health
Education	Child Care	Childcare
Employment	Clothing	Education
Housing	Education	Employment
Income	Employment	Food Insecurity
Literacy	Family Living Situation	Health Behaviors
Occupational Exposure	Food Insecurity	Housing Instability
Other Psychosocial Needs	Health Insurance	Immigration Status
Psychosocial Needs	Housing Instability	Income
Social Environment	Incarceration History (optional)	Language
Social Support	Income	Race and Ethnicity
	Interpersonal Safety (optional)	Social Support and Social Isolation
	Language	Transportation
	Migrant and/or Seasonal Worker	Utilities
	Race and Ethnicity	Violence
	Refugee (optional)	
	Safe Environment (optional)	
	Social Support/Social Isolation	
	Stress	
	Transportation	
	Utilities (including phone)	
	Veteran Status	

Embedding SDOH into Data Elements through IMPACT Act

IMPACT Act of 2014 requires CMS to:

- Collect standardized data elements for use in the post-acute care (PAC) Prospective Payment System; and
- Assess appropriate adjustments to quality measures, resource measures, and other measures, and to assess and implement appropriate adjustments to payments.

Stakeholder Feedback (December 2018):

- Prioritize data elements under consideration;
- Customize assessment tools by local needs;
- Allow patients to self-identify;
- Broaden beyond medical care; and
- Provide best practices for question design.

Why Collect Standardized Patient Assessment Data Elements for SDOH?

- Facilitates coordinated care and care planning based on a broader view of the patient's circumstances;
- Improves quality of care & outcomes for beneficiaries by considering a larger set of factors affecting health;
- Provides data for analysis of disparities, development of equity solutions, improved measures, and more appropriate payment.

Post-Acute Care Prospective Payment System Regulation Revisions

- **Finalized Rulemaking for four sites of post-acute care (2019):**
  - IRF: Inpatient Rehabilitation Facility
  - SNF: Skilled Nursing Facility
  - LTCH: Long Term Care Hospital
  - HH: Home Health
- **CMS added SDOH Standardized Patient Assessment Data Elements (SPADE)**
  - Race and Ethnicity
  - Preferred Language/Interpreter Services
  - Health Literacy
  - Transportation
  - Social Isolation

Proposed Data Elements

(1) Race
- 2011 HHS Data Standards

(2) Ethnicity
- 2011 HHS Data Standards

(3) Preferred Language and Interpreter Services
- LTCH [Long Term Care Hospital] CARE [Continuity Assessment Record and Evaluation] Data Set (LCDS) and the Minimum Data Set (MDS)

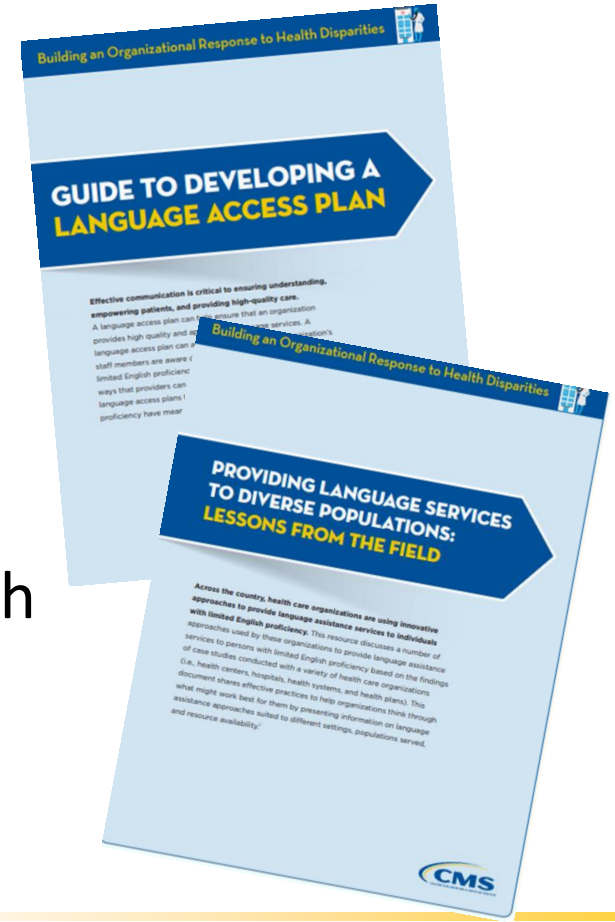
(4) Health Literacy
- based on Single Item Literacy Screener (SILS)

(6) Transportation
- Patient-Reported Outcomes Measurement Information System (PROMIS) and the Accountable Health Communities (AHC)

(7) Social Isolation
- PROMIS and AHC

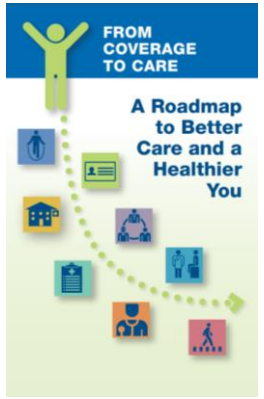
Providing Language Services

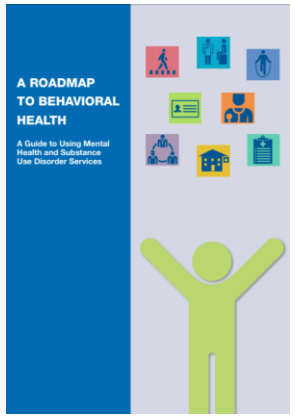
- Guide to Developing a Language Access Plan
  - Conducting a needs assessment
  - Offering language services
  - Notices
  - Training
  - Evaluation
- Lessons From the Field
  - Data collection and Electronic Health Records
  - Streamlining processes
  - Including interpreters on rounds



From Coverage to Care

- Roadmap to Better Care and a Healthier You
- 5 Ways to Make the Most of Your Health Coverage
- Roadmap to Behavioral Health
- Manage Your Health Care Costs
- Enrollment Toolkit
- Prevention Resources
- Partner Toolkit and Community Presentation





go.cms.gov/c2c

CoverageToCare@cms.hhs.gov

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2019 CMS Health Equity Award Winner: Centene Corporation

- Centene partnered with the National Council on Independent Living (NCIL) to increase the percentage of providers that meet disability access standards. 36,000 of Centene's members now have improved access to their providers.

- CMS is accepting nominations for the 2020 CMS Health Equity Award (10/9-11/15).

Health Equity Technical Assistance

ACT

Implement targeted interventions to reduce health disparities.

PRIORITIZE

Identify disparities, plan initiatives, and set SMART aims.

IMPROVE

Evaluate and improve your plan to reduce disparities.

HealthEquityTA@cms.hhs.gov

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Contact Us

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Health Equity Technical Assistance:

HealthEquityTA@cms.hhs.gov.

CMS OMH Homepage:

go.cms.gov/omh

Appendix

SDOH data elements used in Post Acute Care rulemaking

SDOH in the Rules: Race and Ethnicity

A1010. Race What is your race?	
↓ Check all that apply	
☐	A. White
☐	B. Black or African American
☐	C. American Indian or Alaska Native
☐	D. Asian Indian
☐	E. Chinese
☐	F. Filipino
☐	G. Japanese
☐	H. Korean
☐	I. Vietnamese
☐	J. Other Asian
☐	K. Native Hawaiian
☐	L. Guamanian or Chamorro
☐	M. Samoan
☐	N. Other Pacific Islander
☐	X. Patient unable to respond

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond

SDOH in the Rules:
Preferred Language & Interpreter Services

A1110. Language

Enter Code

A. What is your preferred language?

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

SDOH in the Rules: Health Literacy

B1300. Health Literacy

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code ☐

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
8. **Patient unable to respond**

SDOH in the Rules: Transportation

A1250. Transportation Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓ Check all that apply	
☐	A. Yes, it has kept me from medical appointments or from getting my medications
☐	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	C. No
☐	X. Patient unable to respond

SDOH in the Rules: Social Isolation

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code	
☐	0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 8. **Patient unable to respond**