

Podcast episode transcript: Dr. Melissa Clarke, Lauren Riplinger and Priya Bathija

Melissa Clarke: Welcome to the 3M Inside Angle podcast. My name is Dr. Melissa Clarke, and I'm your host today as we discuss management of social drivers of health data and the medical record and its relationship to health equity.

We are by now familiar with social drivers of health, those social factors that occur at a system or community-wide level that play an outsized role in health outcomes. When these drivers like housing, clean air and water, nutrition stability, reliable transportation, racism and discrimination, or employment opportunities are working against an individual, they give rise to unmet social needs and help to create the conditions for health inequities.

But how do we know and share these factors as part of the medical record? Does documenting them play a role in assessing payment and quality of care in the health care system? And can sharing them ultimately improve care and close health equity gaps? We're going to answer these questions and more with my two esteemed guests.

My first guest is Lauren Riplinger, JD. She serves as Chief Public Policy and Impact Officer for the [American Health Information Management Association, or AHIMA](#). In this capacity, she's responsible for providing strategic and operational oversight for AHIMA's advocacy and programmatic strategy to demonstrate mission impact. With over two decades of health care policy experience, Lauren previously worked on Capitol Hill where she served multiple roles, including chief of staff.

My next guest is Priya Bathija. She's a nationally recognized health care leader, attorney, law professor, and policy expert who works with organizations like AHIMA and the American Hospital Association as they design tools and resources, as well as educational campaigns to support health care providers in improving health equity. She's also founder and CEO of [Nyoo Health](#), an organization dedicated to improving health and health care for women.

Welcome, Priya and Lauren. Thanks so much for joining us on the 3M Inside Angle podcast.

Lauren Riplinger: Thank you for having us.

Priya Bathija: Yeah, same. Excited to be here.

Melissa Clarke: Lauren, why don't you start us off by describing what AHIMA does and the advocacy role that the organization plays when it comes to health equity?

Lauren Riplinger: Absolutely. Thanks for the question, Melissa. And for those that may not be familiar with AHIMA, we are a global nonprofit association of health information professionals. We see ourselves as a leading voice and authority and health information wherever it's found. And we have a mission to empower people to impact health. Our folks and our members work at the intersection of health care, technology and business. While often it's the case that patients don't see us, health information professionals see patients in a way that no other

health care professional does. The reason for that is because our AHIMA certified professionals ensure that sensitive health stories remain accurate, accessible, protected, and complete at all times. So some examples of who our members are in health information professionals, they include people who are working on such issues as data quality, revenue cycle management, privacy risk and compliance, informatics, data analytics, and consumer health information.

So given our members and where they sit in health care, we are often seen as leading advocates for things like patient identification and matching with our work through the Patient ID Now coalition, as well as helping to ensure that end-users have a voice in shaping health IT policy and standards development from a regulatory perspective. We also are really advocating for the improved collection sharing and use of social determinants of health data, which really leads us to our data for Better Health Initiative. Last year we launched [Data for Better Health](#) to increase awareness of how collecting, using and sharing social determinants of health data can improve individual and community health and health care outcomes. I'm sure many of your listeners are aware at this point, but as we know, social determinants of health or SDoH are conditions in the environment as you shared in which people are born, live, learn, work, play, worship, and age, that affect individuals' health and quality of life.

And they play such a large role in our lives that there's many that say they determine about [80 percent of our health](#). So a key component of our Data for Better Health Initiative is to advance policy solutions that support an environment that better allows health information professionals and the broader health care ecosystem to address these social determinants of health. We're also focused on supporting health care professionals and the field as they collect, share, and use this data. So as part of this initiative, we'll offer tips and strategies and models of success related to collecting, using and sharing SDoH data to maximize impact. We know this is not easy work and as a field it's going to require a lot of learning and collaboration and AHIMA will help lead those efforts.

Melissa Clarke: You recently had a health equity summit. What was the goal and the main themes that emerged? And I'll give that one to you, Priya.

Priya Bathija: Yeah, absolutely. So AHIMA hosted its inaugural data for [Better Health Executive Leadership Summit](#) in November in Washington DC. And the goal was to bring together health care leaders to learn, engage, and share. And it was a really energizing day and just exciting to bring a group of people who are truly invested in this issue together and give them the opportunity to learn and think about the future together. There were several important things that were raised that day, but I think three themes that came up regularly throughout the conversation. The first is that there's no one right way to take on social determinants of health data. We had over 20 speakers from across the health care ecosystem, and it quickly became clear that there are so many different ways we can be collecting, sharing and using social determinants of health data to improve outcomes for patients and populations at the local, state and federal levels.

But no matter how we do it, we need to make sure that teams on the ground have what they need to do this work. So that can be everything from providing support, facilitating dialogue among teams, and breaking down some of the silos that exist today or embracing a culture

that supports learning. The second theme was that partnership is critical. That can be partnership both internal to an organization or external with outside organizations. But the reality is that no one person, department, or organization is going to be able to do this work alone. So successful partnership will involve things like transparency and helping others understand how this work is done and how the decisions being made are impacting patients.

And then the third theme that I want to touch on is trust. Trust is very important in this work, and that includes trust between leaders, trust between partners, but most importantly trust between patients and the care teams that are gathering this data. It really involves understanding how we got to where we are today and what has happened in the health care environment that has caused distrust or mistrust with our patients. Providers need to educate patients about why we're asking these questions and what we plan to do with the data once we have it. And this last piece of trust with patients is really acknowledging and being okay that it will take time to build trust in many cases. And that sometimes even when we've done what we think we need to do to build trust, patients may not want to share this data. They may feel it's too sensitive to share and that's okay too. So those were some of the high-level themes that came out of that day, but just a really exciting and energizing opportunity to bring folks together.

Melissa Clarke: Thanks so much for explaining that. Now, one of the roles that the health information management professionals that you represent play in the revenue cycle is data capture and coding. Please describe what that is and the role that it can play when it comes to addressing health inequities. And why don't you start us off, Lauren?

Lauren Riplinger: Sure. One of the things that we're most often known for health information professionals is their ability to capture data on the social needs of their patient population using the ICD-10 CM Z codes. And we all know that certain Z codes identify non-medical factors that may influence a patient's health status. So when we look at the existing Z codes, we know that there's a number of issues related to a patient's socioeconomic situation that we can code for. That includes things like education and literacy, employment, housing, lack of adequate food or water or occupational exposure to risk factors like dust, radiation or toxic agents. And these codes originally became available in the fiscal year of 2016, but we all know that their adoption has been slow. So let's translate that to the real world. So when it comes to Z codes, ideally in a perfect world, there's three things that should happen.

One, the member of the care team can screen that patient for social determinants of health or social needs. Two, any SUH data or determinants that are identified are then in turn documented in the patient's record. And then the coder turns and takes that information and captures them on a claim by utilizing the appropriate Z code depending on the documentation itself. So the most visible role here for health information professionals is when coders capture the Z codes on the claim. However, I would say that health information professionals are and should be involved in this whole entire process.

As I mentioned earlier, health information professionals play an important role in making sure that that data is accurate, it's accessible, protected, kept, confidential, and that it's complete. And when we think about the broad spectrum of health data or health-related information that applies to SDoH data as much as it does to any other type of information about that patient.

So in addition to coding, we're seeing these individuals play a role in developing the screening protocols and identifying the best way to document this SDoH data as well as analyzing once it's collected.

Priya Bathija: Yeah. So I just want to build on what Lauren said. Everything she said is absolutely right. Health information professionals have a really important role to play in every step. And Melissa, I just wanted to touch on the second part of your question and how this work actually impacts health equity. So having social determinants of health data allows providers to do a number of things at the local level that we know can result in improved health and health care outcomes. So they can address any social needs that are identified for individual patients, really allowing for personalized care that addresses both medical and non-medical needs. Providers can also aggregate that data across patients to determine how to focus their health equity strategy, and they can also use that SDoH data to identify population health trends and guide community partnerships. And when providers do all of this, we get the additional benefit at the national level.

So adding SDoH data to hospital claims by utilizing Z codes enables us to get a better understanding of the health-related social needs of patients and communities around the country. And when we know that, we can perhaps tailor federal programs to meet those needs. And it also becomes important as we move towards value-based payment and when we're moving towards volume to value, having claims data connected to social needs can support policy and payment reforms, including appropriate risk adjustments. So all of this, whether it's at the local level or the national level, helps us move health equity forward.

Melissa Clarke: Thanks so much for that comprehensive answer. You covered a lot in that topic. I want to move to talking about some of the considerations when it comes to social drivers of health data and transferring it from clinical documentation by way of coding into claims. Lauren, can you elaborate on that for us?

Lauren Riplinger: Before I talk about challenges and considerations, I want to mention something that we call her our coding guru, and that is our Senior Director of Coding Policy and Compliance, Sue Bowman. And she always reminds me of this and that is that the actual process of coding a Z code on a claim is no different than the process of coding any other ICD-10-CM code, whether it's for diagnoses, symptoms or procedures, the mechanics and the foundations of coding, those Z codes are very much the same. That said, we know when we ask this question, that there's real challenges to be dealt with in terms of this context.

So for example, information on social needs may not be readily apparent in the documentation. We hear this a lot. In other instances, it may not be documented at all, or it could be documented in a part of the record that may not be accessible to that health information professionals. Other things we've heard consistently is that there's not enough slots on the claims form to enter the Z code information. The other thing I'd say is that the data from a [survey that we did with NORC at the University of Chicago](#), we released this survey last year, is that the biggest challenge in collecting and coding SDoH data was lack of training. And that's lack of training for the clinician and also lack of training by the health information professional. So what this tells us is that this really highlights the need to further train and educate both clinical staff and health information professionals on what documentation is actually needed to support a code assignment.

Melissa Clarke: What are some of the biggest challenges that hospitals and health systems are finding in the management of social drivers of health data? And can you elaborate on how clinicians have responded to the increased focus on SDoH documentation?

Priya Bathija: Yeah, absolutely. So I guess I'll just start by saying that this work is hard, really hard, and I think that it's important to acknowledge that. And when we look at organizations regardless of shape and size, they face common challenges when managing social determinants of health data. So that includes things like data standards, interoperability and health IT systems that aren't meant to support population health management. And then when it comes to a clinician perspective, the challenge actually starts with collecting the data. At our [AHIMA23 Conference](#) in the fall, Chuck Callahan, who is VP of population health at University of Maryland Medical Center said it best I think. And Dr. Callahan said, "It's not like sticking a vein and getting a live test result. It's an interview and it's difficult, sometimes sensitive." In addition, social determinants of health data is tricky to interpret. It often changes over time and it's hard to do something about it.

I've worked with hospitals and health systems on this issue for six years now, and this theme has remained consistent. It's an intimidating process for care teams. They may not always feel prepared to discuss these sensitive topics with patients. They may feel that they need more time than they have in a patient visit to create the environment and the trust that's needed to collect this information and then document it. And as we touched on before, patients just may be reluctant to disclose this personal information.

But that being said, what we are seeing is that when care teams are involved with creating the process, so they're involved with helping to decide where and when to screen, they're educated on what to do. If there is a positive screen, those clinicians are more than willing to take this on, and they want to be a part of using this data to improve outcomes for their patient. And to be honest, it's why they went into their profession. So some of those steps are really important for hospitals and health systems and other organizations to take into consideration as they put together the processes and the procedures needed to address social determinants of health data.

Melissa Clarke: Are there best practices that are emerging in managing SDoH data, including capturing, coding, and sharing? Lauren, can you elaborate on that for us?

Lauren Riplinger: Absolutely. We've talked a lot about challenges and how this work is so hard, but we do believe that there's a lot of bright spots out there in the field today. So one of the things we did in '23 is that we hosted a series of [webinars called Data Breaks](#) where we dive into a little bit of these best practices. And I want to share a little from one of our latest data breaks that we had in December with Dr. Alicia Jackson, who's the president of the Lloyd Dean Institute for Human Kindness and Health Justice with Common Spirit Health. So many folks know that Common Spirit is a very large health system, and they have multiple programs in place related to SDoH data, and this includes multiple ways to collect this data and multiple EHRs in which they store it and document it. So as a result, they have a lot of really great learnings to share related to collecting, using and sharing SDoH data.

So with regard to collecting SDoH data, one program they have is called the [Total Health Roadmap](#). And this runs in many markets and it relies on community health workers to screen patients in primary care clinics. One of the best practices that they've adopted through this program is universal screening. So anyone who comes through the door, regardless of insurance status, age, anything, they are screened. And what they found was that every community, including their most affluent suburban communities, had people that were dealing with some social needs.

So when it comes to using the data, the system, or I should say Common Spirit, created a homegrown analytics tool called [SoNA, or the Social Needs Analytics Platform](#). And this platform can generate reports at the national, regional market, clinic and facility level, and then that data can be segmented in many different ways. What this has done is it's allowed them to see what their most pressing needs are, that they're facing the communities that they serve, and where there's commonalities, they're showing up in the different communities.

And they found that addressing food and housing and was a challenge for every community that they serve. Now because they now know that they can now develop a strategy to better leverage their community investment dollars and partner more effectively with community-based organizations. Which of course leads to the sharing of the data with these community-based organizations. And in that work, they've recognized that these organizations don't always necessarily have the capacity to address the referrals that are coming from Common Spirit. So what that leads them to is they have to think about how do they partner differently. So it's not just about we just refer a patient out to that community-based organization, but rather helping these food banks and other CBOs build and grow their capacity so that they are able to accept those referrals when they send a patient their way. And giving them access to this data actually helps them figure out the pathways to grow their capacity.

Now, Common Spirit is now at the point where they are figuring out how to standardize the work that they've done and really disseminate the best practices that they've adopted. And they now have a system-wide committee that's specifically focused on SDoH data. Now, we recognize not every organization has the capacity as a common spirit and wouldn't necessarily have the same opportunities or resources as might be available to a larger health system, but I do believe strongly that we can learn from their experiences.

Melissa Clarke: Priya, and then maybe Lauren can round this out, how is the data being used once it's captured? Is there any tie in to national and local value-based care work, accreditations, or certifications in this area?

Priya Bathija: So I'll take the first part of that question and then hand it to Lauren to take the second. But initially, once a clinician has this information, it can be used to address social needs that are identified for that individual patient. Again, that allows personalized care that addresses both medical and non-medical needs. As I mentioned earlier, providers can then aggregate that data across patients to determine how to focus their health equity strategy, or more specifically, how to design programs that can address these social determinants for patients in their community. So not just an individual patient, but more broadly across the community. And they can also use this aggregated data to identify trends and guide community partnerships. So we're seeing a lot of organizations make impact here.

Another good example came from a [Data Break that we did with New York Presbyterian and a team from NYP in New York City](#) joined us to share their work and how screening was taking place across their system. So in September of 2022, they launched an expanded social determinants of health screening in department initiative, which screens for social challenges that are facing their patients currently. And right now, that program exists across seven of their emergency departments within the system.

So they started by conducting needs assessments and for their community, they determined that the top three social challenges that individuals were facing were housing, food insecurity, and transportation. So the screenings that they developed really focused on those three needs. The screenings were conducted in the emergency department by patient navigators who are representatives of the communities they serve. So in most cases, they share the same language, the same lived experiences as the patients they're working with. And that helps to build trust. And they're uniquely positioned to understand the needs of those patients because they look like them, they've had the same lived experience, and therefore they're better able to support them as they navigate the health care system and address their social needs.

So these patient navigators meet with patients at the bedside in the emergency department. They assess evidence-based social determinants of health questions, which are embedded in their Epic electronic health record. And then depending on the results of the screen, there's three pathways that can be taken. The first of course, is no intervention. They don't identify a social need. The patient has not presented in the ED for anything within the past year, so they don't need to do anything.

The second, if there's an identified social need, but there hasn't been an ED visit in the past year, the patient receives a resource guide for an appropriate community-based organization, and they have the opportunity to get help meeting that social need. And then third, if there is an identified social need, plus, there has been a history of one or more emergency department visits for that patient in the past year, there's actually a handoff to a community-based organization by that patient navigator. And there's ongoing outreach to the patient to make sure that they actually connect and connect successfully with the resources they need.

So since this program's been in place since September of 2022, they've screened more than 18,000 individuals across those seven emergency departments. And it's really too early to know what the long-term impact and overall health impact is going to be on patients. But for right now, it's delivering really great results in connecting patients with community resources they need. And New York Pres is also doing these screenings in other departments. They have community health workers screening in outpatient settings and clinical teams screening in inpatient settings. And in doing all of this work collectively, they have found a number of opportunities to improve systems and workflows. They've developed health information technology systems and electronic health record workflows that really truly support transferring this information and being able to use it to improve health care outcomes. They've come up with solutions related to interoperability, coding and data capture that help them do this in a much better way.

And they've learned that this screening and using this data to connect patients to the

resources they need, is really critical to moving forward their health equity efforts and to improving patient outcomes. So it's serving a really great benefit for patients, and it's also helping them prepare to comply with future waivers and regulations that are coming their way. And I'll let Lauren talk a little bit about those.

Lauren Riplinger: Thanks, Priya. And Melissa, I want to touch on the second portion of your question around the accreditation and certification from a regulatory perspective. And I'll say that there's been a lot of activity from our federal regulators on SDoH data. So for example, and many folks are very familiar with this at this point, but beginning earlier this month in January, [CMS started requiring that hospitals comply with reporting to additional quality measures related to SDoH data as part of its inpatient quality reporting program](#).

So the first measure is around screening for social drivers. So providers are now on the hook for reporting the number of patients that have been screened for the health related social needs tool compared to the number of people who have been admitted. And there's five social needs that they need to screen for, and that includes food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

The second measure is related to the screen positive result rate for social drivers of health. So providers then need to report the number of patients that were screened that actually had a social need that needs to be addressed. And each need is calculated and reported separately. But even beyond that, the Centers for Medicare and Medicaid services has imposed some requirements for Medicare Advantage and Part D plans and have indicated that there are future plans for quality measures related to geriatric care. So if we even look beyond just collecting the quality measures, CMS is also in very small ways starting to indicate of tying payment to SDoH data. So for example, CMS has now designated certain ICD-10 PCS codes that describe homelessness as a complication or comorbidity under the hospital inpatient perspective payment system.

In addition to that, what we saw in the [2024 physician fee schedule rule](#), was that they are now allowing some payment for time spent for screening for social determinants of health. Even beyond that, we're also seeing other parts of the Biden administration, like the Office of the National Coordinator for Health IT who has jurisdiction over certified health IT systems, make sure that these systems have data fields and data classes and data elements related to social determinants of health. And then taking the regulatory stuff and setting that aside, we also see accreditation organizations like the Joint Commission looking at and requiring certification requirements that will encourage that capture and use of SDoH data.

Melissa Clarke: Priya, maybe you can explain to us, are there health systems that are seeing improvements in quality outcomes like readmissions through enhanced SDoH data collection and the resulting initiatives that come about? Are these hospitals and health systems seeing closure of health disparity gaps as a result of SDoH data collection?

Priya Bathija: So Melissa, I'll take that one and I'll just say, yes, absolutely. There are so many examples of these outcomes from across the country, and I just want to share one with you today because I think it does a good job of showing that improved outcome and how it can not only make lives better for patients, but lower health care costs for the system. And that's

MetroHealth in Cleveland. And we had a leader from MetroHealth join us at [AHIMA's Advocacy Summit](#) to share the work that's being done at their [Institute of HOPE and HOPE](#) stands for Health Opportunity Partnership and Empowerment. They address social determinants of health using evidence-based strategies with the goal of helping patients live their healthiest lives.

And an essential piece of their work through the Institute of HOPE is collecting and using social determinants of health data to benefit patients. Patient responses are then mapped to 18 different Z codes in 10 different social determinants of health domains. And some examples of those include social isolation or stress, physical activity, and then ones we've touched on before, like food insecurity, housing instability, and so on. But once a patient shares this information, it's reviewed and addressed together with that patient. Then the institute takes that data and aggregates it together so that they can track overall patient needs and help clinical teams address those needs across the communities that they serve.

So the institute developed a really nice dashboard internally for their teams to use to monitor and filter the data in real time and intervene as early as possible with patients in their communities. And as a result of having this dashboard that is updated on a regular basis, they can see the big picture of what's actually happening in the communities that they serve. And they've been able to show that those with food insecurity are 25 percent more likely to have three or more emergency department visits within the last year. They're also 62 percent more likely to have 10 or more ED visits within the past year. And we know that those ED visits are expensive and costly, and it's not always the best setting in which to address the medical and non-medical needs of these individuals.

The institute has also shown how unaddressed social determinants of health affects cost. For example, those individuals who are at risk for physical activity have an expected increase of \$12,210 a year in the cost of caring for those individuals. And those who are at risk for financial resource strain, have an expected increase of \$4,126 each year. So that shows how it improves outcomes, how it lowers cost.

And another example of their work, they are evaluating this data regularly, and they found that patients who have identified social isolation as a determinant of health have 1.9 times as many hospitalizations and 2.4 times as many emergency department visits as patients who are not socially isolated. They're also 2.4 times more likely to skip scheduled primary care visits. So now that they have this data, MetroHealth has been able to create a program that connects socially isolated patients with trained volunteers for weekly telephone calls. And those calls are just social in nature. They're not about their medical needs. They're just to check in. And volunteers are trained to assist those patients in identifying other ways to reduce social isolation. So this is just one example of how these efforts are not only improving outcomes, but also reducing disparities and lowering the cost of care for individual patients and the system as a whole.

Melissa Clarke: Well, this has really been an enlightening discussion. Lauren, I'm hoping that you can help to round it out by telling us what's next in this work from AHIMA's perspective? What's the vision for the future?

Lauren Riplinger: We started this conversation today, Melissa, just talking about our mission for data for better health. Around how do we increase this awareness around how the collection, sharing and use of SDoH data can improve health and health care outcomes. So our objective for this year and beyond is to continue the work that we've started to engage health care professionals, including our membership of health information professionals in this work. Particularly because we know this work is so difficult and it's really going to take all of us to get the work done and to make progress. So what that means from our perspective is more tools, more resources and education to help everyone understand what their role is and how do we advance this work.

But I'll say we also have a broader vision, and that is to use our expertise grounded in health information to lead and convene conversations and to collaborate with others on SDoH data. So to that end, we're going to continue to host events that bring leaders in this field together, similar to our summit that Priya talked about earlier. One example is the thought leadership that you're a part of Melissa. So we've been bringing together a group of experts in this space to identify where we can work together, how we can amplify each other's work, because there's a lot of people out there that are doing really fantastic work in this space, and how we can go beyond tools and resources to actually truly making an impact and changing the policy landscape.

So we have those big, hairy, audacious goals, but we know we can't do it alone. And it's really that partnership with others in the field that is going to be critically important to maximize our impact on this issue. And I'll say in closing, we're just so thrilled for the partnership we have with 3M and the opportunity to work with you all to move this issue forward.

Melissa Clarke: Well, thank you so much, Priya and Lauren, for this incredibly insightful discussion in the management of social drivers of health data and its relationship to population health and advancing health equity. This has been Dr. Melissa Clarke, your host, thanking you, our audience, for tuning in to the 3M Inside Angle podcast.

Lauren Riplinger: Thank you, Melissa.