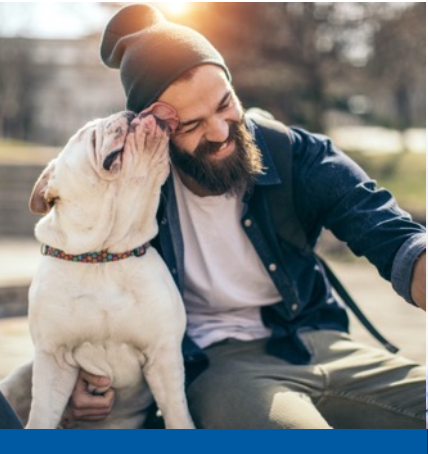


W O R K I N G T O A C H I E V E H E A L T H E Q U I T Y



Chamber of Commerce Social Determinants of Health Panel

Marina Diaz, Staff Director

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Rural Health Overview

Rural communities comprise vast and varied landscapes that encompass micropolitan, frontier, and tribal lands, as well as U.S. territories and other island communities. These communities are increasingly diverse; nearly a quarter of people living in rural areas are from racial or ethnic minority groups. CMS is working to advance health equity across the nation's health system to enable people living and working in rural, tribal, and geographically isolated communities to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

CMS Framework for Rural Health Priorities



Priority 1: Apply a Community-Informed Geographic Lens to CMS Programs and Policies



Priority 2: Increase Collection and Use of Standardized Data to Improve Health Care for Rural, Tribal, and Geographically Isolated Communities



Priority 3: Strengthen and Support Health Care Professionals in Rural, Tribal, and Geographically Isolated Communities



Priority 4: Optimize Medical and Communication Technology for Rural, Tribal, and Geographically Isolated Communities

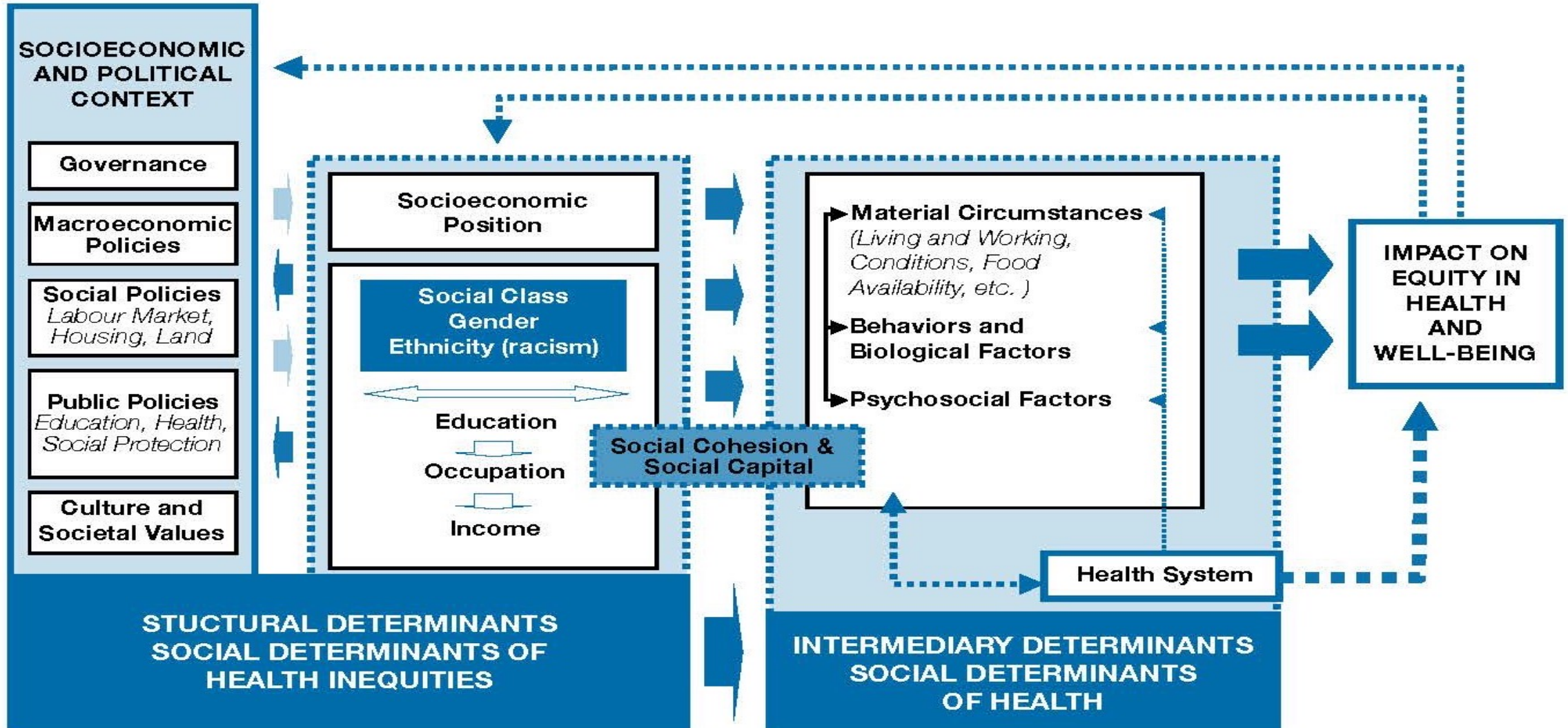


Priority 5: Expand Access to Comprehensive Health Care Coverage, Benefits, and Services and Supports for Individuals in Rural, Tribal, and Geographically Isolated



Priority 6: Drive Innovation and Value- Based Care in Rural, Tribal, and Geographically Isolated Communities

Framework for Action on Social Determinants of Health



Z Codes Journey Map Infographic

USING Z CODES:

The **Social Determinants of Health (SDOH)**
Data Journey to Better Outcomes

What are
Z
codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM diagnosis codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.¹

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.²

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A **Disparities Impact Statement** can be used to identify opportunities for advancing health equity.

For Questions: Contact the [CMS Health Equity Technical Assistance Program](#)

¹ <https://www.cms.gov/medicare/icd-10/2024-icd-10-cm>
² <https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf>

Chapter 21 of the ICD-10-CM Manual contains all Z codes that influence health status and contact with health services.

– Category Z00-Z99
Z55-Z65 (SDOH)

People with potential health risks related to socioeconomic and psychosocial circumstances

CMS 2024 Final Rules

- Medicare Physician Fee Schedule Final Rule www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule
- Inpatient Prospective Payment System (IPPS) Final Rule: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page>
- Interoperability and Prior-Authorization Final Rule: <https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f>
- Hospice Final Rule 2024: <https://www.federalregister.gov/documents/2023/08/02/2023-16116/medicare-program-fy-2024-hospice-wage-index-and-payment-rate-update-hospice-conditions-of>
- Home Care Prospective Payment System (PPS) Final Rule 2024: <https://www.federalregister.gov/documents/2023/11/13/2023-24455/medicare-program-calendar-year-cy-2024-home-health-hh-prospective-payment-system-rate-update-hh>

References

https://www.afro.who.int/sites/default/files/2017-06/SDH_conceptual_framework_for_action.pdf

<https://www.cms.gov/priorities/health-equity/minority-health>

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Thank you!

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