

Health Equity Toolkit

2022

Patient Safety Awareness

*Your guide to raising awareness
among staff, patients, and families*



Patient Safety is Everyone's Responsibility

To build a Culture of Health—where every person, no matter where they live, has an equal opportunity to live the healthiest life possible—we must improve people’s opportunities to be healthier in the places where they live, learn, work and play. Are you aware of the circumstances in your community that can impact how healthy it is?

Health Equity – Use these images, messages, and links in your public social media and internal staff education.

Clinical Messages

Message 1: The COVID-19 pandemic’s disproportionate impact on people of color has accelerated the integration of health equity into health care strategy playbooks across the nation. Within health care settings, from urban to rural and from hospitals to ambulatory care sites and clinics, there is renewed focus on efforts to advance health equity. Furthermore, there is growing recognition that a commitment to promoting equitable practices is tied to the core work of improving quality and patient safety. Learn how to achieve health equity in your organizations with the [AHA’s Institute for Diversity and Health Equity Toolkit](#).



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Message 2: Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, and age. Z Codes- ICD-10-CM codes that are specific to SDOH, range from Z55-Z65, and include social influencers of housing, food insecurity, transportation, etc. To begin your data journey to better outcomes for your community, follow the steps in this [CMS Tool](#) for using Z Codes.

USING Z CODES: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes

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 in an individual's health care record by any member of the care team.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.

What are 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.).
SDOH are the conditions in the environments where people are born, live, learn, work, play, and age.

USING SDOH Z CODES Can Enhance Your Quality Improvement Initiatives

Health Care Administrators
Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.
- Develop a plan to use SDOH Z code data to:
 - Enhance patient care.
 - Improve care coordination and referrals.
 - Support quality measurement.
 - Identify community/population needs.
 - Support planning and implementation of social needs interventions.
 - Monitor SDOH intervention effectiveness.

Health Care Team
Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals
Follow the ICD-10-CM coding guidelines.³

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.⁴
- Coding teams/managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

SDOH Z Codes

- 255 - Problems related to education and literacy
- 256 - Other problems related to primary support group, including family circumstances
- 257 - Accidental exposure to risk factors
- 259 - Problems related to housing and economic circumstances
- 265 - Problems related to other psychosocial circumstances
- 266 - Problems related to social environment

This list is subject to revision and additions to improve alignment with SDOH data elements.

Community Messages

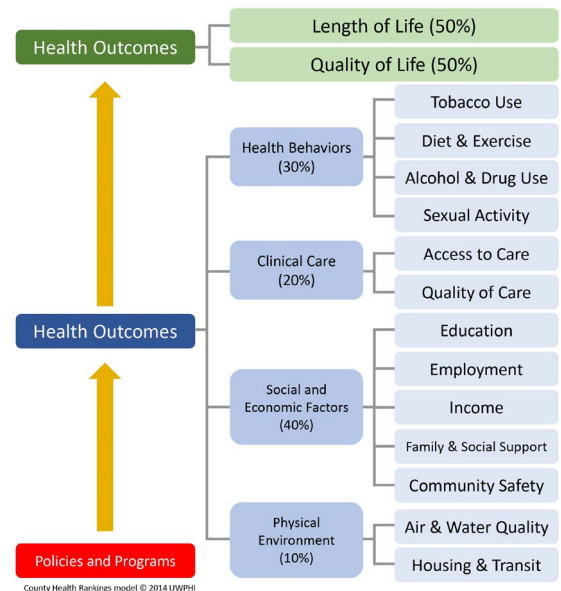
Message 3: For the first time in our history, the United States is raising a generation of children who may live sicker and shorter lives than their parents. In 2020, we witnessed the steepest plunge in life expectancy since World War II, [largely fueled by the coronavirus pandemic](#). Reversing this trend will of course depend on healthy choices by each of us. But not everyone in America has the same opportunities to be healthy. We know that the drivers of inequitable social, economic, built, and physical conditions within and across place and race can dramatically reduce opportunities for better health and well-being. Learn more about the life expectancy in your neighborhood and how it compares with others: [Life Expectancy: could where you live influence how long you live?](#)



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Both Clinical & Community Messages

Message 4: Health is more than what happens at the doctor's office. A wide range of factors influence how long and how well we live from education and income to what we eat and how we move to the quality of our housing and the safety of our neighborhoods. [County Health Rankings & Roadmaps](#), a program of the University of Wisconsin Population Health Institute, is working to improve health outcomes for all and to close the health gaps between those with the most and least opportunities for good health. Visit the website to learn more about your community.



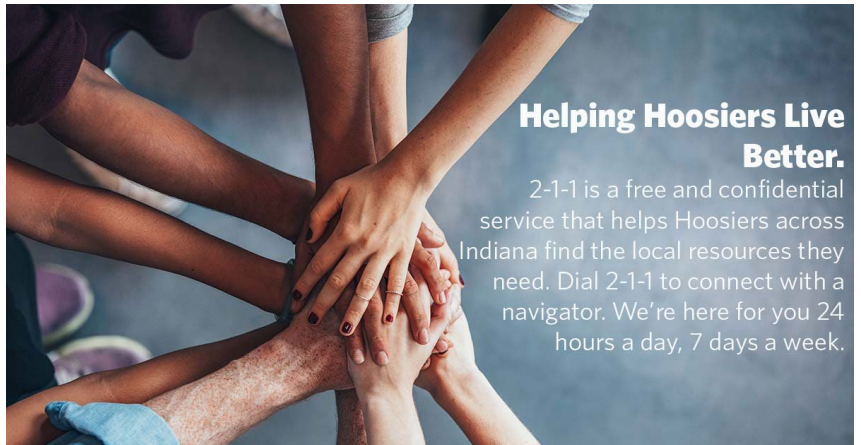


Indiana Patient Safety Center

of the Indiana Hospital Association

Message 5: Did you know that Indiana has a program through the Office of Healthy Opportunities, that can connect you to resources if you are between jobs, need childcare, healthcare, food, housing, transportation, or are impacted by substance use or personal safety?

Indiana 211 is a free service that connects Hoosiers with help and answers from thousands of health and human service agencies and resources right in their local communities - quickly, easily, and confidentially. Visit the [Indiana 211](#) Connect website for more information.



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Additional Resources

A variety of resources are available to support your Health Equity campaign. Check out the websites below for information and tools and use the video links in your education and social media.

[NEW 10 Questions Boards Can Answer to Advance Equity | AHA Trustee Services](#)

[NEW Mapping US Medicare Disparities | CMS](#)

[NEW Social Determinants of Health in Rural Communities Toolkit](#)

[NEW Food Insecurity and the Role of Hospitals](#)

[NEW Understanding the Social Determinants of Health for Rural Healthcare Teams](#)

[Updated CMS study on top 5 Z codes](#)

[Updated AHA ICD 10 SDoH Update](#)

[Updated AHRQ National Health Care Quality & Disparities Report](#)

[Find out how your county fares with social determinants of health](#)

[Healthy People 2030 data-driven national objectives](#)

[CDC resource to help communities address social determinants of health](#)

[Social Determinants of health for rural people](#)

Printable Resources

[AHA ICD 10 SDoH Update](#)

[CMS Tool for using Z Codes](#)

[PRAPARE Assessment Tool for SDOH](#)