



Effectively Improving the Health Status of Rural Populations: Social Determinant of Health

Presenter:

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Key Statics

- Members with social concerns are two times more likely to be readmitted within 30 days of discharge.
- Members with specific housing concerns or homelessness tend to visit the ER five times more than members without that concern.
- Members with social adversity have six times higher cost PMPM (per member, per month) annually, when compared to a non-SDOH population.
- According to the American Hospital Association, 3.6 million people in the United States do not obtain medical care because they do not have transportation.
- A study of Medicaid population revealed that housing insecure patients can spend up to nine times as much on emergent medical care than housed patients.

Connecting The Dots... “aha moments”

Medical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population.

80%

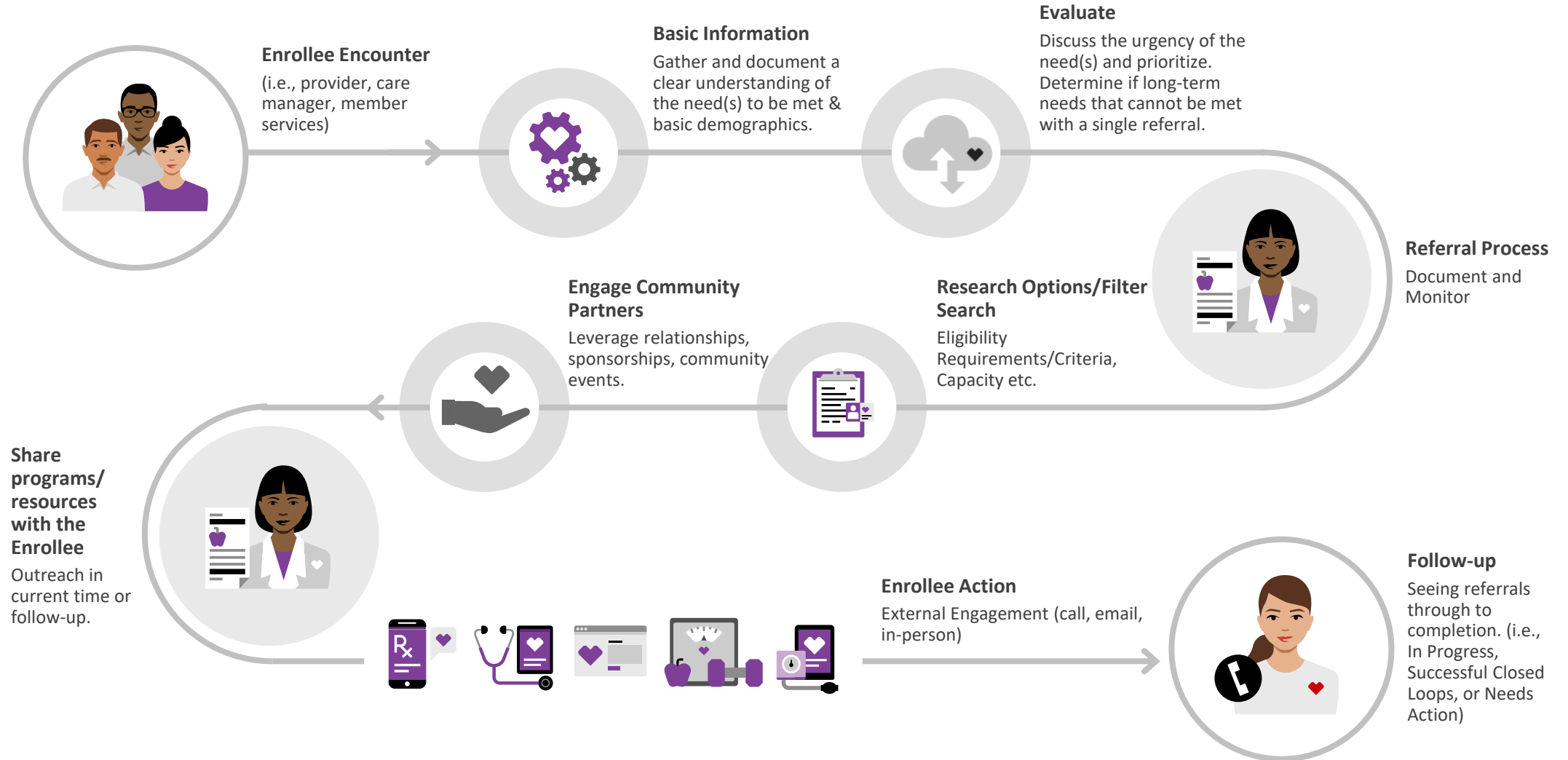
of health outcomes are driven by SDOH.

Front-line clinicians can see patterns of key determinants for populations



- Focus on displaying SDOH data in a way that allows clinicians to integrate it for clinical documentation easily.
- Take the data that is collected in the screening questions, and then map that data with ICD-10 codes, otherwise known as Z codes for social determinants of health.
- Have SDOH data in the patient EHR problem list to ensure that barriers are viewable by every clinician that encounters the patient.
- Identify a workflow(s) that automatically alerts care team members when a patient is positive for an SDOH factor.
- After that, an ABHLA care team member reaches out to the patient and works with them to understand what help they need.

Closed-Loop Referral Journey



The goal is to build a system that will help to break down barriers for communities that are traditionally marginalized.

ABHLA Incentive and Resources

Effective 12/13/2021, ABHLA began reimbursing a **flat rate incentive payment of \$30** for a one-time billing of Z Codes per claim per member encounter. To ensure receipt of this incentive payment, providers must:

- Bill CPT Code G9919 with 1 unit and must include at least one of the Z Codes listed (see below) in this notification as a diagnosis on a claim.
 - Note: CPT Code G9919 must be billed in the amount of \$30.00 to receive the incentive payment, this includes claims from Rural Health Clinics / Federal Qualified Health Clinics.
 - Note: CPT Code G9919 must be linked and submitted on the same claim line level as the corresponding Z Code(s) to be billed and paid appropriately.
 - Note: Please refer to the table of Z Codes provided, as they are considered eligible for the incentive (e.g., Z55-65).
- Providers of all types may bill Z Codes in the above manner for the flat rate reimbursement (i.e., ABHLA does not limit any provider types or specialties to bill this incentive. If the rendering 'provider' on the claim (e.g., CHWs, etc.) is valid, has an NPI, and is associated with the group and credentialed to bill a claim, then the provider group is eligible).
- There is no maximum number of Z Codes which can be included on the claim. The flat rate incentive payment of \$30 is per claim – not per diagnosis. This can be billed for each encounter a member presents and is identified through screening as having a SDoH need.

Our care management team supports members based on their personal health risks and unmet needs. A care manager is assigned to each member. They're part of the medical management team and their job is to make sure members get all the care and services they need.

The goal of the program is to positively impact the health status of the population enrolled with Aetna Better Health of Louisiana (ABHLA). Our commitment is to improve our members' health outcomes, enhance their quality of life, assist with self-management skills, and reduce racial, social, and ethnic health disparities by providing needed care in the most appropriate setting.

A key focus of the program is improving the member's biological and psychological health with an emphasis on quality of care including non-clinical aspects of services and attention to Social Determinants of Health.

Click link for direct access: [ABHLA Care Management Provider Referral Form](#)

Scan code for direct access
to the Care Management
Referral form:



Or head to <https://www.aetnabetterhealth.com/louisiana/providers/materials-forms.html>

- Go to **Forms** section → Open **General Provider Forms** tab

ABHLA's "aha moment"... Tackling loneliness and social isolation for vulnerable patients

An ABHLA Community Health Worker (CHW) may meet/talk with a patient with multiple chronic conditions, social determinants of health and behavioral health co-morbidities, and conclude, "What this patient needs is a friend."

At these times members are at a higher risk for poor health outcomes in part due to loneliness and social isolation.



Pyx Health provides 24/7 companionship and support for patients via a mobile platform and compassionate support center after they have been discharged from the emergency room or inpatient care.

Once the member has been on-boarded by Pyx Health they receive companionship to help treat loneliness through a non-clinical, whole-person care approach.

Pyx Health

Because no one gets better alone



Meet Pyxir,
a new friend to count on!



No one should go through life's challenges alone. That's why our friendly robot Pyxir and the compassionate humans at Pyx Health are here to help you:

- Find resources to support your physical and mental health
- Make the most of what your health plan offers
- Feel better each day with companionship and humor

Sign up for the program today!

Use your smart phone to go to www.HiPyx.com or aim your smart phone camera at this QR code. Call Pyx Health at 1-855-499-4777 for a helping hand.



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Aetna Better Health[®] of Louisiana

Improving the collection of SDOH data (go.cms.gov/OMH)

IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes



What Are Z Codes?

- SDOH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation)
- Z codes refer to factors influencing health status or reasons for contact with health services that are not classifiable elsewhere as diseases, injuries, or external causes

Using Z Codes for SDOH

- SDOH information can be collected before, during, or after a health care encounter through structured health risk assessments and screening tools
- These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor that influences the patient's health
- Coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record

What Are SDOH & Why Collect Them?

- SDOH are the conditions in the environment 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 risks¹
- The World Health Organization (WHO) estimates that SDOH accounts for 30-55% of health outcomes²



Collecting SDOH can improve equity in health care delivery and research by:

- Empowering providers to identify and address health disparities (e.g., care coordination and referrals)
- Supporting quality measurement
- Supporting planning and implementation of social needs interventions
- Identifying community and population needs
- Monitoring SDOH intervention effectiveness for patient outcomes
- Utilizing data to advocate for updating and creating new policies

ICD-10-CM Z Codes Update

- New SDOH Z codes may become effective each April 1 and October 1. New codes are announced prior to their effective date on [CDC website](https://www.cdc.gov/nchs/icd).
- Use the CDC National Center for Health Statistics [ICD-10-CM Browser tool](#) to search for all the current Z codes.
- Join the public process for SDOH code development and approval through the [ICD-10-CM Coordination and Maintenance Committee](#)

[VIEW JOURNEY MAP](#)

¹Healthy People 2030 ²World Health Organization

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For Questions Contact: [The CMS Health Equity Technical Assistance Program](#) | [ICD-10-CM Official Guidelines for Coding and Reporting FY 2024](#)



IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) data with ICD-10-CM Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy

- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- NEW** Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)

- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)
- NEW** Z58.8 – Other problems related to physical environment

NEW Z58.81 – Basic services unavailable in physical environment

NEW Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances

- Z59.0 – Homelessness (Updated)
 - Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)
 - Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)
 - Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
- Z59.1 – Inadequate Housing (Updated)

NEW Z59.10 – Inadequate housing, unspecified

NEW Z59.11 – Inadequate housing environmental temperature

NEW Z59.12 – Inadequate housing utilities

NEW Z59.19 – Other inadequate housing

Z59.4 – Lack of adequate food (Updated)

- Z59.41 – Food insecurity (Added, Oct. 1, 2021)
- Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)

Z59.8 – Other problems related to housing and economic circumstances (Updated)

- Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)
 - Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)

- Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
- Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)

Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)

Z59.86 – Financial insecurity (Added, Oct. 1, 2022)

Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)

- Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing

- Z62.2 – Upbringing away from parents

NEW Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)

NEW Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)

- Z62.8 – Other specified problems related to upbringing (Updated)
 - Z62.81 – Personal history of abuse in childhood

NEW Z62.814 – Personal history of child financial abuse

NEW Z62.815 – Personal history of intimate partner abuse in childhood

- Z62.82 – Parent-child conflict

NEW Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)

NEW Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)

NEW Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)

NEW Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)

NEW Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)

- Z62.89 – Other specified problems related to upbringing

NEW Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

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