# **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.**


## 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.



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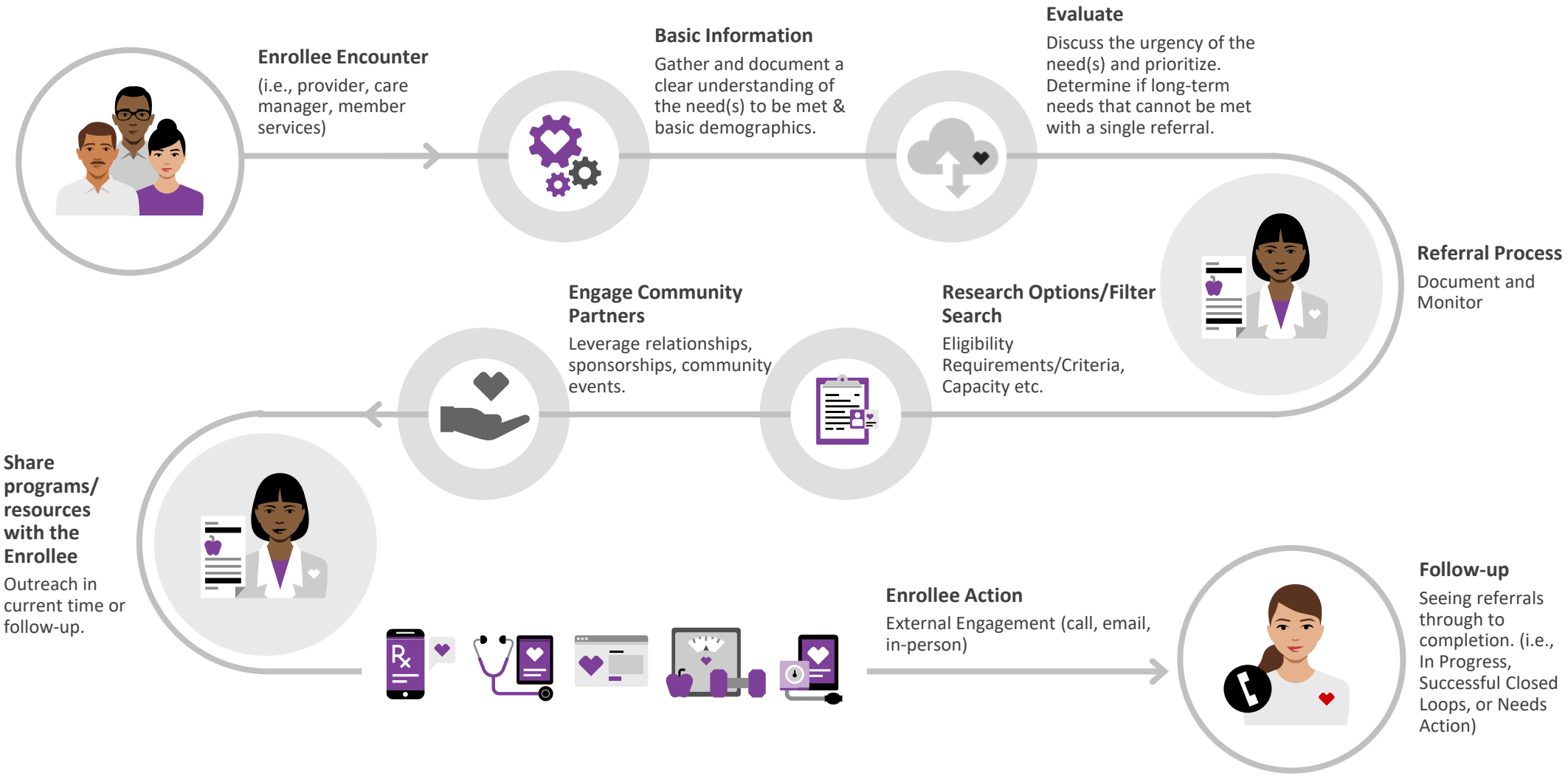
# Closed-Loop Referral Journey




*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

Questions and Support: For questions, please contact LAProvider@AETNA.com or lockwooda@aetna.com or call 1- 855-242-0802 and follow the prompts.

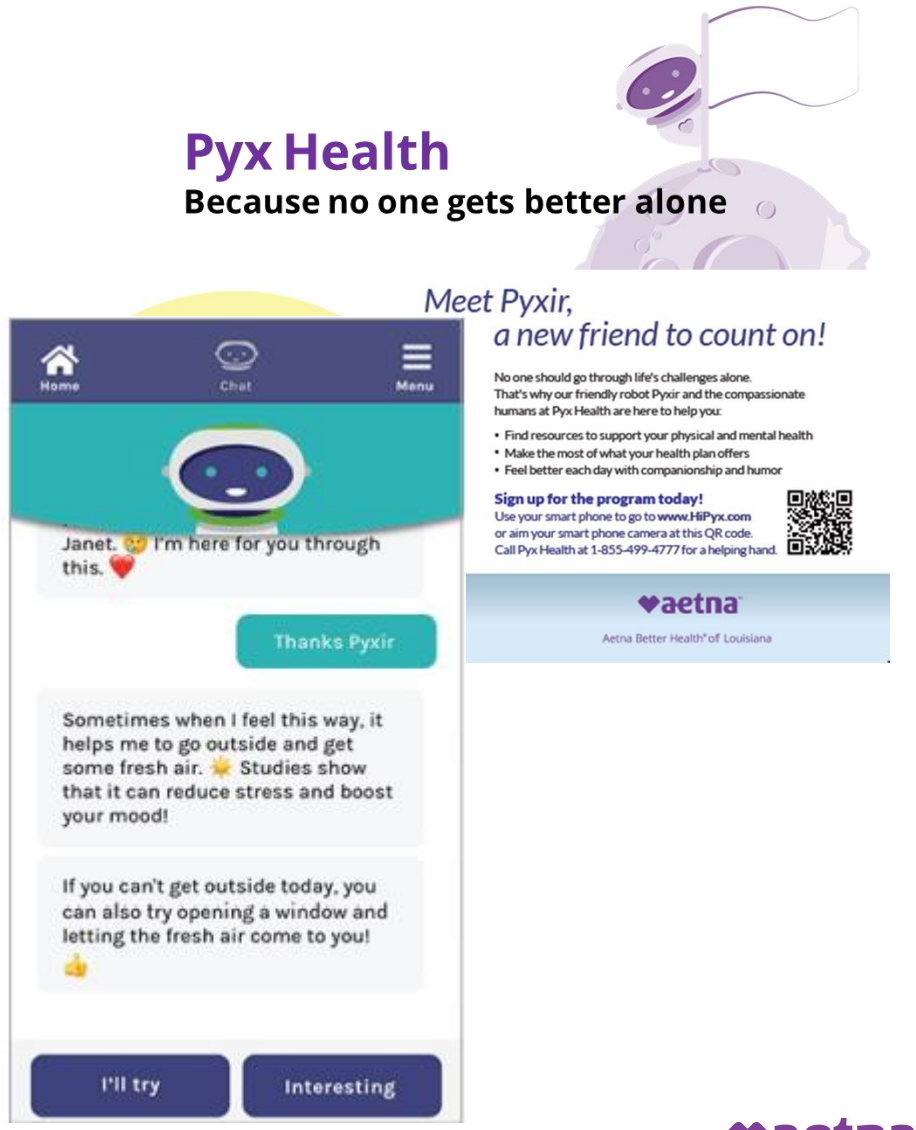
# ABHLA's "aha moment"… Tackling loneliness and social isolation for vulnerable patients

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."

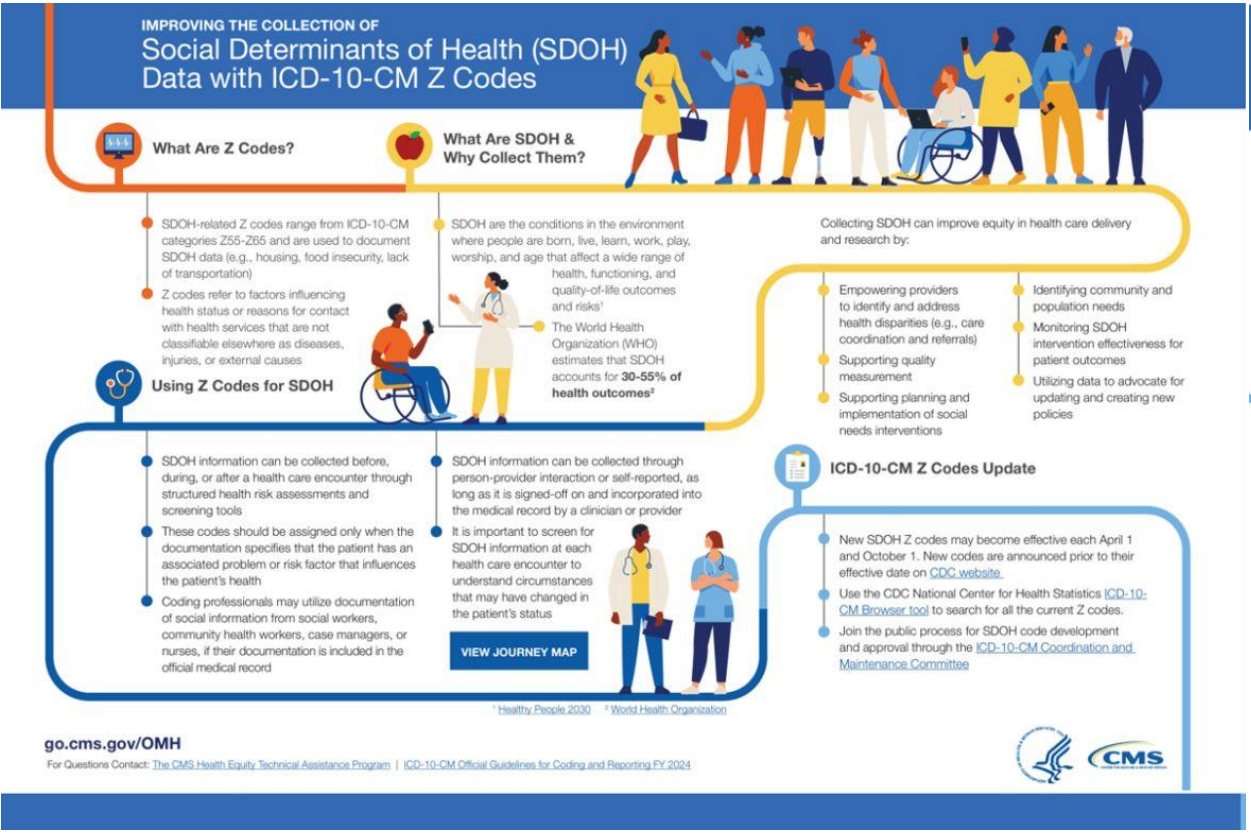
At these times members are at a higher risk for poor health outcomes in part due to loneliness and social isolation.

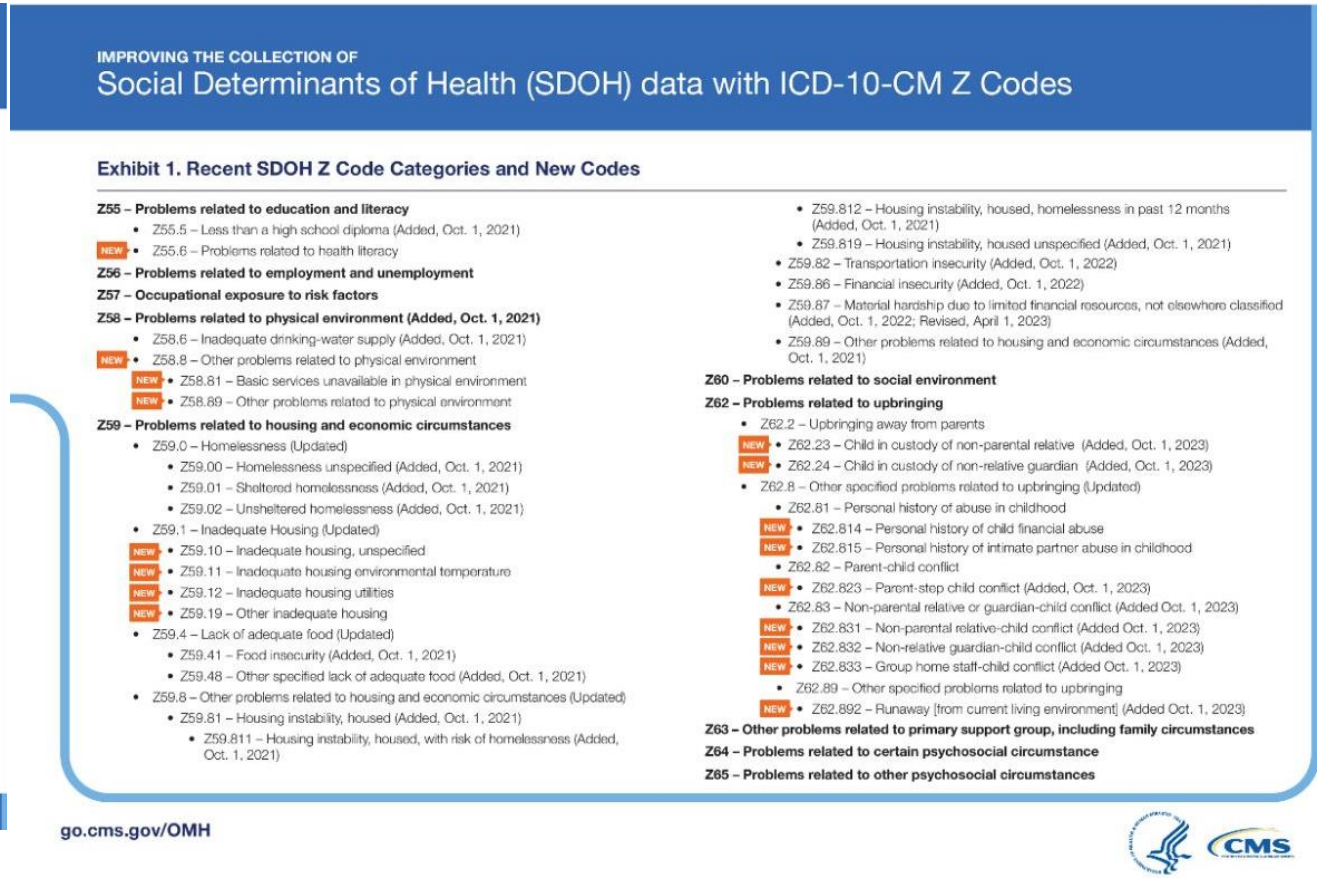
**Pyx Health provides 24/7 companionship and support for patients via a mobile platform and compassionate support center after they have been discharged from the emergency room or inpatient care.**

**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.**



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



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