American Hospital Association™

Advancing Health in America

AHA Events

Eliminating Health Disparities in Your Community through Z Codes

Madeline Wilson, MSN, RN, CLSSBB

Indiana Hospital Association

Karen Bartrom, MSN, RN, CCM

Cameron Memorial Community Hospital

The Indiana Hospital Association

- Founded in 1921
- The Indiana Hospital Association (IHA) is a nonprofit organization that serves as the professional trade association for more than 170 Hoosier hospitals.
- IHA's mission is to provide leadership, representation, and services in the common best interests of its members as they promote the improvement of community health status.
- IHA's primary responsibility is to represent the interests of hospitals in matters of public policy. IHA also provides members with education, patient safety, communications, and data analytics services.

IHA Work on Health Equity

Small Rural Hospital Improvement Grant Program (SHIP)-

- Funded 2019-2023
- 14 Hospitals participating in Special Innovation Project under SHIP grant to track and increase z codes
- Use this data to work with Community Health Needs Assessment findings to support better health outcomes in identified high-risk populations

Safety PIN C–

- Funded 2021-2024
- Goal is 100% participation of Indiana birthing hospitals to integrate health equity framework by implementation of Social Determinants of Health screening, systemized coding, data analysis and report visualization followed by action using the PETAL framework to connect women and infants to resources prior to crisis.
- Why – Year after year, the Indiana Infant Mortality Disparities Fact Sheets produced by the IDOH Maternal Child Health Division shows the unacceptable and substantial difference in infant mortality rates by race and ethnicity, both in causes of infant death as well as in birth outcome indicators.

Objectives

- Learn how to leverage partnerships and cross sector collaboratives to advance health equity through understanding of history and future expectations of CMS;
- Mobilize leaders to engage in activities in support of health equity and support multidisciplinary team participation;
- Use provided resources to help identify system baseline for social determinants of health through Z code tracking;
- Build processes that impact hospital performance and support reducing health inequalities in local communities by targeting specific Z codes

Social Determinants of Health Definition

The World Health Organization defines Social Determinants of Health as circumstances in which people are born, grow up, live, work and age, and the systems put into place to deal with illness.

How Does Healthy People 2030 Address SDOH?

Social Determinants of Health - Healthy People 2030 | health.gov

Impact of Health Factors

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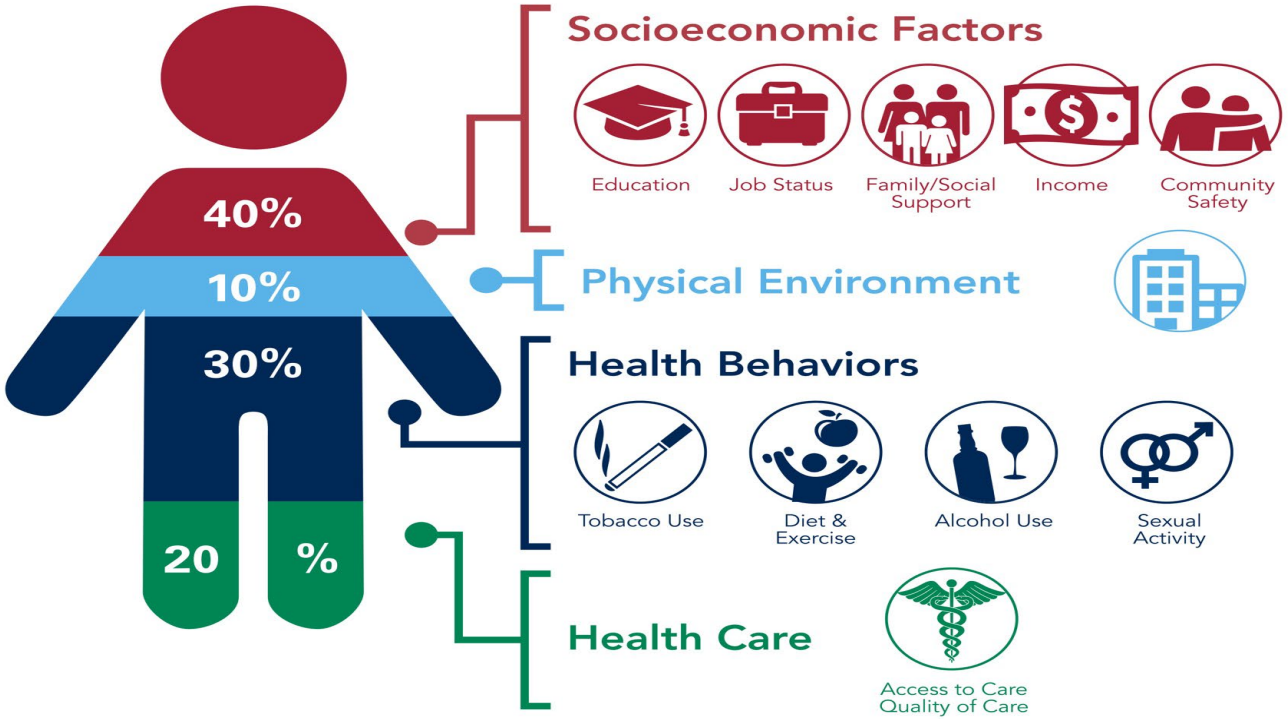
IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



SDOH Impact

- **20 percent** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment**, **social determinants** and **behavioral factors** drive **80 percent** of health outcomes

Image source: https://www.promedica.org/socialdeterminants/pages/default.aspx

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

https://sponsored.aha.org/rs/734-ZTO-041/images/March122020_FinalHandouts.pdf

SDOH Influencers

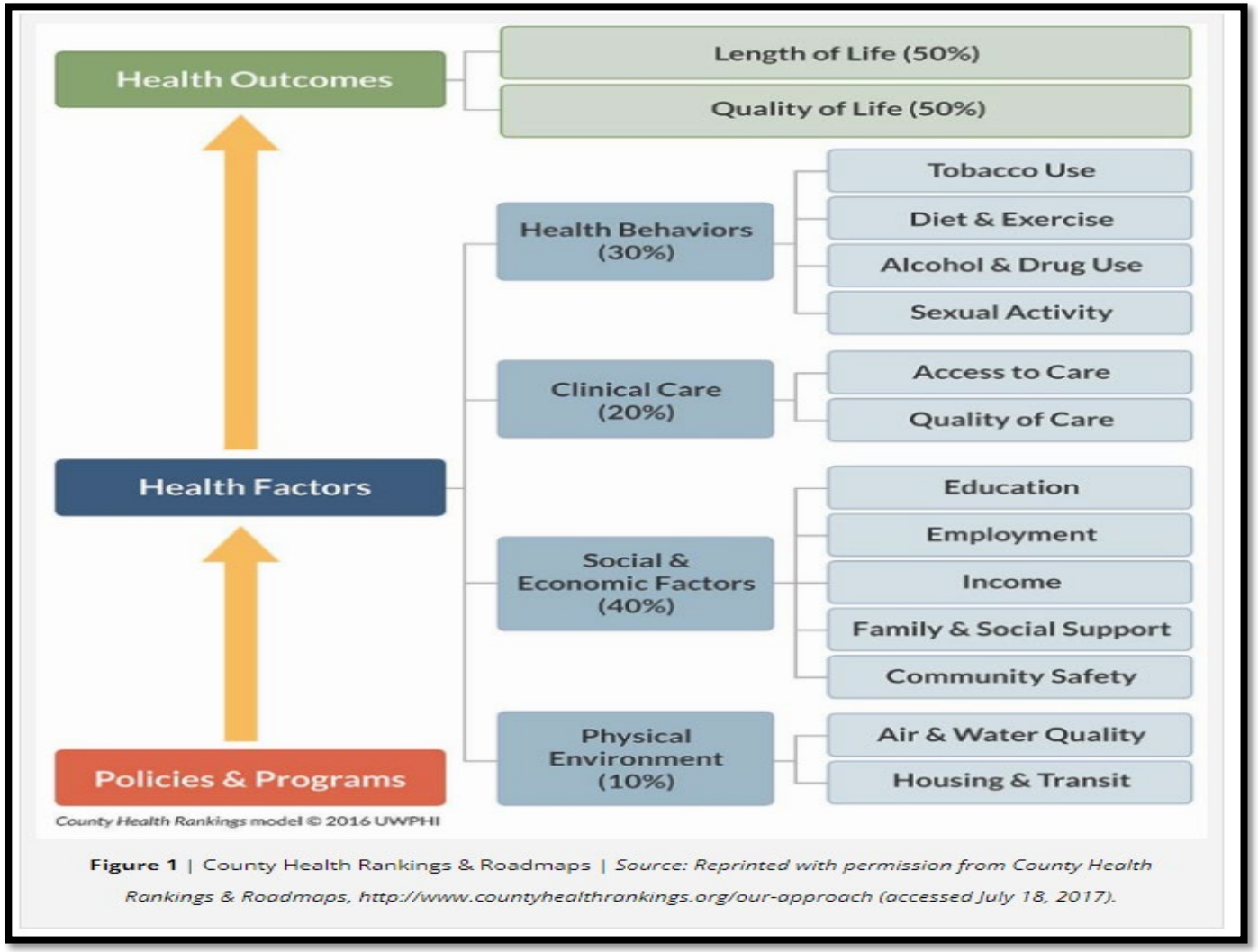


Figure 1 | County Health Rankings & Roadmaps | *Source: Reprinted with permission from County Health Rankings & Roadmaps, http://www.countyhealthrankings.org/our-approach (accessed July 18, 2017).*

CMS Topic of Discussion

https://www.cmsqualityconference.com/

Equity Objective

Leverage Quality Measures to Promote Equity and Close Gaps in Care

Objective
Commit to a patient-centered approach in quality measure and value-based incentives programs to ensure that quality and safety measures address healthcare equity

- Expand confidential feedback reports stratified by dual eligibility in all CMS value-based incentive programs as appropriate by the end of 2021
- Introduce plans to close equity gaps through leveraging the pay-for-performance incentive programs by 2022
- Ensure equity by supporting development of Socioeconomic Status (SES) measures and stratifying measures and programs by SES or dual eligibility as appropriate. Partner with OMH regarding HESS measures (health equity)
- Develop multi year plan to promote equity thru quality measures

https://www.cmsqualityconference.com/

Today's CMS Strategy

"CMMI plans to advance health equity through its models by requiring participants to collect and report demographic data and data on social needs and **social determinants of health**, as appropriate. New models will also include patients from historically underserved populations and safety-net providers, such as community health centers and disproportionate share hospitals, according to the white paper."

https://revcycleintelligence.com/news/cms-lays-out-new-strategy-for-advancing-value-based-care-apms

How Do We Identify Social Barriers?

- Z codes are a subset of ICD-10-CM diagnosis codes that represent factors influencing health status and contact with health services that may be recorded as diagnoses.
- ICD-10-CM categories Z55-Z65 are a more specialized group of codes to identify social determinants of health.

UPDATED AHA Resource

American Hospital Association™
Advancing Health in America

ICD-10-CM Coding for
Social Determinants of Health

Introduction

Hospitals and health systems are working to address the societal factors that influence health, including the social needs of their patients, social determinants of health in their communities and the systemic causes that lead to health inequities. These societal factors include access to food and transportation, housing security, education, violence, social support, health behaviors and employment status.

Robust social needs data is critical to hospitals' efforts to improve the health of their patients and communities. And, employing a standardized approach to screening for, documenting and coding social needs will enable hospitals to:

- Track the social needs that impact their patients, allowing for personalized care that addresses patients' medical and non-medical needs
- Aggregate data across patients to determine how to focus a social determinants strategy; and
- Identify population health trends and guide community partnerships.

At the national level, adding social needs data to hospital claims enables system-wide research to gain a better understanding of the health-related social needs of patients and communities around the country. Federal programs could be tailored to meet those needs. Furthermore, as payment moves from volume to value, having claims data connected to social needs can support policy and payment reforms, including appropriate risk-adjustments.

Hospitals can capture data on the social needs of their patient population using the ICD-10-CM codes included in categories Z55-Z65 ("Z codes"), which identify nonmedical factors that may influence a patient's health status. Existing Z codes identify issues related to a patient's socioeconomic situation, including education and literacy, employment, housing, lack of adequate food or water, or occupational exposure to risk factors like dust, radiation or toxic agents.

Z codes became available in fiscal year 2016; however, their adoption has been slow. The Centers for Medicare & Medicaid Services reports that health care providers used Z codes for 1.6% of Medicare fee-for-service beneficiaries in 2019. Adoption has been limited due to a lack of clarity on who can document a patient's social needs, absence of operational processes for documenting and coding social needs, and unfamiliarity with Z codes. In addition, coders may need encouragement and support from hospital leaders to collect these codes that were once perceived as a lower priority.

AHA Advocacy on Equity and Societal Factors that Influence Health

The AHA advocates for policies that enable hospitals to address health equity concerns among their patients and communities. This includes supporting: coordinated collection of race and ethnicity data; increased funding for health equity infrastructure in the Department of Health and Human Services to better address the needs of historically marginalized communities; and encouraging cultural competency training. Through its membership in Aligning for Health, AHA supports legislative solutions to address societal factors that influence health, including the Leveraging Integrated Networks in Communities to Address Social Needs Act and the Social Determinants Accelerator Act (SDAA). In December 2020, Congress incorporated provisions related to the development of the SDAA into its appropriations package; the CDC is tasked with issuing $3 million in grants to state, local, territorial and tribal jurisdictions to support these efforts.

Learn more about how AHA's Advocacy Agenda works to improve health equity.

What You Can Do

1. Hospital leaders should educate key stakeholders, including physicians, nonphysician health care providers and coding professionals of the important need to screen, document and code data on patients' social needs. Utilizing Z codes will allow hospitals and health systems to better track social needs and identify solutions to improve the health of their patients and communities.

2. As coding professionals review a patient's medical record to identify the appropriate ICD-10-CM codes to include, they should be aware of and begin utilizing the ICD-10-CM codes included in categories Z55-Z65, listed in Table 1.

3. Hospital leaders can prioritize the importance of documenting and coding patients' social needs and allow coders extra time to integrate coding for social determinants into their processes.

value-initiative-icd-10-code-social-determinants-of-health.pdf (aha.org)

ICD-10-CM SDOH Categories

Indiana Hospital Association

Z55 – Problems related to education and literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z59 – Problems related to housing and economic circumstances

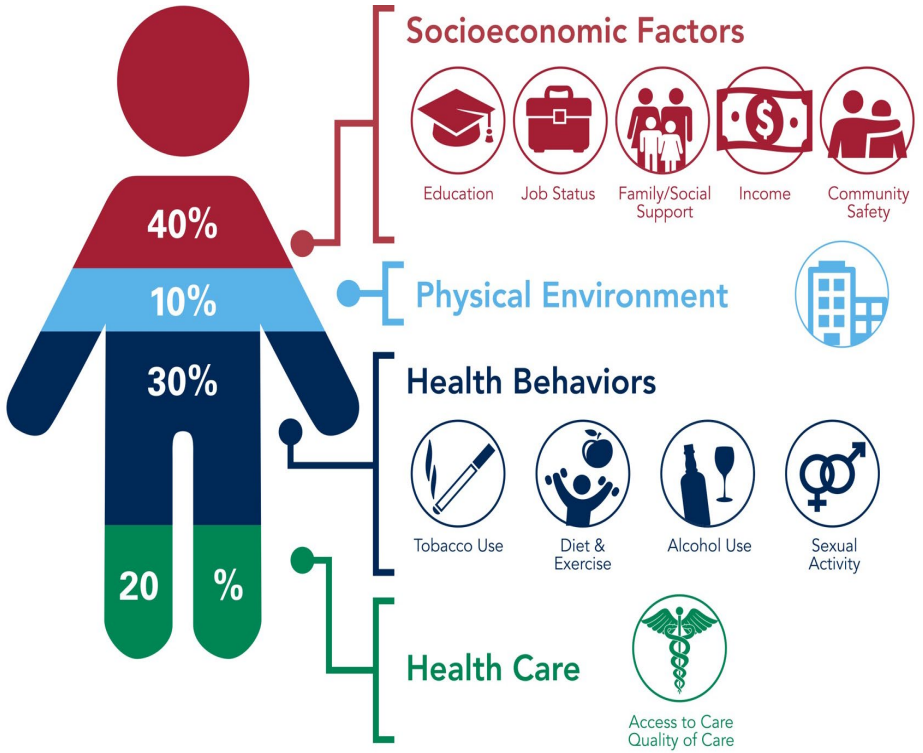
Z60 – Problems related to social environment

Z62 – Problems related to upbringing

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

Z64 – Problems related to certain psychosocial circumstances

Z65 – Problems related to other psychosocial circumstances



Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProM

Developing Z-Code Reporting

Indiana Hospital Association

Generally sourced from administrative claims

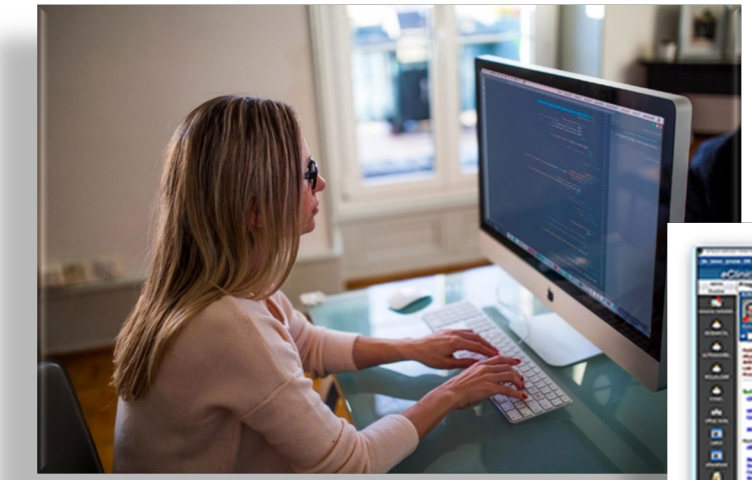
- Decision Support systems: Crimson, MIDAS, EPIC Workbench, etc.

Analytics team guidance

- Z-Code position in longitudinal records
- Look beyond primary diagnosis
- Focus on Inpatient, but don't neglect OP settings as well
- Use crosswalks

Improving documentation

- Standardizing documentation templates
  - Example: PRAPARE Toolkit, others
- Guiding coding staff to look for opportunities to code
- Key point: must be a coordinated effort



Health Equity Snapshot: A Toolkit for Action | AHA

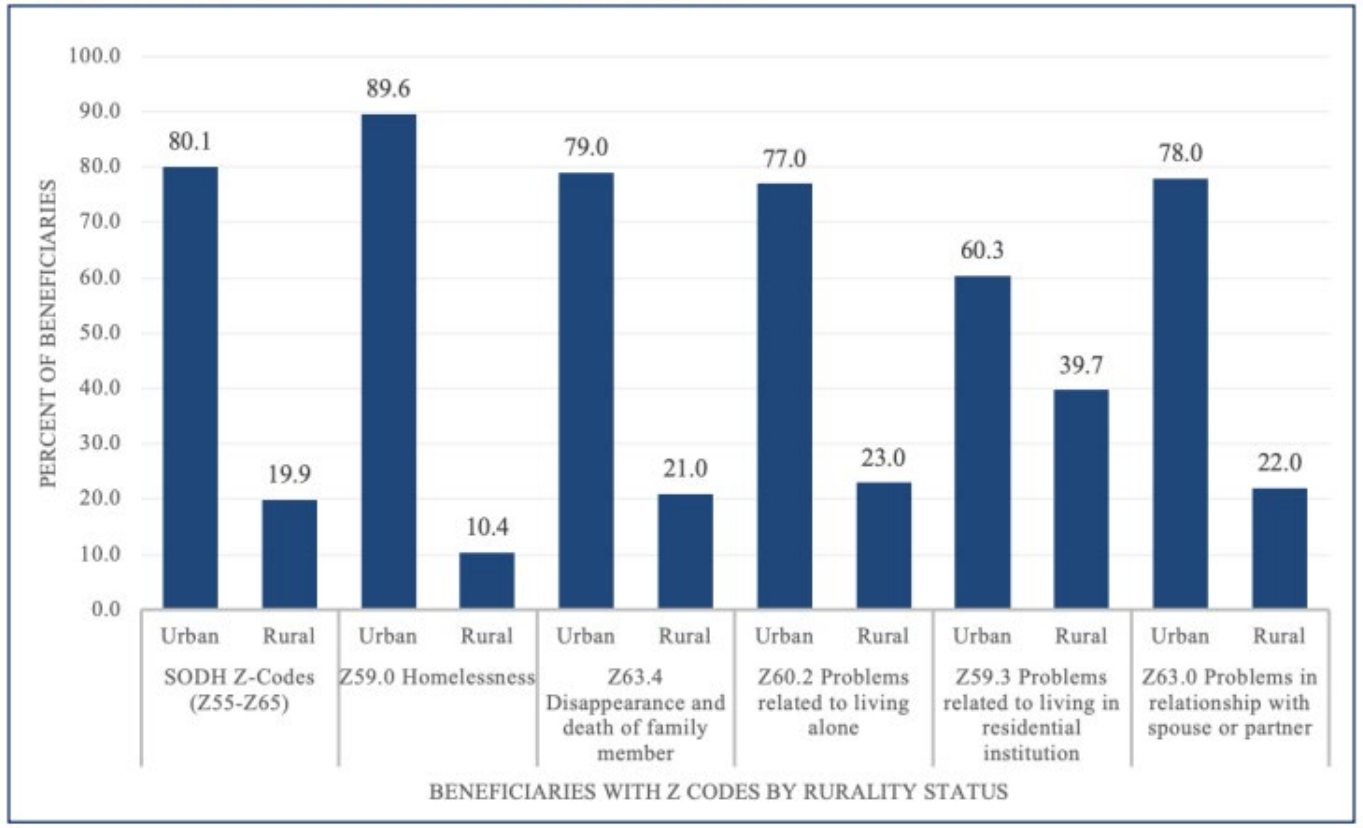
Obstacles in Data Collection

- Lack of definitions for SDOH terms
- Unfamiliarity with social needs
  - Providers and coders
- Perceived priority/lack of incentives
- Operational processes
  - EHR-based screening tool
  - Standard documenting process
  - Coding processes
- Lack of clarity about who can screen and document
- Productivity challenges

CMS Study on Z Code Utilization for Medicare Beneficiaries

Indiana Hospital Association

Figure 9. Proportion of Medicare FFS Beneficiaries with Z Code Claims across Rurality Status, Any Z Code and Top Five Most Utilized Z Codes, 2019.



NOTE: All Medicare beneficiaries were assigned to one of three categories based on the Zip Code of their mailing address and the corresponding Census Bureau core-based statistical area (CBSA). Metropolitan statistical areas consist of populations of 50,000 or more, while micropolitan statistical areas consist of populations between 10,000 and 50,000 and non-CBSAs are areas with populations less than 10,000. Beneficiaries categorized as rural live in non-metropolitan areas (i.e. micropolitan and non-CBSA areas).

Key Findings:

Among the 33.1 million continuously enrolled Medicare FFS beneficiaries in 2019, **1.59%** had claims with Z codes, as compared to 1.31% in 2016.

The 5 most utilized Z codes were:

1) **Z59.0** Homelessness
2) **Z63.4** Disappearance and death of family member
3) **Z60.2** Problems related to living alone
4) **Z59.3** Problems related to living in a residential institution
5) **Z63.0** Problems in relationship with spouse or partner

The top 5 provider types representing the largest proportions of Z codes were family practice physicians (15%), internal medicine physicians (14%), nurse practitioners (14%), psychiatry physicians (13%), and licensed clinical social workers (12%).

Beneficiaries dually eligible for Medicare and full-benefit Medicaid were overrepresented among the top 5 Z code claims.

Beneficiaries in rural areas were overrepresented (39.7%) among those with a **Z59.3** – Problems related to living in a residential institution claim.

Male beneficiaries who accounted for 45.4% of the overall FFS population represented 67.1% of those with a **Z59.0** – Homelessness claim.

Black and Hispanic beneficiaries accounted for 8.8% and 5.9% of the overall FFS population, respectively, but represented 24.8% and 9.2%, respectively, of those with a **Z59.0** – Homelessness claim.

Most (49.6%) Z codes were billed on Medicare Part B non-institutional claims.

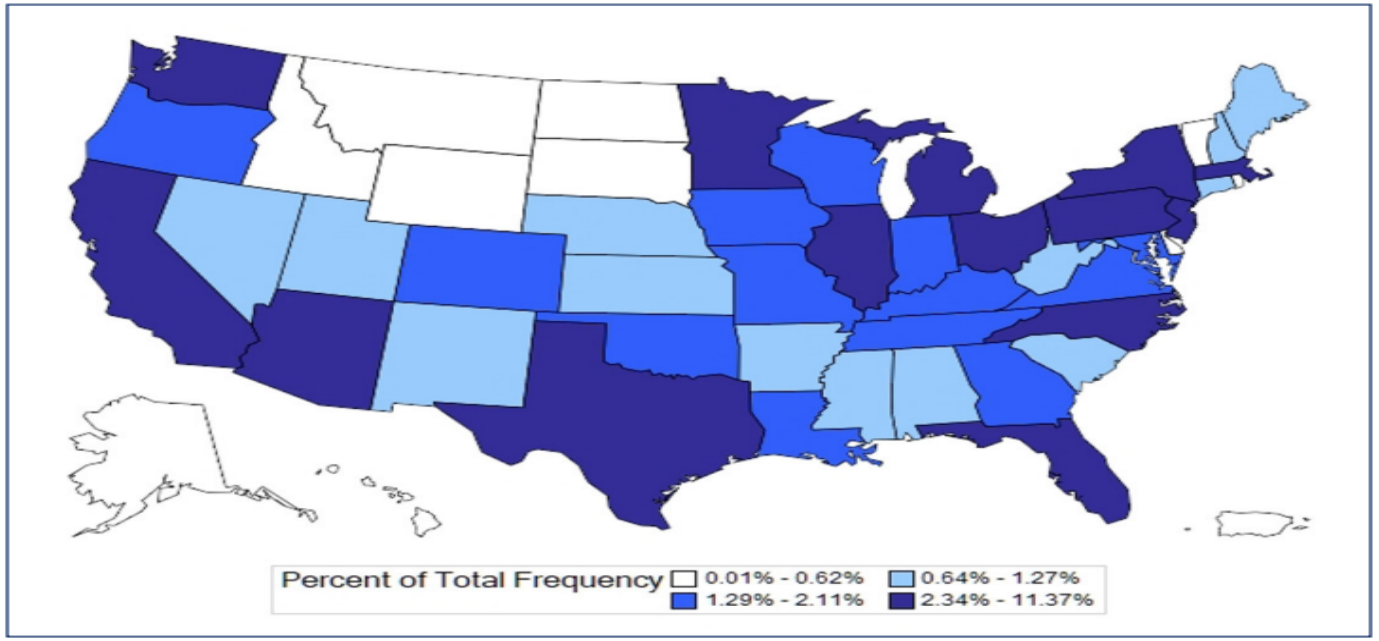
[Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019 (cms.gov)]

Proportion of Z Codes per State-Medicare

Indiana Hospital Association

Claims

Figure 10. Proportion of Medicare FFS Z Code Claims by State, 2019.



State	*n*	Proportion of all Z code claims
California (CA)	143,429	11%
Texas (TX)	74,764	6%
Massachusetts (MA)	68,734	5%
New York (NY)	67,744	5%
Pennsylvania (PA)	50,593	4%

[Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019 (cms.gov)]

Indiana's Z Code Utilization

Indiana Hospital Association

			2019	2020	2021 (Through Q3)
		Total Inpatient Records (Statewide)	781,060	716,089	506,462
		Total Outpatient Records	6,123,156	5,287,991	5,118,351
		Total	6,904,216	6,004,080	5,624,813
		All records containing Z-codes	40,748	41,356	35,524
		Prevalence	**0.59%**	**0.69%**	**0.63%**
Z55	Educational Circumstances	(Education & Literacy)	1898	980	582
Z56	Effects of Work Environment	(Employment)	4526	5742	5676
Z62	Foster Care	(Parental issues/abuse in childhood)	562	511	634
Z59, Z60	Homelessness/Other Housing	(Lack of food/water, poverty, low income)	17377	19183	14780
Z59	Inadequate Material Resources	(Medical services not available at home)	2029	1575	3066
Z65	Legal Circumstances	(Imprisonment, victim of crime, exposure to war, hostilities)	594	716	1608
Z60	Other Social Factors	(Living alone, discrimination, social exclusion)	888	716	994
Z62, Z63	Parent/Child/Family	(Relationship issues, absence or death of family member)	12874	11933	8184

*Data obtained from IHA internal data dashboard- All Payor

SIP Hospital Improvement

- 14 hospitals
- 15% increase from 2018 baseline to 2019
- 2018-3.7% rate
- 27% increase from 2019-2020
- 2019-4.1% rate
- On track for over 50% increase from 2020-2021
- 2020-5% rate

SDoH Z-Codes

Capturing the Story of Our Lives

Karen Bartrom MSN, RN, CCM
Cameron Memorial Community Hospital
February 9, 2022

Everyone has a story…

What you will learn

- Identify what three stakeholders are needed for consistent SDoH documentation and z-code capture
- State four add-on programs that can expand social determinant screenings and minimize staff burden
- Describe how a ‘just do it’ implementation model can work for real results

Our Corner of Paradise

Steuben County

www.countyhealthrankings.com

Steuben (SU)

Health Outcomes

Steuben (SU) is ranked among the healthiest counties in Indiana (Highest 75%-100%)

Health Factors

Steuben (SU) is ranked among the healthiest counties in Indiana (Highest 75%-100%)

CAMERON
MEMORIAL COMMUNITY HOSPITAL

Angola, Indiana

Independent,
Not-for-profit,
Critical Access Hospital

Cameron's Vision

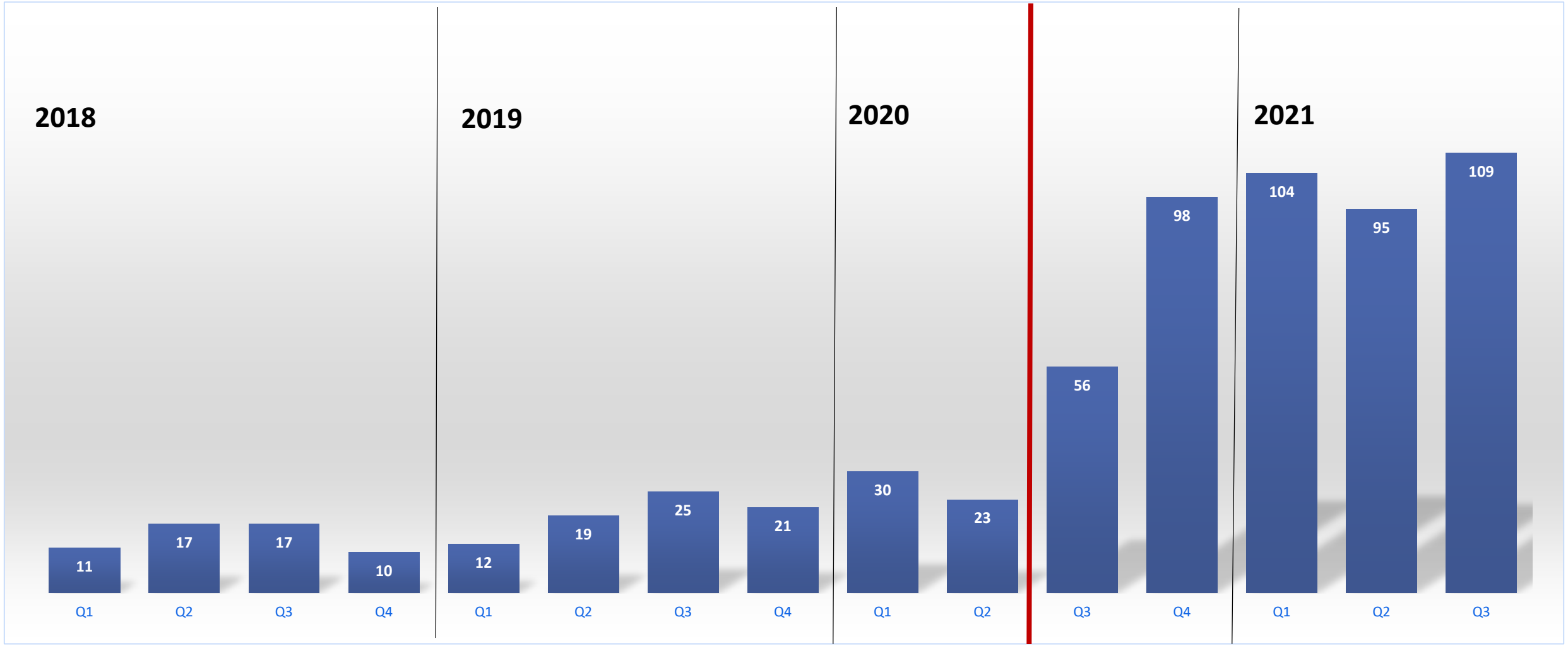
- *Cameron will provide high quality, innovative and individualized care that is focused on health and wellness by establishing community and strategic partnerships, integrations and technologies.*

2021

Cameron Hospital Statistics

HOSPITAL DISCHARGES	1556
Average Daily Census	19
ED VISITS	20,579
TRANSITIONAL CARE UNIT DISCHARGES (Swing)	128

Z- Code Capture 2018 – Q3 2021



Catalyst to Rapid Improvement

- **Ongoing partnership with the Indiana Hospital Association**
  - Special Innovation Project
- **Coding Department**
  - Education to coding professionals
- **Clinical Integration team awareness**
- **Organizational readiness**
- **Buy-in from providers**
  - Assessment and documentation education

It Started With an Idea…

Develop a program that goes beyond identifying the social determinants and assuring the code is captured

Nurture a culture of care transitions that decreases non-medical visits to the ED

Create a consistent workflow to be expanded across the organization

Cameron's Case Study

Understanding the problem	Developing solutions	Focused execution
• Data in discrete fields • Codable data in patient encounter	• Rapid testing of documentation • Workflow mapping across organization	• Small team • Agree on solution • Agility

Understanding the problem

Electronic Health Record

What we have:

-contract with local health system who is the vendor

-What we do not have:

-Population Health platform

-Case Management module

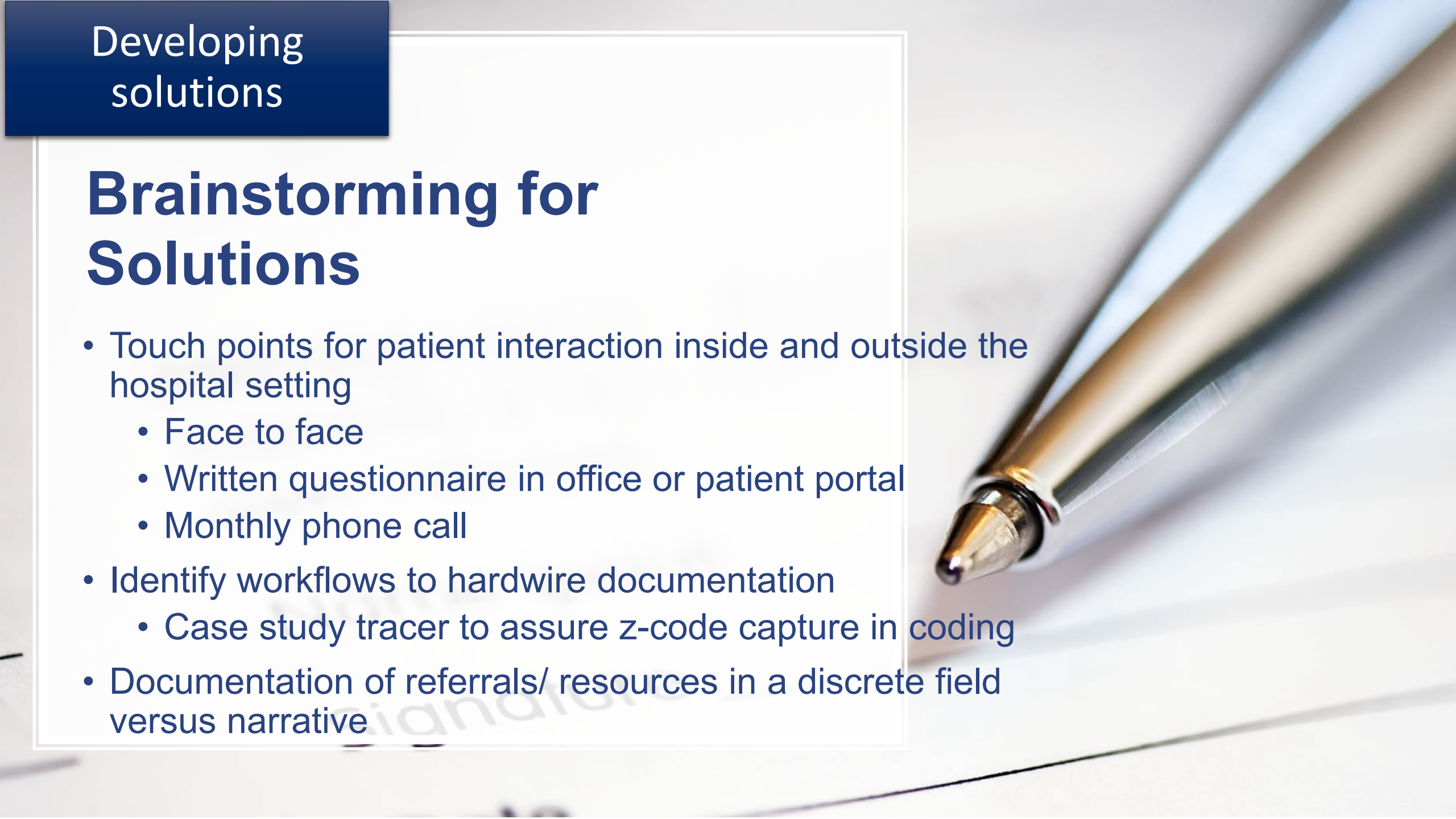
-Interoperability of single view portal

-Data analysis for reporting expertise

Developing solutions

Brainstorming for Solutions

- Touch points for patient interaction inside and outside the hospital setting
  - Face to face
  - Written questionnaire in office or patient portal
  - Monthly phone call
- Identify workflows to hardwire documentation
  - Case study tracer to assure z-code capture in coding
- Documentation of referrals/ resources in a discrete field versus narrative



Focused execution

Clinical Integration Team





Social Work, Utilization Review and Clinical Documentation Specialist

Focused execution

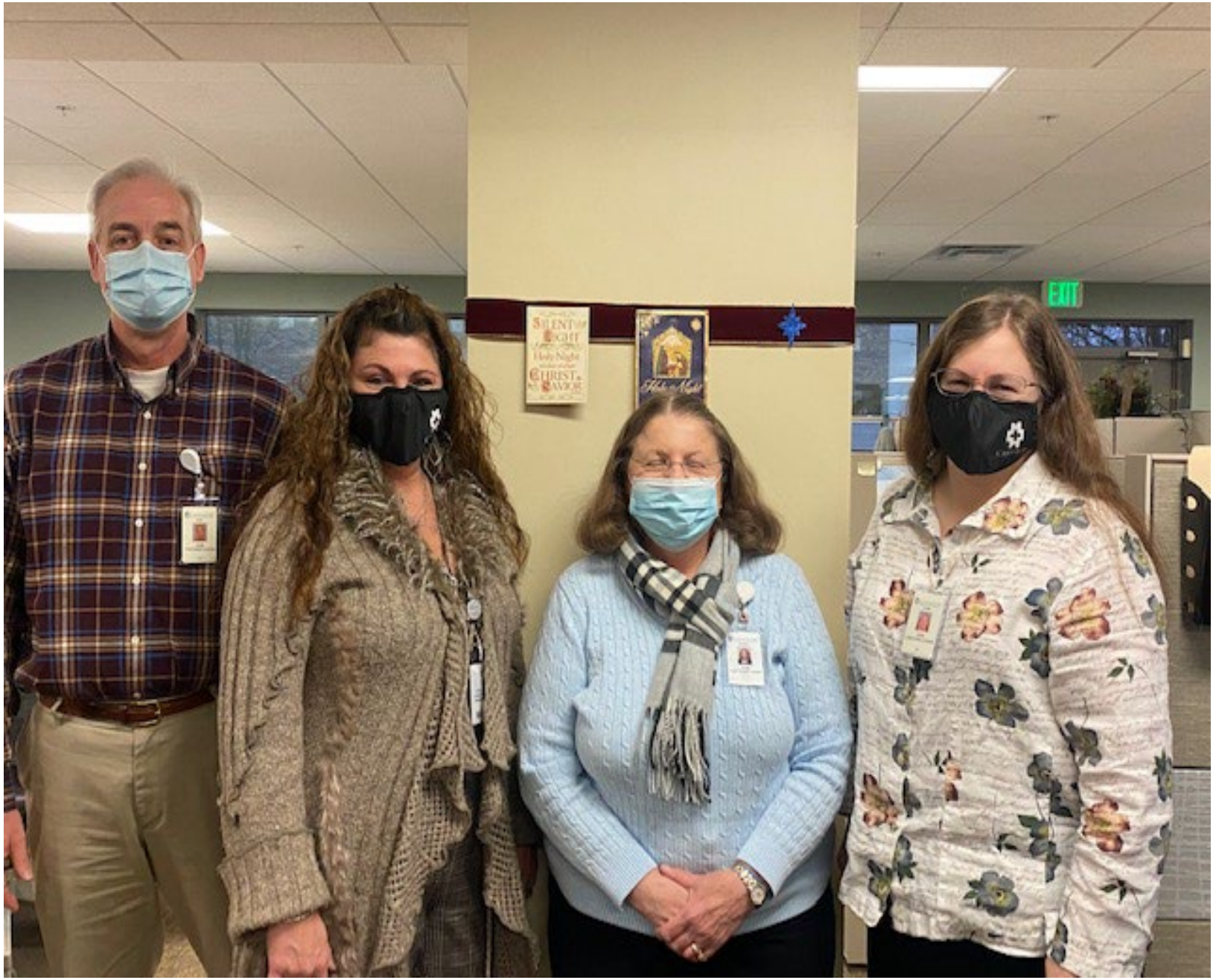
Defining the Roles

- **Inpatient Social Worker**
  - Medical Surgical Unit
  - Family Birthing Center
  - Transitional Care Program
- **Care Transitions Social Worker**
  - Emergency Department
  - High Utilizer Program
  - Provider offices
  - Urgent Clinic
  - Referrals from Chronic Care Management

Documentation standardization
Use of SDoH flowsheet in EHR
Narrative when required
Referrals/Resources in discrete field
Follow up phone calls

Focused execution

Coding Team



“Continuous improvement is better than delayed perfection”

-Mark Twain

Emergency Department

- Monitor emergency department tracking board
- Payor(s) reports for high utilizers
- Referrals from emergency room staff
- Chart review of all patients during working hours
- Face to face assessments and SDoH screening

Medical Surgical Unit

- Bedside rounding with hospitalist
- Initial assessment includes SDoH
- SDoH data pulled into encounter record
- Social worker counseling, resources and referrals
- Follow-up call made post discharge at 48 hours

Transitional Care Program (Swing)

- Social Work completes admission screening for discharge planning and social determinants of health
- Documentation is completed in centralized flowsheet and data is pulled into patient's medical record

Provider Office Referrals

Patients:

- with inappropriate use of the ED visits
- frequently calling provider office for non-medical requests
- anxious about evolving life events

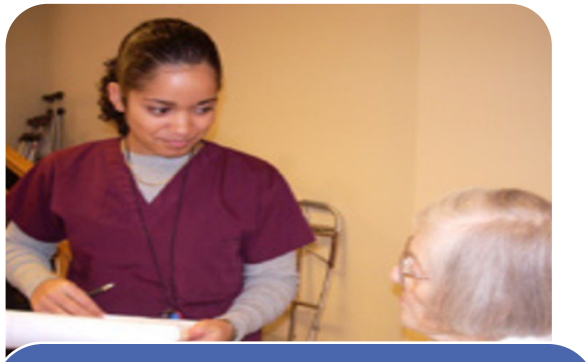
High-Utilizer Non-Urgent ED Patients

Patient identified

- Payer reports
- ED Staff

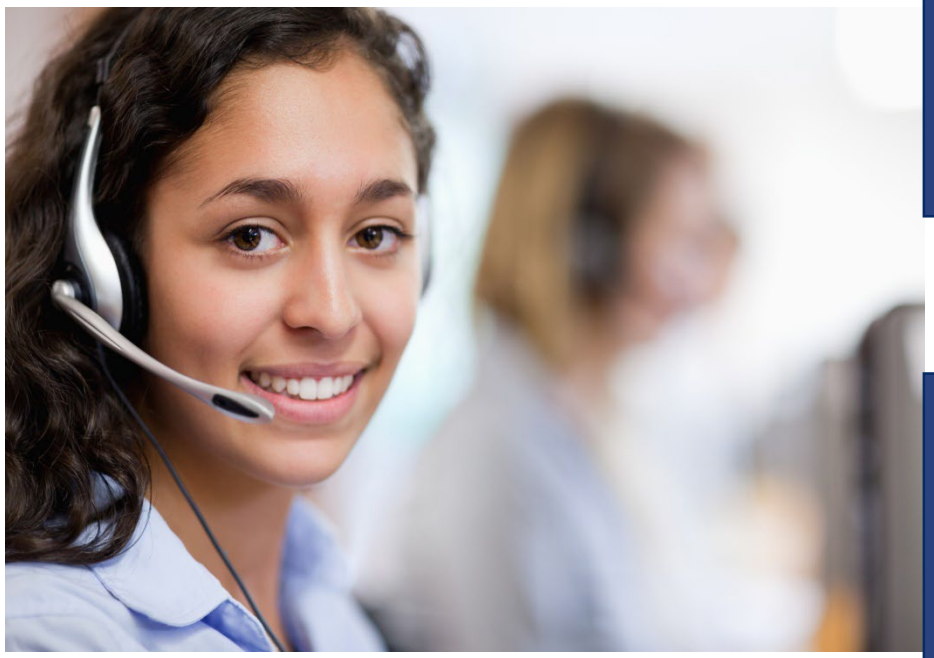
Referral

- Medical record of ED visits, provider office notes, telephone encounters reviewed
- Consult with ED provider



Social Worker

- Face to face with patient
- Phone call if discharged
- Plan of care determined
- FYI note added if needed
- Referrals and resources
- Follow up call at 48 hours



Chronic Care Management

Positive response

- Conversational questions in monthly call
- Encounter documented in EHR
- Z code captured, if present

Patient outreach

- Message in EHR sent to social worker
- Social worker reviews medical record

Patient follow up 48 hours

- Referral and resources provided to patient
- Encounter documented in EHR
- Social Worker follow up call

“Stories create community, enable us to see through the eyes of others, and open us to the claims of others”

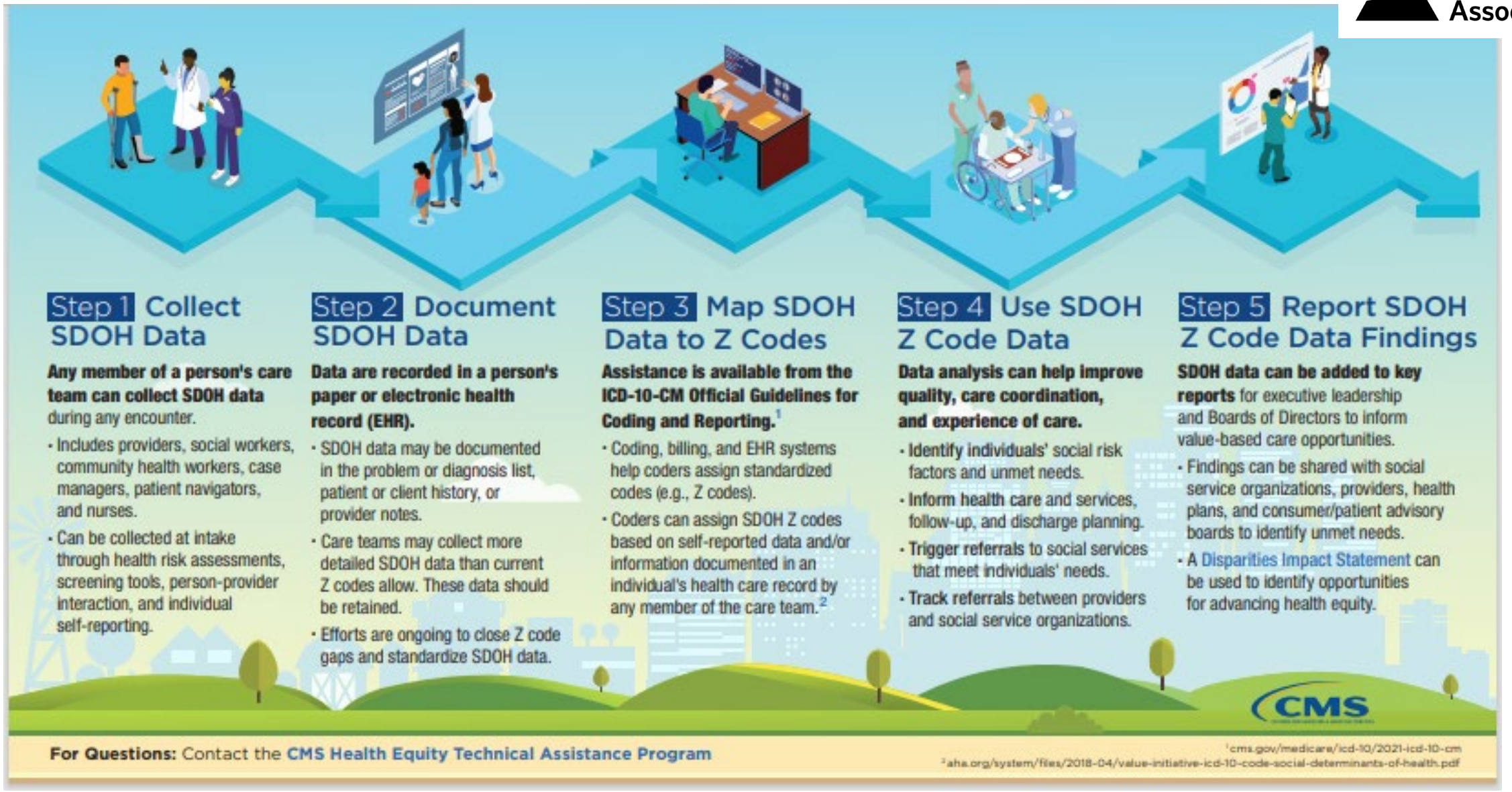
-Peter Forbes

Our Future is Bright…

- Cameron Community Wellness Program
- Community Health Assessment 2022
- Clinical internships with local universities
- Steuben County Foundation partnerships
- Population Health initiatives

Thank you!

kbartrom@cameronmch.com
260-667-5277



[Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes (cms.gov)]

Indiana Hospital Association

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 team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code Categories

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z59** – Problems related to housing and economic circumstances
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- **Z65** – Problems related to other psychosocial circumstances

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

[3] cms.gov/medicare/icd-10/2021-icd-10-cm
[4] cdc.gov/nchs/icd/icd10cm.htm

Revision Date: February 2021

go.cms.gov/omh

[Using Z Codes: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes (cms.gov)]

AHA Advocacy on Equity

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value-initiative-icd-10-code-social-determinants-of-health.pdf (aha.org)

Current Legislation

Social Determinants and Health Disparities Legislation

Aligning for Health has been active in advocating for key legislative solutions to address social determinants, including through the introduction of the Leveraging Integrated Networks in Communities (LINC) to Address Social Needs Act (S. 509/H.R. 6072) and the reintroduction of the Social Determinants Accelerator Act of 2021 (H.R. 2503/S. 3039).

Social Determinants Accelerator Act	LINC to Address Social Needs Act	Letters to Congress	Other Letters of Support

Aligning for Health is proud to support the ***Social Determinants Accelerator Act of 2021***, a bipartisan bill introduced in the House (H.R. 2503) by Reps. Bustos (D-IL), Cole (R-OK), McGovern (D-MA), and Mullin (R-OK) and in the Senate (S. 3039) by Senators Young (R-IN) and Stabenow (D-MI). The ***Social Determinants Accelerator Act of 2021*** will help states and communities devise strategies to better leverage existing programs and authorities to improve the health and well-being of those participating in Medicaid by creating an inter-agency social determinants council and providing planning grants and technical assistance to state, local and Tribal governments to help them devise innovative, evidence-based approaches to coordinate services and improve outcomes and cost-effectiveness.

https://aligningforhealth.org/social-determinants-legislation/

Funding Resources

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)

Our Role

NCCDPHP is uniquely positioned to:

- Focus on primarily upstream, evidence-based interventions that can be expanded in many communities to advance health equity.
- Identify gaps in the evidence base, inform research priorities, and accelerate translation and implementation science to minimize health disparities.
- Work with partners from different sectors, such as education, housing, health care, community development, or transportation, to expand proven interventions that address SDOH.
- Conduct high-quality surveillance and use datasets to identify disparities and equitably target funding, guidance, and technical assistance.

Social Determinants of Health | CDC

Funding Resources

- CDC's Community Health Workers for COVID Response and Resilient Communities (CCR) initiative provides financial support and technical assistance to 69 states, localities, territories, tribes, tribal organizations, urban Indian health organizations, and health service providers to tribes. The CCR initiative consists of two funding opportunities intended to put more trained community health workers in communities that have been hit hardest by COVID-19 and among populations at high risk for COVID-19 exposure, infection, and illness.

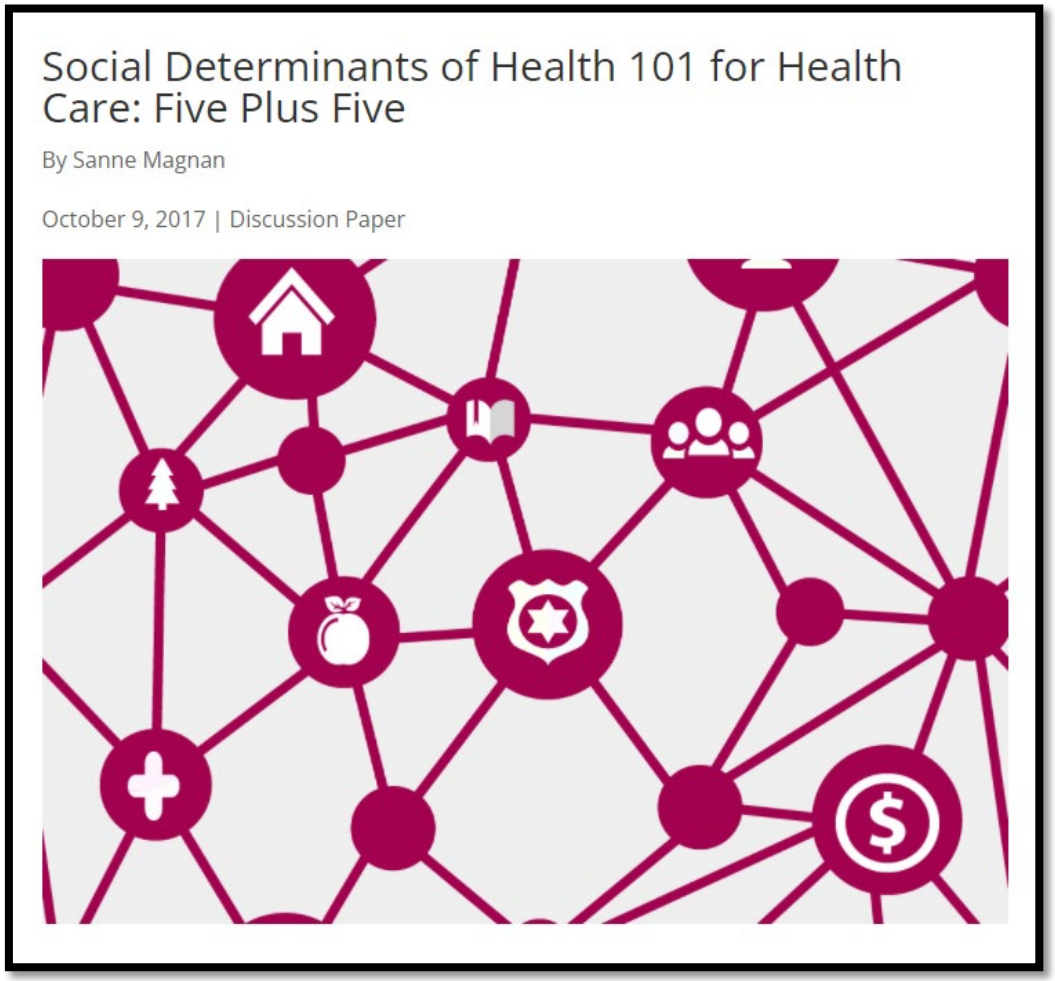
- Closing the Gap with Social Determinants of Health Accelerator Plans is meant to accelerate actions in state, local, tribal, and territorial jurisdictions that lead to improved chronic disease outcomes among people experiencing health disparities and inequities.

- CDC has also awarded funds to the Association of State and Territorial Health Officials (ASTHO) and National Association of City and County Health Officials (NACCHO) to lead a series of community pilots that assess which interventions are most successful in improving chronic disease outcomes by addressing SDOH

Social Determinants of Health | CDC

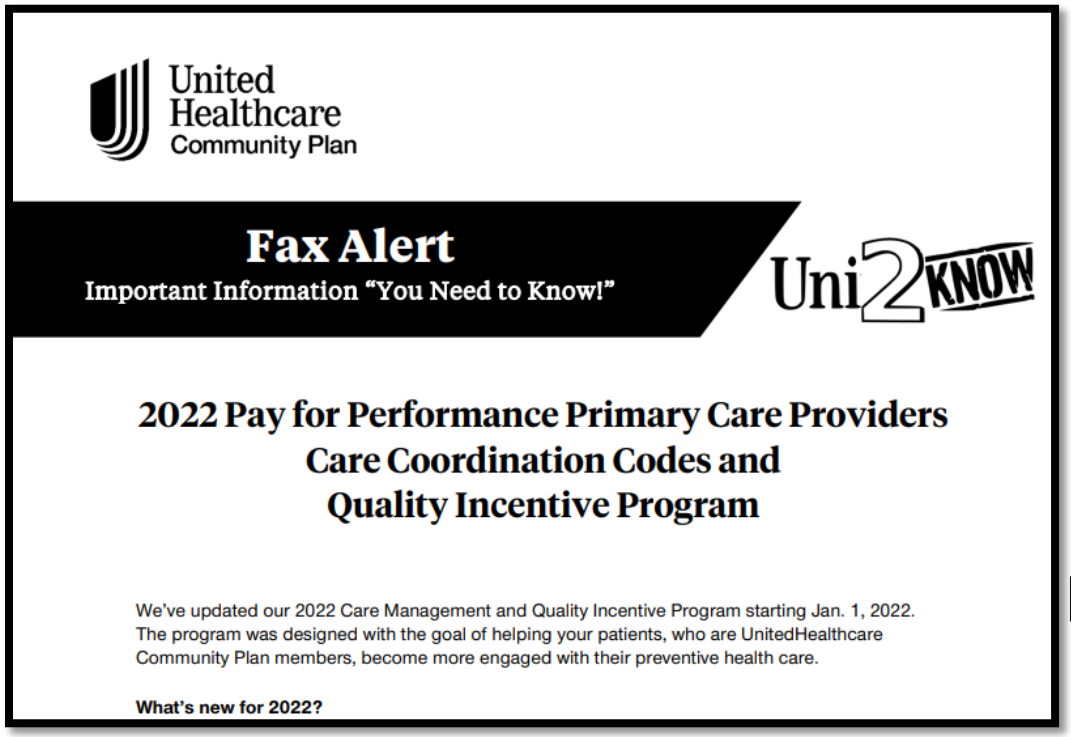
Social Determinants of Health 101

NATIONAL ACADEMY OF MEDICINE



[Social Determinants of Health 101 for Health Care: Five Plus Five - National Academy of Medicine (nam.edu)]

What About Reimbursement?



United Healthcare Community Plan

Fax Alert

Important Information "You Need to Know!"

Uni2KNOW

2022 Pay for Performance Primary Care Providers Care Coordination Codes and Quality Incentive Program

We've updated our 2022 Care Management and Quality Incentive Program starting Jan. 1, 2022. The program was designed with the goal of helping your patients, who are UnitedHealthcare Community Plan members, become more engaged with their preventive health care.

What's new for 2022?

Z Code Submission:

Primary care providers have a new opportunity to earn incentives for the submission of Social Determinant of Health (SDoH) ICD-10 Z codes (Z55-Z65 and Z75) based on the results of SDoH assessments. Providers who submit SDoH-related Z codes for 5% of their seen members will earn a $0.50 pmpm payment while providers who submit these codes for 10% of their seen members will earn a $1.00 pmpm payment. Membership for the pmpm payment will be based on the provider's entire assigned membership for the year. Z code incentives will be paid annually at the time of quality incentive payments.

https://lakelandcare.com/sites/lakelandcare.com/files/attachments/2022%20P4P%20notice%20%282%29.pdf

DIVE BRIEF

Humana program to reimburse providers for identifying social determinants like homelessness, food insecurity

Published March 5, 2020

By Hailey Mensik

Humana isn't the first payer to try this approach.

CMS has also aimed to expand value-based programs that reward health care providers for the quality of care they provide, especially in the MA program.

https://www.healthcaredive.com/news/humana-program-to-reimburse-providers-for-identifying-social-determinants-l/573557/


Indiana
Hospital
Association
Questions?

Karen Bartrom- Director of Clinical Integration and Documentation
Cameron Memorial Community Hospital
kbartrom@cameronmch.com
260-667-5277

Madeline Wilson- Quality & Patient Safety Advisor/Health Equity Lead
Indiana Hospital Association
mwilson@ihaconnect.org
317-974-1407