MISSOURI HOSPITAL ASSOCIATION

Aligning Z Codes with Closed Loop Referral Process Two Part Webinar Series

Stephen Njenga, Director of Quality Measurement and Population Health Improvement

June 26, 2025, 10-11:30 a.m.

Session 2: Payer and Provider Perspectives of Z Codes and Close Loop Referral Network

Overview

This session will highlight the payer and provider perspective of screening for Z codes and how they influence cost and patient outcomes. The integration of these approaches from both the payer and provider perspective can contribute to closing identified gaps and reducing health care disparities. This session will highlight the crucial role of payers and providers with a focus on the impact of policies and programming. Attendees will learn how closed-loop referral platforms can be leveraged to create a seamless and well-coordinated approach in improving health outcomes and reducing costs. These platforms help ensure patients are connected with the right services, fostering better care coordination and support for vulnerable populations.

Pre- Poll Questions

Presenters

Rashmi Srivastava, Chief Medical Officer, Missouri and Iowa Health Plan, United Healthcare Community and State

Alexandra Garrick, Collective Impact Director
National Kidney Foundation

Megan Schultz, Senior Manager, Population Health Partnerships
National Kidney Foundation

Payor Perspective of SDOH and Z Codes

June 26, 2025

Rashmi Srivastava MD
Chief Medical Officer United Healthcare Community and State

United Healthcare

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

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 risks[1]
- The World Health Organization (WHO) estimates that SDOH accounts for **30-55% of health outcomes**[2]

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

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
- SDOH information can be collected through person-provider interaction or self-reported, as long as it is signed-off on and incorporated into the medical record by a clinician or provider
- It is important to screen for SDOH information at each health care encounter to understand circumstances that may have changed in the patient's status

VIEW JOURNEY MAP

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
- 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

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)
  - 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

Closed Loop Referral System

•Identifying Patients with HRSNs: Integrated SDOH screening tools, often linked to EHR systems, can automatically assign relevant Z codes, helping providers identify patients with unmet social needs.

•Facilitating Referrals to CBOs: Once social needs are identified through Z codes, CLR systems can facilitate referrals to appropriate CBOs that can provide necessary support services, such as housing assistance or food programs.

•Tracking and Following Up: CLRs track the status of referrals and ensure follow-up with patients to ensure they access needed services and address any barriers they may encounter.

•Improving Communication and Coordination: CLRs, especially those integrated with EHR systems, facilitate bidirectional communication between healthcare providers and CBOs, creating a seamless and coordinated approach to care

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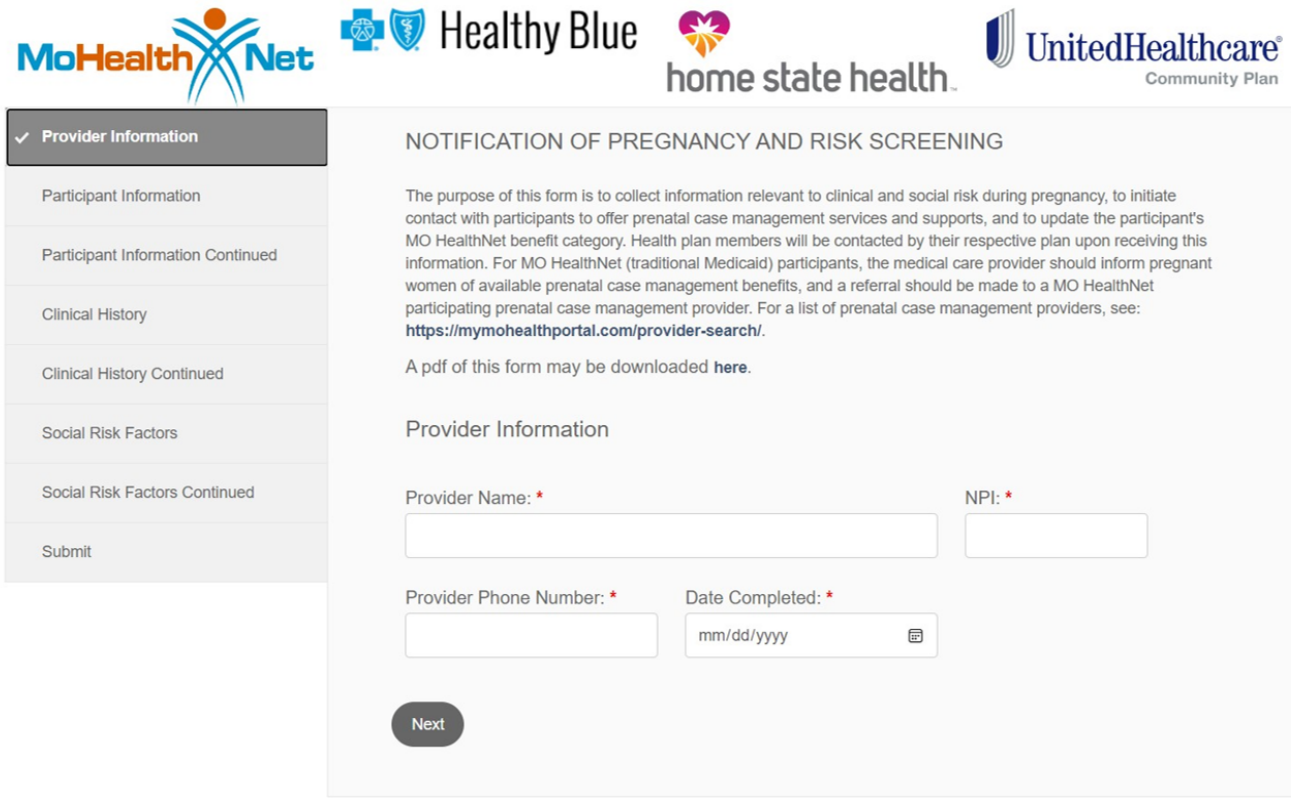
UNITE US

How is Missouri using Z codes to improve health outcomes?

Notice of Pregnancy Form

Notification of Pregnancy Form

Website vs. Paper



- ✓ Provider Information
- Participant Information
- Participant Information Continued
- Clinical History
- Clinical History Continued
- Social Risk Factors
- Social Risk Factors Continued
- Submit

NOTIFICATION OF PREGNANCY AND RISK SCREENING

The purpose of this form is to collect information relevant to clinical and social risk during pregnancy, to initiate contact with participants to offer prenatal case management services and supports, and to update the participant's MO HealthNet benefit category. Health plan members will be contacted by their respective plan upon receiving this information. For MO HealthNet (traditional Medicaid) participants, the medical care provider should inform pregnant women of available prenatal case management benefits, and a referral should be made to a MO HealthNet participating prenatal case management provider. For a list of prenatal case management providers, see: **https://mymohealthportal.com/provider-search/**.

A pdf of this form may be downloaded **here**.

Provider Information

Provider Name: *

NPI: *

Provider Phone Number: *

Date Completed: *

mm/dd/yyyy

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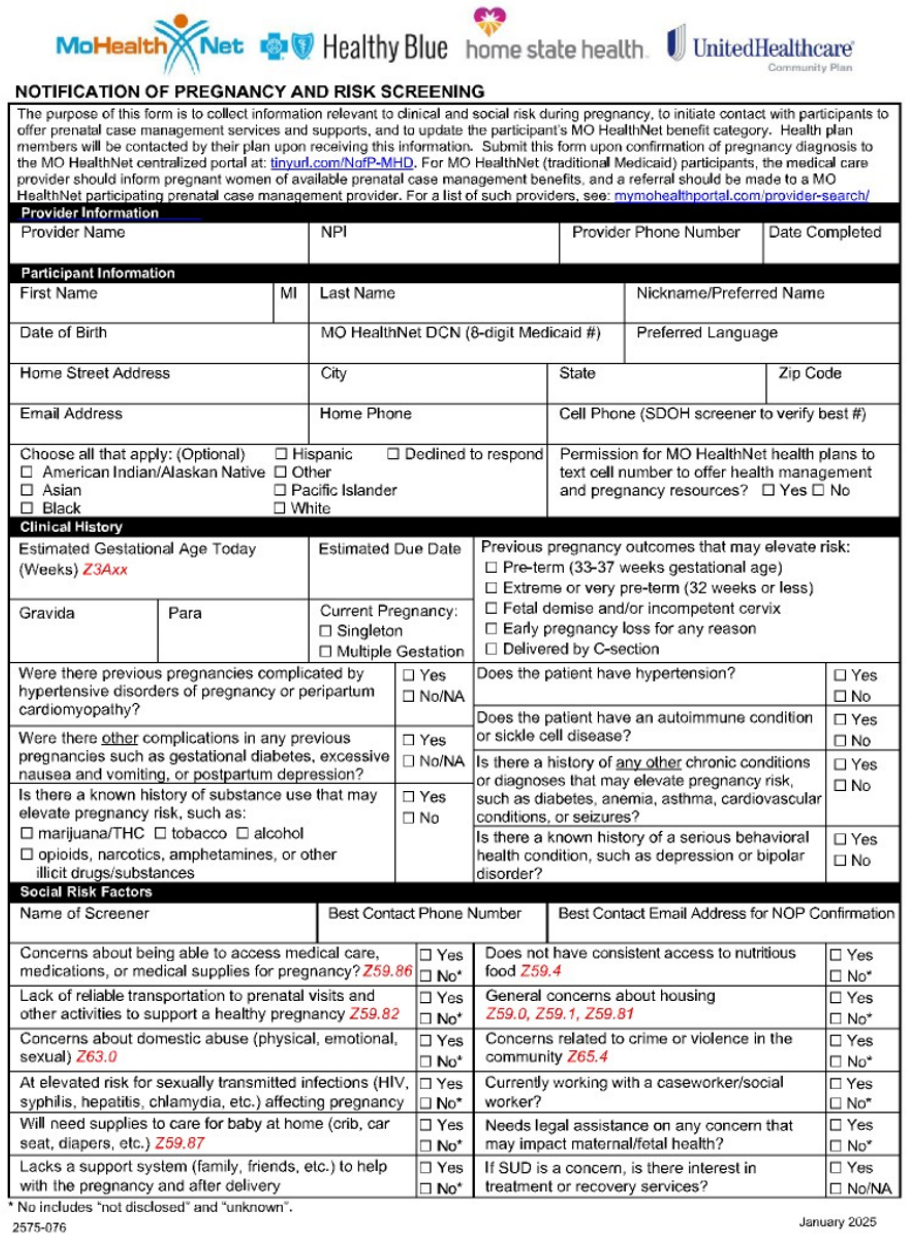

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Provider Information

Provider Name	NPI	Provider Phone Number	Date Completed

Participant Information

First Name	MI	Last Name	Nickname/Preferred Name
Date of Birth		MO HealthNet DCN (8-digit Medicaid #)	Preferred Language
Home Street Address		City	State / Zip Code
Email Address		Home Phone	Cell Phone (SDOH screener to verify best #)

Choose all that apply: (Optional) ☐ Hispanic ☐ Declined to respond ☐ American Indian/Alaskan Native ☐ Other ☐ Asian ☐ Pacific Islander ☐ Black ☐ White

Permission for MO HealthNet health plans to text cell number to offer health management and pregnancy resources? ☐ Yes ☐ No

Clinical History

Estimated Gestational Age Today (Weeks) Z3Axx		Estimated Due Date	Previous pregnancy outcomes that may elevate risk: ☐ Pre-term (33-37 weeks gestational age) ☐ Extreme or very pre-term (32 weeks or less) ☐ Fetal demise and/or incompetent cervix ☐ Early pregnancy loss for any reason ☐ Delivered by C-section
Gravida	Para	Current Pregnancy: ☐ Singleton ☐ Multiple Gestation	

Were there previous pregnancies complicated by hypertensive disorders of pregnancy or peripartum cardiomyopathy?	☐ Yes ☐ No/NA	Does the patient have hypertension?	☐ Yes ☐ No
		Does the patient have an autoimmune condition or sickle cell disease?	☐ Yes ☐ No
Were there other complications in any previous pregnancies such as gestational diabetes, excessive nausea and vomiting, or postpartum depression?	☐ Yes ☐ No/NA	Is there a history of any other chronic conditions or diagnoses that may elevate pregnancy risk, such as diabetes, anemia, asthma, cardiovascular conditions, or seizures?	☐ Yes ☐ No
Is there a known history of substance use that may elevate pregnancy risk, such as: ☐ marijuana/THC ☐ tobacco ☐ alcohol ☐ opioids, narcotics, amphetamines, or other illicit drugs/substances	☐ Yes ☐ No	Is there a known history of a serious behavioral health condition, such as depression or bipolar disorder?	☐ Yes ☐ No

Social Risk Factors

Name of Screener	Best Contact Phone Number	Best Contact Email Address for NOP Confirmation

Concerns about being able to access medical care, medications, or medical supplies for pregnancy? Z59.86	☐ Yes ☐ No*	Does not have consistent access to nutritious food Z59.4	☐ Yes ☐ No*
Lack of reliable transportation to prenatal visits and other activities to support a healthy pregnancy Z59.82	☐ Yes ☐ No*	General concerns about housing Z59.0, Z59.1, Z59.81	☐ Yes ☐ No*
Concerns about domestic abuse (physical, emotional, sexual) Z63.0	☐ Yes ☐ No*	Concerns related to crime or violence in the community Z65.4	☐ Yes ☐ No*
At elevated risk for sexually transmitted infections (HIV, syphilis, hepatitis, chlamydia, etc.) affecting pregnancy	☐ Yes ☐ No*	Currently working with a caseworker/social worker?	☐ Yes ☐ No*
Will need supplies to care for baby at home (crib, car seat, diapers, etc.) Z59.87	☐ Yes ☐ No*	Needs legal assistance on any concern that may impact maternal/fetal health?	☐ Yes ☐ No*
Lacks a support system (family, friends, etc.) to help with the pregnancy and after delivery	☐ Yes ☐ No*	If SUD is a concern, is there interest in treatment or recovery services?	☐ Yes ☐ No/NA

* No includes "not disclosed" and "unknown".

2575-076

January 2025

UHC Community Plan Maternity Case Management

Maternity Case Management Team consists of:

- RN's, LPN's
- CHW's
- Licensed Social Worker

Once a referral is received and reviewed, a Case Manager is assigned to member:

- The appropriate Case Manager is assigned based on acuity level
- Outreach is initiated with member within the appropriate time frames.

All pregnant members receive outreach, from:

- Healthy to Low-Risk and
- Moderate to High-Risk

Member referrals received within the health plan through multiple avenues:

- Member referrals received from OB Providers / NOP (Notice of Pregnancy) forms – **Incentivized eNOP**
- Social workers in the Community / Providers offices
- IP admissions / BH admissions / ER visits / Monthly Claims Reports

Holistic approach utilizing a multidisciplinary team to:

- Assess & Address SDOH needs first
- Assess & Address Medical, Dental & BH Needs

Ashley
32yo 31wk G3P2
Resides in SE MO

Patient identification from NOP
Recently moved to MO from WA due to safety concerns
Limited family support
She and spouse were unemployed
Experiencing food insecurity

Clinical history
Bariatric surgery (BMI39.9)
HX of:
Pre-e
2 previous c/s deliveries
Depression
SUD/AUD
Current smoker

Additional Needs Medical support for pregnancy
BH/PSS assistance
Dental care (none for 2 years)
Transportation – Ashley's OB care was one hour away

Intervention
Located local PCP, BH and Dental providers
Resources for community/financial resources including food banks/food pantries

Ashley's UHC Care Team
Peer Support
Housing Coordinator
Social worker
Dental Advocate
Maternity Care Manager
OB office RN

Results
Established care with needed providers for OB, Medical, BH conditions.
Connected with community and financial resources to address her food insecurities

UHC Clinical Team Approach

Case Manager

Outreach to member & enrolled into HFS Case Management program. Provided member with VAB's, breast pump. Educated member about the WIC Program, how to sign up, and assisted with address to local office. Continued support during pregnancy and after delivery to address depression, CHTN, asthma, provide smoking cessation resources, & transportation. Case Manager continued to work with PSS to provide on going reinforcement.

PSS - Peer Support Specialist

Peer Support Specialist visited member at her home throughout the pregnancy and up to one year after delivery. Recovery and resources provided. As well as continued support to aid in sobriety journey. Member & husband active in AA.

Dental Advocate

Outreach to member to assist with locating dental provider, assisting with scheduling an appointment and educated member on good dental hygiene.

Maternity Social Worker / CHW / Housing Coordinator

Provided member with community resources, local food pantries, Walmart gift card, sent emergency food box as members husband out of work, and assisted with housing needs.

Questions?

Show me

CKD intercept®

Session 2: Payer and Provider Perspective of Z Codes and Closed Loop Referral Network

Advancing Health Equity Across Chronic Kidney Disease

MHA
MISSOURI HOSPITAL ASSOCIATION

40% of people with diabetes and 80% of people with hypertension don't get appropriately tested for CKD

1 in 3 adults is at risk for chronic kidney disease (CKD)

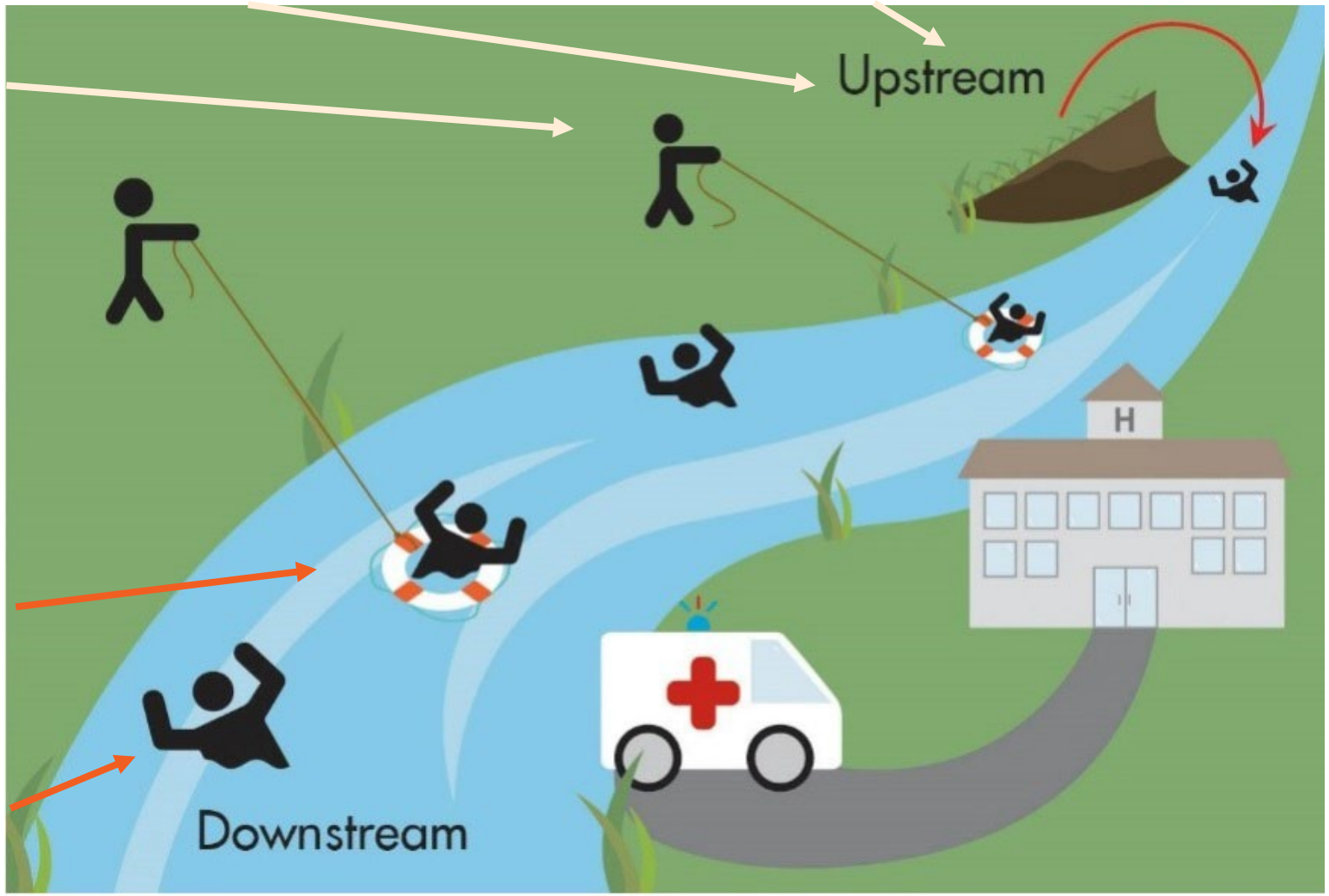
1 in 7 adults has CKD, 90% don't know they have it

Communities of color, lower income communities and rural populations experience higher rates of CKD

Most people with CKD will die of a cardiovascular incident before advancing to end-stage

100,000 patients on the transplant waitlist, 12 people die per day waiting for a transplant.

808,000 people are living with ESKD with over 565,600 people on dialysis right now.



Source: Public Health Sudbury & Districts www.phsd.ca

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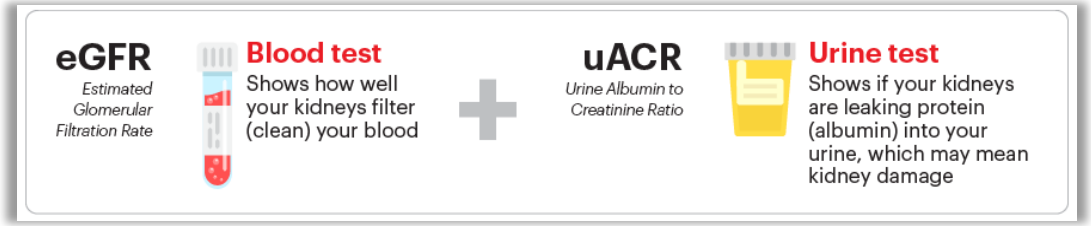
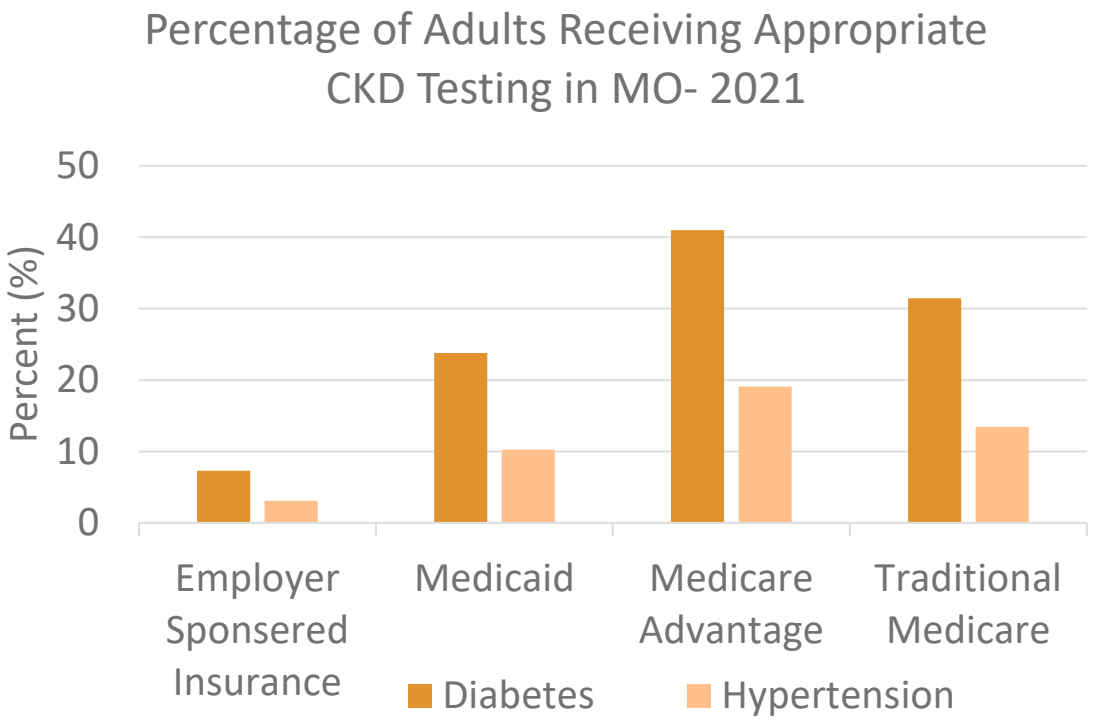
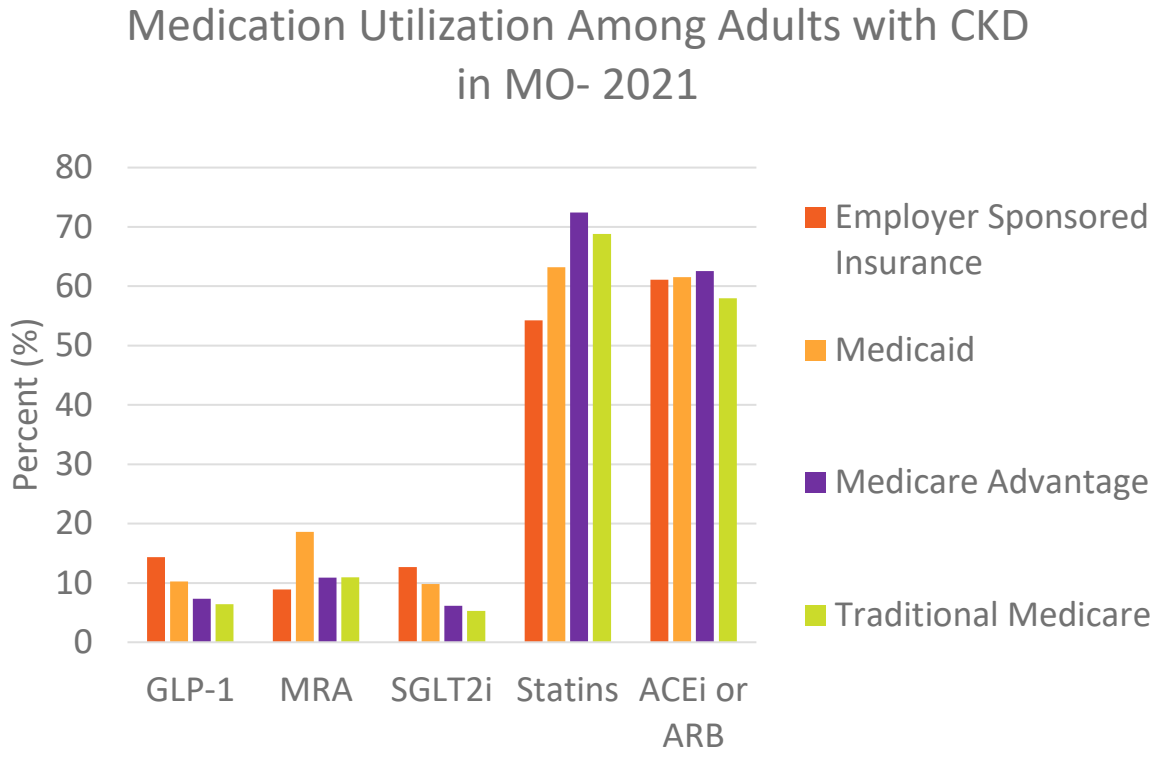
How Health Disparities Impact Lives

- JaMarcus Crews was predisposed to diabetes from birth
- His mother, Mildred, had diabetes and eventually kidney failure, but was not able to manage it. Healthcare was too expensive and few doctors in Alabama would touch her.
- JaMarcus was raised in a segregated neighborhood in one of the poorest states in the country with the highest rates of diabetes.
- JaMarcus was diagnosed with diabetes in 9th grade but aged out of Medicaid at age 18. Health insurance was only sometimes affordable after that.
- When JaMarcus' kidneys failed at age 30, he was uninsured.
- Living donation was out of reach because of the higher rates of disqualifying medical conditions among his family.
- The fragmentation and shifting of responsibility that plagues kidney care precluded JaMarcus from being waitlisted for a transplant when he was eligible.
- He saw his son heading down a similar trajectory to his mother's and his own.
- Due to his reliance on in-center dialysis, JaMarcus was not able to self-isolate during the pandemic
- JaMarcus passed away from COVID-19 in July 2020.

Chronic Kidney Disease Care in Missouri







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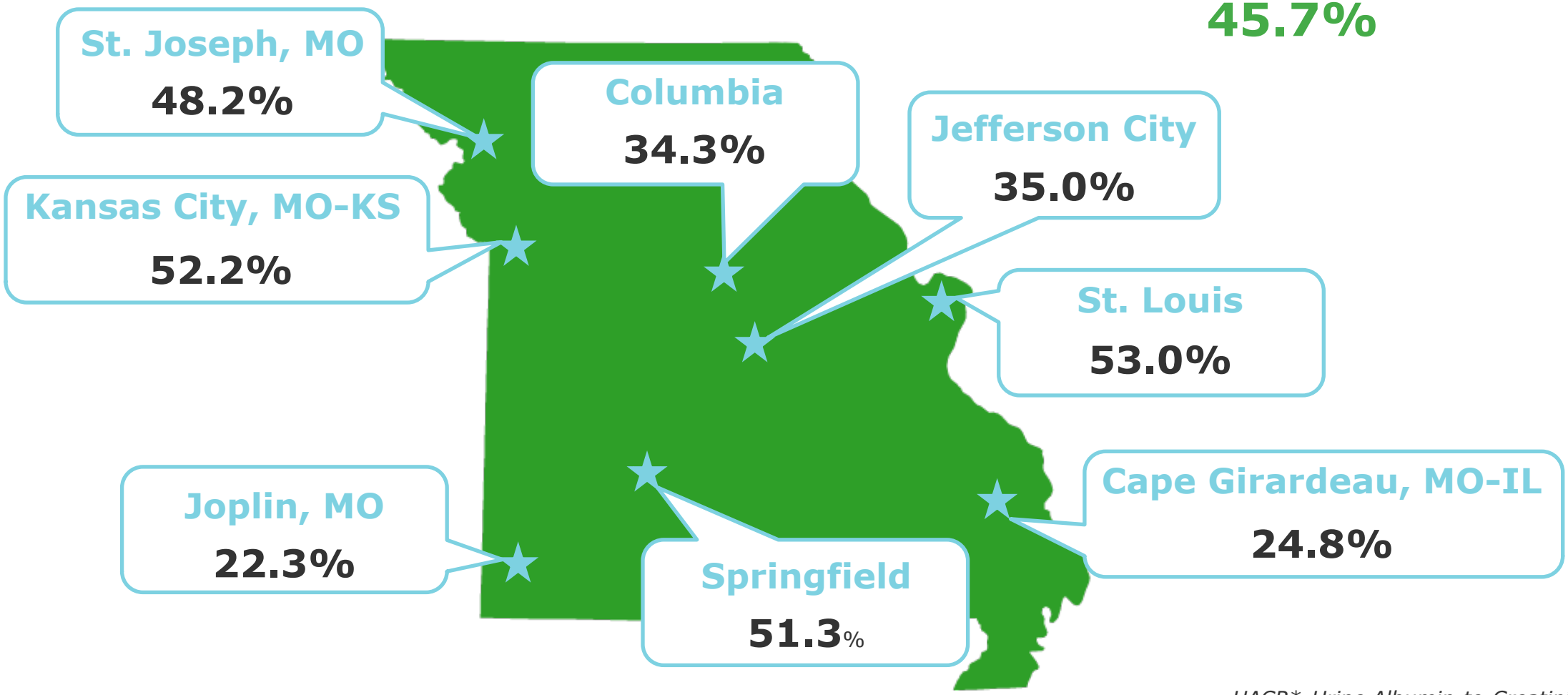
National Kidney Foundation and Health Care Cost Institute. CKD Spotlight. ckdspotlight.healthcostinstitute.org/

% of 18-64 year olds with a diagnosis of diabetes who received both UACR* and eGFR** assessment in 2023 (both UACR* and eGFR** assessment)

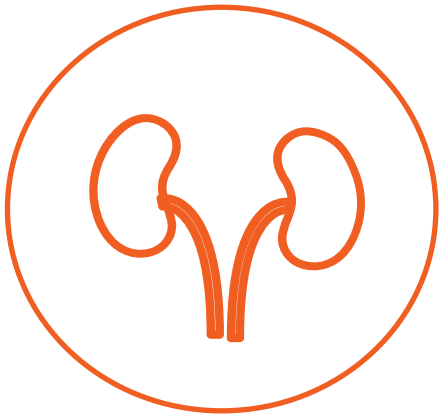
Missouri, Statewide Rate
45.7%



Data Source: Midwest Health Initiative's dataset of commercially insured Missourians

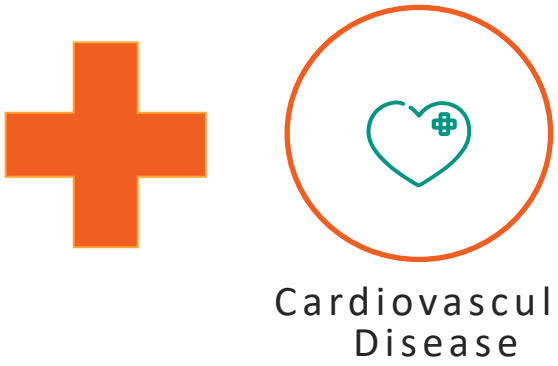
*UACR** Urine Albumin-to-Creatinine Ratio
*eGFR*** Estimated Glomerular Filtration Rate

CKD is a costly, disease multiplier



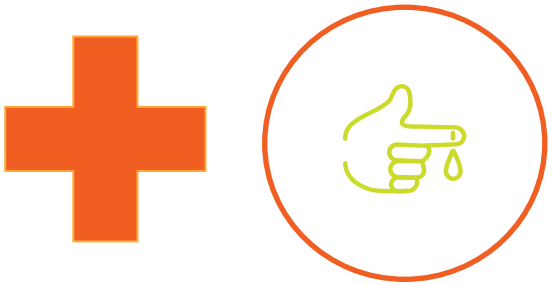
CKD

Annual medical costs 30% higher than non-CKD



Cardiovascular Disease

Annual medical costs: 185% higher



Diabetes

Annual medical costs: 135% higher

Heart Failure

Annual medical costs: 275% higher

CKD + Diabetes + Heart Failure: 370% higher

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Nichols et al. JASN 2020;31:1594-1601

CKD Change Package: Translating your data into actionable insights to bridge care gaps

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Is CKD Care Equitable?

Black Americans make up 14% of the US population but represent 30% of end-stage kidney disease (ESKD) population.
Black Americans are more than 4 times more likely to develop ESKD,
Hispanic and Native Americans are more than 2 times more likely to develop ESKD,
Asian Americans are 1.6 times more likely to develop ESKD
(compared to White Americans)

1. Are there population subgroups where disparities exist in access and care?
2. Are there specific zip codes or clinics with lower testing?
3. Are there groups/zip codes with greater negative impacts from social determinants?
4. Are there innovative interventions that can be employed (i.e., standing orders for CKD testing ordered by pharmacy, home testing, CHW deployment)?
5. Is there alignment between the data you have compiled and the organization's equity vision?

Case Example 1: CKD Learning Collaborative

Program Description

The NKF CKD Learning Collaborative is a quality improvement initiative that leads clinical staff to work together to redesign their systems to become more efficient and embed equity into clinical operations and program evaluation.

Participating practice teams:

- Develop data strategies utilizing medical record data to identify individuals with laboratory evidence of CKD
- Develop and implement clinical decision support to ensure routine testing of people at-risk for CKD
- Establish care coordination models to recruit patients for CKD and risk stratify the severity of CKD
- Provide primary care-focused CKD education

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Outcomes

60%	**Increase in the rate of guideline concordant CKD testing**
25%	Decrease in the number of undiagnosed CKD patients
20+%	Increase in use of guideline recommended therapies for CKD

Realized in 12 months of program inception in a safety-net health system.

universityhealth

Case Example 1: CKD Learning Collaborative

Alignment with Healthcare Equity Initiatives

- UH Health Equity Committee partnered with NKF to address SDoH barriers for patients with or at risk for CKD
  - Analyzed CKD Learning Collaborative data to identify disparities
  - Integrated NKF patient educational handouts into the EHR to be included in after-visit summaries (multiple languages)
  - Referred patients facing food insecurity to the onsite Food Pantry
    - Provided dietary recommendations for CKD prevention and management
  - Collaborating with NKF on a pilot for facilitated CKD patient education model

Outcomes

- Enhances TJC accreditation status
- Reduces healthcare disparities
- Process to create internal alignment and best practices
- Differentiates your organization

The Joint Commission

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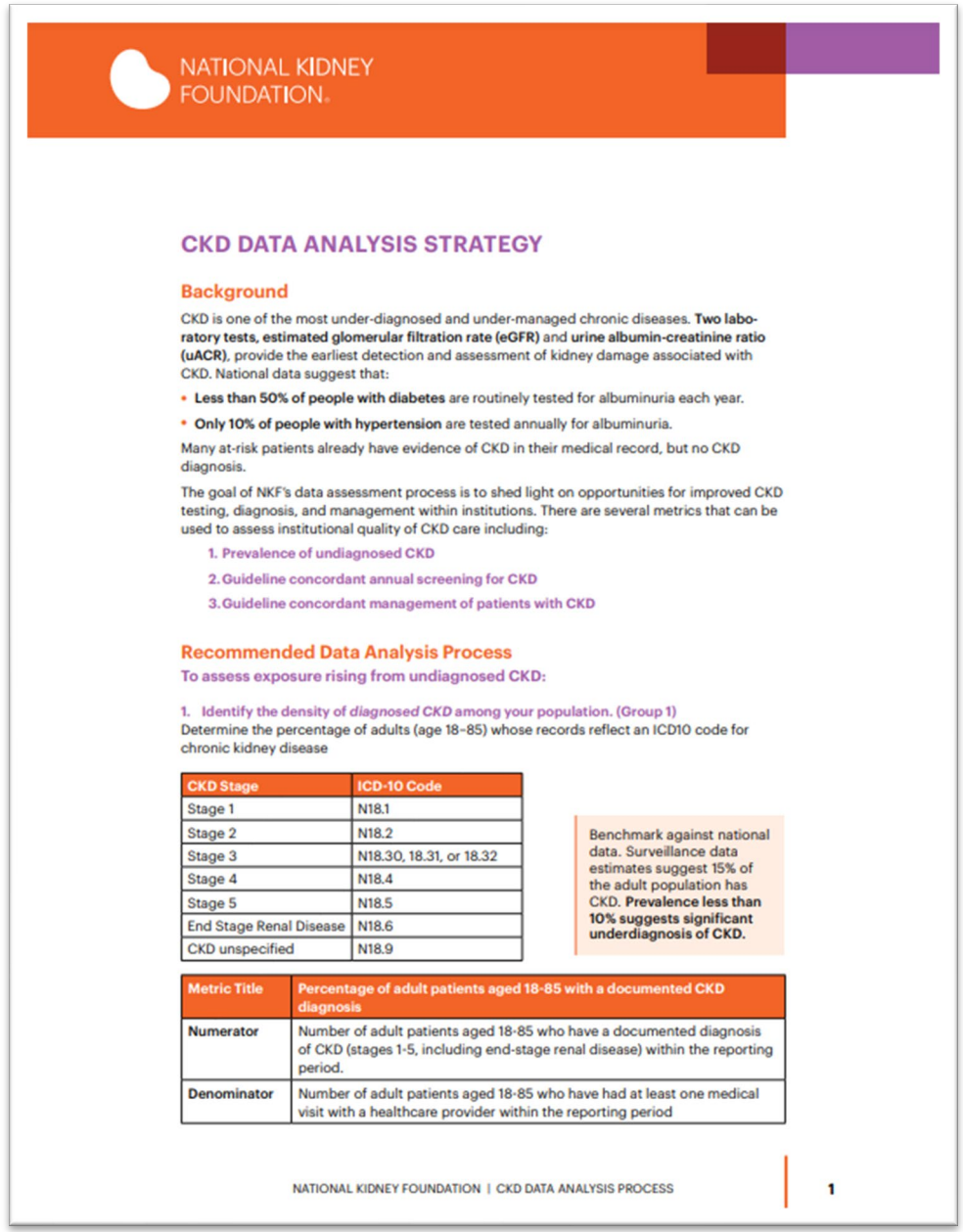
Step 1: Assess the Quality of CKD Care

Goal: Shed light on opportunities for improved CKD testing, diagnosis, and management

Metrics include:

1. Density of diagnosed CKD
2. Burden of CKD risk due to diabetes and/or hypertension prevalence
3. Guideline concordant screening for CKD
4. Guideline concordant management of CKD



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CKD DATA ANALYSIS STRATEGY

Background

CKD is one of the most under-diagnosed and under-managed chronic diseases. **Two laboratory tests, estimated glomerular filtration rate (eGFR)** and **urine albumin-creatinine ratio (uACR)**, provide the earliest detection and assessment of kidney damage associated with CKD. National data suggest that:

- **Less than 50% of people with diabetes** are routinely tested for albuminuria each year.
- **Only 10% of people with hypertension** are tested annually for albuminuria.

Many at-risk patients already have evidence of CKD in their medical record, but no CKD diagnosis.

The goal of NKF's data assessment process is to shed light on opportunities for improved CKD testing, diagnosis, and management within institutions. There are several metrics that can be used to assess institutional quality of CKD care including:

1. Prevalence of undiagnosed CKD
2. Guideline concordant annual screening for CKD
3. Guideline concordant management of patients with CKD

Recommended Data Analysis Process

To assess exposure rising from undiagnosed CKD:

1. Identify the density of *diagnosed CKD* among your population. (Group 1)

Determine the percentage of adults (age 18-85) whose records reflect an ICD10 code for chronic kidney disease

CKD Stage	ICD-10 Code
Stage 1	N18.1
Stage 2	N18.2
Stage 3	N18.30, 18.31, or 18.32
Stage 4	N18.4
Stage 5	N18.5
End Stage Renal Disease	N18.6
CKD unspecified	N18.9

Benchmark against national data. Surveillance data estimates suggest 15% of the adult population has CKD. **Prevalence less than 10% suggests significant underdiagnosis of CKD.**

Metric Title	Percentage of adult patients aged 18-85 with a documented CKD diagnosis
Numerator	Number of adult patients aged 18-85 who have a documented diagnosis of CKD (stages 1-5, including end-stage renal disease) within the reporting period.
Denominator	Number of adult patients aged 18-85 who have had at least one medical visit with a healthcare provider within the reporting period

NATIONAL KIDNEY FOUNDATION | CKD DATA ANALYSIS PROCESS 1

NATIONAL KIDNEY FOUNDATION

Step 2: Stratify your CKD and high-risk populations by demographics to identify health disparities

- Race
- Ethnicity
- Gender
- Age
- Primary Language Spoken
- Primary Insurance Type
- Zip Code
- **Z-Codes (SDoH barriers):**
  - Z55 – Problems related to education and literacy
  - Z56 – Problems related to employment and unemployment
  - Z57 – Occupational exposure to risk factors
  - Z58 – Problems related to physical environment
  - 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

Utilizing External Data Sources to Map Geographies Impacted by Health Disparities

Tools:

•Center for Health Disparities Research-University of Wisconsin SMPH: Area Deprivation Index mapping tool showing neighborhood-level socioeconomic conditions

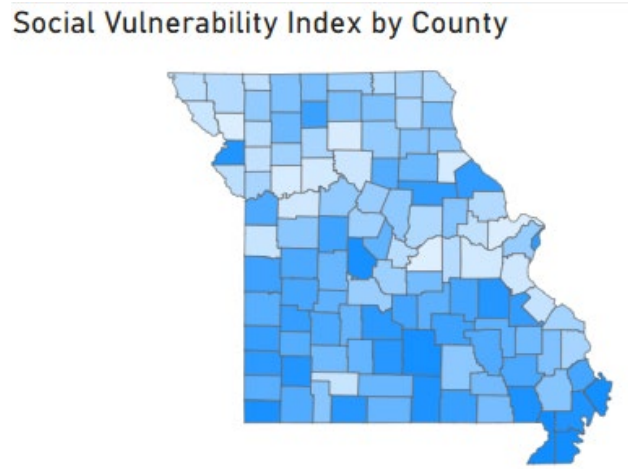
•US Census Bureau American Community Survey Data: Open-access, annually updated data on social, economic, housing, and demographic profiles by geography

•AHRQ Social Determinants of Health Database: County, ZIP Code, and tract level data on SDoH

•CMS Data Mapping Medicare Disparities by Hospital: Interactive tool showing Medicare disparities by SDoH, hospital, and patient populations

•Missouri Hospital Association's Health Equity Dashboards: County and census-level mapping of social vulnerability by health domains

•CDC Local Area Deprivation Tool: Framework for integrating SDoH into clinical and preventive care using area deprivation data.



Step 3: Build the Case to Improve CKD Care

- Support your rationale for deploying care improvement with evidence-based resources and tools that address kidney care inequities
  - Consider all possible leverage points for leadership buy-in (including ROI)

Resources:

- Am J Health Syst Pharm (2024) Moving forward from Cockcroft and Gault creatinine clearance to race-free eGFR rate to improve medication-related decision making in adults across healthcare settings
- Prepared for *CMS* by *NCQA* CKD Disparities: Educational Guide for Primary Care: Approaches to reducing disparities in CKD identification, treatment and monitoring, and patient-centered care
- Clin J Am Soc Nephrol (2019) Trends in Quality of Care for Patients with CKD in the US: Study revealing high prevalence of uncontrolled hypertension and diabetes and low use of statins
- Semin Nephrol (2019) Social Determinants of CKD Hotspots: Examines CKD hotspots in connection with SDoH
- Semin Nephrol (2021) Social Justice as a Tool to Eliminate Inequities in Kidney Disease: Highlights social justice approaches to addressing kidney disease disparities and SDoH
- HHS Health Equity in Healthy People 2030: Overview of the program's focus including overarching goals, health literacy, SDoH, and tools for action

Step 4: Convene a multi-disciplinary team to coordinate the intervention model

Laboratory Leaders

Have access to CKD data in LIS. Interest in ↑ Pop Health role. Can advocate for SBAR around Kidney Profile usage.

Social Determinants of Health

Insight regarding internal/external resources and strategies available

Pop Health/Quality Teams

Invaluable insight into current workstreams, implementation models, programs/outcomes design
Internal facilitators

Primary Care Leaders/Teams

Vested interest in leading program. Must be at the table for leadership buy-in. Offer practical implementation ideas.

Payers/Contracting

Value-based models? Medicaid? Alignment on reimbursement for new interventions?

Risk Adjustment

Can provide insight into ROI calculations.
Interest in ↑ HCC coding

Health Equity

Consider role in Joint Commission, CMS, AHA and other accreditations.

Nephrology Leaders

Vested interest participation. Credibility regarding program impact. Co-management improvements. Alignment with other initiatives (value-based models, improved transplant access, etc.)

Informatics Team

Data extraction, clinical decision support, and other electronic tools

Step 4: Convene a multi-disciplinary team

- Review population health data to identify care improvement opportunities
  - Characterize the impact of SDoH within interested geographies or target populations
- Build consensus on evidence-based, guideline-driven interventions that prioritize addressing SDoH and CKD care disparities

Tools:

• CMS (2023) USING Z CODES: The Social Determinants of Health (SDOH) Data Journey to Better Outcomes: Downloadable guide to using SDoH codes

• CMS (2021) CKD Disparities: Educational Guide for Primary Care: Approaches to CKD identification, management, and patient-centered care

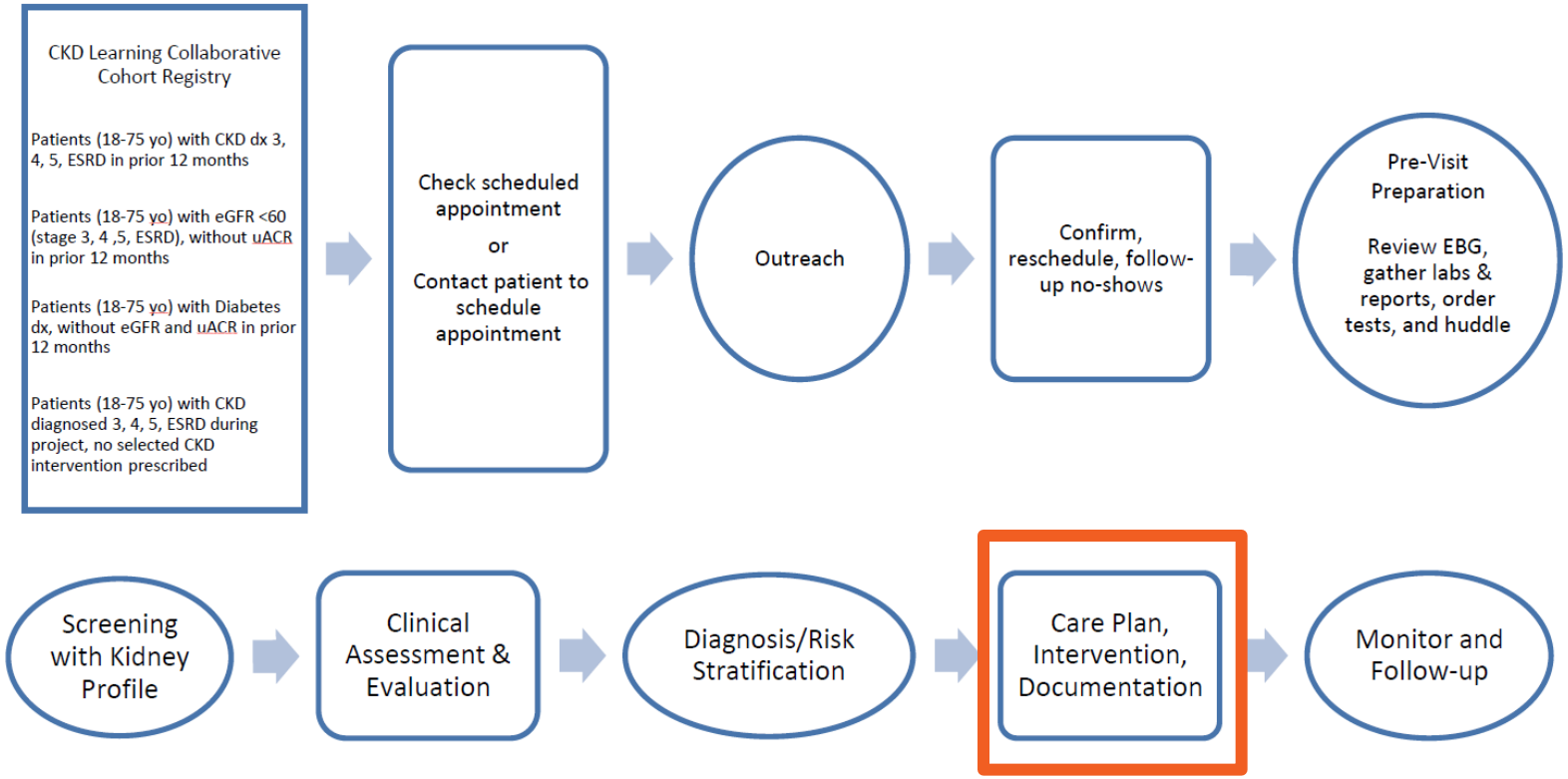
• AAFP The EveryONE Project Toolkit: Strategies to advance health equity within the clinician practice and community

Step 5: Develop the Implementation Plan

- Identify and implement strategies to build equity into the clinical infrastructure and enhance access to quality care
  - Include SDoH assessment/screening tools in the CKD intervention
  - Consider resources and community-level approaches to address needs, including:
    - UNITE US: Supports cross-sector collaborative solutions among clinicians, payers, government, non-profits and others to improve health and well-being
    - The 211 Network: Confidentially connects those in need to expert, caring assistance
  - Consider a facilitated quality improvement program – *NKF's CKD Learning Collaborative* – or engagement of frontline healthcare workers to engage and support patients disproportionately burdened by CKD

Step 4: Evaluate and Measure the Impact

- Embed equity into the program evaluation metrics
  - Ensure the care team receives ongoing feedback about the agreed upon CKD interventions/quality metrics
- Engage practice staff in the refinement and application of the implementation strategy in their own workflows



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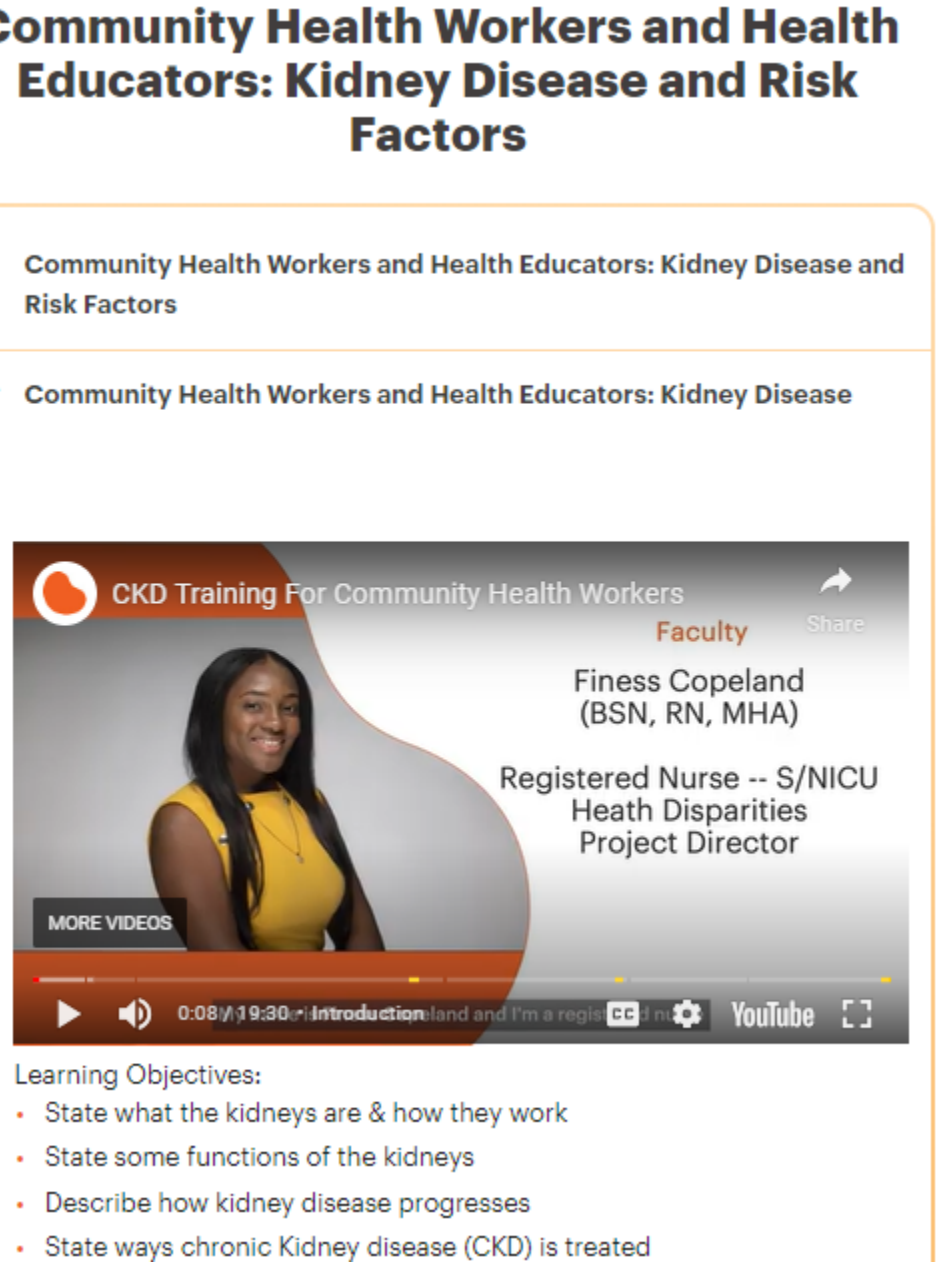
Case Example 2: Frontline Healthcare Worker Education and Engagement

- Free tools for CHWs, Community Paramedics, Care Managers, and other frontline staff to facilitate CKD awareness and connection to care
  - Toolkit available at kidney.org/NKF-Community-Health-Workers
- Components:
  - Module video series
  - Training slides and scripts
  - Patient educational resources, including multilingual, low-literacy tools



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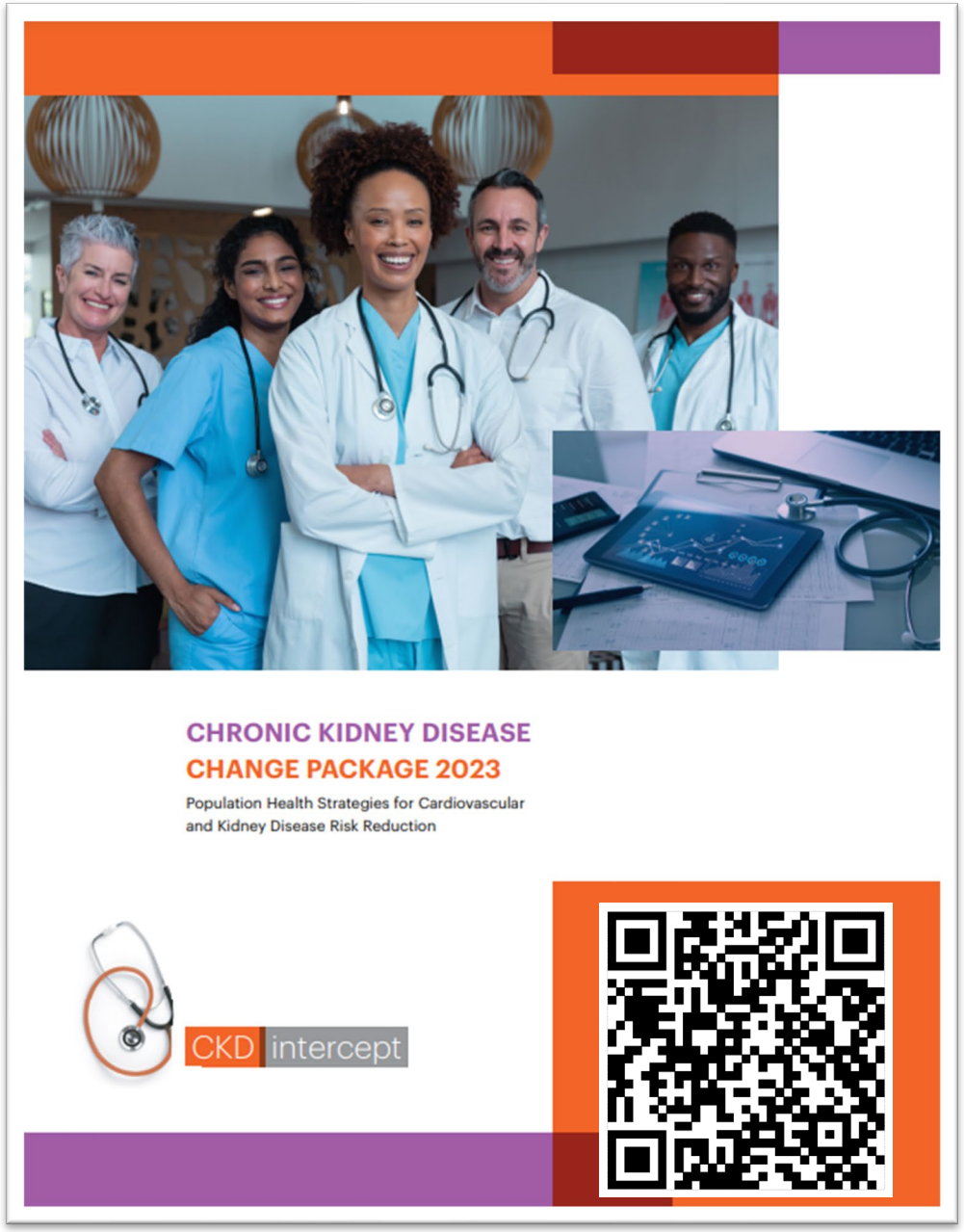
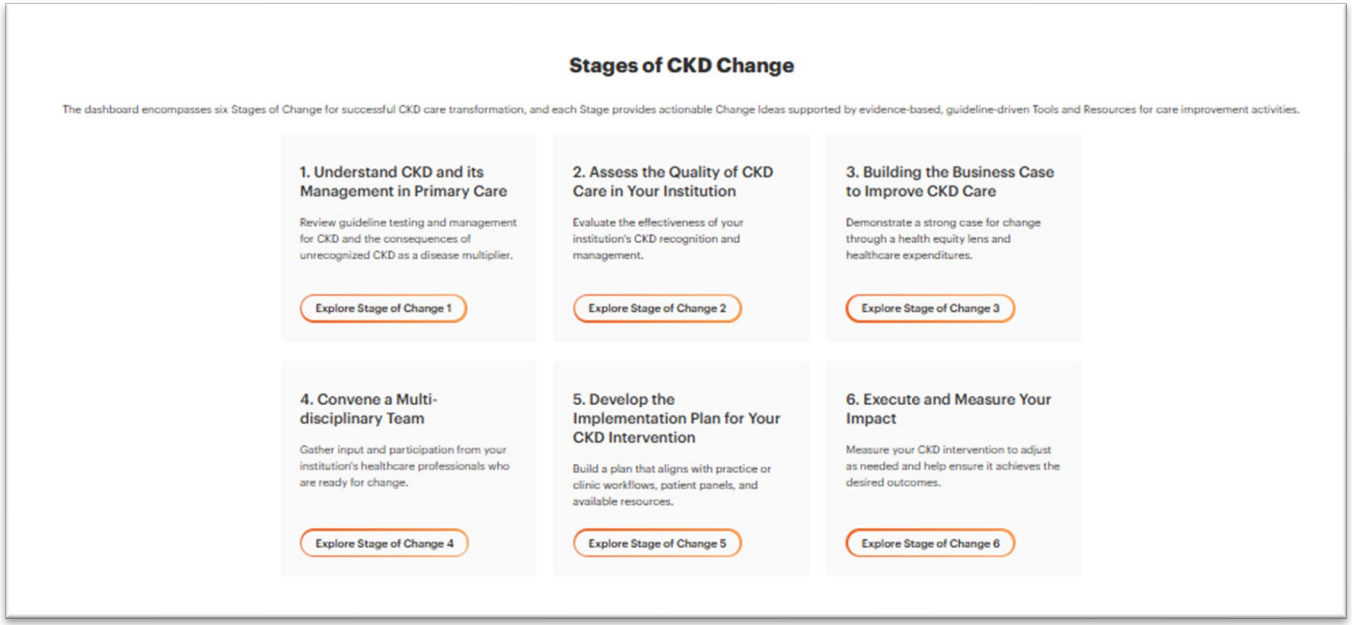


NKF CKD Change Package

Population Health Strategies for Cardiovascular and Kidney Disease Risk Reduction

- Recommended quality improvement program structure
- Step-by-step discussion of process steps involved in improving CKD care
- Tools/resources/best practices



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https://www.kidney.org/professionals/ckdintercept/ckd-change-package

Interested in learning more about these SDoH tools or receiving additional implementation support from NKF?

Please fill out this brief from to share your interest with NKF! We are here to help YOU!

kidneyforms.tfaforms.net/4728083

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Q&A Discussion

For more information, please email:
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Post – Poll Questions

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Community and Hospital Social Worker Resource

Missouri Resource Guide

Department of Social Services

Office of Workforce Community Initiatives Team (OWC)

For more information, please email dss.owciconnect@dss.mo.gov