# CMHN Blue KC Social Determinants of Health (SDoH) Screening FAQ

The following FAQ was developed to address Blue KC's 2022 quality performance measure on 'Social Determinants of Health Screening' as part of the 2022 Blue KC / CMHN Medical Home Agreement. See the Slide Deck Overview of CMHN's Blue KC Medical Home Value Based Agreement Agreement for additional information.

## Key Information to Inform SDoH Screening in Your Practice

**What:** Perform a SDoH screening at least once during the calendar year 2022 for all patients receiving primary care services. The SDoH screening must address at least ***transportation, food insecurity, housing issues or concerns, and social environment***.

**How:** Screening should be implemented utilizing evidence-based screening questions derived from clinically validated screening tool(s). See examples of clinically validated survey tools in Question 13. Your practice can also leverage the comprehensive screening tool developed by CMHN in Appendix B.

In 2022, Blue KC is requiring CMHN to have a 2% or greater positivity rate to earn 50% of the incentive dollars. Be sure to code positive screens correctly in order to achieve compliance.

**G9920**: Screening Performed and Negative
**G9919**: Screening Performed and Positive and Provision of Recommendations

If a positive screening is identified and coded, **the appropriate ICD-10 diagnostic codes must be included on the date of the positive screen.** Interventions must be offered to the patient in follow up to any positive screen. An attestation is required to meet the measure.

Screening results and follow up action must be documented in the medical record. Blue KC may conduct chart reviews for evidence of screening and any necessary intervention. Substantial errors of fact may result in loss of Blue KC incentive payments or termination from the program.

(See Question 3 for ICD-10 codes expected to be used most frequently for positive screens).

**How to Address Positive Screenings**: If your patient screens positive, interventions must be offered and documented in the EMR. You can help provide interventions by:

- Refer the patient/family to a resource using Lift Up KC through InNote – a quick and easy way to connect patients to community-based organizations (CBOs) with just a few clicks.
  - Recommend or refer to "full-service" centers that can address many needs, such as food insecurity, housing insecurity, financial assistance, etc.
  - Recommend or refer to "no wrong door centers" that can help connect a patient to another organization if they are unable to help.
- Utilize a "super-user" in your practice, trained on Lift Up KC and local resources, to help connect the patient and family with a CBO.
- If the patient/family refuse your practice's help in facilitating a referral to a CBO on their behalf, you can provide the patient/family with liftupkc.org postcards to help access resources on their own. This option is only appropriate if the patient does not want your practice's help being connected.

See Appendix C for workflow diagram and recommended talking points.

**Who:** The SDoH screening can be completed by any member of the care team. In fact, parents or patients can complete the screening on paper or electronically while waiting for the visit. Practices also have the option of completing the social needs screening in advance of a patient's visit (see Question 7).

**Why:** Multiple studies have found that healthcare only impacts approximately 20% of a patient's health outcomes. As we transition toward value based models in which incentives are aligned to keep patients healthy and well, it becomes increasingly important and economically beneficial for practices to invest in the infrastructure to help address non-healthcare factors. For calendar year 2022, Blue KC has an additional incentive of approximately $1.2 million ($1.50 PMPM) to complete an SDoH screening on more than 70% of all CMHN patients receiving primary care services and acheive a 2% or greater positivity rate (demonstrated by eligible ICD-10-CM Z Codes).

## Question 1: How is the 'Social Determinants of Health Screening' measure defined? Specifically, how is Blue KC defining the eligible patients?

See **Appendix A** for the definition provided by Blue KC. The eligible population includes all attributed members (all ages) with at least one (1) primary care office visit claim (CPT codes 99381-99397 or E&M codes 99201-99215) within the 2022 calendar year.

The measure denominator does not include a 'continuous enrollment' requirement similar to HEDIS quality measures (i.e. no more than 1 gap in enrollment up to 45 days for the measurement year). However, patients will only be included in the SDoH Screening measure if:

- The patient has active Blue KC eligibility and attributed to CMHN both at the start of January 2022 and at the end of September 2022 (Blue KC freezes the measure denominator at this time for 2022 performance) AND
- The patient had a PCP visit (based on CPT codes 99381-99397 or E&M codes 99201-99215) during the calendar year.

Please note that both well visits and sick visits are included.

## Question 2: For the SDoH Screening measure, is measure compliance based exclusively on claims for non-payable CPT codes G9920 and G9919 as noted in the Blue KC SDoH Coding Letter (Appendix A)?

Yes, screening compliance is based exclusively on claims containing one of these two codes. Supplemental data cannot be submitted for this measure. For quick reference, below are the two CPT codes used for screening.

**G9920**: Screening Performed and Negative
**G9919**: Screening Performed and Positive and Provision of Recommendations.

If a positive screening is identified and coded, ***the appropriate ICD-10 diagnostic codes must be documented on the claim*** indicating the applicable SDoH reason (**See Appendix A, page 9**).The screening HCPCS codes can be pointed or tied to any diagnosis code on the claim. CMHN recommends pointing the G9920 HCPCS code (negative SDoH screening) to the well visit or sick visit diagnosis and the G9919 (positive SDoH screening) to the applicable positive SDOH ICD-10 diagnosis code (see question #3). No modifier is needed for these codes since they don't carry any payment.

**Tip/Insight:** Blue KC has confirmed that the **ICD-10 Z code is required for compliance for positive screenings**.

## Question 3: Is the list of ICD-10 diagnostic codes included in the Blue KC letter (Appendix A) an all-inclusive list of currently available codes that practices may use to identify the reason for a positive screen?

Yes, the ICD-10 diagnostic codes provided are an all-inclusive list of currently available codes. If Blue KC or CMHN becomes aware of additional codes, a communication will be sent to inform all CMHN practices.

ICD-10 codes that are expected to be used most frequently with a positive SDoH screening (CPT code G9919) based on the minimum screening requirements include:

- Transportation
  - Z91.89 – Other specified personal risk factors, not elsewhere classified (transportation difficulty)
- Food Insecurity
  - Z59.4 – Lack of adequate food and safe drinking water
- Housing
  - Z59.1 – Inadequate housing
  - Z59.8 – Other problems related to housing and economic circumstances
  - Z59.9 – Problem related to housing and economic circumstances, unspecified
- Social Environment
  - Z60.4 – Social exclusion and rejection
  - Z60.9 – Problem related to social environment, unspecified

**Tip/Insight:** See **Appendix A, page 9**, for a complete list of ICD-10 diagnostic codes applicable for positive SDoH screenings.

## Question 4: Do SDoH diagnosis codes (z-codes) impact the calculation of a patient's risk score (i.e. based on the Milliman MARA risk model)?

Blue KC has verified that the following diagnostic codes do impact the calculation of a patient's risk score:

- Z591 – Inadequate Housing
- Z594 – Lack of adequate food
- Z91.89 – Other specified personal risk factors, not elsewhere classified (Transportation)
- Z60.0 to Z60.9 – Social Environment

## UPDATED Question 5: What are the minimal requirements to complete an SDoH screening?

CMHN practices have flexibility in how they administer an SDoH screening. According to Blue KC, screening must at least address ***transportation, food insecurity, housing issues or concerns, and social environment***.

**Practice screening tool must use standardized clinically validated questions.**

- Practices cannot create their own screening questions in 2022. Questions must not be "adapted" from a validated tool, but must be worded exactly as is in the validated screener.
- Practices have flexibility in selecting a clinically validated screening tool and may even select questions from various validated screening tools.
- See Question 13 and Appendix B for clinically validated screening tool options your practice can leverage.

**The name of the screening tool and the results of the screening tool must be documented in Electronic Health Record.**

- Blue KC may conduct chart reviews for evidence of screening.

**Practice must offer to facilitate follow up services for any patient that screens positive and record intervention in the patent's chart.**

- See Appendix C for CMHN recommended workflow options for follow up.

Ensure you are coding appropriately to receive credit for the screening.

**Tip/Insight:** The social needs screening does not need to be completed by the provider. Parents or patients can complete the screening on paper or electronically while waiting for the visit. In fact, it has been found that screening responses are more accurate when not asked verbally.

Source: Gottlieb et al. https://pdfs.semanticscholar.org/e11e/b3107fc9dba419d05b112497d751745f77e3.pdf

## Question 6: How should a practice code for screening when a patient declines to complete the SDoH screening? Do you submit the G code for a negative screening?

A practice should not submit a G code if a patient/family declines SDoH screening. The G codes (i.e. G9920, G9919) should only be used when a screening was successfully completed. As a result, a refusal to participate in screening will not impact measure compliance. It is understood that not all patients/families will want to participate in the SDoH screening, which is why 70% is considered the top performance target.

## Question 7: Do CMHN practices have the option or the ability to complete the social needs screening in advance of the visit?

Blue KC has confirmed that it is acceptable to complete the social needs screening in advance of a patient's visit. However, the screening has to have occurred during the calendar year 2022 (i.e. the measurement year). If the screening is performed in advance, the results of the screening are expected to be reviewed at the visit and updated as applicable. The practice will then associate the applicable non-billable CPT code for SDoH screening (i.e. G9920, G9919) with the visit's standard billable services.

NEW

## Question 8: What is Blue KC's justification for a 2% Positivity Rate?

Blue KC has monitored SDoH screening and positivity rates for almost two years and the CMHN reported Z codes appear lower than expected based on what we know of the membership and nationwide studies about unmet SDoH. Blue KC believes moving to a tiered incentive for SDoH screening and data reporting will encourage providers to focus on drivers of low positivity rates for unmet SDoH. The 2% level of positivity that will allow a participating group to meet the higher incentive tier is still well below published SDoH prevalence data.

A review of the 100 most populous residential zip codes for CMHN attributed members showed 10% of members live in zip codes identified as having a high (greater than 50%) prevalence of households living at less than 200% of the Federal Poverty Level.

Blue KC's approach to Social Determinant of Health screening and expected positivity rates in pediatric populations is a step on the path to advancing SDoH and health equity measurements. It is essential that members have a full and complete Social Determinants of Health screening as part of the trusted health care provider-patient relationship, and the results of that screening be accurately recorded and submitted to Blue KC, and follow-up be offered to the member, when appropriate. See Appendix E for Blue KC's full response.

NEW

## Question 9: How can CMHN practices increase true positive screens?

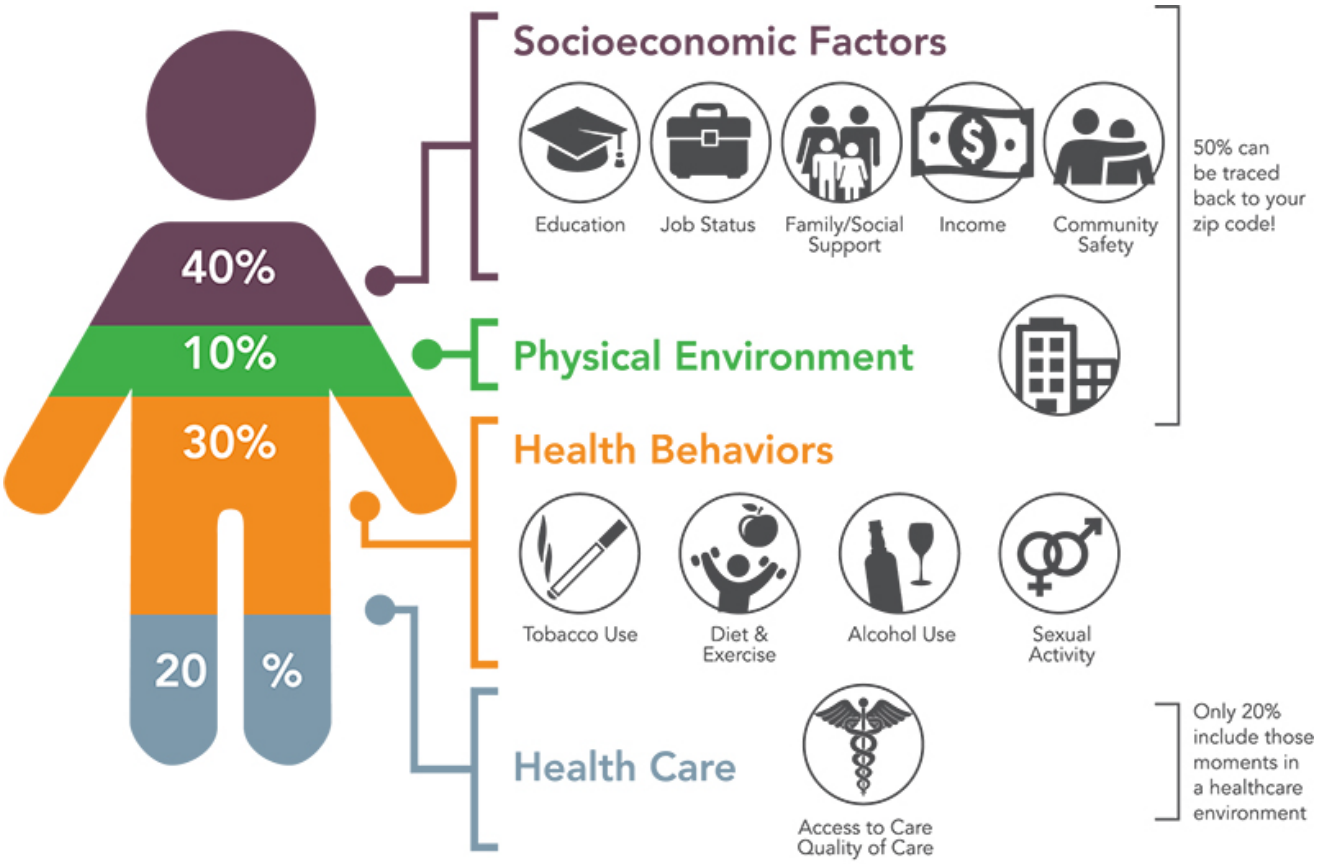
- Ensure that every patient is receiving an SDOH screen at each visit.
- Use clinically validated questions within your practice-specific screening tool.
- If patients receive an electronic screen before the visit, ensure there is a mechanism to catch any patients that fail to fill out the screen before the visit.
- Frame questions as "do you need help with…?" instead of "do you have a concern with…?" or be sure to ask an additional question of "do you need help with any of these concerns?"
- Include more questions in the screening including questions about financial needs or ability to pay for medication.
- When a screening is complete and positive, make sure you record the appropriate g-code and z-code(s).
- Implement a quick and easy workflow to follow up on positive screens (see Appendix C for recommendations).

## Question 10: If screenings are performed by pediatric specialists, will those patients 'receive credit' for having completed a social needs screening?

Screenings performed by specialists will not count toward compliance for the SDoH screening measure. Credit for screenings will only occur for those patients screened by a primary care provider in Blue KC's medical home / value based program.

## Question 11: Why is Blue KC requiring SDoH screening? Are other payers requiring SDoH screening?

Across the country, CMS (Center for Medicare & Medicaid Services) and other commercial payers are recognizing the importance of Social Determinants of Health on health outcomes. As shown in the diagram below, multiple studies have found that health care only impacts approximately 20% of a patient's health outcome. As we transition toward value based models in which incentives are aligned to keep patients healthy and well, it becomes increasingly important and economically beneficial for practices to invest in the infrastructure (e.g. screenings, social workers, relationships with community benefit organizations, etc.) to help address non-health care factors. Assuming the transition to value based care continues and practices are eventually paid a set amount for each patient (i.e. a capitated model), the investment in the infrastructure will help keep our patients healthy and well while also generating increased margins.




Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

## Question 12: Can we screen and code SDoH on a telehealth visit?

With the increasing number of Primary Care tele-health visits in 2020, and continued demand for telehealth visits, the SDoH screening can be completed via telehealth in 2022. Primary Care visits conducted via telehealth will be included in the SDoH screening denominator. The Place of Service (POS) code 02, must be included on the claim to designate that the visit was provided via telehealth.

## Question 13: What examples of "evidence-based" SDoH screening tools are available?

CMHN has developed a comprehensive screening tool based on the clinically validated Health Leads survey (**See Appendix B**). Additionally, practices can utilize any screening tool they choose or even select questions from various tools. Below are a few additional tools practices can utilize.

- PRAPARE – The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (http://www.nachc.org/research-and-data/prapare/toolkit/)
- The American Academy of Family Physicians Social Needs Screening Tool (https://www.aafp.org/dam/AAFP/ documents/patient_care/everyone_project/patient-long-print.pdf)
- American Academy of Pediatrics: Standardized Screening for Health-Related Social Needs in Clinical Settings (https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf)
- Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations Center for Health Care Strategies, Inc. (https://www.chcs.org/media/VCU-Health-Social-Needs-Assessment_102517.pdf)
- CMS Accountable Health Communities Health Related Social Needs (https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf)

## Question 14: What should be done when a practice has already coded 12 or more diagnoses on a claim or our clearing house removes any identified ICD-10 Z code diagnoses?

Blue KC has stated that they understand that there will be times where the identified Z code will not fit on the claim due to a limitation of 12 diagnosis codes and other codes will take precedence. This is ultimately up to the provider to determine priority of filing claims and check with the clearing house. ***An ICD-10 Z-code must accompany any positive SDoH screening in order to receive "credit" for the screening.***

## Question 15: What ICD-10 Z code should be used for Transportation?

There currently isn't an ICD-10 code for Transportation. It has been determined that until this changes practices can use Z91.89 – Other specified personal risk factors, not elsewhere classified. Once a code is developed and published specific to transportation, Blue KC will send out a notification of the change.

# Appendix A: Blue KC Social Determinants of Health (SDoH) Screening Measure Definition

Kansas City

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## Social Determinants of Health (SDoH) Screening

**Description:**

The percentage of attributed members 0-74 years of age screened using standardized screening questions, for at least but not limited to, Transportation, Food Insecurity, Social Environment and Housing issues or concerns, AND if positive, the appropriate Z code or codes are submitted on the date of the positive screen.

**Denominator/Eligible Population:**

All attributed members aged 0-74 at the beginning of the measurement period with at least one eligible encounter at the attributed Advanced Primary Care Entity during the measurement period.

Denominator Criteria:

1. Attributed members aged 0-74 at the beginning of the measurement period, AND
2. An eligible Office (POS 01) or Telehealth (POS 02) encounter at the attributed Advanced Primary Care Entity during the measurement period: CPT 99381 – 99397 or E&M 99201 – 99215

**Numerator:**

Attributed members screened for Social Determinants of Health AND if positive, the appropriate Z code or codes are submitted on the date of the positive screen.

Numerator Criteria:

1. Member is included in the denominator, AND
2. A claim for eligible Office or Telehealth encounter at the attributed Advanced Primary Care Entity includes a Social Determinant of Health Screening CPT code:
    a. G9920 - Screening performed and negative
    b. G9919 - Screening performed and positive and provision of recommendations, AND
3. If the screening is positive and CPT G9919 is submitted, a corresponding Z code or codes are also submitted on the date of the positive screen with corresponding documentation of interventions offered to the patient. The Social Determinants of Health Z codes for 2021 are: See Last Page.

**Measurement Period:** Calendar Year 2022 (January 1, 2022 through December 31, 2022)

**Screening:** Completion of a Social Determinants of Health assessment using an age-appropriate and evidence-based screening tool for at least but not limited to, Transportation, Food Insecurity, Social Environment and Housing issues or concerns. The name of the screening tool and the results of the screening must be documented in the Electronic Health Record. An intervention must be offered to any patient with a positive screen and documented in the medical record.

## Reporting Type:

Claims Only

## Coverage Evaluation:

The numerator and denominator are based on attributed membership meeting eligibility for inclusion and are not evaluated for continuous enrollment or gaps in coverage.

# ICD-10 SOCIAL DETERMINANTS OF HEALTH (SDOH) Z-CODES – 2021

**New Codes effective 10/1/2021**

| Problems related to education and literacy (Z55) |
|---|
| **Z55.0** Illiteracy and low-level literacy |
| **Z55.1** Schooling unavailable and unattainable |
| **Z55.2** Failed school examinations |
| **Z55.3** Underachievement in school |
| **Z55.4** Educational maladjustment and discord with teachers and classmates |
| **Z55.5 (New code)** Less than a high school diploma |
| **Z55.8** Other problems related to education and literacy |
| **Z55.9** Problems related to education and literacy, unspecified |

| Problems related to employment and unemployment (Z56) |
|---|
| **Z56.0** Unemployment, unspecified |
| **Z56.1** Change of job |
| **Z56.2** Threat of job loss |
| **Z56.3** Stressful work schedule |
| **Z56.4** Discord with boss and workmates |
| **Z56.5** Uncongenial work environment |
| **Z56.6** Other physical and mental strain related to work |
| **Z56.81** Sexual harassment on the job |
| **Z56.82** Military deployment status |
| **Z56.89** Other problems related to employment |
| **Z56.9** Unspecified problems related to employment |

| Contact with and suspected exposure (Z57) |
|---|
| **Z57.0** Occupational exposure to noise |
| **Z57.1** Occupational exposure to radiation |
| **Z57.2** Occupational exposure to dust |
| **Z57.31** Occupational exposure to environmental tobacco smoke |
| **Z57.39** Occupational exposure to other air contaminants |
| **Z57.4** Occupational exposure to toxic agents in agriculture |
| **Z57.5** Occupational exposure to toxic agents in other industries |
| **Z57.8** Occupational exposure to other risk factors |
| **Z57.9** Occupational exposure to unspecified risk factor |

| Problems related to physical environment (Z58) |
|---|
| **Z58.6 (New code)** Inadequate drinking-water supply |

| Problems related to housing and economic circumstances (Z59) |
|---|
| **Z59.0** Homelessness |
| **Z59.00 (New code)** Homelessness unspecified |
| **Z59.01 (New code)** Sheltered homelessness |
| **Z59.02 (New code)** Unsheltered homelessness |
| **Z59.1** Inadequate housing |
| **Z59.2** Discord with neighbors, lodgers and landlord |
| **Z59.3** Problems related to living in residential institution |
| **Z59.4** Lack of adequate food and safe drinking water |
| **Z59.41 (New code)** Food insecurity |
| **Z59.48 (New code)** Other specified lack of adequate food |
| **Z59.5** Extreme poverty |
| **Z59.6** Low income |
| **Z59.7** Insufficient social insurance and welfare support |
| **Z59.8** Other problems related to housing and economic circumstances |
| **Z59.811 (New code)** Housing instability, housed, with risk of homelessness |
| **Z59.812 (New code)** Housing instability, housed, homelessness in past 12 months |
| **Z59.819 (New code)** Housing instability, housed unspecified |
| **Z59.89 (New code)** Other problems related to housing and economic circumstances |
| **Z59.9** Other problems related to housing and economic circumstances, unspecified |

| Problems related to social environment (Z60) |
|---|
| **Z60.0** Problems of adjustment to life-cycle transitions |
| **Z60.2** Problem related to living alone |
| **Z60.3** Acculturation difficulty |
| **Z60.4** Social exclusion and rejection |
| **Z60.5** Target of (perceived) adverse discrimination and persecution |
| **Z60.8** Other problems related to social environment |
| **Z60.9** Problem related to social environment, unspecified |

| Problems related to upbringing (Z62) |
|---|
| **Z62.0** Inadequate parental supervision and control |
| **Z62.1** Parental overprotection |
| **Z62.2** Upbringing away from parents |
| **Z62.21** Child in welfare custody |
| **Z62.22** Institutional upbringing |
| **Z62.29** Other upbringing away from parents |
| **Z62.3** Hostility towards and scapegoating of child |
| **Z62.6** Inappropriate (excessive) parental pressure |
| **Z62.810** Personal history of physical and sexual abuse in childhood |
| **Z62.811** Personal history of psychological abuse in childhood |
| **Z62.812** Personal history of neglect in childhood |
| **Z62.819** Personal history of unspecified abuse in childhood |
| **Z62.82** Parent-child conflict |
| **Z62.822** Parent-foster child conflict |
| **762.891** Sibling rivalry |
| **Z62.898** Other specified problems related to upbringing |

| Other problems related to primary support group, including family circumstances (Z63) |
|---|
| **Z63.0** Problems in relationship with spouse or partner |
| **Z63.3** Absence of family member |
| **Z63.31** Absence of family member due to military deployment |
| **Z63.32** Other absence of family member |
| **Z63.4** Disappearance and death of family member |
| **Z63.5** Disruption of family by separation and divorce |
| **Z63.6** Dependent relative needing care at home |
| **Z63.7** Other stressful life events affecting family and household |
| **Z63.71** Stress on family due to return of family member from military deployment |
| **Z63.72** Alcoholism and drug addiction in family |
| **Z63.79** Other stressful life events affecting family and household |
| **Z63.8** Other specified problems related to primary support group |
| **Z63.9** Problem related to primary support group, unspecified |

| Problems related to certain psychosocial circumstances (Z64) |
|---|
| **Z64.0** Problems related to unwanted pregnancy |
| **Z64.1** Problems related to multiparity |
| **Z64.4** Discord with counselors |

| Experiences with crime, violence and the judicial system (Z65) |
|---|
| **Z65.0** Conviction in civil and criminal proceedings without imprisonment |
| **Z65.1** Imprisonment and other incarceration |

# ICD-10 SOCIAL DETERMINANTS OF HEALTH (SDOH) Z-CODES – 2021

| |
|---|
| **Z65.2** Problems related to release from prison |
| **Z65.3** Problems related to other legal circumstances |
| **Z65.4** Victim of crime and terrorism |
| **Z65.5** Exposure to disaster, war and other hostilities |
| **Z65.8** Other specified problems related to psychosocial circumstances |
| **Z65.9** Problem related to unspecified psychosocial circumstances |

| **Stress (Z73)** |
|---|
| **Z73.3** Stress, not elsewhere classified |
| **Z73.4** Inadequate social skills, not elsewhere classified |
| **Z73.89** Other problems related to life management difficulty |
| **Z73.9** Problem related to life management difficulty, unspecified |

| **Problems related to medical facilities and other health care (Z75)** |
|---|
| **Z75.3** Unavailability and inaccessibility of health care facilities |
| **Z75.4** Unavailability and inaccessibility of other helping agencies |

| **Contact with and suspected exposure (Z77)** |
|---|
| **Z77.010** Contact with and suspected exposure to arsenic |
| **Z77.011** Contact with and suspected exposure to lead |
| **Z77.090** Contact with and suspected exposure to asbestos |

| **Transportation Difficulty (Z91)** |
|---|
| **Z91.89** Other specified personal risk factors, not elsewhere classified |

A full SDoH screening can be conducted annually and updates provided at each visit to resolve prior concerns or add new ones. These Healthcare Common Procedure Coding System (HCPCS) codes can be used when reporting:
G9919 – Screening performed and positive and provision of recommendations
G9920 – Screening performed and negative

American Hospital Association. ICD-10-CM Coding for Social Determinants of Health. Nov. 2019, www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

# Appendix B: CMHN Recommended Social Needs Screening Survey – Health Leads

## SOCIAL NEEDS SURVEY

Our goal is to provide the best possible care for your child and family. Being a parent is not always easy, and we want to make sure that you know all the community resources that are available to you and your family. Many of these resources of free of charge.

Please complete and hand to your child's medical assistant at the beginning of the visit.

Thank you!

Name: _____ Phone Number: _____

Preferred Language: _____ Best Time to Call: _____

| | | |
|---|---|---|
|  | In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food? | Yes ☐ No ☐ |
|  | In the last 12 months, has your **utility company shut off your service** for not paying your bills? | Yes ☐ No ☐ |
|  | Are you worried that in the next 2 months, you **may not have stable housing?** | Yes ☐ No ☐ |
|  | Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)* | Yes ☐ No ☐ |
|  | In the last 12 months, have you needed to see a doctor, **but could not because of cost?** | Yes ☐ No ☐ |
|  | In the last 12 months, did you **skip medications to save money**? | Yes ☐ No ☐ |
|  | In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?** | Yes ☐ No ☐ |
|  | Do you ever need help **reading hospital materials?** | Yes ☐ No ☐ |
|  | Are you **afraid you might be hurt** in your apartment building or house? | Yes ☐ No ☐ |
|  | If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs? | Yes ☐ No ☐ |
|  | **Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight | Yes ☐ No ☐ |

# Appendix C: Addressing a Positive Screen

If a patient screens positive for any of the needs identified in the SDOH screening, such as food insecurity or houselessness, ask them if they would like help with any of the identified concerns. Here is a sample of how you can talk to the patient about resources:

> *I appreciate your willingness to answer these screening questions to help with your care. You answered that you have a concern with having enough food to eat. Would you like me to connect you with a community organization that can help you with this need or would you like a way to do this yourself?*

If the patient would like help you can:

- Refer patient/family to a resource using Lift Up KC through InNote – a quick and easy way to connect patients to community-based organizations (CBOs) with just a few clicks
- Recommend or refer to "full-service" centers that can address many needs, such as food insecurity, housing insecurity, financial assistance, etc.
- Recommend or refer to "no wrong door centers" that can help connect a patient to another organization if they are unable to help
- Utilize a "super-user" in your practice, trained on Lift Up KC and local resources, to help connect the patient and family with a CBO
- Provide the patient/family with liftupkc.org postcards so they can access resources and navigate their own care

CMHN can help provide recommendations of these organizations in your service area.

Additionally, CMHN can help facilitate a relationship between your practice and one "full service" CBO in your geographic area. This will allow your practice to refer all patients who screen positive for SDOH to one organization.

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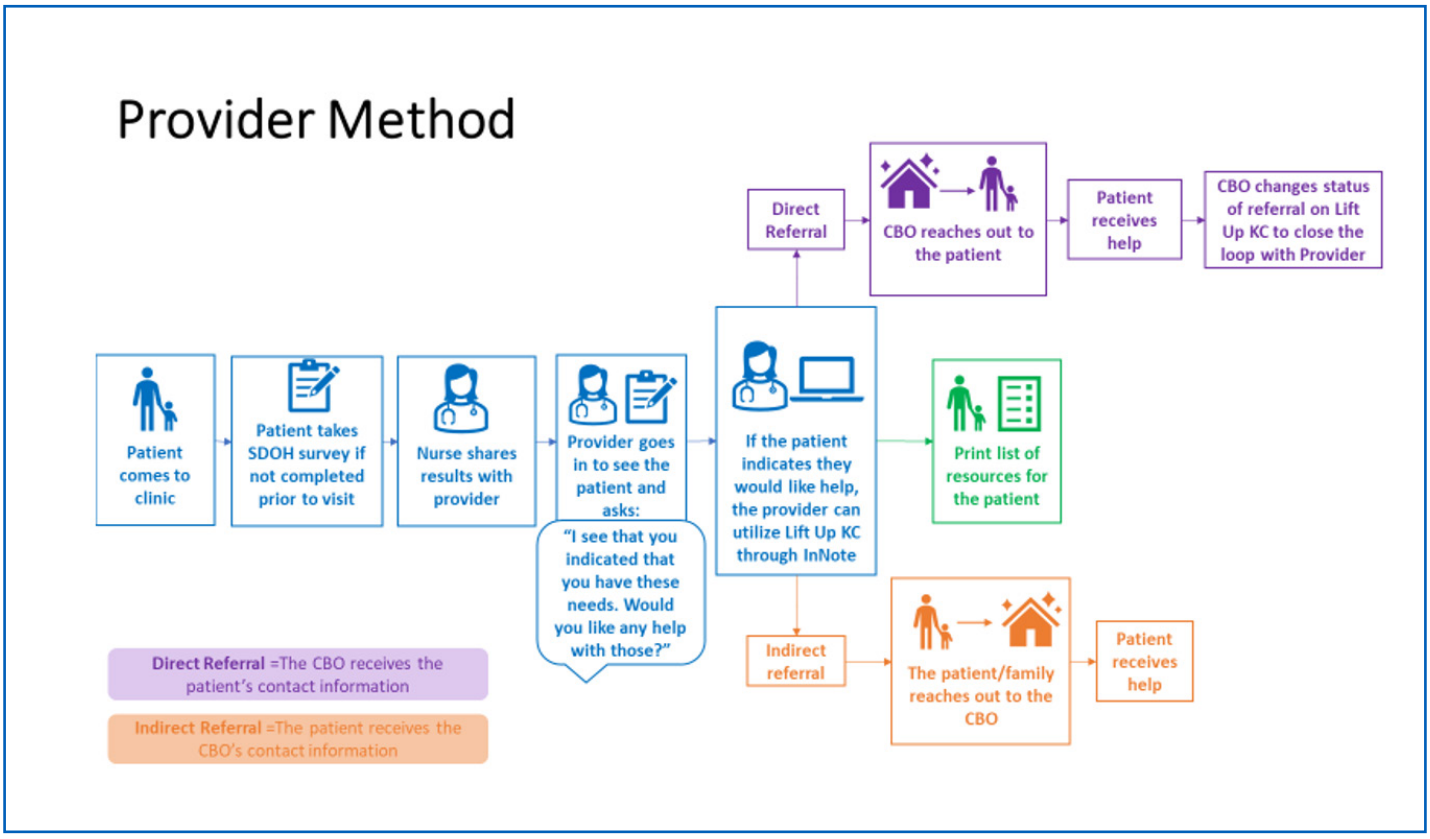
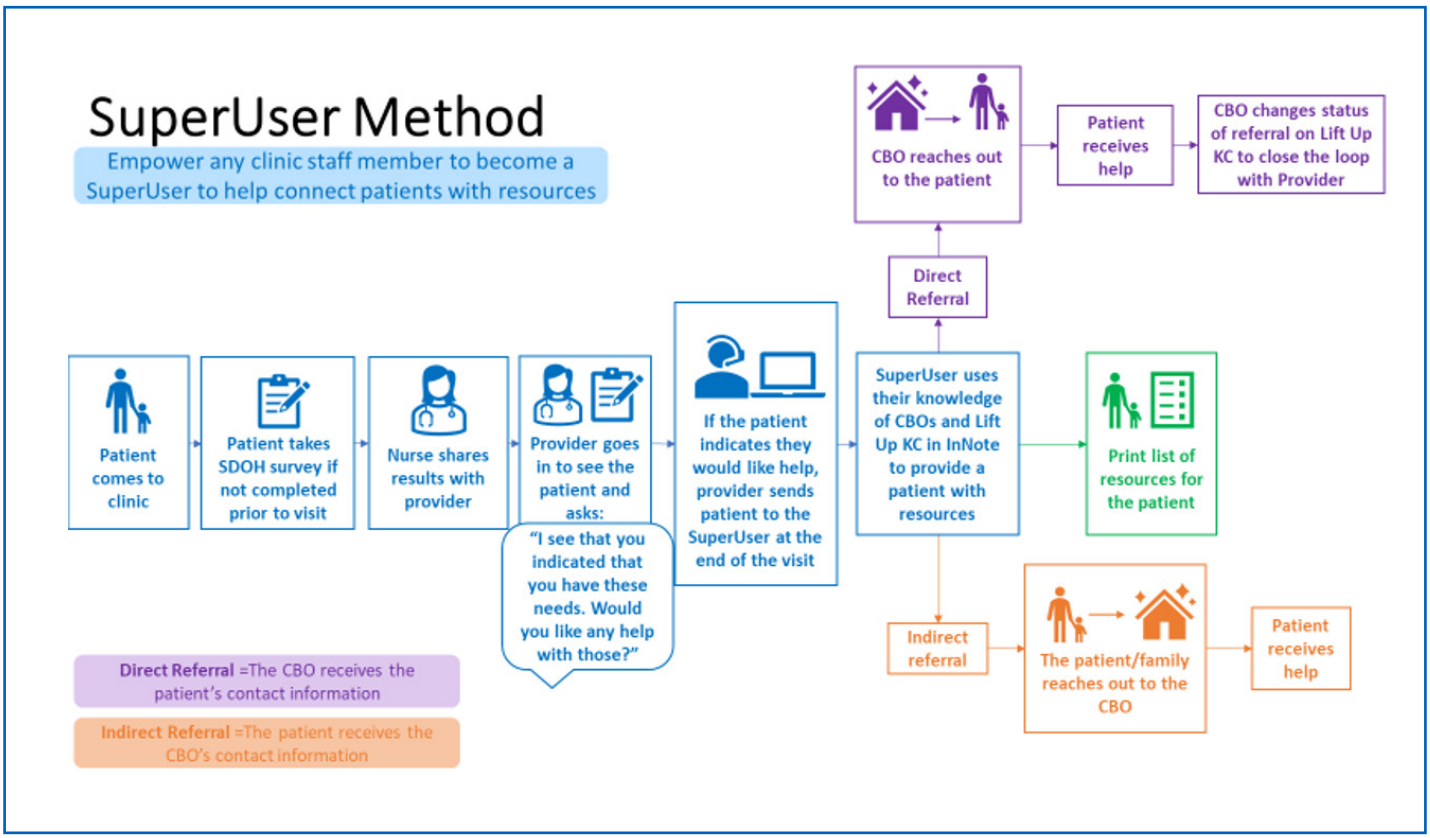
[1]https://www.cmics.org/cmhn/LoadImagesFiles/LoadFile?contentGUID=4DFD26B5-8C28-4B55-B9C0-1B9A96493FA6

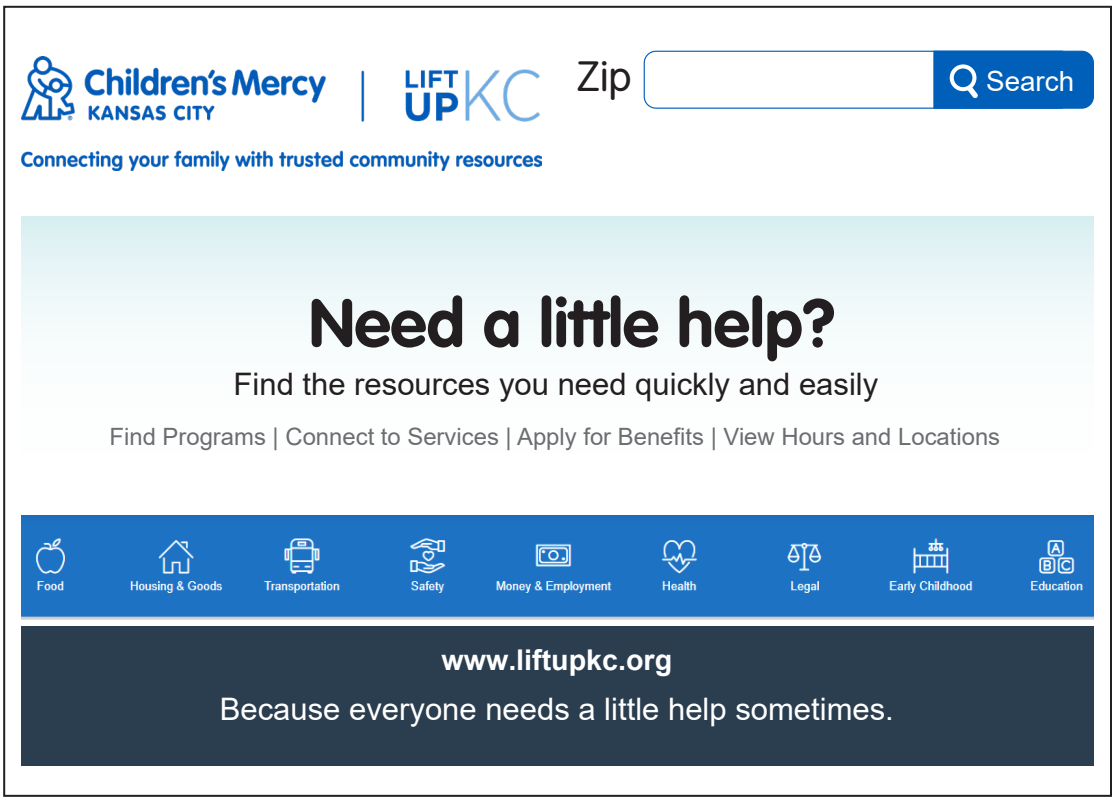
[2]Colvin,"Screening & Referring for Social Determinants of Health in General Pediatrics" September 29, 2021.

# Recommended workflows for addressing positive screens:



# Appendix D: Lift Up KC Referral Card Options for Patients / Families

# Appendix E: SDoH Measurement PY2022

Kansas City

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Blue Cross and Blue Shield of Kansas City (Blue KC) has offered participation in an optional value-based program for pediatric primary care providers called Advanced Primary Care – Pediatric. The program has certain care delivery requirements, including a requirement to screen members of BCBSKC for unmet Social Determinants of Health (SDoH) at least once a year using standardized screening questions, and if the screening identifies an unmet SDoH need, to submit the associated ICD-10 Z-code diagnosis for the identified need on the visit claim and offer interventions to the member.

**Background:**

Social Determinants of Health are the non-clinical factors that influence health outcomes. The World Health Organization reports Social Determinants are the "conditions in which people are born, grow, live, work and age," which includes security in food, housing, income, environment, and social context.[1]

Adversity at a young age, including factors that influence poverty and income, food security, early childhood development and access to health services, is interconnected to eventual health outcomes. The University of Michigan describes "long-term health outcomes associated with early adversity include increased rates of alcoholism, depression, heart disease, diabetes, and other chronic diseases."[2] Additionally, unmet pediatric social determinants of health can persist through the lifespan including low education attainment, unemployment, housing insecurity, financial insecurity, and mental health struggles.

Blue KC implemented a performance-based incentive payment for participating groups who systematically screened their population for SDoH in 2020. It was recognized that SDoH data, and most importantly the ICD-10 Z-code that identifies unmet SDoH, is essential to understanding the needs of the member and the community, and that incentivizing the screening would encourage more participation in SDoH screening.

SDoH screening data can be immediately leveraged by stakeholders across the healthcare community to offer a holistic picture of the health and needs of an individual or family. As a longer-term focus, the data stratified across large populations can be used to identify community-level opportunities for changing policy, enhancing supports, and implementing outreach programs.

**Tiered Incentive Opportunity:**

Blue KC has monitored SDoH screening and positivity rates for almost two years and the reported Z codes appear lower than expected based on what we know of the membership

[1] https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
[2] https://sph.umich.edu/pursuit/2020posts/screening-for-social-determinants-of-health-in-pediatric-settings.html

and nationwide studies about unmet SDoH. We believe moving to a tiered incentive for SDoH screening and data reporting will encourage providers to focus on drivers of low positivity rates for unmet SDoH. The 2% level of positivity that will allow a participating group to meet the higher incentive tier is still well below published SDoH prevalence data.

Kaiser Permanente commissioned research to study the prevalence of unmet Social Determinants of Health and found that across demographic segments, a third of respondents were frequently or occasionally stressed over providing for their families' housing, food, transportation, of social support needs.[3] The same research reported those stresses are present even at the highest income levels ($125k of more) with 40% of those families experiencing at least one unmet social need in the last year.

Poverty is highly correlated to unmet SDoH in childhood and into adulthood.[4] A review of the 100 most populous residential zip codes for CMICS-attributed members showed 10% of members live in zip codes identified as having a high (greater than 50%) prevalence of households living at less than 200% of the Federal Poverty Level[5].

The Children's Hospital Association published a landmark whitepaper in 2018 that was further updated in 2020 offered the Process Improvement tactic for SDoH screening to presume need. They found providers were surprised by how much need there truly was, and therefore offered the guidance to simply presume a need is present.[6]

**Conclusion:**

Blue KC's approach to Social Determinant of Health screening and expected positivity rates in pediatric populations is a step on the path to advancing SDoH and health equity measurements. It is essential that members have a full and complete Social Determinants of Health screening as part of the trusted healthcare provider-patient relationship, and the results of that screening be accurately recorded and submitted to Blue KC, and follow-up be offered to the member, when appropriate.

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[3] https://about.kaiserpermanente.org/content/dam/internet/kp/comms/import/uploads/2019/06/KP-Social-Needs-Survey-Key-Findings.pdf
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6039226/
[5] https://www.census.gov/topics/income-poverty/poverty/data/tables/acs.html
[6] https://www.childrenshospitals.org/-/media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Child_Health/Population_Health/pophlth_social_determinants_health_report.pdf