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

The following FAQ was developed to address Blue KC's 2023 quality performance measure on 'Social Determinants of Health Screening' as part of the 2023 Blue KC / CMHN Medical Home Agreement. See the Slide Deck Overview of CMHN's Blue KC Medical Home Value Based 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 2023 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 2023, 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 2023, 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 2023 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 2023 and at the end of September 2023 (Blue KC freezes the measure denominator at this time for 2023 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
  - Z59.82 – Transportation Insecurity
  - 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)?

Currently, the following Social Determinant categories contribute to the MARA risk score:

Housing Disruption	Social Support
Family Member Disruption	Lifestyle Related Issues

Later in 2023, Blue KC anticipates upgrading to MARA 4.62, which will expand to the following Social Determinant categories:

Child/Parent-related Issues	Lifestyle Related Issues
Criminal-related Issues	Occupational-related Issues
Donor Status	Social Support
Education-related Issues	Social-related Issues
Housing Disruption	Unwanted Pregnancy

*Please see Appendix A for a list of ICD-10 SDOH Categories and Z-codes.

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 2023. 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 2023 (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?

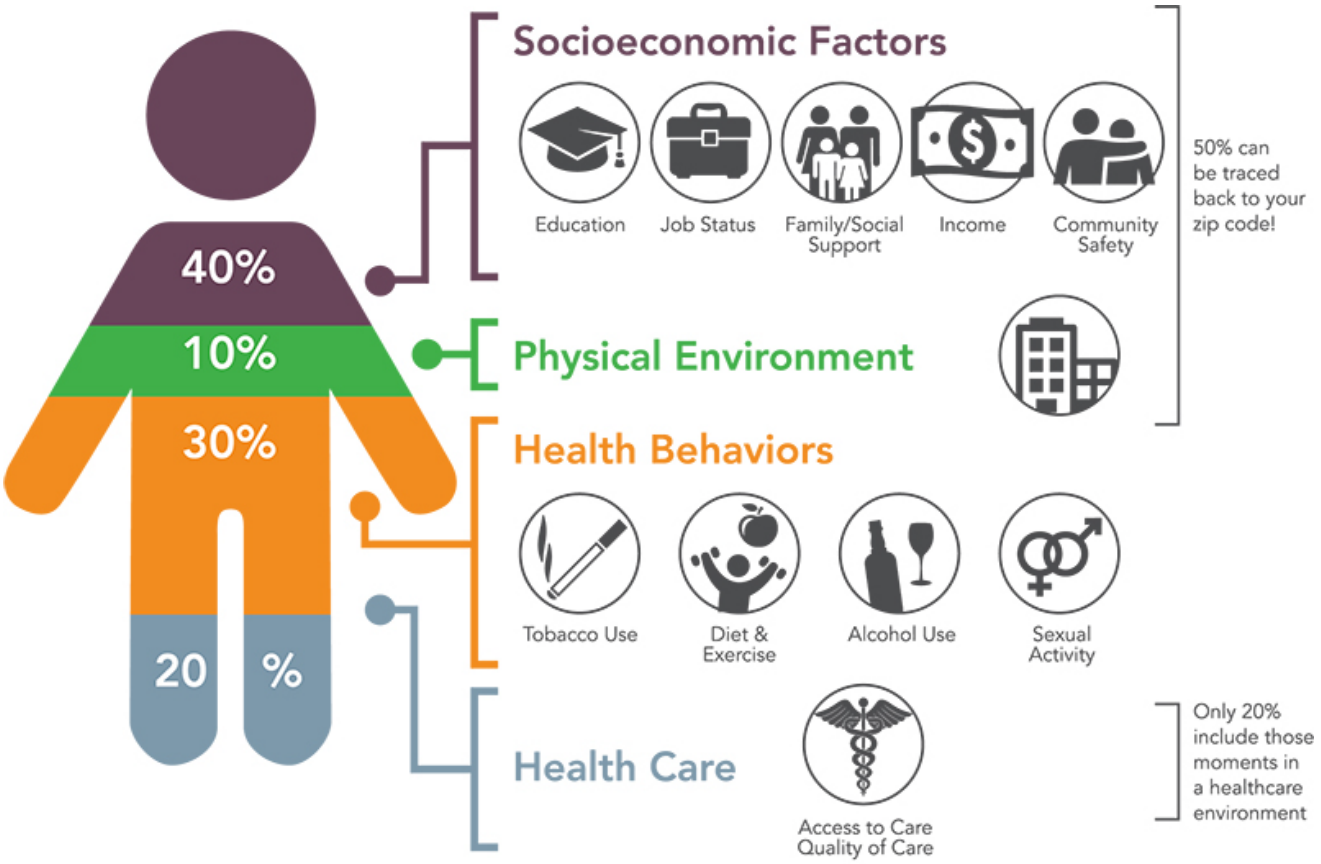
- Ensure that every patient is receiving an SDOH screen at each visit.
- Use clinically validated questions within your practice-specific screening tool.
- If patients receive an electronic screen before the visit, ensure there is a mechanism to catch any patients that fail to fill out the screen before the visit.
- Tailor the screening to your population by adding clinically validated questions that cover specific topics, such as financial needs, ability to pay for medication, social support, or bullying.
- 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 telehealth visits in 2021, and continued demand for Telehealth visits, the SDoH screening can be completed via telehealth in 2023. Primary Care visits conducted via telehealth will be included in the SDoH screening denominator. The Place of Service (POS) code 02 or POS code 10, 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?

The new ICD-10 code specifically for Transportation Insecurity is Z59.82 or Z91.89 may also be used.

NEW

Question 16: Can we submit a G code for screening if the parent completed the screening for another child in the family at a prior visit (on the same day or different day), or does the parent have to complete the screening for each child?

If a claim is being submitted, the expectation of Blue KC is that the screening is performed on each child/member.

NEW

Question 17: What is Blue KC doing to ensure that Community Based Organizations (CBOs) have capacity to meet the new demand that may be uncovered?

Blue KC's Community Health team is committed to addressing our members' social needs to ensure equitable health outcomes for all. Numerous studies evidence that more than 80% of health outcomes are attributed to non-clinical factors, leaving only up to 20% of outcomes attributable to clinical care and genetics. Collectively, these factors are understood as the social determinants of health (SDOH). Among these are lack of reliable transportation, safe and affordable housing, and access to nutritious food. SDOH needs often impede the management and improvement of chronic conditions, resulting in exacerbated illnesses, high-cost members, and increased health disparities.

Blue KC has partnered with the Mid-America Regional Council (MARC) to meet the SDOH needs of members identified in a clinical setting and through our Care Management program. MARC's Community Services Network (CSN) partners with dozens of community-based organizations (CBOs) and ensures these organizations have the capacity to provide utility assistance, home-delivered meals, connections to behavioral health services, among other forms of social care.

In 2023, Blue KC will launch its partnership with findhelp (formerly known as Aunt Bertha) as our social health referral platform (SHRP) solution. This partnership will include the creation of a publicfacing database of SDOH programs that will allow Blue KC members to self-refer for resources.

Blue KC will use insights from findhelp to partner with CBOs, allowing providers to make closed-loop referrals and demonstrate the ROI of meeting patients' social needs. By encouraging the use of findhelp, Blue KC will gain data-driven understanding of which CBOs in our community are being most utilized and therefore could benefit from additional capacity.

Blue KC's Community Health team is also piloting a client-based Community Health Worker (CHW) program. Our CHWs will assist members with social needs in navigating the CBO ecosystem and provide high-touch support to ensure they receive appropriate SDOH services. This pilot will also provide the necessary data to inform a scalable and sustainable solution that addresses SDOH needs of our members in the years to come.

Finally, the Community Health team's Community Health Consultant partners with Blue KC's Healthcare Transformation Consultants to assist PCF practices in addressing the unique SDOH needs of their patient populations.

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

Social Determinants of Health (SDoH) Screening Measure– 2025

Description:

At least 70% of attributed members aged 0-74 screened annually for unmet SDoH 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 ICD-10-CM Z code or codes are submitted on the date of the positive screen, and interventions are offered to the member.

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 Blue KC Primary Care First (PCF) 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 11), Independent Clinic (POS 49), Federally Qualified Health Center (FQHC) (POS 50), Public Health Clinic (POS 71), Rural Health Clinic (POS 72) or Telehealth (POS 02) encounter at the attributed Blue KC PCF 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 ICD-10 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 Blue KC PCF 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 ICD-10 Z code or codes are also submitted on the date of the positive screen. The

Social Determinants of Health ICD-10 Z codes for 2024 are listed on pages 3 and 4.

4. If the initial screening is negative, but through further assessment other risk factors are identified, and an ICD-10 Z code(s) is on the same claim, this will count towards the SDoH positivity rate.

Definitions:

Measurement Period: Calendar Year 2025 (January 1, 2025, through December 31, 2025)

Screening: Completion of a Social Determinants of Health assessment using age-appropriate and evidence-based screening questions, for at least but not limited to, Transportation, Food Insecurity, Social Environment and Housing issues or concerns. The results of the screening must be documented in the Electronic Health 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.

Social Determinants of Health (SDoH) Screening Measure – 2025

Highlighted code indicates new in 2025.

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 Less than a high school diploma
Z55.6 Problems related to health literacy
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

Occupational exposure to risk factors (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
Z57.6 Occupational exposure to extreme temperature
Z57.7 Occupational exposure to vibration
Z57.8 Occupational exposure to other risk factors
Z57.9 Occupational exposure to unspecified risk factor

Problems related to physical environment (Z58)
Z58.0 Problems related to physical environment
Z58.6 Inadequate drinking-water supply
Z58.8 Other problems related to physical environment
Z58.81 Basic services unavailable in physical environment
Z58.89 Other problems related to physical environment

Problems related to housing and economic circumstances (Z59)
Z59.00 Homelessness, unspecified
Z59.01 Sheltered homelessness
Z59.02 Unsheltered homelessness
Z59.10 Inadequate housing, unspecified
Z59.11 Inadequate housing environmental temperature
Z59.12 Inadequate housing utilities
Z59.19 Other inadequate housing utilities
Z59.2 Discord with neighbors, lodgers and landlord
Z59.3 Problems related to living in residential institution
Z59.41 Food insecurity
Z59.48 Other specified lack of adequate food
Z59.5 Extreme poverty
Z59.6 Low income
Z59.7 Insufficient social insurance and welfare support
Z59.71 Insufficient health insurance coverage
Z59.81 Housing instability, housed
Z59.811 Housing instability, housed, with risk of homelessness
Z59.812 Housing instability, housed, homelessness in past 12 months
Z59.819 Housing instability, housed unspecified
Z59.82 Transportation insecurity
Z59.86 Financial insecurity
Z59.87 Material hardship
Z59.89 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
Z62.23 Child in custody of non-parental relative
Z62.24 Child in custody of non-relative guardian
Z62.29 Other upbringing away from parents
Z62.3 Hostility towards and scapegoating of child
Z62.6 Inappropriate (excessive) parental pressure
Z62.8 Other specified problems related to upbringing
Z62.81 Personal history of abuse in childhood
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
Z62.813 Personal history of forced labor or sexual exploitation in childhood
Z62.814 Personal history of child financial abuse
Z62.815 Personal history of intimate partner abuse in childhood
Z62.819 Personal history of unspecified abuse in childhood
Z62.820 Parent-biological child conflict
Z62.821 Parent-adopted child conflict
Z62.822 Parent-foster child conflict
Z62.823 Parent-step child conflict
Z62.83 Non-parental relative or guardian-child conflict
Z62.831 Non-parental relative-child conflict
Z62.832 Non-parental guardian-child conflict
Z62.833 Group home staff-child conflict
Z62.89 Other specified problems related to upbringing
Z62.890 Parent-child estrangement NEC
762.891 Sibling rivalry
Z62.892 Runaway [from current living environment]

Z62.898 Other specified problems related to upbringing
Z62.9 Problem related to upbringing, unspecified

Other problems related to primary support group, including family circumstances (Z63)
Z63.0 Problems in relationship with spouse or partner
Z63.1 Problems in relationship with in-laws
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
Z63.71 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

Problems related to other psychosocial circumstances (Z65)
Z65.0 Conviction in civil and criminal proceedings without imprisonment
Z65.1 Imprisonment and other incarceration
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)
Z75.1 Person awaiting admission to adequate facility elsewhere
Z75.3 Unavailability and inaccessibility of health care facilities
Z75.4 Unavailability and inaccessibility of other helping agencies

Patient's and Caregiver's noncompliance (Z91)
Z91.1 Patient's noncompliance with medical treatment and regimen
Z91.110 Patient's noncompliance with dietary regimen, due to financial hardship
Z91.11 Patient's noncompliance with dietary regimen
Z91.118 Patient's noncompliance with dietary regimen, for other reason
Z91.119 Patient's noncompliance with dietary regimen, due to unspecified reason
Z91.12 Patient's intentional underdosing of medication regimen
Z91.120 Patient's intentional underdosing of medication regimen, due to financial hardship
Z91.128 Patient's intentional underdosing of medication regimen, for other reason
Z91.13 Patient's unintentional under dosing of medication regimen
Z91.130 Patient's unintentional underdosing of medication regimen, for other reason
Z91.14 Patient's other noncompliance with medication regimen
Z91.141 Patient's other noncompliance with medication regimen, due to financial hardship
Z91.148 Patient's other noncompliance with medication regimen, due to financial hardship
Z91.15 Patient's noncompliance with renal dialysis
Z91.151 Patient's noncompliance with renal dialysis, due to financial hardship
Z91.158 Patient's noncompliance with renal dialysis for other reason
Z91.19 Patient's noncompliance with other medical treatment and regimen
Z91.190 Patient's noncompliance with other medical treatment and regimen, due to financial hardship
Z91.198 Patient's noncompliance with other medical treatment and regimen, for other reason
Z91.199 Patient's noncompliance with other medical treatment and regimen, due to unspecified reason
Z91.A Caregiver's noncompliance with patient's medical treatment and regimen
Z91.A1 Caregiver's noncompliance with patient's dietary regimen
Z91.A10 Caregiver's noncompliance with patient's dietary regimen due to financial hardship
Z91.A18 Caregiver's noncompliance with patient's dietary regimen for other reason
Z91.A2 Caregiver's intentional underdosing of patient's medication regimen
Z91.A20 Caregiver's intentional underdosing of patient's medication regimen die to financial hardship
Z91.A28 Caregiver's intentional underdosing of patient's medication regimen for other reason
Z91.A3 Caregiver's unintentional underdosing of patient's medication regimen
Z91.A4 Caregiver's other noncompliance with patient's medication regimen
Z91.A41 Caregiver's other noncompliance with patient's medication regimen due to financial hardship
Z91.A48 Caregiver's noncompliance with patient's medication for other reason
Z91.A5 Caregiver's noncompliance with patient's renal dialysis
Z91.A51 Caregiver's noncompliance with patient's renal dialysis due to financial hardship
Z91.A58 Caregiver's noncompliance with patient's renal dialysis for other reason
Z91.A91 Caregiver's noncompliance with patient's other medical treatment and regimen due to financial hardship

Z91.A98 Caregiver's noncompliance with patient's other medical treatment and regimen for other reason
Z91.4 Personal history of psychological trauma not elsewhere classified
Z91.41 Personal history of adult abuse
Z91.410 Personal history of adult physical and sexual abuse
Z91.411 Personal history of adult psychological abuse
Z91.412 Personal history of adult neglect
Z91.413 Personal history of adult financial abuse
Z91.414 Personal history of adult intimate partner abuse
Z91.419 Persona history of unspecified adult abuse
Z91.42 Personal history of forced labor or sexual exploitation
Z91.49 Other personal history of psychological trauma not elsewhere classified
Z91.5 Personal history of self-harm
Z91.51 Personal history of suicidal behavior
Z91.52 Personal history of nonsuicidal self-harm
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. Jan. 2022, www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

CMS. ICD-10-CM Official Guidelines for Coding and Reporting FY 2023 -- UPDATED April 1, 2023 https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf

CMS. IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes Sept 2023, https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

ICD-10 Data.com Personal risk factors, not elsewhere classified Z00-Z99/Z77-Z99/Z75/Z91, 2024 https://www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z77-Z99/Z91-

American Academy of Professional Coders. ICD-10-CM Code for Insufficient health insurance coverage, 2024 https://www.aapc.com/codes/icd-10-codes/Z59.71

Appendix B: CMHN Recommended Social Needs Screening Survey

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 ☐
	Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. **How stressed are you?** Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer this question ☐	
	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 ☐

Screening questions from the Health Leads Social Needs Screening and the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Screening

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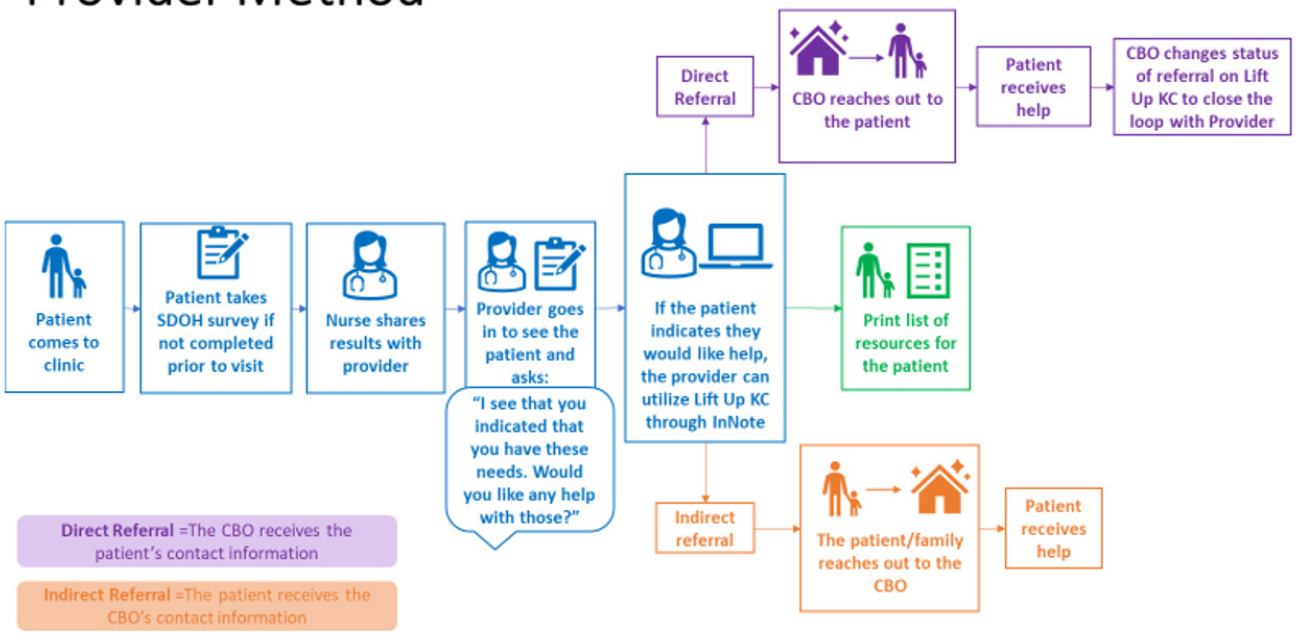
[1]https://www.cmics.org/cmhn/LoadImagesFiles/LoadFile?contentGUID=4DFD26B5-8C28-4B55-B9C0-1B9A96493FA6

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

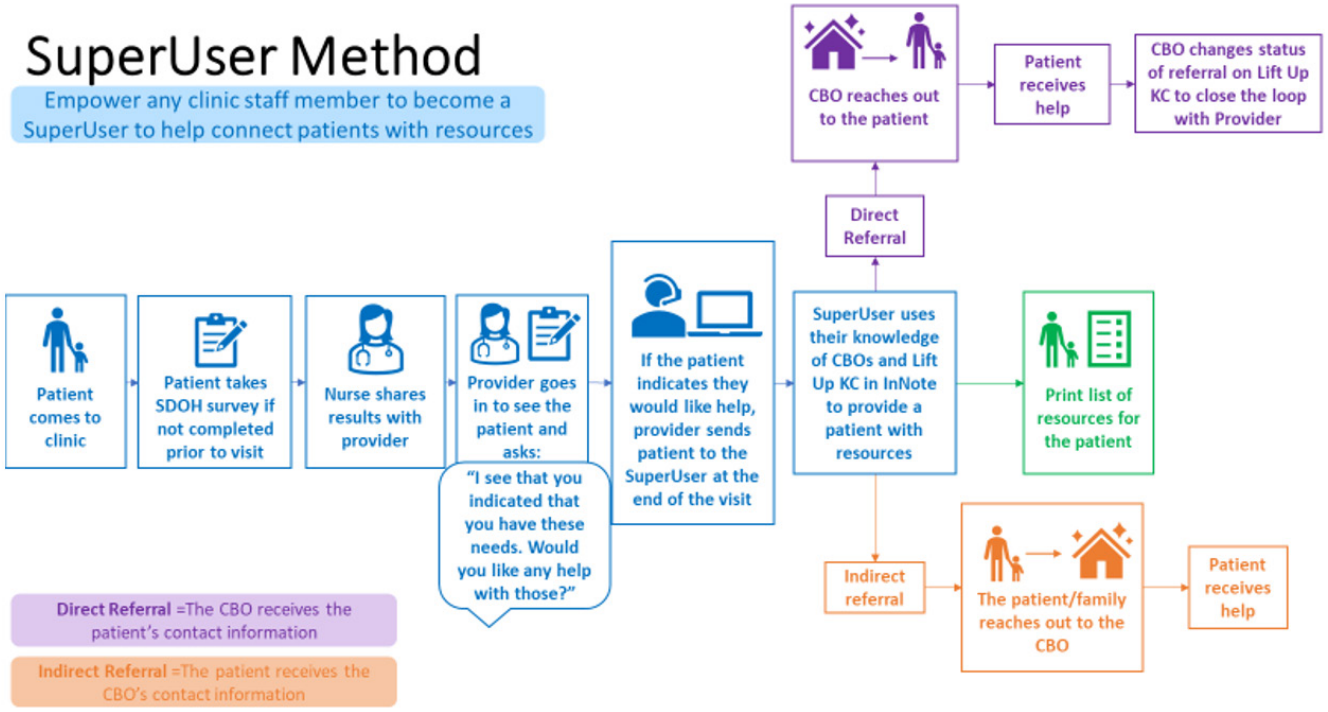
Recommended workflows for addressing positive screens:

Provider Method

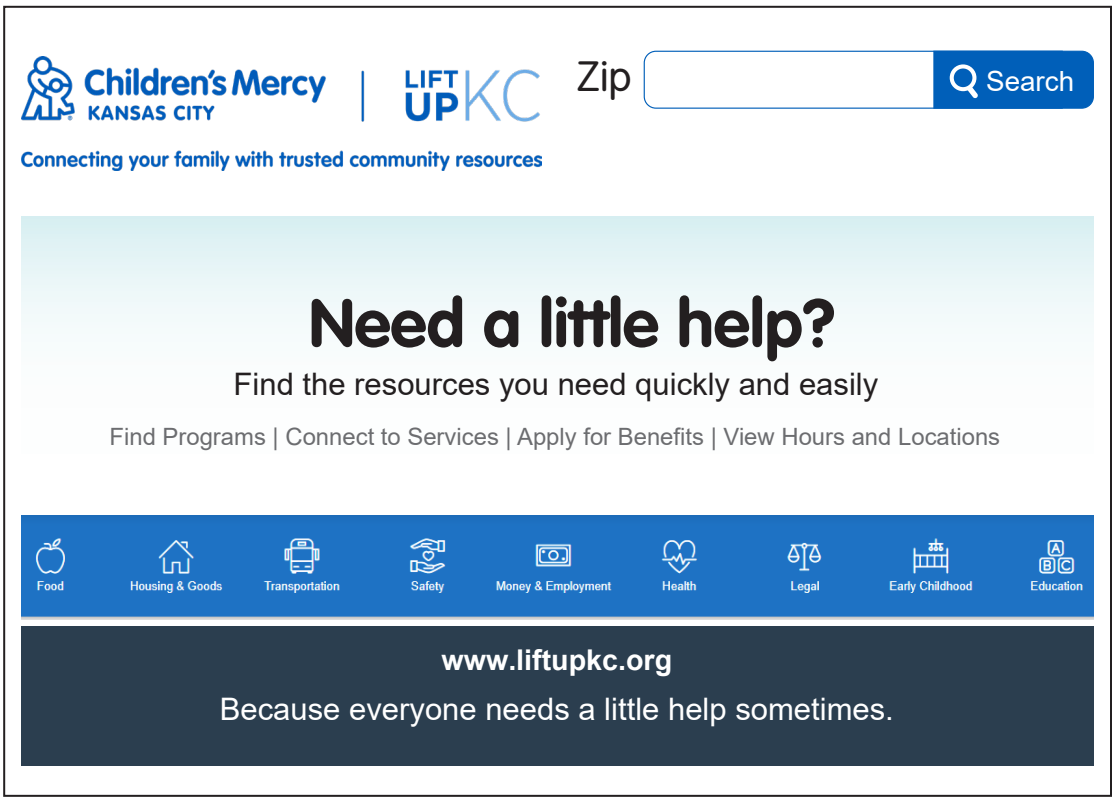


SuperUser Method

Empower any clinic staff member to become a SuperUser to help connect patients with resources



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



Appendix E: SDoH Measurement PY2023

Kansas City

2301 Main Street Kansas City, MO 64108 • (816) 395-2222 • BlueKC.com

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