CMHN Social Determinants of Health (SDoH) Screening FAQ

The following FAQ was developed to address Blue KC's 2021 quality performance measure on 'Social Determinants of Health Screening' as part of the 2021 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 2021 for all patients receiving primary care services. The SDoH screening must address at least ***transportation, food insecurity, housing issues or concerns, and social environment***. Social environment is new to the SDoH screening measure in 2021 and addresses the social aspect of SDoH. This requirement can be met using a screening question such as: How often do you see or talk to people that you care about and feel close to?; Do you have at least one adult in your life that you can talk to about any problems or worries?; Are you afraid you might be hurt in your apartment building or house?; How often do you feel lonely or isolated from those around you?

How: Screening can be implemented utilizing a set of questions that address the requirements listed above. Additionally, a practice can leverage the comprehensive screening tool developed by CMHN, based on the clinically validated WE-CARE survey (**See Appendix B and Appendix C**).

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

How to Address Positive Screenings: In the short-term, CMHN recommends referring families/patients to www.AuntBertha.com to find resources available in their area (See **Appendix D** for Aunt Bertha flyers). CMHN will be developing capabilities through CMHN's population health management platform (Innovaccer) to refer and perform closed-loop referrals to address social needs.

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 8).

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 2021, Blue KC has an additional incentive of approximately $974 million ($1.50 PMPM) to complete an SDoH screening on more than 75% of all CMHN patients receiving primary care services.

UPDATED

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 2021 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 2021 and at the end of September 2021 (Blue KC freezes the measure denominator at this time for 2021 performance) AND
- The patient had a PCP visit (based on CPT codes 99381-99397 or E&M codes 99201-99215) during the calendar year.

Important Update for 2021: Please note that both well visits and sick visits are included.

UPDATED 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 B)?

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** in 2021.

UPDATED Question 3: Is the list of ICD-10 diagnostic codes included in the Blue KC letter (Appendix B) 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

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

UPDATED 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***.

Potential Minimum Screening Verbiage to Parent/Patient:

- "Do you need any help (or have concerns) with transportation, food, or housing?"
- A question that addresses social environment, such as one of the examples below.
  - "How often do you see or talk to people that you care about and feel close to?"
  - "Do you have at least one adult in your life that you can talk to about any problems or worries?"
  - "Are you afraid you might be hurt in your apartment building or house?"
  - "How often do you feel lonely or isolated from those around you?"

In 2021, Blue KC has added a requirement that the name of the screening tool and the results of the screening tool must be documented in the Electronic Health Record. CMHN practices have flexibility in selecting a screening tool and may even select questions from various screening tools.

CMHN practices are expected to implement an SDoH screening process that evolves and matures over time. Over time, your practice may consider more comprehensive screening tools such as one of the recommended screening tools provided in **Appendix B** and **Appendix C**. Please note that the survey may be tailored to fit the current capabilities of your practice. The survey in **Appendix C** purposely removes questions related to urgent needs. If your practice would like to use one of these tools and/or tailor the tools to your practice, please contact your PHM Network Representative.

Note: If your practice currently has a process in place to screen for SDoH, you may continue to use that process if it meets the minimum requirements. 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 75% is considered the top performance target.

Question 7: What if my practice is not prepared to address positive screenings for social needs?

In the short-term, CMHN recommends referring families/patient to www.AuntBertha.com. Aunt Bertha is a publicly available resource dedicated to connecting people to social needs programs in a particular area. It's simple, it's free, and can help connect patients/families that are in need of a little help. CMHN has developed two patient/family flyers that can be shared with patients/families. See **Appendix D**. Please contact your PHM Network Representative if you would like print copies or e-versions of these flyers.

CMHN has also developed a one-page social needs resource guide (See **Appendix E**) that includes organizations and/or programs in the Kansas City metropolitan area that you may refer families to. These organizations/programs are often used by Children's Mercy staff to support and/or address family social needs. This resource may be used as a quick reference for your practice care teams. If you have suggestions and/or recommendations on additional agencies to include, please share with your PHM Network Representative.

Note: CMHN will be developing capabilities through CMHN's population health management platform (Innovaccer) to refer and perform closed-loop referrals to address social needs. This capability will be important as CMHN prepares for the potential long-term need to report 'closed-loop' referrals to Blue KC in 2022. Please note that for calendar year 2021, Blue KC is only evaluating whether the SDoH screening is completed.

Question 8: 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 2021 (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.

Question 9: Do CMHN practices have the option or the ability to use the results of a screening from one family member for another family member?

Yes. However, Blue KC has indicated that if a claim is being submitted, the expectation is that the screen is performed on each child/member. If you use the results of another child's screening that occurred earlier in the measurement year, it is expected that the results of the screening are reviewed at the visit and updated as applicable. Based on the measure definition, each family member will be included in the measure denominator and must have the SDoH screening code (i.e. G9920 or G9919) included in claims data to be considered compliant.

Important: Carefully consider the administrative complexity of trying to utilize SDoH screening results for members of the same family that would typically receive primary care at different times of the year. When feasible, it may be more efficient and effective to simply perform the SDoH screening with the same parent at different times of the year. While this may be a little repetitive, social and environment factors may change throughout the course of the year that may make multiple screens valuable.

UPDATED

Question 10: CMHN's expectation is that increased social needs screening will substantially increase demand for services from community benefit organizations (CBOs). How is Blue KC developing or supporting relationships with CBOs to influence both the demand on and capacity of CBO services?

Blue KC Response: Blue KC is assuming a leadership position in the region with our Community Health Department around social determinants of health. Numerous studies provide evidence that 80% of health outcomes are attributed to non-clinical factors, leaving only 20% 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, housing and food insecurity challenge and often preclude management and improvement of chronic conditions, resulting in exacerbated illnesses and high cost members.

The key innovation to address Social Determinants of Health in the marketplace is our development of a Social Needs Referral Network using the Healthify platform Blue KC is working with United Way of Greater Kansas City and the Mid-America Regional Council to curate a network of social service organizations that provide coordinated non-clinical care to our members.

Utilizing ICD-10 z-code data as well as feedback from the participating organizations in the Social Needs Referral Network, Blue KC will routinely evaluate capacity of the network. Blue KC and our APC provider partners will uncover the unmet needs of families in the region as well as identify where capacity of the network needs to be fortified to address those challenges. Through the Social Needs Referral Network, providers will have the ability to connect families to the United Way 211 when a specific social need cannot be met through our curated network of community-based providers. Anticipating the increased capacity, Blue KC is supplying our partnering organizations with funding.

Question 11: Is Blue KC attempting to collect when social needs screenings are completed at other locations? If screenings are performed at other locations/sources (e.g. by a Blue KC care manager, school), will those patients 'receive credit' for having completed a social needs screening?

Blue KC indicated that screenings at non-healthcare locations will NOT be considered for 2021. Blue KC does not receive SDoH screening data from non-healthcare locations. Blue KC believes a patient's medical home

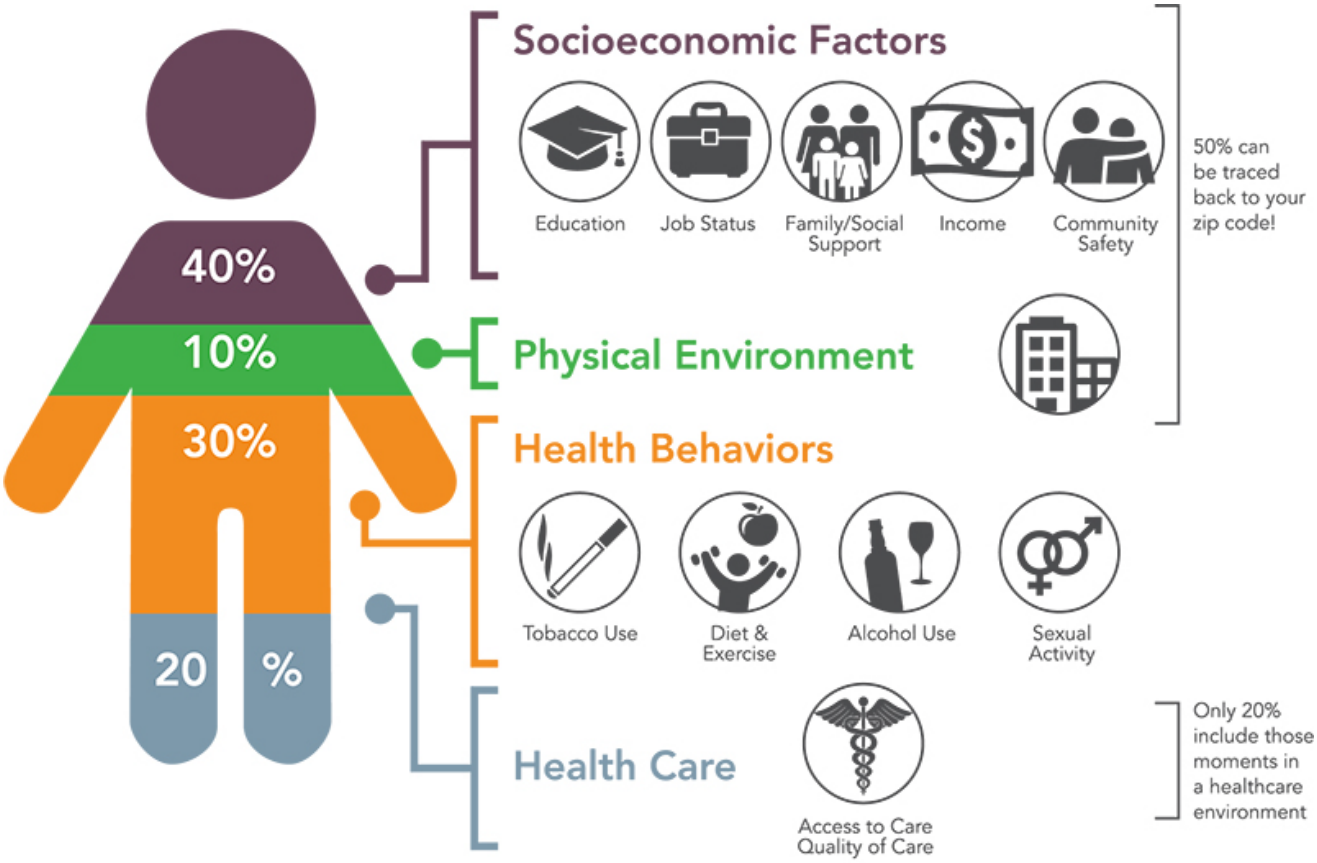
is responsible and accountable for completing an annual Social Determinants of Health Screening. Since Blue KC funds medical home entities with incentives (i.e. CMHN value based incentives), Blue KC does not have dedicated care managers and/or care coordinators serving these patients. Therefore, Blue KC care managers are not completing SDoH screenings. Blue KC incentive funds are expected to be used by practices to support and/or advance applicable care coordination services.

Question 12: 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 13: 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)

NEW

Question 14: 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 2021. 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.

NEW

Question 15: What examples of "evidence-based" SDoH screening tools are available?

CMHN has developed a comprehensive screening tool based on the clinically validated WE-CARE survey (**See Appendix B and Appendix C**). 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)

NEW

Question 16: 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.***

NEW

Question 17: 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 11) 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. The Social Determinants of Health Z codes for 2021 are: See Last Page.

Definitions:

Measurement Period: Calendar Year 2021 (January 1, 2021 through December 31, 2021)

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.

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

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
Z55.8 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 housing and economic circumstances (Z59)
Z59.0 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
Z59.5 Extreme poverty
Z59.6 Low income
New Code Z59.61 Unable to pay for prescriptions
New Code Z59.62 Unable to pay for utilities
New Code Z59.63 Unable to pay for medical care
New Code Z59.64 Unable to pay for transportation for medical appointments or prescriptions
New Code Z59.65 Unable to pay for phone
New Code Z59.66 Unable to pay for adequate clothing
New Code Z59.67 Unable to find or pay for childcare
Z59.7 Insufficient social insurance and welfare support
Z59.8 Other problems related to housing and economic circumstances
Z59.9 Other problems related to housing and economic circumstances, unspecified
New Code Z59.91 Worried about losing housing

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
New Code Z60.81 Unable to deal with stress
New Code Z60.82 Inadequate social interaction – limited to once or twice a week
New Code Z60.83 Can hardly ever count on family and friends in times of trouble
New Code Z60.84 Feeling unsafe in current location
New Code Z60.85 Stressed quite a bit or very much
New Code Z60.86 Stressed somewhat
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

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

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

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
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

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

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

Appendix B: CMHN Recommended Social Needs Screening Survey (with Urgent Needs Included)

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: _____

	**Do you have a high school degree or diploma?**	Yes ☐ No ☐
	If **no**, would you like help to get a GED?	Yes ☐ No ☐ Maybe Later ☐
	**Do you have a job?**	Yes ☐ No ☐
	If **no**, would you like help with finding employment and/or job training?	Yes ☐ No ☐ Maybe Later ☐
	**Do you need daycare for your child?**	Yes ☐ No ☐
	If **yes**, would you like help finding it?	Yes ☐ No ☐ Maybe Later ☐
	**Do you think you are at risk of becoming homeless?**	Yes ☐ No ☐
	If **yes**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	If **yes**, is this an emergency?	Yes ☐ No ☐
	**Do you always have enough food for your family?**	Yes ☐ No ☐
	If **no**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	If **yes**, do you need food for tonight?	Yes ☐ No ☐
	**Do you have trouble paying your heating bill and/or electricity bill?**	Yes ☐ No ☐
	If **yes**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	If **yes**, are you at risk of having your utilities shut off in the next week?	Yes ☐ No ☐
	**Do you have transportation to get to appointments, work, or other places you need to go?**	Yes ☐ No ☐
	If **no**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	**Are you afraid you might be hurt in your apartment building or house?**	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 ☐

Based on WE-CARE Survey: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education
Source: Gary A, Butz AM, et al. The WE CARE Project. Pediatrics. 2007.

Appendix C: CMHN Recommended Social Needs Screening Survey (with Urgent Needs Excluded)

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!

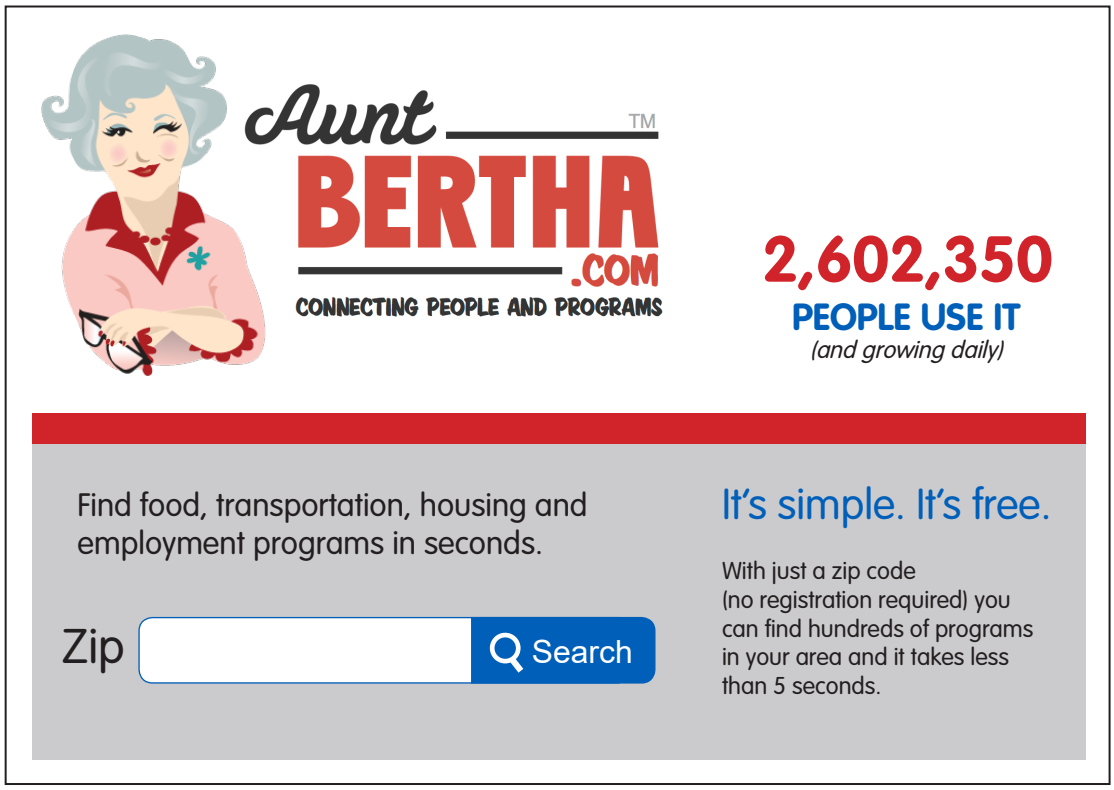
Name: _____ Phone Number: _____

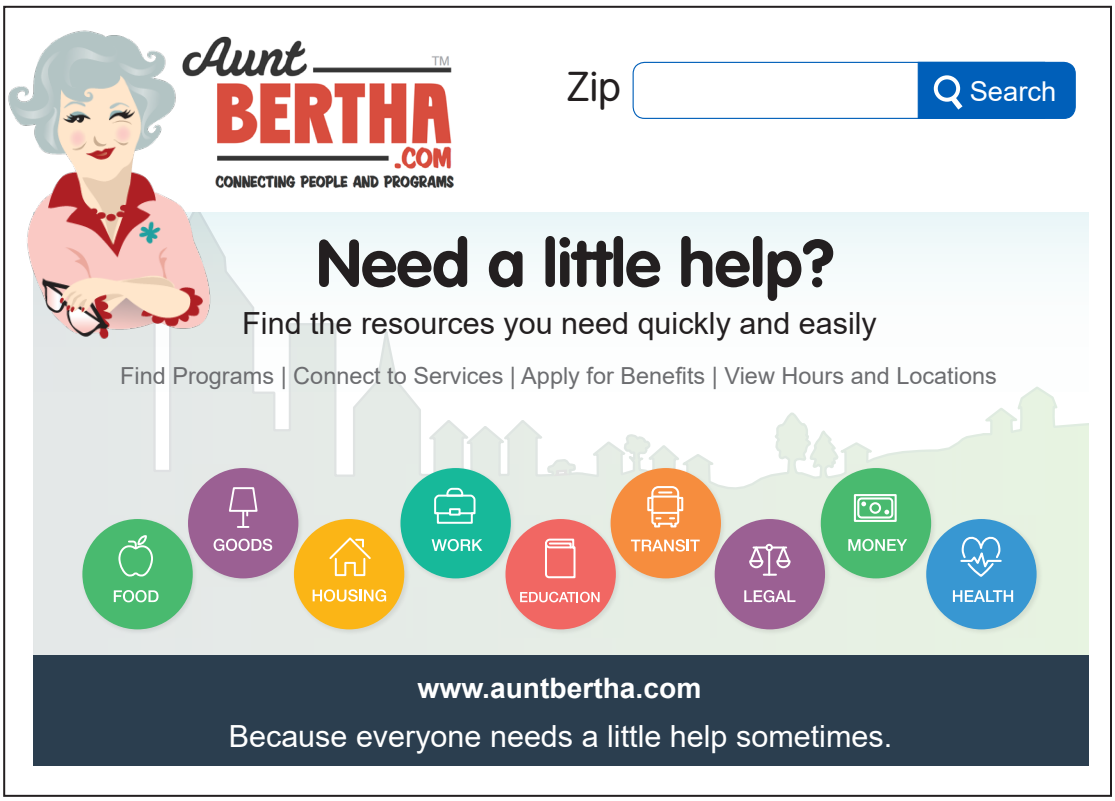
Preferred Language: _____ Best Time to Call: _____

	**Do you have a high school degree or diploma?**	Yes ☐ No ☐
	If **no**, would you like help to get a GED?	Yes ☐ No ☐ Maybe Later ☐
	**Do you have a job?**	Yes ☐ No ☐
	If **no**, would you like help with finding employment and/or job training?	Yes ☐ No ☐ Maybe Later ☐
	**Do you need daycare for your child?**	Yes ☐ No ☐
	If **yes**, would you like help finding it?	Yes ☐ No ☐ Maybe Later ☐
	**Do you think you are at risk of becoming homeless?**	Yes ☐ No ☐
	If **yes**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	**Do you always have enough food for your family?**	Yes ☐ No ☐
	If **no**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	**Do you have trouble paying your heating bill and/or electricity bill?**	Yes ☐ No ☐
	If **yes**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	**Do you have transportation to get to appointments, work, or other places you need to go?**	Yes ☐ No ☐
	If **no**, would you like help with this?	Yes ☐ No ☐ Maybe Later ☐
	**Are you afraid you might be hurt in your apartment building or house?**	Yes ☐ No ☐

Based on WE-CARE Survey: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education
Source: Gary A, Butz AM, et al. The WE CARE Project. Pediatrics. 2007.

Appendix D: Aunt Bertha Referral Card Options for Patients / Families





Appendix E: Social Needs Resource Guide

MULTI-SERVICE

Bishop Sullivan Center (Serves MO)	6435 Truman Rd, Kansas City, MO 64126 ☎ (816) 231-0984
Catholic Charities of Kansas City (Serves MO)	4001 Blue Parkway, Suite 250, Kansas City, MO 64130 ☎ (816) 221-4377
Catholic Charities of Northeast Kansas (Serves KS)	9720 W 87th St, Overland Park, KS 66212 ☎ (913) 433-2100 catholiccharitiesks.org
City Union Mission - Family & Youth Center (Serves KS & MO)	1310 Wabash Ave, Kansas City, MO 64127 ☎ (816) 474-4599
Community Action Agency of Greater Kansas City (Serves MO)	6323 Manchester Ave, Kansas City, MO 64133 ☎ (816) 358-6868
Hope Faith Ministries (Serves KS & MO)	705 Virginia Ave, Kansas City, MO 64106 ☎ (816) 471-4673

GED / JOB ASSISTANCE

Full Employment Council (Serves MO)	1740 Paseo, Kansas City, MO 64108 ☎ (816) 471-2330
Bishop Sullivan Kansas (Serves KS)	2220 Central Ave, Kansas City, KS 66102 ☎ (913) 220-2480

FOOD

Harvesters - The Community Food Network (Food Assistance Locator) (Serves KS & MO)	3801 Topping Ave, Kansas City, MO 64129 https://www.harvesters.org/get-help

HOUSING / HOMELESSNESS

Hillcrest Transitional Housing (Serves MO)	PO Box 901924, Kansas City, MO 64190 ☎ (816) 994-6934
Housing Information Center - Housing Services (Serves KS & MO)	3200 Wayne, Mohart Center, Kansas City, MO 64109 ☎ (816) 931-0443 greaterkchousinginformationcenter.org
KCK Family Shelter (Serves KS)	1201 ½ Minnesota, Kansas City, KS ☎ (913) 621-1052

UTILITIES

Mid-America Assistance Coalition - LIHEAP (Serves MO)	4001 Blue Pkwy, Ste 270, Kansas City, MO 64130 ☎ (816) 768-8900
Kansas Dept For Children And Families – LIEAP (Serves KS)	402 State Ave, Kansas City, KS 66101 ☎ (800) 432-0043 Johnson, Leavenworth, and Wyandotte County DCF location

DOMESTIC VIOLENCE

Newhouse (Serves MO)	Kansas City, MO 64124 ☎ (816) 474-6446
Safehome (Serves KS)	PO Box 4563, Overland Park, KS 66204 ☎ (913) 262-2868

DAYCARE

Child Care Aware	Missouri: https://www.mo.childcareaware.org/ Kansas: https://www.ks.childcareaware.org/