PCN Social Determinants of Health (SDoH) Screening FAQ

The following FAQ has been updated for 2023 to address questions regarding the 'Social Determinants of Health Screening' measure.

Key Information to Begin SDoH Screening in Your Practice

When: Your practice will be evaluated on the completion of SDoH screenings throughout the 2023 calendar year.

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, and housing issues or concerns.

How: Screening is based exclusively on claims data and must be captured with the following non-payable CPT codes:
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 code should be included (See Question 3 for ICD-10 codes expected to be used most frequently for positive screens).

How to Address Positive Screenings: PCN recommends referring families/patients to www.liftupkc.org to find resources available in their area. PCN will be developing capabilities through PCN's population health management platform (Innovaccer) to refer, intervene, 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.

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.

Question 1: How is the 'Social Determinants of Health Screening' measure defined?

The eligible population includes patients 0 through 21 years of age with at least one visit with a primary care provider in the measurement year. There is a continuous enrollment requirement. Patients can have no more than one gap in enrollment of up to 45 days during the measurement year.

Question 2: For the SDoH Screening measure, is measure compliance based exclusively on claims for non-payable CPT codes G9920 and G9919?

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 screening is positive, an ICD-10 Z code should be documented on the claim indicating the applicable SDoH reason. The screening HCPCS codes can be pointed or tied to any diagnosis code on the claim. PCN 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.

Tip/Insight: The ICD-10 Z code is not required for compliance for positive screenings. However, inclusion of the applicable ICD-10 code is highly encouraged since it will impact the risk score of the patient.

Question 3: Is the list of ICD-10 diagnostic codes included in 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 PCN becomes aware of additional codes, a communication will be sent to inform all PCN 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
  - Z594 – Lack of adequate food and safe drinking water
- Housing
  - Z591 – Inadequate housing
  - Z598 – Other problems related to housing and economic circumstances
  - Z599 – Problem related to housing and economic circumstances, unspecified

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

Question 4: What are the minimal requirements to complete an SDoH screening?

PCN practices have flexibility in how they administer an SDoH screening. Screening must at least address transportation, food insecurity, and housing issues or concerns.

Potential Minimum Screening Verbiage to Parent/Patient:

- "Do you need any help (or have concerns) with transportation, food, or housing?"

PCN 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**. Please note that the survey may be tailored to fit the current capabilities of your practice.

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

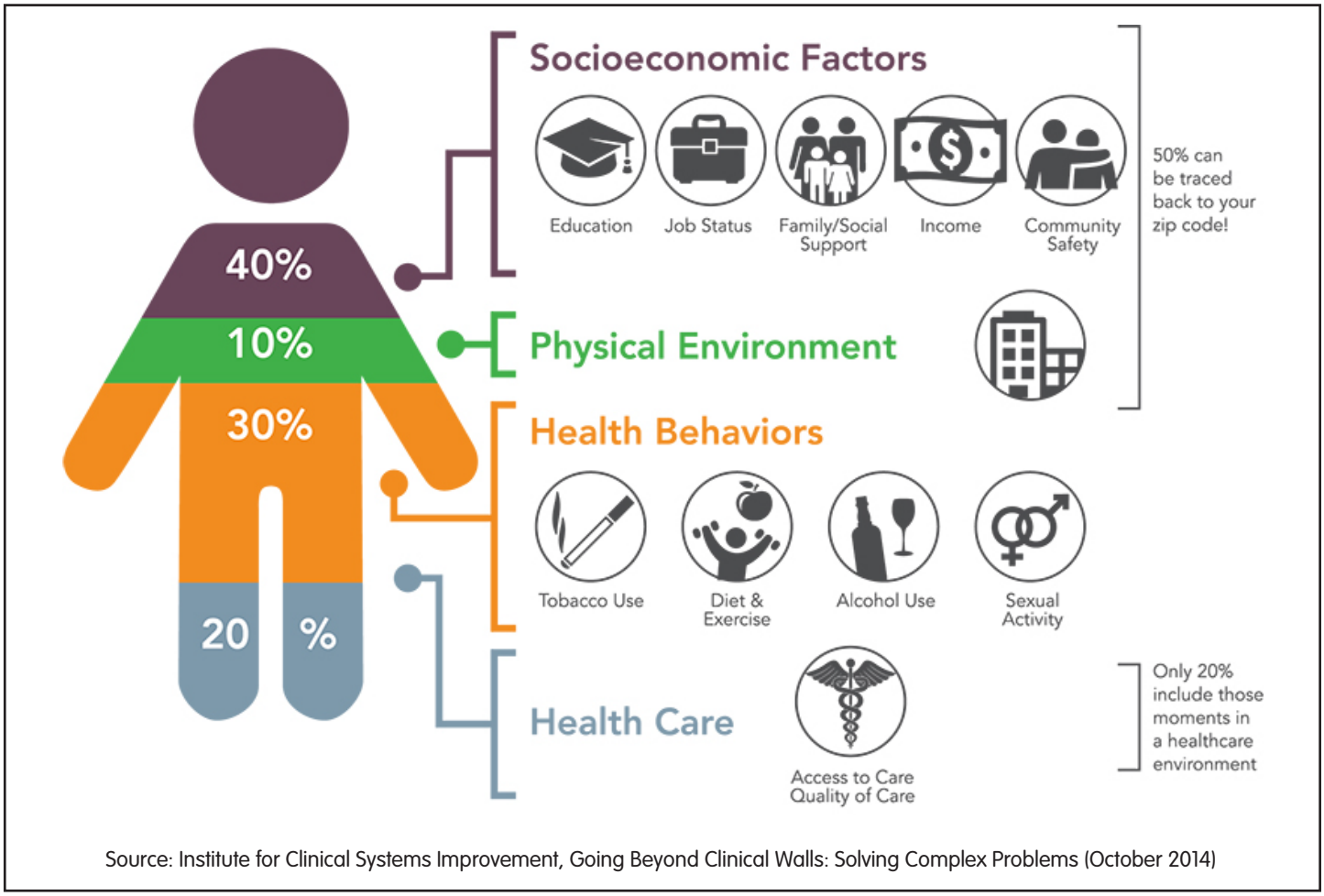
Question 5: What if my practice is not prepared to address positive screenings for social needs?

To understand different methods of helping patients who screen positive for social needs, refer to **Appendix C**. PCN recommends referring families/patient to www.liftupkc.org. Lift Up KC 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. See **Appendix D**. Please contact your PCN PHM Network Representative if you would like print copies or e-versions of these flyers.

Note: PCN will be developing capabilities through PCN's population health management platform (Innovaccer) to refer, intervene, and perform closed-loop referrals to address social needs. This capability will be important as PCN prepares for the long-term need to report 'closed-loop' referrals.

Question 6: Why is PCN adding a SDoH Screening measure? Are other payers adding SDoH screening requirements?

Across the country, CMS (Center for Medicare & Medicaid Services) and other 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 continue to transition toward more advanced 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.



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

NEW

Question 7: What examples of "evidence-based" SDoH screening tools are available?

PCN has developed a comprehensive screening tool based on the clinically validated Health Leads survey and PRAPARE 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/wp-content/uploads/2019/04/NACHC_PRAPARE_Full-Toolkit.pdf)
- 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)

Appendix A: ICD-10 Diagnostic Codes

ICD-10 SOCIAL DETERMINANTS OF HEALTH (SDOH) Z-CODES – 2023

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 (New code eff. 4/1/2023)
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)
Z58.6 Inadequate drinking-water supply
Z58.8 Other problems related to physical environment
Z58.81 Basic services unavailable in physical environment (New code eff. 4/1/2023)
Z58.89 Other problems related to physical environment (New code eff. 4/1/2023)

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 (New code eff. 4/1/2023)
Z59.12 Inadequate housing utilities (New code eff. 4/1/2023)
Z59.19 Other inadequate housing utilities (New code eff. 4/1/2023)
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
Z59.81 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 (New code eff. 10/1/2022) Prior to the creation of this code, **Z91.89** Other specified personal risk factors, not elsewhere classified, was used for Transportation Insecurity
Z59.86 Financial insecurity (New code eff. 10/1/2022)
Z59.87 Material hardship (New code eff. 10/1/2022)
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 (New code eff. 10/1/2023)
Z62.24 Child in custody of non-relative guardian (New code eff. 10/1/2023)
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 (New code eff. 4/1/2023)
Z62.815 Personal history of intimate partner abuse in childhood (New code eff. 4/1/2023)
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 (New code eff. 10/1/2023)
Z62.83 Non-parental relative or guardian-child conflict (New code eff. 10/1/2023)
Z62.831 Non-parental relative-child conflict (New code eff. 10/1/2023)
Z62.832 Non-parental guardian-child conflict (New code eff. 10/1/2023)
Z62.833 Group home staff-child conflict (New code eff. 10/1/2023)
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] (New code eff. 10/1/2023)
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)
Z75.3 Unavailability and inaccessibility of health care facilities
Z75.4 Unavailability and inaccessibility of other helping agencies

Patient's noncompliance (Z91)
Z91.11 Patient's noncompliance with dietary regimen (New code eff. 4/1/2023)
Z91.12 Patient's intentional underdosing of medication regimen (New code eff. 4/1/2023)
Z91.13 Patient's unintentional under dosing of medication regimen (New code eff. 4/1/2023)
Z91.14 Patient's other noncompliance with medication regimen (New code eff. 4/1/2023)
Z91.15 Patient's noncompliance with renal dialysis (New code eff. 4/1/2023)
Z91.19 Patient's noncompliance with other medical treatment and regimen (New code eff. 4/1/2023)

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

Appendix B: PCN Recommended Social Needs 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

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

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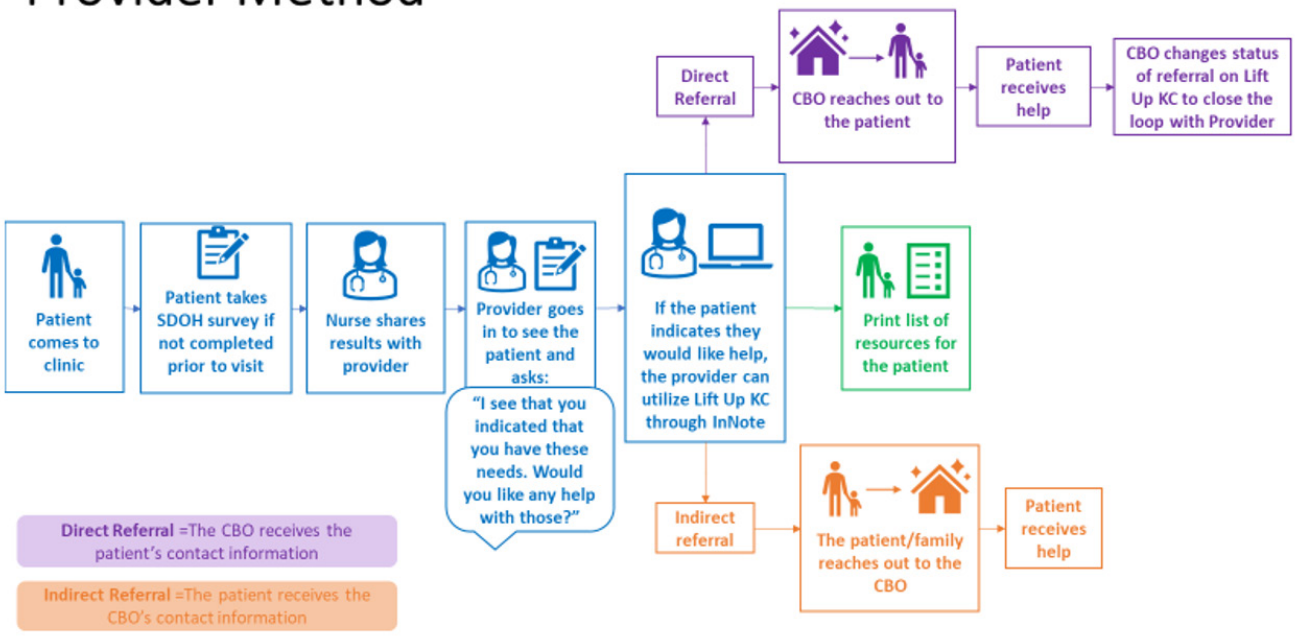
[1]https://www.cmics.org/cmhn/LoadImagesFiles/LoadFile?contentGUID=4DFD26B5-8C28-4B55-B9C0-1B9A96493FA6

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

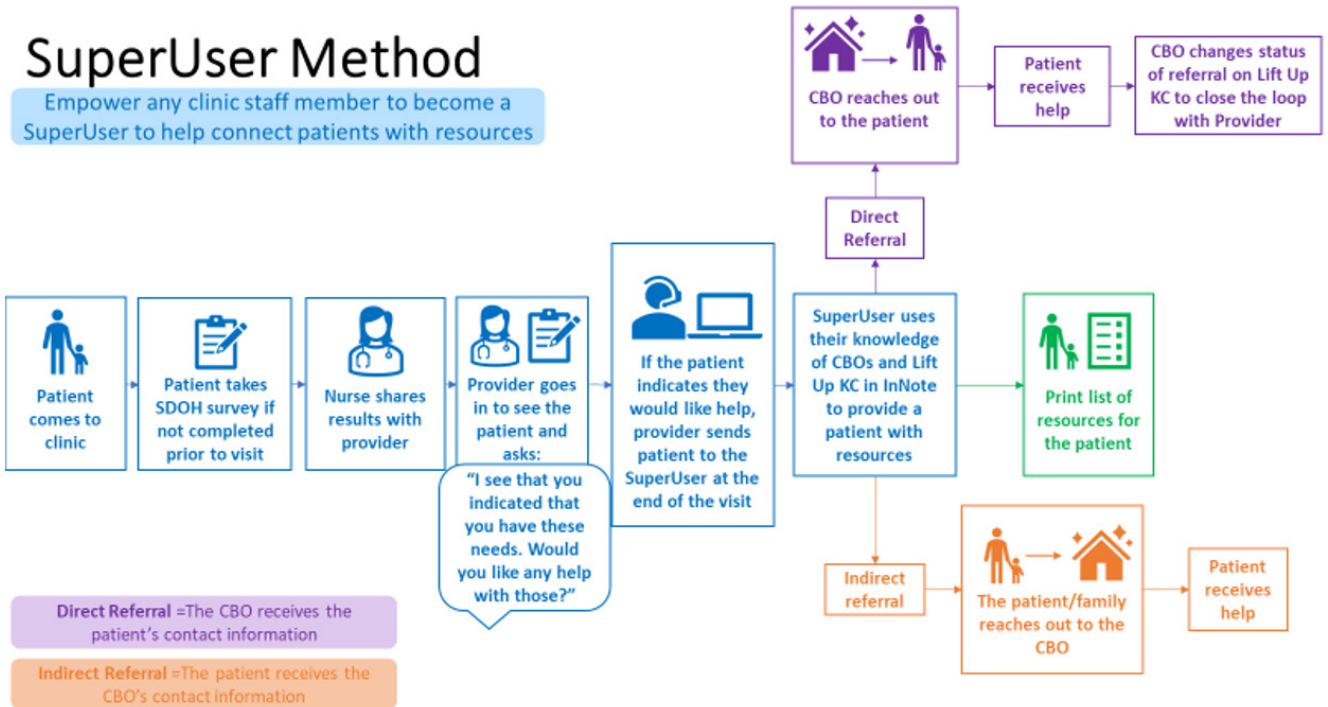
Recommended workflows for addressing positive screens:

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