Documenting Social Determinants of Health (SDOH), Z Codes and Social Needs Screening (SNS- E) Codes

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Agenda

- L.A. Care's Commitment
- Regulatory Requirements
- Social Needs Screening and Intervention (SNS-E) Explained
- Social Determinants of Health (SDOH) Z Codes Explained
- Screening Tools
- Common Challenges/Addressing Challenges
- L.A. Care Support
- Frequently asked questions

L.A. Care Health Plan Commitment To Health Equity

The 2023-2025 Health Equity and Disparities Mitigation Plan

Mission

To support, guide and inspire staff and providers to provide equitable and accessible health care for all.

Vision

In partnership with our members, community partners and providers, we strive towards making Los Angeles County a leader in ensuring that everyone has a fair and just opportunity to be as healthy as possible.

L.A. Care Health Plan Commitment To Health Equity

Health Equity Zone includes four priority focus areas:

1. ***Address key health disparities:*** close racial and ethnic gaps in health outcomes among members.

2. ***Lead change:*** provide leadership and be an ally for community partners to promote health equity and social justice.

3. ***Move towards equitable care:*** ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care.

   - Strengthening the collection and linkages of SDOH information on the need for food, housing, and transportation among L.A. Care members.

4. ***Embrace diversity, equity, and inclusion:*** serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices.

L.A. Care Health Plan Commitment To Health Equity

- Prioritizing the collection and reporting of **social determinants of health (SDOH) Z codes** and National Committee for Quality Assurance's (NCQA) new **Social Needs Screening and Intervention-Electronic (SNS-E) measure**.

- Collaborating with our network providers to reliably and consistently collect SDOH Z code and SNS-E data so we can better identify our members' needs and support them.

Regulatory Requirement for SDOH and SNS-E

Agency	Policy/Contract	SDOH/SNS-E Codes	Collection Date Start
Covered California (CC) 2024	*2024 Amendment for CC Qualified Health Plan Issuer Contract for 2023-2025 for Individual Market	Contractor must screen all Covered California Enrollees at least annually for unmet food, housing, and transportation needs food insecurity. Contractor must use one or more screening instruments specified in the Social Need Screening and Intervention (SNS-E) measure specifications.	MY 2024 (Jan 1 - Dec 31)
National Committee for Quality Assurance (NCQA) New HEDIS Measure	Social Need Screening and Intervention (SNS-E)	The percentage of members who were screened, using pre specified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.	MY 2023 (Jan 1 - Dec 31)
Department of Health Care Services (DHCS)	Department of Health Care Services (DHCS) APL 21-009 (Revised)	25 prioritized Z codes	February 3, 2022

Social Need Screening and Intervention (SNS-E)

This is a first-year measure with 6 different sub-measures, 2 for each of the 3 screening categories.

Description: The percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for **unmet food, housing, and transportation needs**, and received a corresponding intervention if they screened positive.

- ***Food Screening.*** The percentage of members who were screened for food insecurity.
- ***Food Intervention.*** If screened positive, the percentage of members who received a corresponding intervention within 1 month of the positive screening.
- ***Housing Screening.*** The percentage of members who were screened for housing instability, homelessness or housing inadequacy.
- ***Housing Intervention.*** If screened positive, the percentage of members who received a corresponding intervention within 1 month of the positive screening.
- ***Transportation Screening.*** The percentage of members who were screened for transportation insecurity.
- ***Transportation Intervention.*** If screened positive, the percentage of members who received a corresponding intervention within 1 month of the positive screening.

Social Need Screening and Intervention (SNS-E)

- Measurement period: January 1 – December 31.
- Entire Population (all ages) for all lines of business (MY2023 reportable for Medicaid and Medicare).
- Ensure these questions are being asked and entered into the patient's medical record/electronic health record (EHR).
- While NCQA has listed screening tools in the HEDIS Tech Specs, health plans and providers do not need to use the exact survey tool as long as the questions are identical.
- Any response to one of the pre-specified items included in the measure specification counts as numerator compliant for the screening numerator, including a documented decline.

Social Need Screening and Intervention (SNS-E)

- SNS-E measures how well health plans and providers screen and intervene for barriers to care at the population level.
- Community Health Workers (CHWs) and Social Worker (SW) are great exemplars in removing Social Determinants of Health (SDOH) barriers.
- Use SNS-E data as a powerful lever to scale social needs support at a membership level to support health optimization, experience and improving health equity.
- Building SNS-E structure into existing touchpoints for each visit being done.
- Ensuring timely and adequate response.

Social Need Screening and Intervention (SNS-E)

Value Set Codes for Food Insecurity Instruments

Screening instruments	LOINC Code details	Screening Item LOINC Codes	Positive Finding LOINC Codes
Food Insecurity Instruments	Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	88122-7	LA28397-0 - Often true LA6729-3 - Sometimes true
		88123-5	LA28397-0 - Often true LA6729-3 - Sometimes true
	American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88122-7	LA28397-0 - Often true LA6729-3 - Sometimes true
		88123-5	LA28397-0 - Often true LA6729-3 - Sometimes true
	Health Leads Screening Panel®[1]	95251-5	LA33-6
	Hunger Vital Sign™[1] (HVS)	88124-3	LA19952-3
	Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®[1]	93031-3	LA30125-1
	Safe Environment for Every Kid (SEEK)®[1]	95400-8	LA33-6
		95399-2	LA33-6
	U.S. Household Food Security Survey [U.S. FSS]	95264-8	LA30985-8 - Low food security LA30986-6 - Very low food security
	U.S. Adult Food Security Survey [U.S. FSS]	95264-8	LA30985-8 - Low food security LA30986-6 - Very low food security
	U.S. Child Food Security Survey [U.S. FSS]	95264-8	LA30985-8 - Low food security LA30986-6 - Very low food security
	U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 - Low food security LA30986-6 - Very low food security
	We Care Survey	96434-6	LA32-8
	WellRx Questionnaire	93668-2	LA33-6

Social Need Screening and Intervention (SNS-E)

Value Set Codes for Housing Instability and Homelessness Instruments

Screening instruments	LOINC Code details	Screening Item LOINC Codes	Positive Finding LOINC Codes
Housing Instability and Homelessness Instruments	Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	71802-3	LA31994-9 - I have a place to live today, but I am worried about losing it in the future LA31995-6 - I do not have a steady place to live
	American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99550-6	LA33-6
	Children's Health Watch Housing Stability Vital Signs™1	98976-4	LA33-6
		98977-2	≥3
		98978-0	LA33-6
	Health Leads Screening Panel®1	99550-6	LA33-6
	Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93033-9	LA33-6
		71802-3	LA30190-5
	We Care Survey	96441-1	LA33-6
	WellRx Questionnaire	93669-0	LA33-6

Social Need Screening and Intervention (SNS-E)

Value Set Codes for Housing Inadequacy Instruments

Screening instruments	LOINC Code details	Screening Item LOINC Codes	Positive Finding LOINC Codes
Housing Inadequacy Instruments	Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	96778-6	LA31996-4 - Pests such as bugs, ants, or mice
			LA28580-1 - Mold
			LA31997-2 - Lead paint or
			LA31998-0 - Lack of heat
			LA31999-8 - Oven or stove
			LA32000-4 - Smoke detectors missing or not working
			LA32001-2 - Water leaks
	American Academy of Family Physicians (AAFP) Social Needs Screening Tool	96778-6	LA32691-0 - Bug infestation
			LA28580-1 - Mold
			LA32693-6 - Lead
			LA32694-4 - Inadequate
			LA32695-1 - Non-functioning oven/stove
			LA32696-9 - No or non-
			LA32001-2 - Water leaks

Social Need Screening and Intervention (SNS-E)

Value Set Codes for Transportation Insecurity Instruments

Screening instruments	LOINC Code details	Screening Item LOINC Codes	Positive Finding LOINC Codes
Transportation Insecurity Instruments	Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool	93030-5	LA33-6
	American Academy of Family Physicians (AAFP) Social Needs Screening Tool	99594-4	LA33-6
	Comprehensive Universal Behavior Screen (CUBS)	89569-8	LA29232-8 - My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured
			LA29233-6 - My transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured
			LA29234-4 - I have no access to transportation, public or private; may have car that is inoperable
	Health Leads Screening Panel®1	99553-0	LA33-6
	Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]®1	93030-5	LA30133-5 - Yes, it has kept me from medical appointments or from getting my medications
			LA30134-3 - Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	PROMIS®1	92358-1	LA30024-6 - I am not at all confident
			LA30026-1 - I am a little confident
			LA30027-9 - I am somewhat confident
	WellRx Questionnaire	93671-6	LA33-6

Supplemental Data Submissions

L.A. Care's Lab File Layout

- Order: 12, 14 & 15
- Field Header Name: LOINC, Lab Value & Result Flag
- Data Type: character or numeric

Order	Field Header Name	Data Type	Length	Required for HEDI	Expected Value	Description
12	LOINC	char	16	Optional		Code for Test done. It can be LOINC codes for the test. If test is present, Code flag should be present (e.g HEDIS measure DMS can expect this Test field to be"44261-6". In this case CPT code field can be blank) The value for either Procedure_Code or Test should be present in the file. Records without Procedure_Code or Test value will be rejected by the system during Data Intake.
13	SNOMED	char	16	Optional		Code for Test done. It can be SNOMED codes for the test. If test is present, Code flag should be present (e.g HEDIS measure DMS can expect this Test field to be"44261-6". In this case CPT code field can be blank) The value for either Procedure_Code or Test should be present in the file. Records without Procedure_Code or Test value will be rejected by the system during Data Intake.
14	Lab_Value	numeric	(20,4)	Optional		Lab result value or test result, i.e. "8.2" for HbA1c.PHQ-9 total score, populate the lab result value or test result in the "Lab_Value" field and corresponding code value in the "LOINC" field as applicable.
15	Result_Flag	char	1	Optional	P = Positive N = Negative	Binary field to indicate lab test result as Positive/Negative. (e.g. Diabetes Retinal Screening test result) It is used for CDC measure, Hybrid Chase Request/Response files

Supplemental Data Submissions

Examples for Food Insecurity Instruments using Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

Supplemental Data Submissions

Examples for Food Insecurity Instruments using Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool

Positive Screening

Order	Field Header Name	Expected Value
12	LOINC	88122-7
14	Lab_Value	LA6729-3
15	Result_Flag	P

Negative Screening/Declined

Order	Field Header Name	Expected Value
12	LOINC	88122-7
14	Lab_Value	Null
15	Result_Flag	N

Social Need Screening and Intervention (SNS-E)

- Documented decline responses are allowed and counted for screening (no intervention is required).
- If fielding a full screening tool or one or more questions per screening area, you have to document a refusal to the screening for numerator credit.
- When you place screening questions in the patient's medical record/electronic health record (EHR), Health Risk Assessment (HRA), portal questionnaire, or annual wellness visit form, you have to add 'declined' as a response option.
- Missing answers (no response) don't count as a decline, per NCQA.
- If it's a telephonic survey, and the member states they decline to answer, that counts. You don't have to offer 'decline' as a response option on an interactive survey; you just have to document it.

Social Need Screening and Intervention (SNS-E)

Qualitative Data Collection

- **Barriers:**
  - The screening numerator codes are LOINC codes, which are not a part of claims.
    - We are not getting the LOINC codes as standard data which is a reason for the missing numerator hits.
  - Many provider and provider groups do not have the screening numerator codes or the intervention codes entered as LOINCs in their EHR systems.

- **Actions Needed:**
  - Provide education and provider resources to screen each member/patient for social need and timely intervention if positive.
  - Documentation and submission of supplemental data.
  - Close gaps within Cozeva platform.
  - Extract LOINC code data from EHR systems and submit as supplemental data if available.

- **Assessment:**
  - Review impact on data submission and continue with closing gaps and submit incremental data monthly.
    - If no improvement from month to month, reach out to L.A. Care, our plan partners and IPA for support and guidance.

SDOH Diagnosis Codes Explained

- SDOH Z codes are based on the International Classification of Diseases, Tenth Revision, and Clinical Modification (ICD-10-CM) for providers to utilize when coding for patients' social barriers.

- The Z codes help to ensure reliable data collection of patients' social need(s), which impact health outcomes, are captured.

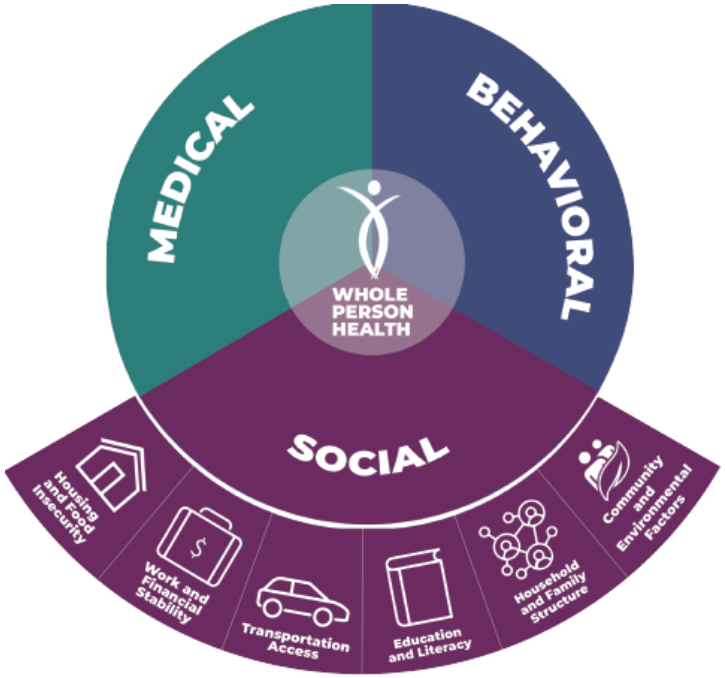
- L.A. Care is prioritizing **25** of those Z codes

Overview of Prioritized SDOH Z Codes

Code	Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.7	Insufficient social insurance and welfare support
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
Z59.89	Other problems related to housing and economic circumstances
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problems)

Screening Tools

- Accountable Health Communities Health-Related Social Needs Screening Tool (AHC)
- Comprehensive Universal Behavior Screen (CUBS)
- Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE)



Common Challenges

- **Lack of familiarity with properly coding and documenting SDOH** among providers and medical billers/coders.
- **Limitations on providers' end** as some providers recognize the social, economic, and environmental challenges that some of their patients face, yet may feel limited in what they can do and/or may require guidance on how best to assist their patients in addressing their non-medical needs.
- **Understaffed** clinician offices to support and prioritize the collection of data.
- **Priority for pressing health needs** overshadows Z code collection.
- **Absence of standardization** in data collection and sharing.
- **Screening tools** can be lengthy, not seamless in capturing SDOH Z codes, and do not prioritize the SDOHs to best meet needs.
- **Specific SNS-E Challenges** includes interventions take place and ensuring the screening code is being submitted.

Addressing Challenges

- Prioritize training staff about the codes.
- Identify who in the office staff can collect SDOH Z code information.
- If a patient identifies an SDOH health concern, please ensure to document them in the EHR.

L.A. Care Community Resources

- Programs that are *open to L.A. Care members or general public*, include:

- **Community Link** platform serves as a Yelp for resources, allowing one to search and connect to supports such as financial assistance, food pantries, and other free or reduced-cost services. Find more information here.
  - There is a 9-questionnaire PRAPARE screening tool available.

- The 12 L.A. Care and Blue Shield Promise **Community Resource Centers (CRCs)** offer free health and wellness classes that are open to the public. Find more information here or call 1-877-287-6290. Our centers provide:
  - Food pantries, nutrition classes and cooking demonstrations
  - Zumba, yoga, hip-hop dance or aerobics classes
  - Free access to telehealth services
  - Linkages to assistance programs
  - Enrollment support for Medi-Cal and other Health Coverage Programs.

L.A. Care Community Resources

- Programs that need *referral forms*:

- **Enhanced Care Management (ECM)** is a Medi-Cal benefit that provides comprehensive care management services to Medi-Cal members with complex health and/or social needs. Find more information here.
  - ECM referral process here.
  - ECM referral forms.

- The **Homeless and Housing Support Services Program (HHSS)** provides two services to eligible members: housing navigation and tenancy services. HHSS is part of L.A. Care's health services called Community Supports. Find more information here.
  - HHSS referral process here.
  - HHSS referral form.

- **Medically tailored meals (MTM)** provide referrals for nutrition and food access. Find more information here.
  - MTM referral process here.
  - MTM referral form.

L.A. Care Community Resources

The program that needs a *recommendation form*:

- **Doula Support for Expectant Mothers** helps to improve birth outcomes for L.A. Care's pregnant Medi-Cal members and reduce the maternal mortality disparity. Clinician offices can help members access services through L.A. Care's network of doula providers! Find more information here.

- **The Doula Recommendation Form** can be accessed here.

L.A. Care Community Resources

- **Transportation Services**: For our Medi-Cal and Medicare Plus, transportation benefits for members to see their provider and obtain medically necessary covered services at no cost. Members can call L.A. Care Member Services on their health insurance card.
  - The member services phone number: 1-888-839-9909 (TTY 711)
  - For our L.A. Care Covered/Direct and Personal Assistance Services Council (PASC) members, transportation benefits are covered. Review Member Evidence of Coverage (Member Handbook) for important information about transportation services offered by our plan.
  - Member Handbook: 2024 L.A. Care Medi-Cal Member Handbook (lacare.org)
  - L.A. Care Transportation Website: Transportation Services | L.A. Care Health Plan (lacare.org)

Frequently Asked Questions

1. Are the measures incentivized?
   - SDOH value initiative for IPA performance (VIIP) measure will be incentivized for 2023.
   - SDOH pay for performance (P4P) measure will be a payment measure for MY 2024.
   - We have introduced one measure this year, next year we will introduce another one, and in the future, we will introduce more. We hope to incentivize these measures.
   - We would like to work with providers to introduce a screening metric and incentivize them.

2. Who in the office team can enter the codes? Providers or medical assistants?
   - Any member of a person's care team can collect SDOH data during any encounter. This includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
   - Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Frequently Asked Questions

3. Who needs to take action on a positive screening? Provider or administrator?
    - Someone in the office staff who is designated to provide linkages.
    - L.A. Care can help with providing resources via our community link platform where we can document this information.
    - Community Resource Centers are open to members and nonmembers.

4. Is it required to use the ICD-10 code from the priority list, or can we use an ICD-10 SDOH code or Z code that better fits the assessment?
    - You are the expert and will know the right type of code to document when talking to the patient.

5. Can you differentiate between SNS-E and Social Determinants of Health (SDOH)?
    - Z codes for SDOH measure
    - LOINC codes SNS-E measure
        - Acceptable CPT codes for SNS-E for all 3 categories – 96156, 96160 & 96161

Frequently Asked Questions

6. Will Social Determinants of Health (SDOH) screeners, such as PRAPARE be reimbursable in the future? Similar to Adverse Childhood Experiences (ACEs) being reimbursable?
   - The state reimburses for ACEs, but they have not mentioned anything about reimbursing for PRAPARE.
   - For the future, we are working to incentivize SDOH codes via L.A. Care VIIP and P4P as a way to encourage documenting the SDOH codes.