Phoenix Children's®
Care Network

Social Drivers of Health: Screening in the Clinical Setting

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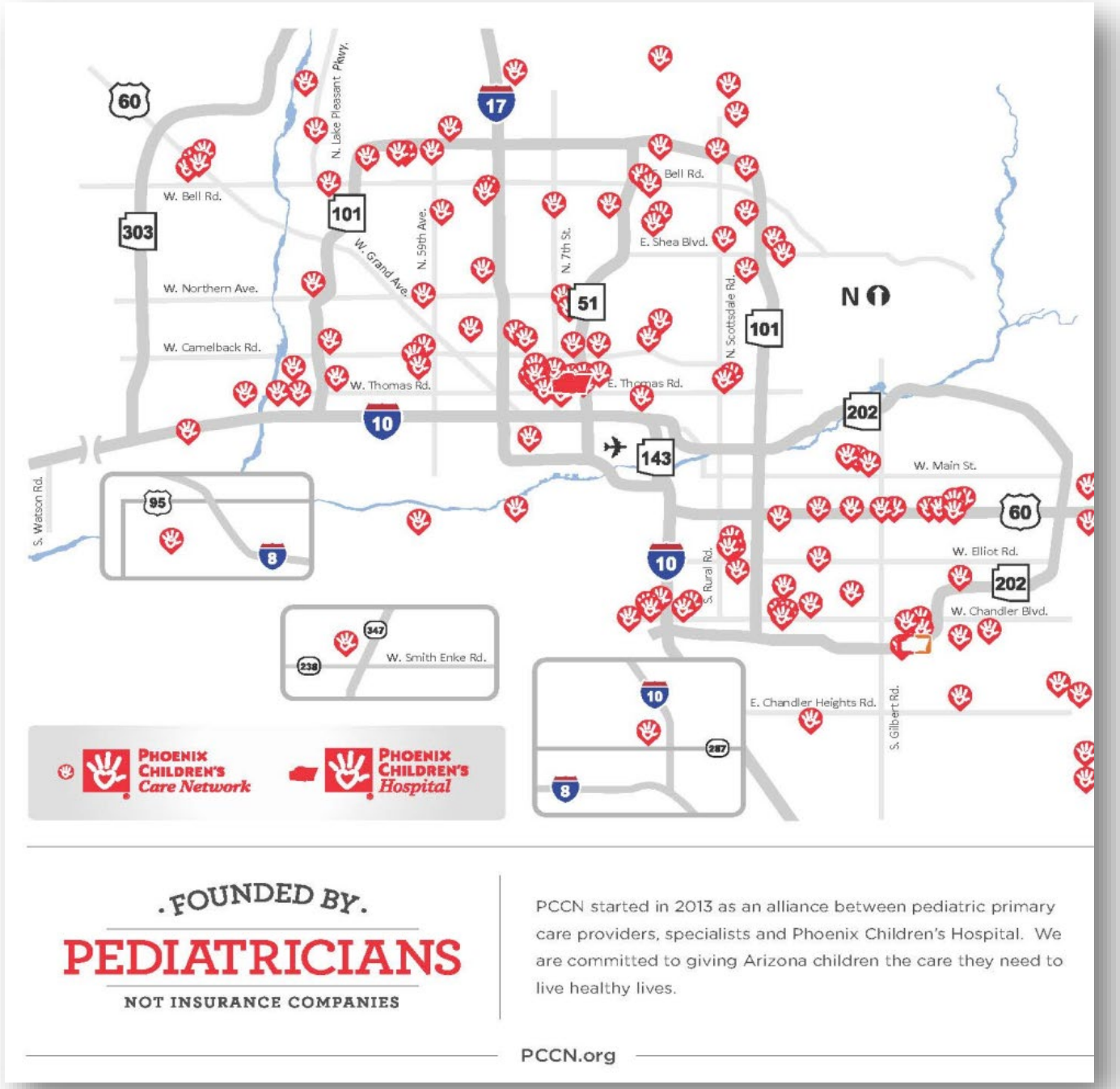
PCCN - At A Glance

Corporate Structure:

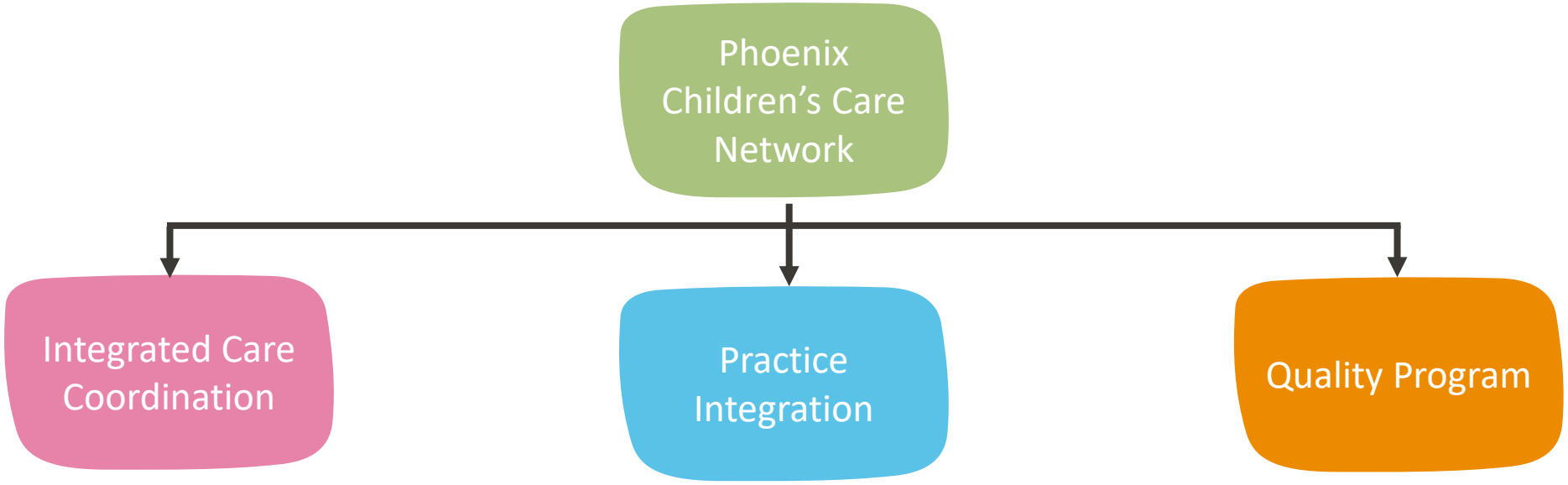
- Founded in 2013
- Operates independently from but in collaboration with Phoenix Children's Enterprise
- Phoenix Children's is PCCN's Sole Corporate Member

Provider Network	Payer Partnerships	Clinical Success
1,380	**+170,000**	**1st**
Total providers	*Attributed Lives*	*URAC Accredited Pediatric CIN*
413 Primary Care Providers	5 Value Based Contracts	Arizona's only Pediatric CIN
967 Specialist and Ancillary Providers	2 Commercial VBCs (30% of Membership)	ICC NPS Score: 80 (World Class)
82 Participating TINs	3 AHCCCS VBCs (70% of Membership)	Consistently outperforms market performance in clinical quality metrics
185 Unique Care Locations	D2E Agreements: Whole Foods & Intel	

PCCN's Footprint



PCCN Programs and Responsibilities

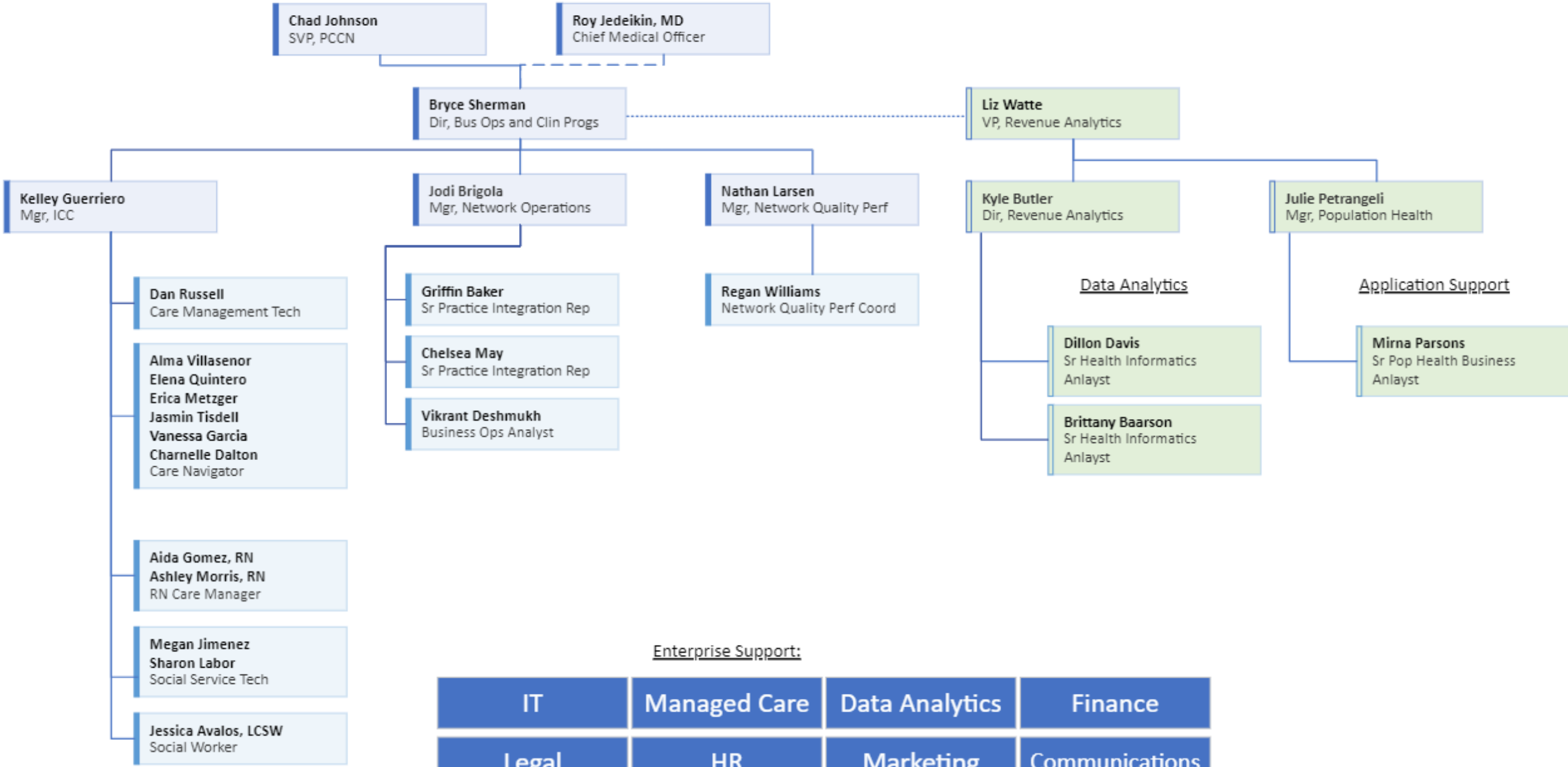


Responsibilities:

Integrated Care Coordination	Practice Integration	Quality Program
Complex Care Coordination Provides Social Drivers of Health Resources Special Needs Initiatives	Meets Practices Each Month to discuss: • Quality Improvement/Scorecard Review • Roster Changes • Training and Education • Shared Savings Distributions • Implements quality initiatives designed through Quality Program	Tracks, monitors, and projects network quality performance Creates, manages, and maintains continuous quality initiatives: • CQI/MOC Programs • Population Health Initiatives

Phoenix Children's
Care Network

Organizational Chart 2024



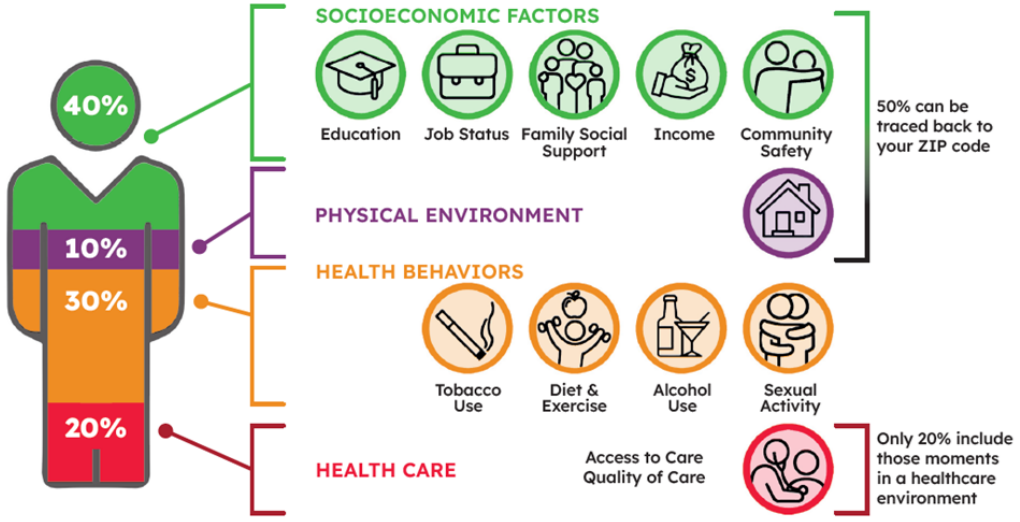
Enterprise Support:

IT	Managed Care	Data Analytics	Finance
Legal	HR	Marketing	Communications

The Importance of SDoH Screening

"Health starts where we live, learn, work and play"

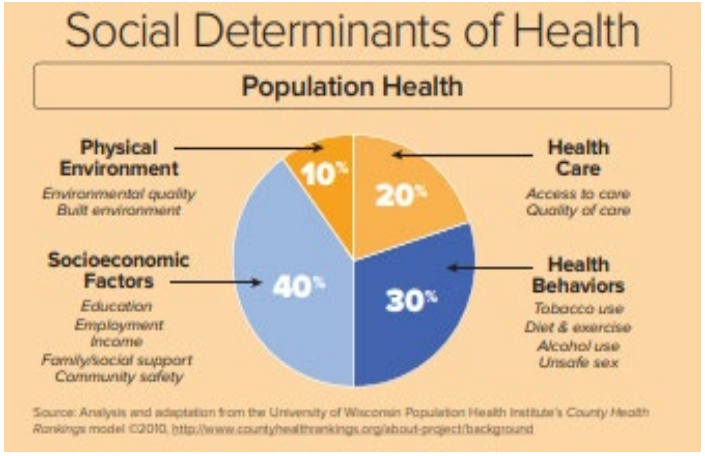
To provide the highest quality of care, it is important to understand the variety of factors that affect a child's overall health and well-being



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

- SDoH are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.
- Data and research suggest that up to 80% of a person's overall health is influenced by Social Drivers of Health.
- Medical care alone is insufficient to improve health as it is estimated to account for only 10-20% of the modifiable contributors to improved health outcomes.

- Unmet SDoH needs can significantly alter a child's health, well-being and socioeconomic trajectories.
- The American Academy of Pediatrics (AAP) recommends screening for SDoH during **all** patient encounters by using a tool to assess basic needs such as food, housing, and heat.
- **Systematically screening and referring for social drivers during well childcare can lead to the receipt of more community resources for families.**



PCCN SDoH Quality Improvement Process
CQI methodology – 7 Question Format

I. Background: Data and Research
- Significant population health concerns
- Insufficient SDoH Screenings
- Unmet SDoH needs
- Development of a Standardized SDoH Screening Tool
- Rationale for a Standardized SDoH Screening Tool

II. Establish a Team
- Identify key stakeholders and decision makers

III. Goals
- Develop, implement, and operationalize a closed-loop system of referral for Social Drivers of Health issues and concerns in the pediatric population.

IV. Measurements (Process, Outcome, and Balancing)
- Baseline practice data.
- Practices using the screening tool, patient needs met, and use of proper codes.

V. Measurement Analysis
- Run chart methodology

VI. Changes to create improvement
- Educational programs
- System Changes

VII. PDSA cycle
- Continuous process improvements to meet changing needs of program

Phoenix Children's Care Network Quality Improvement Module Social Drivers of Health (SDoH)
Screening in the Clinical Setting

Develop, operationalize, and implement a system wide SDoH screener to inform strategy and intervention

Background:

Social circumstances such as food insecurity, housing instability, unmet transportation needs, and interpersonal violence comprise the Social Drivers of Health (SDoH) and can significantly alter a child's health, well-being, and socioeconomic trajectories. This impact on health is well-documented. Research shows that up to 70% of a person's overall health is driven by these social and environmental factors, and the behavior influenced by them. Currently, 90% of health care spending in the United States is on medical care in a hospital or doctor's office. Many healthcare organizations are developing innovative methods to address SDoH within clinical settings as a possible strategy to enhance patient care, improve health outcomes, and prevent avoidable health care utilization. One approach endorsed by the American Academy of Pediatrics is SDoH screening. This process takes place within clinical care settings and relies on clinical teams to administer a validated and standardized survey, which seeks to identify unmet social needs or adverse social circumstances within the patient's experience. Results are discussed with the patients and their families, and an action plan is developed to address their needs. Referrals to community resources are the most common. Overall, screening is a complex process that will require considerable deliberation before implementing. Clinical care settings will need to consider their staffing capabilities, patient needs, and other variables before deciding upon a tool to use. With proper implementation, SDoH screening and the associated referral process have been demonstrated to increase detection and discussion of patients' social needs and to increase families' receipt of beneficial resources. Despite the numerous benefits associated with pediatric screening, no standardized procedure nor tool exists. This policy brief reviews many of the models which implement screening and the characteristics that individual care settings should consider when selecting a tool for their institution. In addition, this brief discusses general implementation strategies and assesses the merits and evidence base of different comprehensive screening tools currently in use. To improve SDoH screening, action is needed at the policy, clinical care setting, and community levels. In terms of policy, innovative funding mechanisms should be implemented to promote screening and care coordination with community resources. Efforts should be made to institutionalize screening and ICD-10 codes should be expanded to account for the full spectrum of SDoH. Clinical care settings must adapt their electronic medical records to include data on patients' social needs and invest in provider training on SDoH screening. Finally, at the community level, clinical care settings and community partners should work together to develop comprehensive resource lists and establish feedback mechanisms to report on the appropriateness, quality, and quantity of referrals.

Phoenix Children's Care Network Quality Improvement Module Social Drivers of Health (SDoH) Screening in the Clinical Setting

Rationale for a Standardized SDoH Screening Tool:

Standardizing a set of SDoH screening questions will help maintain strong network focus on SDoH. Questions that have been externally validated and written at an accessible reading level have the potential to improve the effectiveness of screening, especially in the early and testing phases. Furthermore, having consistent screening questions and processes will allow for network collection of data with respect to the unmet needs of our population and their impact on health outcomes and costs. In turn, this valuable feedback loop will inform policy, planning and investment that can support better ways to address unmet resource needs, improve the quality of care, and improve health care utilization over time.

Development of a Standardized SDoH Screening Tool:

Development of standardized SDoH screening questions has been grounded on the following principles:

- First, the screening questions need to include domains where high-quality evidence exists linking them to health outcomes and must identify needs for which there are some resources and services in the community available to address them.

- Second, the screening questions must be simple, brief, and applicable to most populations, so that they can be easily integrated into workflows in diverse and varied settings across the state. The questions do not have to address all nuances of need; rather, a positive response on a screening question should trigger a more in-depth assessment that allows a greater understanding of specific needs and more targeted navigation to resources by a community health worker, care manager, social worker or other member of the team. Since the questions are intended in time to be used by providers in diverse settings there should be flexibility for providers to include additional domains as needed or desired by the setting or population being served.

- Third, the questions must be validated, draw from best practices and must be written at accessible reading levels to ensure that they can be effectively used.

- Fourth, to the greatest extent possible, the questions should align with existing screening tools (e.g. Bright Futures Questionnaire, Meaningful Use, Uniform Data Set (Community Health Centers), PRAPARE (Community Health Centers), Health Leads, Accountable Health Community, Pregnancy Medical Home Screen, and state Medicaid recommendations. This intentional alignment to existing tools will allow for easier implementation and similar data collection.

Phoenix Children's Care Network Quality Improvement Module Social Drivers of Health (SDoH) Screening in the Clinical Setting

Team Composition:

Dr. Roy Jedeikin, Chief Medical Officer
Jodi Brigola, Manager Practice Integration and Quality Programs
Nathan Larsen, Sr. Practice Integration Rep
Griffin Baker, Sr. Practice Integration Rep
Brittany Baarson, Sr. Health Informatics Analyst
Bryce Sherman, Director Business Operations and Clinical Programs
Kelley Guerriero, Manager Integrated Care Coordination

Goal:

To support practices and providers in adopting a screening tool to assist in identifying and managing the social needs of patients and families.

- Develop, implement, and operationalize a closed-loop system of referral for SDOH issues and concerns in the pediatric population.
- Increase the percentage of practices / providers using SDoH screening tool and Z-codes by 25% in 6 months.

Measurement:

Outcome Measure	Process Measures	Balancing Measures
• Measure the percentage of practices using the screening tool. • Measure the percentage of patients who received a referral for SDOH needs assessment. • Measure the percentage of practices utilizing SDoH Z-codes using payer claims data	• Measure the percentage of clinicians using SDoH screening codes. • Measure the percentage of members who received a referral due to a positive SDoH screen.	• Disruption in the workflow of the ICC team • Level of effort required to implement inside of a pediatric PCP office • Level of effort required to support the program through data and analytics

Measurement Analysis:
Run chart methodology

Phoenix Children's Care Network Quality Improvement Module Social Drivers of Health (SDoH) Screening in the Clinical Setting

Changes to Create Improvement:

Educational Programs:

- Define SDoH and educate practices and PCCN clinical teams
- Coding assistance
- Best practice information
- Proper use of screening tool
- Referral process to ICC
- Educate on utilization of SDoH Z-codes
- Define workflow process

System Changes:

- PCCN system changes
  - ICC team will accept SDoH referrals
    - Standardized tool created by PCCN
    - SCM orders (PCMG PCH internal process)
    - Previously established SDoH tool used by practice
  - ICC team follow-up
    - Team member contacts family
    - Refers to community resources
    - Confirms resource utilization by family
    - Closes loops with PCP
- Practice system changes
  - Screen every patient every visit
    - SDoH tool completed pre-visit (available via email and/or website)
    - SDoH tool completed at check-in
  - Use of a screening tool
    - PCCN standardized tool
    - Established practice tool
  - Documentation in EMR
    - Patient screened
    - Use of Z-code with correlating diagnosis
    - Referral sent
  - Discuss needs with family
    - purpose / function of PCCN interaction
  - Refer to ICC team

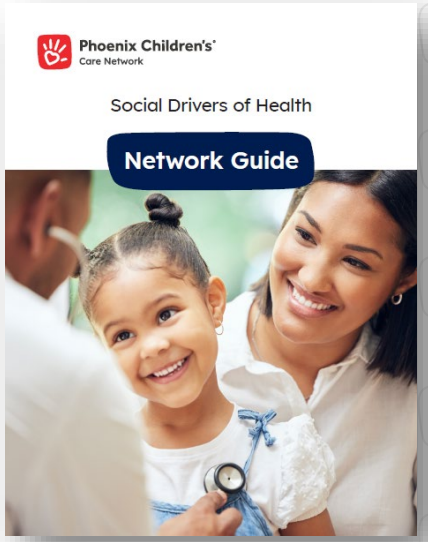
SDoH Screening Challenges

Developing a Screening Tool

Establishing a Workflow

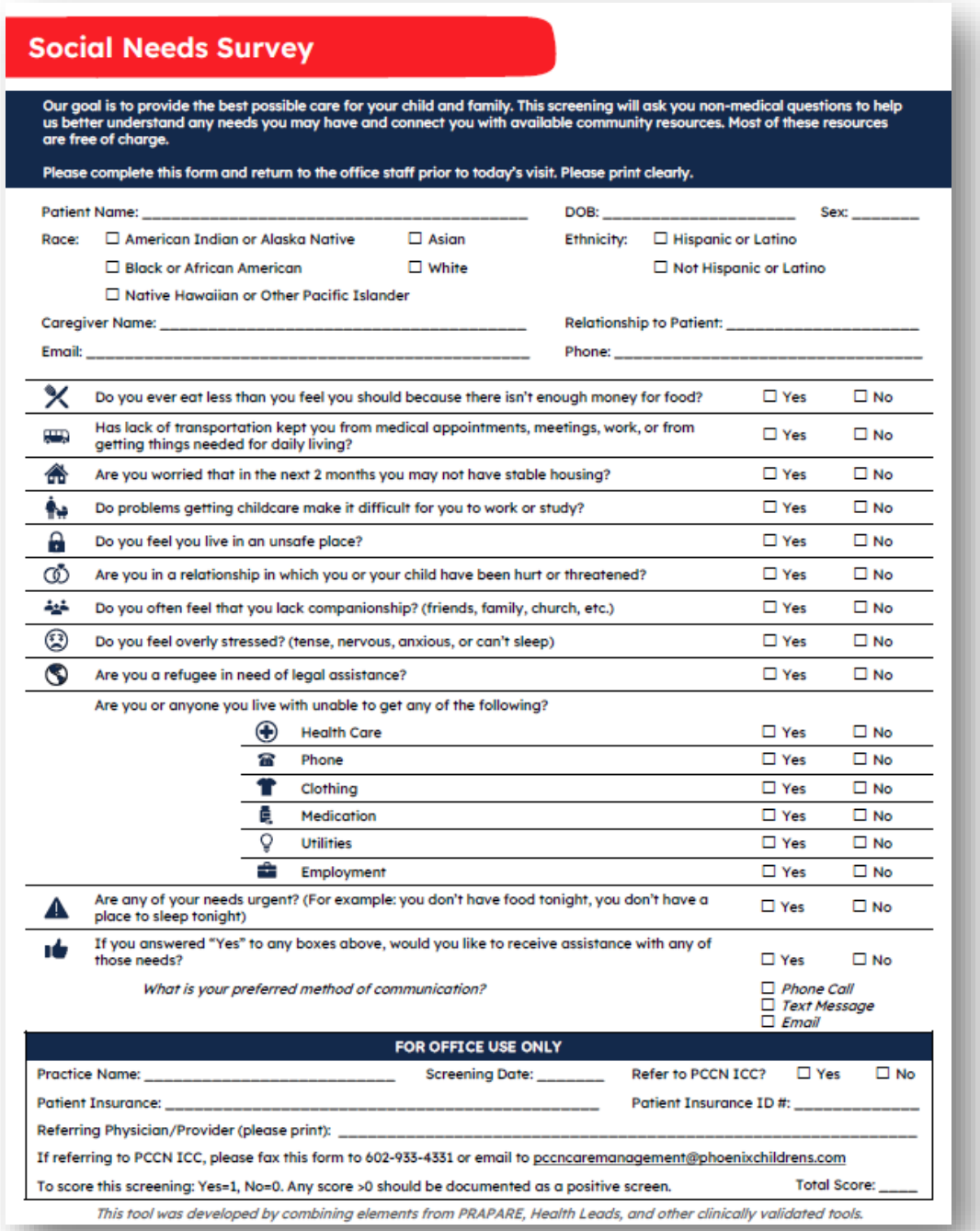
Addressing Positive Screens

Coding and Billing



Developing a Screening Tool

- Reviewed current literature on SDoH screening tools with pediatric relevance
- PCCN developed a validated, standardized, and scoreable tool using PRAPARE and Health Leads
  - If a PCCN practice prefers another validated tool, PCCN will recognize that tool in this process (requiring all aligned domain elements)
- Can be administered on paper or electronically
- Should be completed by the caregiver or patient (if appropriate) upon check-in
- Should be reviewed by clinician with patient and family
- Easy to identify the positive screens
- Ability to refer to ICC for aligned patients
- Leverage an iterative process to incorporate ongoing enhancements



Social Needs Survey

Our goal is to provide the best possible care for your child and family. This screening will ask you non-medical questions to help us better understand any needs you may have and connect you with available community resources. Most of these resources are free of charge.

Please complete this form and return to the office staff prior to today's visit. Please print clearly.

Patient Name: _____ DOB: _____ Sex: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Caregiver Name: _____ Relationship to Patient: _____

Email: _____ Phone: _____

Do you ever eat less than you feel you should because there isn't enough money for food?	☐ Yes	☐ No
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	☐ Yes	☐ No
Are you worried that in the next 2 months you may not have stable housing?	☐ Yes	☐ No
Do problems getting childcare make it difficult for you to work or study?	☐ Yes	☐ No
Do you feel you live in an unsafe place?	☐ Yes	☐ No
Are you in a relationship in which you or your child have been hurt or threatened?	☐ Yes	☐ No
Do you often feel that you lack companionship? (friends, family, church, etc.)	☐ Yes	☐ No
Do you feel overly stressed? (tense, nervous, anxious, or can't sleep)	☐ Yes	☐ No
Are you a refugee in need of legal assistance?	☐ Yes	☐ No
Are you or anyone you live with unable to get any of the following?		
Health Care	☐ Yes	☐ No
Phone	☐ Yes	☐ No
Clothing	☐ Yes	☐ No
Medication	☐ Yes	☐ No
Utilities	☐ Yes	☐ No
Employment	☐ Yes	☐ No
Are any of your needs urgent? (For example: you don't have food tonight, you don't have a place to sleep tonight)	☐ Yes	☐ No
If you answered "Yes" to any boxes above, would you like to receive assistance with any of those needs?	☐ Yes	☐ No
What is your preferred method of communication?	☐ *Phone Call* ☐ *Text Message* ☐ *Email*	

FOR OFFICE USE ONLY

Practice Name: _____ Screening Date: _____ Refer to PCCN ICC? ☐ Yes ☐ No

Patient Insurance: _____ Patient Insurance ID #: _____

Referring Physician/Provider (please print): _____

If referring to PCCN ICC, please fax this form to 602-933-4331 or email to pccncaremanagement@phoenixchildrens.com

To score this screening: Yes=1, No=0. Any score >0 should be documented as a positive screen. Total Score: ____

This tool was developed by combining elements from PRAPARE, Health Leads, and other clinically validated tools.

Establishing a Workflow

Addressing Positive Screens

Patients aligned with PCCN

- Send the completed screening tool to PCCN's Integrated Care Coordination (ICC) Team
  - Fax to 602-933-4331
  - Email to pccncaremanagement@phoenixchildrens.com
  - Submit via PCCN's Online Referral Tool

- SDoH concerns are addressed by the ICC Team
  - Leverages FindHelp.org, 211.org, and internal research for CBO support

- ICC Team contacts caregiver/patient, ensures needs are met and closes the loop with caregiver/patient and practice

ICC Team Composition

- Care Management Tech
- Care Navigators
- Licensed Social Worker
- Social Worker Techs (SST)
- Nurses

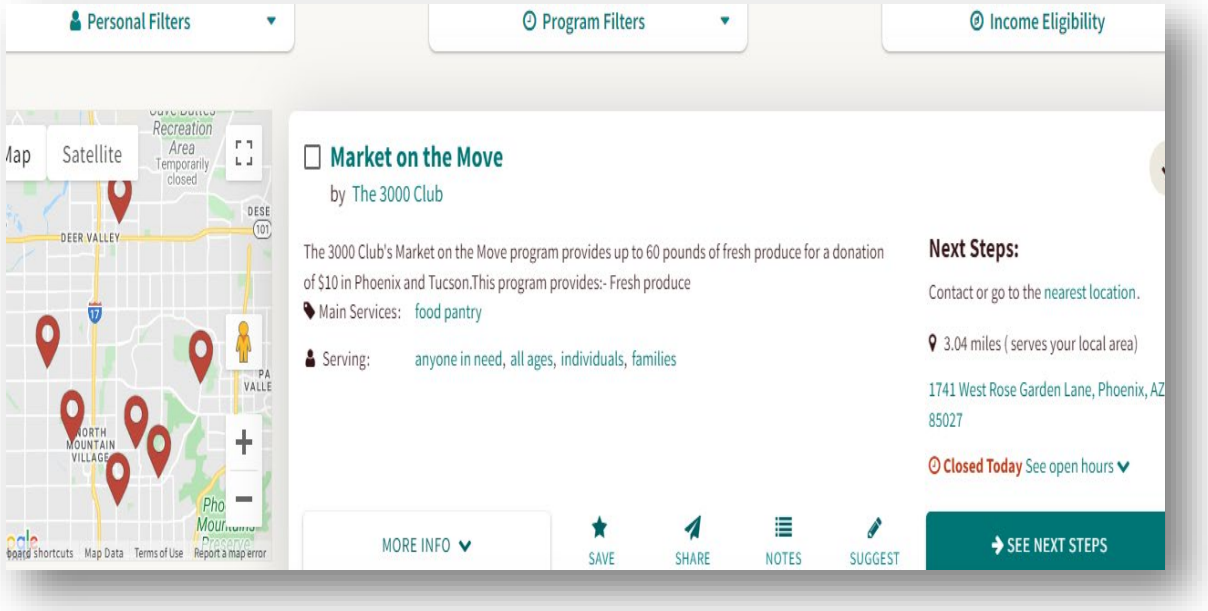
Addressing Positive Screens

Patients not aligned with PCCN

- Refer to available community resources and CBOs, options include:

Findhelp.org

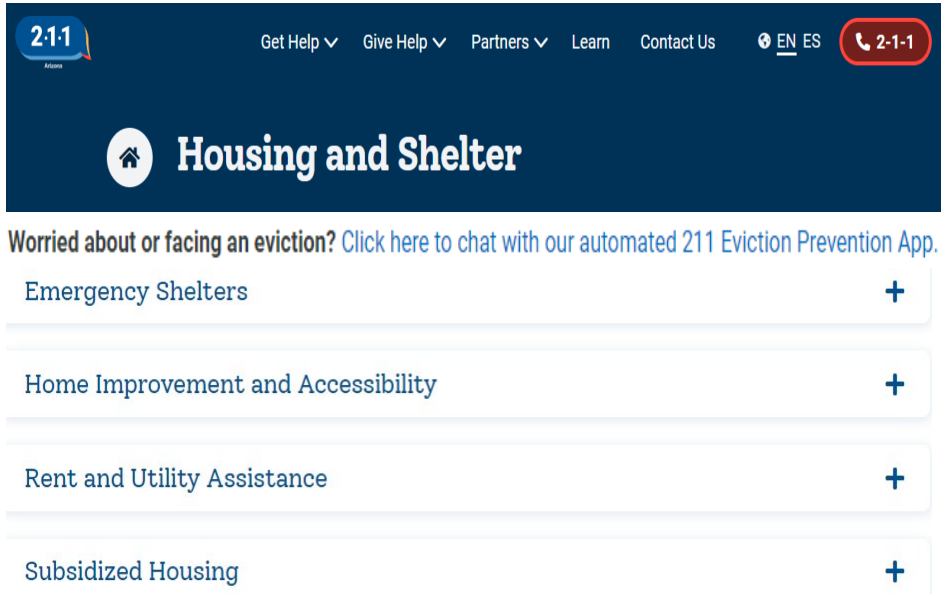
https://www.findhelp.org/



211

https://www.211.org/

Call 211 or use the 211 app



Documentation In Care Coordination Tool

Pediatric Care Constellation My Worklist Patients Candidate Selection Dashboard Help Docs

Case Management

Patient Name

Case
SDOH

Care Coordination
SDOH

Status
CANDIDATE

Edit Case

Close Case

Care Coordination Date
2024-09-06

Case Created
2024-09-09 13:40 by SYSTEM

Tasks

Role	Assigned To	Priority	Due Date/Time	Status	Closed Date	Closed Reason	Intervention	Title
CARE NAVIGATOR	Garcia, Vanessa	STANDARD	2024-09-19 09:00	NOT STARTED			Yes	Gather/send/follow-up: resources pertaining to the appropriate community resource(s).
CARE NAVIGATOR	Garcia, Vanessa	STANDARD	2024-09-19 12:00	NOT STARTED			Yes	Send and Confirm, list of requested and contracted Specialists to the family.
CARE NAVIGATOR	Garcia, Vanessa	STANDARD	2024-09-19 12:00	NOT STARTED			Yes	Send and Confirm, list of requested adult providers to the family.
CARE NAVIGATOR	Garcia, Vanessa	STANDARD	2024-09-19 12:00	NOT STARTED			Yes	Send and Confirm, list of requested and contracted Dentists to the family.
CARE NAVIGATOR	Garcia, Vanessa	ROUTINE	2024-09-23	NOT STARTED			No	Provider Notification
CARE NAVIGATOR	Garcia, Vanessa	URGENT	2024-09-11 11:45	CLOSED	2024-09-11 13:57	REACHED (ONLY FOR ATTEMPT FAMILY CONTACT)	No	Attempt Family Contact/Verifications
CARE NAVIGATOR	Garcia, Vanessa	EMERGENT	2024-09-11	CLOSED	2024-09-11 13:58	COMPLETED	No	Assessment Summary

Assessments

Assessment	Status	Cancel Reason	Started
REFERRAL	COMPLETED	N/A	2024-09-09 13:45 by Russell, Daniel
INITIAL	COMPLETED	N/A	2024-09-11 11:48 by Garcia, Vanessa

Coding and Billing – Reimbursement for Screening

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
90 Years of Caring for Children—1930–2020

Quick Reference for Social Determinants of Health (SDOH) Coding

Determining SDOH Risk Factors

Via Standardized Instrument

If SDOH risk factors are determined by use of a standardized instrument, CPT code 96160 or 96161 can be reported:

96160 *Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument*

96161 *Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument*

CPT defines "standardized instruments" as follows: Used in the performance of these services. Standardized instruments are validated tests that are administered and scored in a consistent or "standard" manner consistent with their validation.

Codes 96160-96161 are reported in addition to the evaluation and management (E/M) code (eg, 99213).

Coding and Billing

Goals Of Coding Methodology

Reimbursement for Screening

Data Tracking and Analytics

PCCN's SDoH Coding Journey

2021:
G Codes + 96160 + Z Codes

2022:
96160 + Z-Codes

2024:
G-Codes + Z-Codes + 96160

Coding and Billing – Reimbursement for Screening

Previous Model

- 96160

-and-

- Z13.89 - Screening performed
  - When the screening detects positive SDoH need(s), add the appropriate diagnosis code(s)

- PCCN assumes a SDoH screening is negative when a practice bills 96160 + Z13.89 and there are no additional Z-codes

Current Model

• G9919 – SDoH screening performed and positive with recommendations (referral to PCCN ICC).

-or- G9920 – SDoH screening performed and negative.

-or- G9921 – SDoH screening performed and positive, but the individual did not want a referral.

-and-

- Z13.89 - Screening performed
  - When the screening detects SDoH need(s), add the appropriate diagnosis code(s)

- In addition to the above codes, recommendation to utilize the following for reimbursement:
  - 96160 - Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
  - -or- • 96161 – Administration of a caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
  - -and- • Z13.89 - Screening performed (must be listed first, is billable and payable

2024 Well Care/SDoH Coding Examples

Vignette 1:

A four-year-old established patient is at a physician's office for her/his annual well-child examination. The patient is medically healthy, and SDoH screening is negative.

	Office visit CPT	SDoH Screening
CPT:	99392	G9920
ICD10:	Z00.129	Z13.89

Vignette 2:

A three-year-old established patient is at a physician's office for her/his annual well-child examination. The patient is medically healthy with abnormal findings due to a positive SDoH screening for housing and food needs. Patient wants assistance/referral for SDoH needs.

	Office visit CPT	SDoH Screening
CPT:	99392	G9919
ICD10:	Z00.121	Z13.89
		Z59.9
		Z59.41

Program Growth

Year	Participating Practices	Participating Clinicians	ICC Referral Volume	Total Screens	Patients Screened
2022	16 (23%)	83 (20%)	654	8,556	6,634
2023	26 (38%)	150 (33%)	871	25,299	18,974
2024[2]	48 (69%)	376[1] (85%)	1,188	48,775	40,627

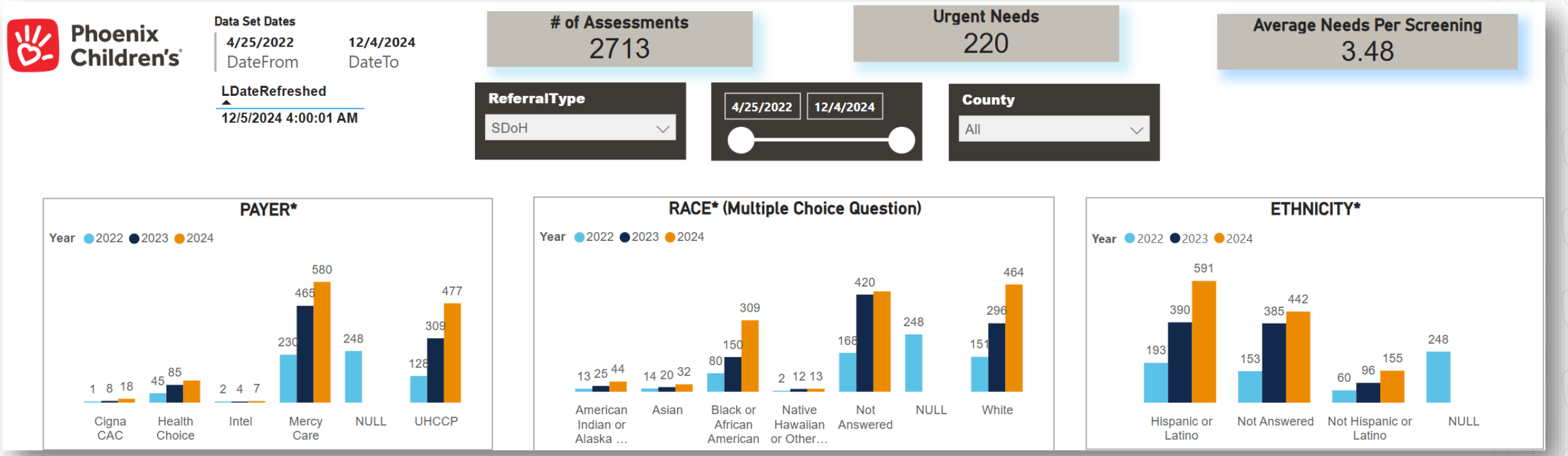
Historical Positive Screening Rate: 6.9%

G Code Positivity Rate[3]: 11%

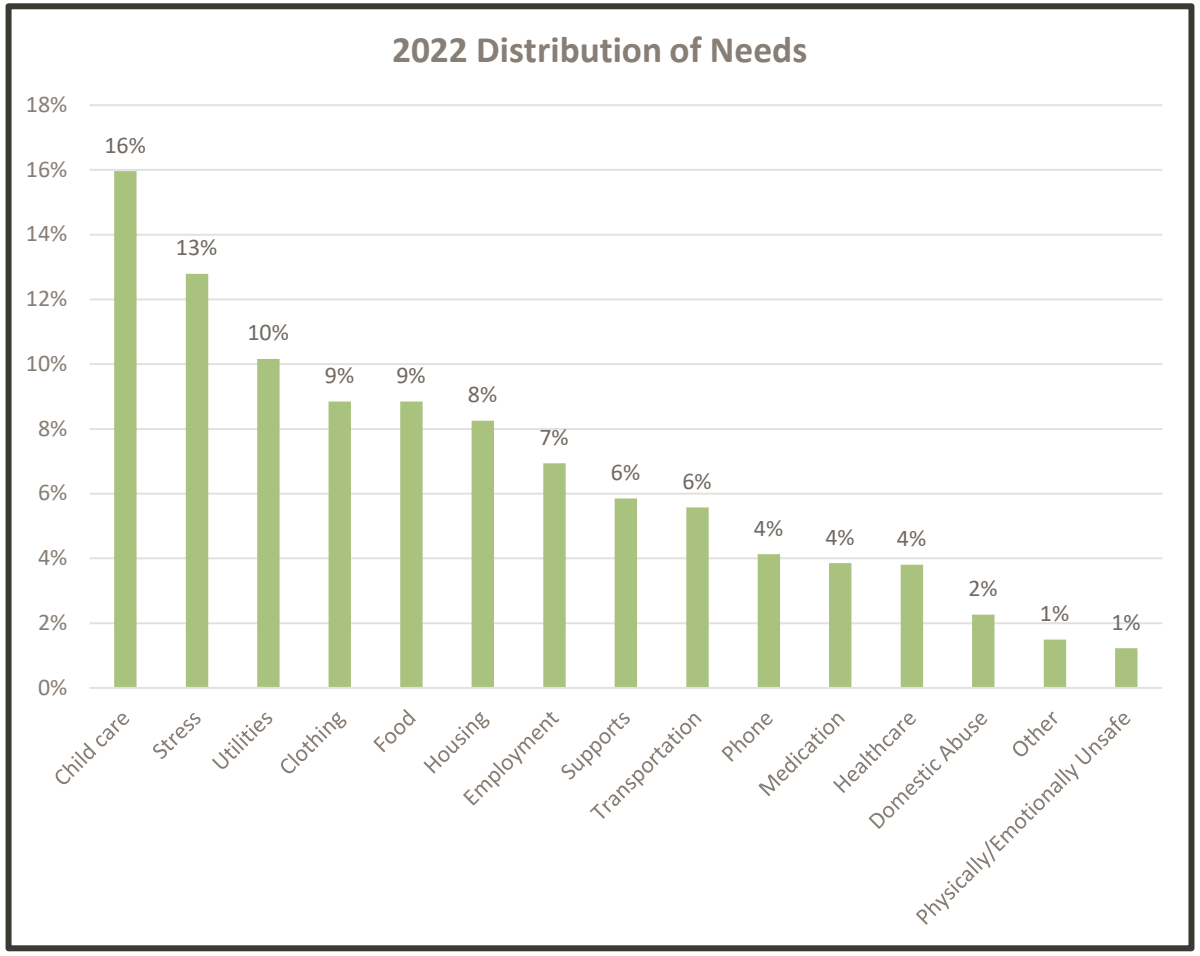
G Code Positivity and Referral Requested[3]: 7.9%

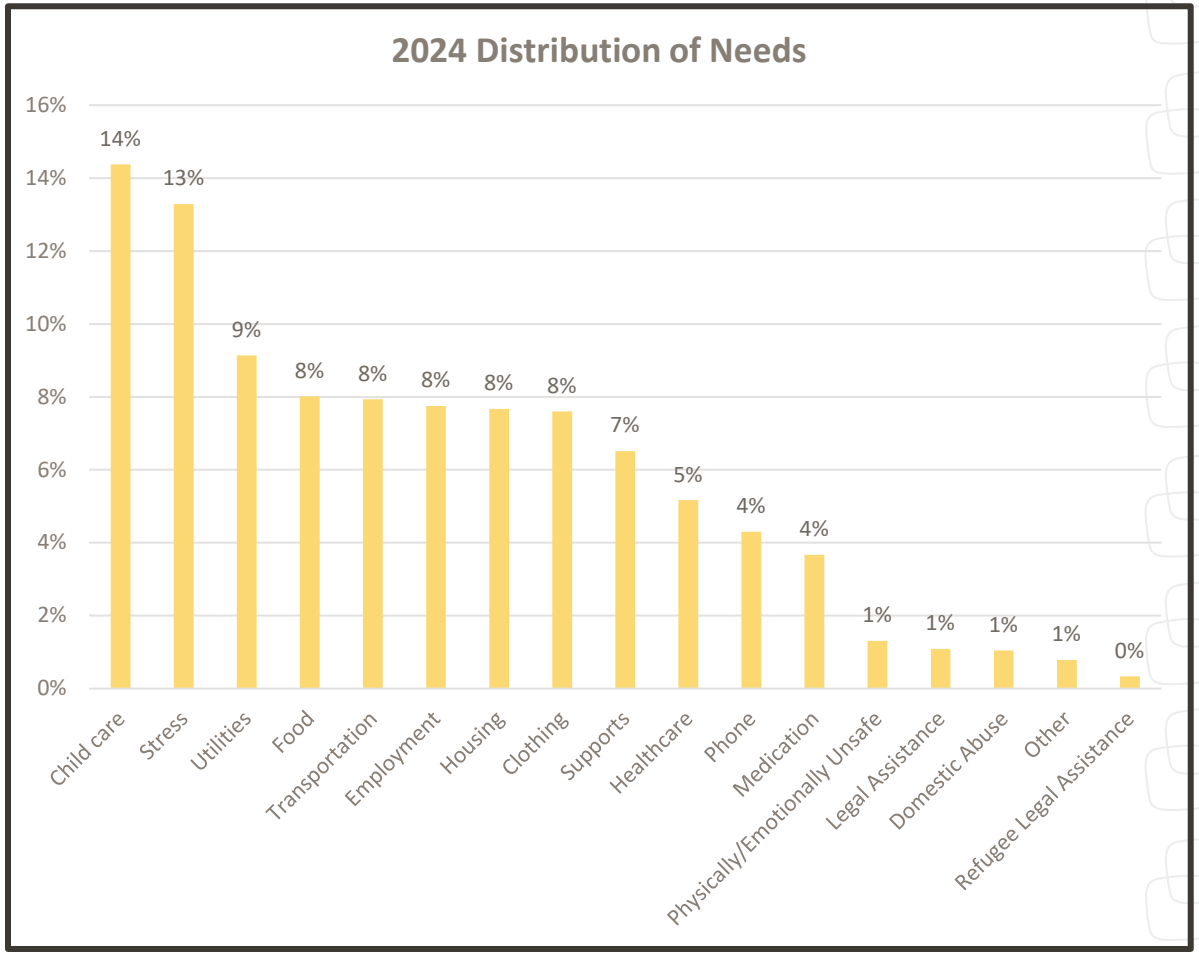
[1] Future participation of 72 PCPs within one of PCCN's largest practices.
[2] YTD includes data collected through December 5, 2024
[3] G Code utilization began in June 2024

Outcome Data



Needs by Percentage





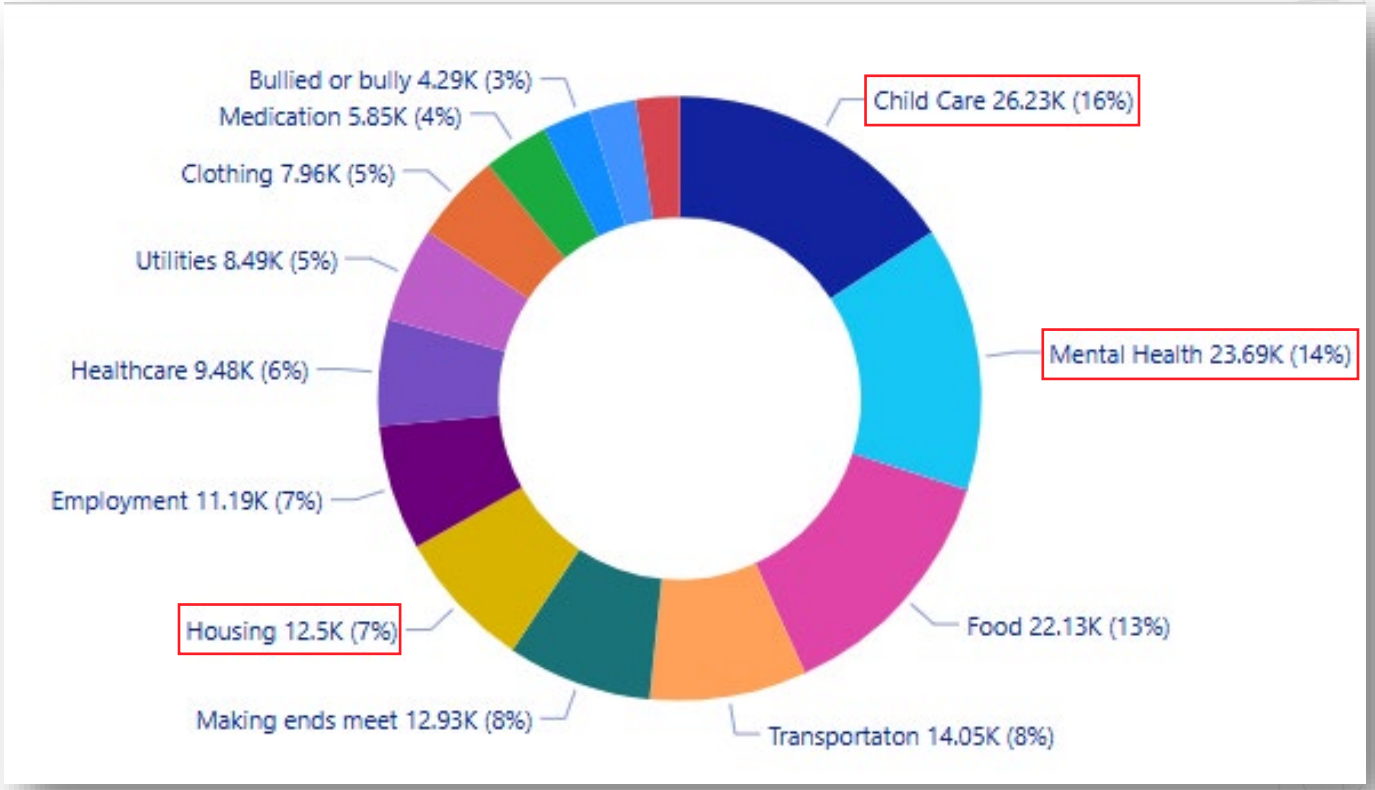
Phoenix Children's Enterprise Approach

October 26, 2022 through October 25, 2024:

- 435,437 screens **sent** via Patient To-Do (email link)
- 296,179 patients **completed** screening
- 62,400 patients **respond** with at least 1 SDOH need (21%)

Scalability:

- 2022: 1.0 FTE Care Navigator addressing families with 8 or more SDOH needs
- 2024: 2.0 FTE Care Navigator addressing families with 5 or more SDOH needs
- Nov 2024: 3.0 FTE Care Navigator to address families with 3 or more SDOH needs across institution, with 1 or more in Primary Care



Future Direction and Lessons Learned

- **Relationships with Payers**
  - Challenges with Medicaid and payer support
- **Future Direction**
  - Zip code mapping
  - SDoH Needs – Correlating outcomes with VBC Measures and to population health initiatives
  - Offering as a paid service to all patients within PCCN practices
- **Lessons Learned and Challenges**
  - Adoption rate requires continuous education to practices
  - Coding nuances by payer (commercial vs Medicaid)
  - Need for an ongoing Data and Analytics platform enhancements to report growth, progress, and outcomes
  - Scaling and Sustainability at the Network Level
  - Administrative and Staffing Lift

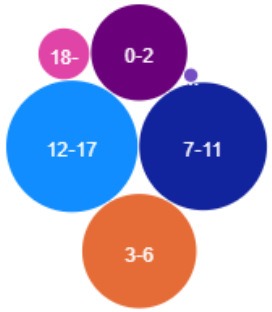
PCCN Population Health Dashboard

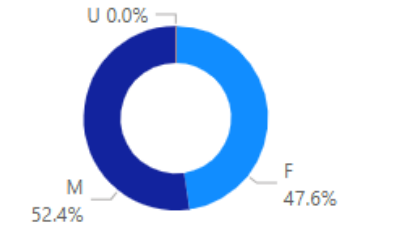
Updated: 10/29/2024

Phoenix Children's Care Network

Member Profile

163K
Total Members





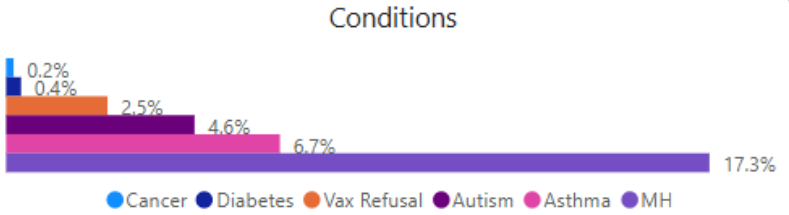
Quality

75.5% W30A	78.3% W30B
46.6% WCV	71.9% CIS3
50.8% FUH7	41.8% FUM7
44.1% DEVCH	12K Depression Screen

Health Equity

Race/Ethnicity	Membership	WCV	W30A	W30B	CIS3
AFRICAN AMERICAN	9.1%	43.0%	65.1%	69.2%	58.7%
AMER INDIAN/ALASKAN	0.0%	0.0%	NaN	NaN	NaN
ASIAN/PACIFIC	1.4%	45.9%	79.5%	82.8%	67.5%
CAUCASIAN	31.5%	46.3%	76.6%	78.0%	72.4%
HISPANIC	0.3%	50.7%	100.0%	NaN	50.0%
NATIVE AMERICAN	1.8%	36.5%	57.0%	62.0%	69.8%
NATIVE HAWAIIAN	0.0%	NaN	NaN	NaN	NaN
OTHER	0.2%	2.8%	NaN	50.0%	50.0%
UNKNOWN	55.7%	48.0%	76.9%	80.4%	74.2%
Total	**100.0%**	**46.6%**	**75.5%**	**78.3%**	**71.9%**

Chronic Conditions



Social Health/SDoH

53K
SDoH Screens

4,219
Positive SDoH

26%
Population Screened

Utilization

342.6
ED/1000

57.0
IP/1000

Q&A