GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

Social Care Needs Coding and Referral Guide

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BACKGROUND

Many health care providers screen their patients for social determinants of health (SDH) and social care needs (SCNs) because factors such as housing instability, food insecurity, and poverty can impact health care outcomes. Identifying SCNs as part of a health care encounter is an important part of whole-person care. Additionally, as health care payment continues to move from fee-for-service toward value-based arrangements, health care providers should include SCNs when developing patient care plans. Successfully addressing SCNs through partnerships and referrals to community-based organizations (CBOs) might reduce unnecessary health care costs and lead to greater success in value-based arrangements. Helping alleviate the impact of SCNs on patients can also help decrease avoidable inpatient and emergency department admissions.

In New York, SDH and SCN screening efforts accelerated under the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) program, a five-year project funded by New York's Section 1115 Medicaid waiver from the Centers for Medicare & Medicaid Services (CMS). While New York's DSRIP program ended in early 2020, many hospitals and health systems maintained and even increased SCN screening via their population health strategies. Hospitals and health systems also have developed referral pathways to CBOs that could address social needs. These activities are likely to continue under DOH's proposed 1115 waiver program, Strategic Health Equity Reform Payment Arrangements: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic (SHERPA).

SOCIAL DETERMINANTS OF HEALTH VS. SOCIAL CARE NEEDS

SDH are environmental factors or conditions that impact health. SDH are place-based and often exist on a neighborhood or community level. SDH solutions typically include investments or initiatives on a community level. For example, to address food access at a neighborhood level, more supermarkets and food pantries may be needed. Some SDHs such as lack of quality education or limited access to transportation would require government involvement and public-private solutions.

SCNs impact health at the individual level, though they often result from SDH and environmental factors. For example, food insecurity is an SCN and may impact an individual's ability to successfully manage diabetes or congestive heart failure. Food insecurity may result from poverty and/or a community that does not have adequate food resources for people who are concerned that their money will not purchase adequate food for their families.

SCN Data

SCN data can be difficult to collect in a standardized way at a hospital, health system, or payer level because providers may use different screening tools that are specific to the populations they serve. One way to standardize this information regardless of the screening tool used is to document identified needs in the electronic medical record (EMR) using diagnosis codes from the 10th revision of the International Statistical Classification of Diseases (ICD-10), a code set used to document diagnoses and submit them on claims for payment. SDH codes, commonly referred to as "z codes," are in the ICD-10 range Z55-Z65. Unlike most other ICD-10 codes, z codes can be

recorded based on a review of documentation entered by clinicians and other members of the care team (such as nurses, community health workers, and social workers) or based on the patient's self-reporting.

Hospitals and health systems could use aggregated z-code data to determine the broader needs of their patient population or identify potential CBO partners. The aggregated data could also help to evaluate investments in CBO services, population health analytics, and tools for risk stratification. Payers are also seeking structured SCN data for use in quality measurement, value-based payment, and risk assessment. The CMS Innovation Center (CMMI) is currently funding the Accountable Health Communities (AHC) Model, which is testing whether identifying and addressing certain social needs for high-risk patients will impact Medicare costs. Other payers are doing their own analyses on whether investments in transportation, meal delivery, and other social service programs impact cost. Having standardized data within health care claims can further these analyses and result in payment that adequately accounts for the complexity of patients with SCNs.

How to Use this Resource

This resource was developed by GNYHA at the request of its members to help hospitals and health systems document SCNs using z codes in a more organized and uniform way. Referral considerations for each listed SCN also are included. The z codes and referral considerations are not an exhaustive list and are intended to provide considerations for documentation and referral strategies. The care team at the hospital or health system should make documentation, coding, and referral decisions.

To assist hospitals with their training efforts, this resource includes an appendix with codes and referral considerations based on commonly used tools: AHC[i]; Protocol for Responding to and Assessing Patient Assets[ii], Risks, and Experiences (PRAPARE); and Health Leads[iii] screeners.

GNYHA will update this document as needed should additional z codes be identified or screening tools become widely used to provide members with the most currently available information.

References

i Accountable Health Communities Screener, CMS, https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf.
ii PRAPARE Screener, https://prapare.org/.
iii The Health Leads Screening Toolkit, https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/.

CODING GUIDE

Potential Codes by SDH Domain (screener-agnostic)

SCN	POTENTIAL CODE	REFERRAL CONSIDERATIONS
Housing		
Risk for eviction or losing one's home	Z59.81 Housing instability, housed, with risk of homelessness	• Legal assistance • Rental assistance • Mortgage assistance • Utility assistance • Homebase (NYC)
Living with friends or family, "doubled up," or at risk of being removed from living situation	Z59.819 Housing instability, housed, unspecified	• May require further screening to determine root causes of housing challenges • Homebase (NYC)
Living in a shelter, hotel/motel, or transitional housing	Z59.01 Sheltered homelessness	
Living outdoors, abandoned building, or other places not meant for human habitation	Z59.02 Unsheltered homelessness	• Shelter, transitional housing, or other housing assistance • NYC Department of Homeless Services Street Outreach Team
Housing Quality		
Pests (rodents, cockroaches, other vermin)	Z77.128 Contact with and (suspected) exposure to other hazards in the physical environment	• Pest control (NYC 311)

SCN	POTENTIAL CODE	REFERRAL CONSIDERATIONS
Mold	Z77.120 Contact with and (suspected) exposure to mold	• Mold remediation (NYC 311) • Home Assessments of Asthma Triggers (if asthmatic; NYC only)
Lead	Z77.011 Contact with and (suspected) exposure to lead	
Utility needs	Z59.9 Problem related to housing and economic circumstances, unspecified (a specific utility needs code is not currently available)	• Utility assistance • Home Energy Assistance Program (NYC + NYS) • Financial assistance
Food Insecurity		
Food insecurity	Z59.41 Food insecurity	• Supplemental Nutrition Assistance Program (SNAP) benefits enrollment • Food pantry • Food bank • Soup kitchen • Community pantry • WIC (Women, Infants & Children Program) • Congregate meal opportunities (senior centers)
If food insecure and needs access to benefits	+Z59.7 Insufficient social insurance and welfare support	

SCN	POTENTIAL CODE	REFERRAL CONSIDERATIONS
Interpersonal Violence		
Physical or sexual abuse	Z91.410 Personal history of adult physical and sexual abuse	• Domestic violence organization • Emergency shelter • Support groups • Counseling • National Domestic Violence Hotline
Psychological abuse	Z91.411 Personal history of adult psychological abuse	
Abuse from spouse or partner	+Z63.0 Problems in relationship with spouse or partner	
Economic Insecurity		
100% federal poverty level (FPL) or below	Z59.5 Extreme poverty	• Financial assistance resources • Benefits enrollment
200% FPL or below	Z59.6 Low income	
Clothing, diapers, other needs not specific to housing	Z59.9 Problem related to housing and economic circumstances, unspecified	
Income concerns are impacting patients' ability to take medications as prescribed or fill prescriptions	Z91.120 Underdosing due to financial hardship	

iv FPL: A measure of income issued annually by the Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits (https://www.healthcare.gov/glossary/federal-poverty-level-fpl/).

SCN	POTENTIAL CODE	REFERRAL CONSIDERATIONS
Other SDH		
Transportation needs if lack of transportation prevents medical appointments	Z75.3 Unavailability and inaccessibility of health care facilities (a specific transportation code is not currently available)	• Hospital transportation program (if available) • Reduced fare programs (if eligible) • Local paratransit (if available) • Local community-based organizations
Unemployed	Z56.0 Unemployment, unspecified	• Workforce organization • Workforce 1 Career Centers (NYC)
Concerns about losing employment	Z56.2 Threat of job loss	
Activities of daily living (If individual lives alone)	Z60.2 Problems related to living alone	• Benefits enrollment (Medicaid/Medicare - home health aide)
Social isolation	Z60.4 Social exclusion or rejection; social isolation	• Social programs • NYC WELL
Education	Z55.5 Less than a high school diploma	• Adult education • Workforce organization • Job training organization
Veteran's status	No code available	• Benefits enrollment • Financial assistance • Mental health and substance services

ADDITIONAL RESOURCES

Coding

Using Z Codes: The Social Determinants of Health Data Journey to Better Outcomes (CMS)
An infographic describing steps that health care providers can take to collect, document, code, and use SDH data.
https://www.cms.gov/files/document/zcodes-infographic.pdf

The Gravity Project
A national public collaborative that aims to develop data standards for common SDH and SCNs. Completed work and work in progress is available on the Gravity Project website.
https://confluence.hl7.org/display/GRAV/The+Gravity+Project

ICD-10 Coding for Social Determinants of Health (American Hospital Association)
High-level guidance on the history and use of SDH and SCN codes and other related resources.
https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

Health-Related Social Needs ICD-10 Z Codes (Oregon Primary Care Association)
An alternative crosswalk of PRAPARE questions and related ICD-10 codes to help clinical teams add social screening information to the problem list and EMR for claims and/or population health management.
https://www.orpca.org/files/OPCA%20z%20code%20crosswalk%20May%202019.pdf

Screening Tools

Social Determinants of Health Screening: Commonly Used Social Needs Screening Tools and Questions (GNYHA)
A compilation of SCN screening tools and questions to help members select or develop a tool appropriate for their organization.
https://www.gnyha.org/tool/social-determinants-of-health-screening-a-repository-of-commonly-used-social-needs-screening-tools-and-questions/

A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights (Mathematica on behalf of CMS)
Implementing universal SCN screening in clinical settings requires planning, which includes aligning priorities, training staff, and developing customized screening protocols. The guide also includes lessons based on the experiences of organizations participating in the AHC Model. The strategies shared in the guide are meant to inform effective universal screening in a wide range of clinical settings.
https://innovation.cms.gov/media/document/ahcm-screeningtool-companion

The Accountable Health Communities Health-Related Social Needs Screening Tool (CMS)
The screening tool developed by CMS for the AHC Model, a CMMI-funded initiative to test the effect of systematic screening and referral for Medicare patients with SCN.
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Health Leads Screening Toolkit (Health Leads)
A document that provides guidance on developing a social needs screening tool.
https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

SDH and SCN

Training Primary Care Residents on the Social Determinants of Health (GNYHA)
A curriculum developed primarily for primary care residents with foundational content that can be used when teaching SDH concepts. Content is also appropriate for teaching other workforce members.
https://www.gnyha.org/tool/training-primary-care-residents-on-the-social-determinants-of-health/

Social Determinants of Health: Know What Affects Health (Centers for Disease Control and Prevention [CDC])
This website includes CDC resources for SDH data, research, and tools for action, programs, and policy for public health professionals, CBOs, research organizations, and health care systems.
https://www.cdc.gov/socialdeterminants/

Using Social Determinants of Health Data & New Technology Tools to Connect with Appropriate Community Resources (Health Information Technology Evaluation and Quality Center)
A set of case studies with examples of technology tools tools that help addresss social non-medical needs identified through screening.
https://hiteqcenter.org/Resources/Population-Health/using-social-determinants-of-health-data-new-technology-tools-to-connect-with-appropriate-community-resources

APPENDIX 1

Coding Guide for Accountable Health Communities Screener

Hospitals and health systems using the Accountable Health Communities screening tool can use this appendix to determine the z codes that may result from the tool's specific questions. Certain screening questions may be excluded if there is not an appropriate ICD-10 code available.

AHC QUESTION	AHC ANSWER (POSITIVE SCREEN)	POTENTIAL CODE	CODE NOTES
What is your living situation today?	I have a place to live today, but I am worried about losing it in the future	Z59.81 Housing instability, housed, with risk of homelessness	Use code if at risk for eviction or losing home
	I do not have a steady place to live. (I am temporarily staying with others in a hotel, a shelter, outside on the street, on a beach, in a car, an abandoned building, a bus or train station, or in a park.)	Z59.819 Housing instability, housed, unspecified	Use code if living with friends or family, "doubled up," or at risk of being removed from living situation
		Z59.01 Sheltered homelessness	Use code if living in a shelter, hotel/ motel, or transitional housing
		Z59.02 Unsheltered homelessness	Use code if living outdoors, in an abandoned building, or other places not meant for human habitation
Think about the place where you live. Do you have problems with any of the following:	Pests (bugs, ants, mice)	Z77.128 Contact with and (suspected) exposure to other hazards in the physical environment	
	Mold	Z77.120 Contact and (suspected) exposure to mold	
	Lead paint or pipes	Z77.011 Contact with and (suspected) exposure to lead	

AHC QUESTION	AHC ANSWER (POSITIVE SCREEN)	POTENTIAL CODE	CODE NOTES
(continued)	Lack of heat	Z59.1 Inadequate housing	
	Water leaks	Z59.1 Inadequate housing	
Within the past 12 months, you worried that your food would run out before you got money to buy more Within the past 12 months, the food you bought just didn't last and you didn't have money to get more	If answer to either question or both questions is: • Often true • Sometimes true	Z59.41 Food insecurity	
		+Z59.7 Insufficient social insurance and welfare support	Use code if food insecure and needs access to benefits
In the past 12 months has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting to things needed for daily living?	Yes	Z75.3 Unavailability and inaccessibility of health care facilities (a specific transportation code is not currently available)	Use code if lack of transportation prevents medical appointments

AHC QUESTION	AHC ANSWER (POSITIVE SCREEN)	POTENTIAL CODE	CODE NOTES
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home	• Yes • Already shut off	Z59.9 Problem related to housing and economic circumstances, unspecified (a specific utility needs code is not currently available)	
Safety questions adopted from HITS Tool (see page 23)	Score of 11 or higher	Z91.410 Personal history of adult physical and sexual abuse	Use code if physical or sexual abuse
		Z91.411 Personal history of adult psychological abuse	Use code if psychological abuse
		+Z63.0 Problems in relationship with spouse of partner	Use code if with spouse or partner
How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is…	• Very hard • Somewhat hard	Z59.9 Problem related to housing and economic circumstances, unspecified	
		Z59.6 Low income	Use code if individual or family is 100% FPL
		Z59.5 Extreme poverty	Use code if individual or family is 200% FPL or below
		Z91.120 Underdosing due to financial hardship	Use code if income concerns are impacting patients' ability to take medications as prescribed or fill prescriptions

AHC QUESTION	AHC ANSWER (POSITIVE SCREEN)	POTENTIAL CODE	CODE NOTES
Do you want help finding or keeping work or a job?	Yes, help finding work	Z56.0 Unemployment, unspecified	Use code if unemployed
	Yes, help keeping work	Z56.2 Threat of job loss	Use code if concerned about losing employment
If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?	• I could use a little more help • I need a lot more help	Z60.2	Use code if individual lives alone and needs assistance with activities of daily living
How often do you feel lonely or isolated from those around you?	• Often • Always	Z60.4 Social exclusion or rejection; social isolation	
Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED, or equivalent?	Yes	Z55.5 Less than a high school diploma	Use code if less than high school education

APPENDIX 2

Potential Codes for Positive Screens using the PRAPARE® Screening Tool

Hospitals and health systems using the PRAPARE® screening tool can use this appendix to determine the z codes that may result from the tool's specific questions. Certain screening questions may be excluded if there is not an appropriate ICD-10 code available.

PRAPARE® QUESTION	PRAPARE® ANSWER (POSITIVE SCREEN)	POTENTIAL CODE (POSITIVE SCREEN)	CODE NOTES
How many family members, including yourself, do you currently live with?	"Positive" screen subject to interpretation of health care team member	Z59.819 Housing instability, housed, unspecified	Use code if living with friends or family, "doubled up," or at risk of being removed from living situation
What is your housing situation today?	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)	Z59.01 Sheltered homelessness	Use code if living in a shelter, hotel/motel, or transitional housing
		Z59.02 Unsheltered homelessness	Use code if living outdoors, abandoned building, or other places not meant for human habitation
Are you worried about losing your housing?	Yes	Z59.81 Housing instability, housed, with risk of homelessness	Use code if at risk for eviction or losing home
What is the highest level of school that you have finished?	Less than high school degree	Z55.5 Less than a high school diploma	

PRAPARE® QUESTION	PRAPARE® ANSWER (POSITIVE SCREEN)	POTENTIAL CODE (POSITIVE SCREEN)	CODE NOTES
What is your current work situation?	• Unemployed • Otherwise unemployed but not seeking work (student, retired, disabled, unpaid primary care giver)	Z56.0 Unemployment, unspecified	
During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.	Use FPL to determine "positive" screen	Z59.6 Low income OR Z59.5 Extreme poverty	Use code if individual or family is 100% FPL
			Use code if individual or family is 200% FPL or below
In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.	Yes, food	Z59.41 Food insecurity	Use code if food insecure and needs access to benefits
	Yes, utilities	Z59.9 Problem related to housing and economic circumstances, unspecified (a specific utility needs code is not currently available)	
	Yes, medicine or any health care (medical, dental, mental health, vision)	Z91.120 Underdosing due to financial hardship	Use if income concerns are impacting patients' ability to take medications as prescribed or fill prescriptions

PRAPARE® QUESTION	PRAPARE® ANSWER (POSITIVE SCREEN)	POTENTIAL CODE (POSITIVE SCREEN)	CODE NOTES
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.	Yes, it has kept me from medical appointments	Z75.3 Unavailability and inaccessibility of health care facilities (a specific transportation code is not currently available)	
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need		
How often do you see or talk to people who you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings.)	Less than once a week	Z60.4 Social exclusion or rejection; social isolation	Use code if individual lives alone
Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?	Quite a bit/Very much		Provider may conduct further mental health screenings

PRAPARE® QUESTION	PRAPARE® ANSWER (POSITIVE SCREEN)	POTENTIAL CODE (POSITIVE SCREEN)	CODE NOTES
In the past year, have you spent more than two nights in a row in a jail, prison, detention center, or juvenile correctional facility?	Yes	Z65.2 Problems related to release from prison	Use code if formerly incarcerated in a prison
		Z65.3 Problems related to other legal circumstances	Use code if other justice involved
Do you feel physically and emotionally safe where you currently live?	No	Z91.410 Personal history of adult physical and sexual abuse	Use code if physical or sexual abuse
		Z91.411 Personal history of adult psychological abuse	Use code if psychological abuse
		Z63.0 Problems in relationship with spouse of partner	Use code if with spouse or partner
In the past year, have you been afraid of your partner or ex-partner?	Yes	Z63.0 Problems in relationship with spouse of partner	Use code if with spouse or partner
		Z91.410 Personal history of adult physical and sexual abuse	Use code if physical or sexual abuse
		Z91.411 Personal history of adult psychological abuse	Use code if psychological abuse

APPENDIX 3

Potential Codes for Positive Screens using the Health Leads Screening Tool

Hospitals and health systems using the Health Leads screening tool can use this appendix to determine the z codes that may result from the tool's specific questions. Certain screening questions may be excluded if there is not an appropriate ICD-10 code available.

HEALTH LEADS QUESTION	HEALTH LEADS ANSWER (POSITIVE SCREEN)	POTENTIAL CODE (POSITIVE SCREEN)	CODE NOTES
In the past 12 months did you ever eat less than you felt you should because there wasn't enough money for food?	Yes	Z59.41 Food insecurity	
In the past 12 months has the electric, gas, oil, or water company threatened to shut off your services in your home?	Yes	Z59.9 Problem related to housing and economic circumstances, unspecified (a specific utility needs code is not currently available)	
Are you worried that in the next two months, you may not have stable housing?	Yes	Z59.81 Housing instability, housed with risk of homelessness	Use code if at risk for eviction or losing home
	Yes	Z59.01 Sheltered homelessness	Use code if living in a shelter, hotel/ motel, or transitional housing
		Z59.02 Unsheltered homelessness	Use code if living outdoors, abandoned building, or other places not meant for human habitation

HEALTH LEADS QUESTION	HEALTH LEADS ANSWER (POSITIVE SCREEN)	POTENTIAL CODE (POSITIVE SCREEN)	CODE NOTES
Do problems getting child care make it difficult for you to work or study? (Leave blank if you do not have children.)	Yes	No code available	
In the past 12 months, have you needed to see a doctor, but have not because of the cost?	Yes	No code available	
		Z91.120 Underdosing due to financial hardship	Use code if impacting medications or preventing prescription fills
In the past 12 months, have you ever had to go without health care because you didn't have a way to get there?	Yes	Z75.3 Unavailability and inaccessibility of health care facilities (a specific transportation code is not currently available)	Use code if lack of transportation prevents medical appointments
Do you ever need help reading hospital materials?	Yes	Z55 Problems related to education and literacy	Use code if individual has problems related to literacy
		No code needed	Use code if related to health literacy
Do you often feel that you lack companionship?	Yes	Z60.4 Social exclusion or rejection; social isolation	
Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight.	Yes	N/A – question is intended to identify an area for immediate action or referral	

APPENDIX 4

HITS Questionnaire

HITS is a validated domestic violence screening tool.[v] The questions have been incorporated into the AHC screener and are included in this appendix as a reference.

How often does anyone, including family and friends, insult or talk down to you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

How often does anyone, including family and friends, threaten you with harm?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

How often does anyone, including family and friends, scream or curse at you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

A score of 11 or more when the numerical values for answers to questions are added together shows that the person might not be safe.

v Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. Fam Med. 1998 Jul-Aug;30(7):508-12. PMID: 9669164.