Health Equity Quickinar Series
Session 6

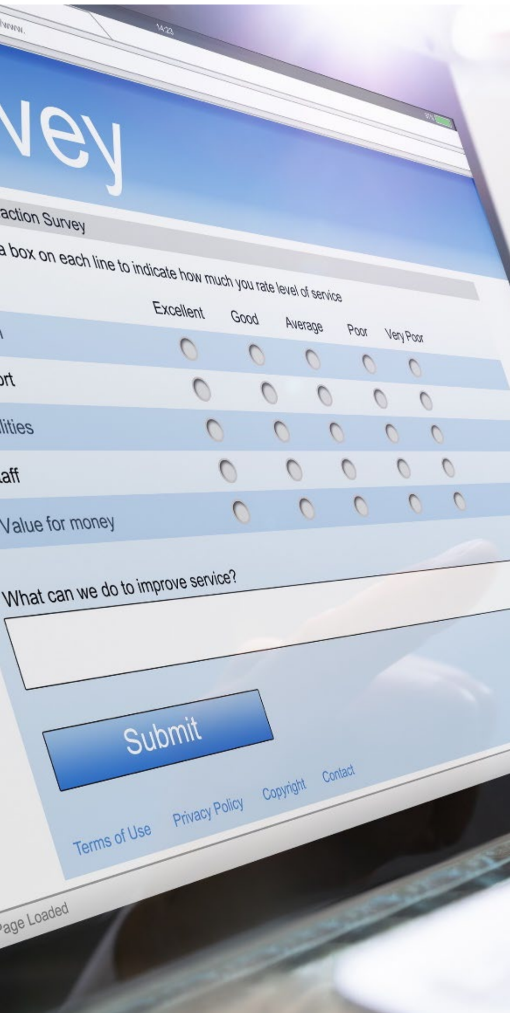
Screening for Social Drivers of Health

OBJECTIVES

- Identify new CMS metrics for social drivers.
- Identify how the social drivers of health are calculated for submission to CMS.
- Define Z codes and how they can be implemented to document social drivers in patients' medical records.

HSAG HEALTH SERVICES ADVISORY GROUP

CMS Hospital Inpatient Quality Reporting (IQR) Program



IQR Social Determinants of Health (SDOH)

- Why is CMS addressing SDOH?
  - Improve outcomes.
  - Lower costs.
  - Support state value-based care strategies.
- What are SDOH?
  - Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes.
- What are social drivers?
  - Non-clinical factors that occur outside of the doctor's office that influence health outcomes.

www.cdc.gov/socialdeterminants/index.htm#:~:text=Social%20determinants%20of%20health%20(SDOH,of%20life%2Drisks%20and%20outcomes

What Are the CMS Data Metrics for Social Drivers?

Health-Related Social Needs (HRSNs)

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

HSAG HEALTH SERVICES ADVISORY GROUP

Social Driver: Food Insecurity

Sample question: Within the past 12 months, were you worried that your food would run out before you got money to buy more?

a) Often true
b) Sometimes true
c) Never true

sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison/peds

HSAG HEALTH SERVICES ADVISORY GROUP

Social Driver: Housing Instability

Sample question: What is your living situation today?

a) I have a steady place to live.
b) I have a place to live today, but I am worried about losing it in the future.
c) I do not have a steady place to live (I am temporarily staying with others; in a hotel; in a shelter; living outside on the street, on a bench, in a car, abandoned building, bus or train station, or in a park).

sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison/peds

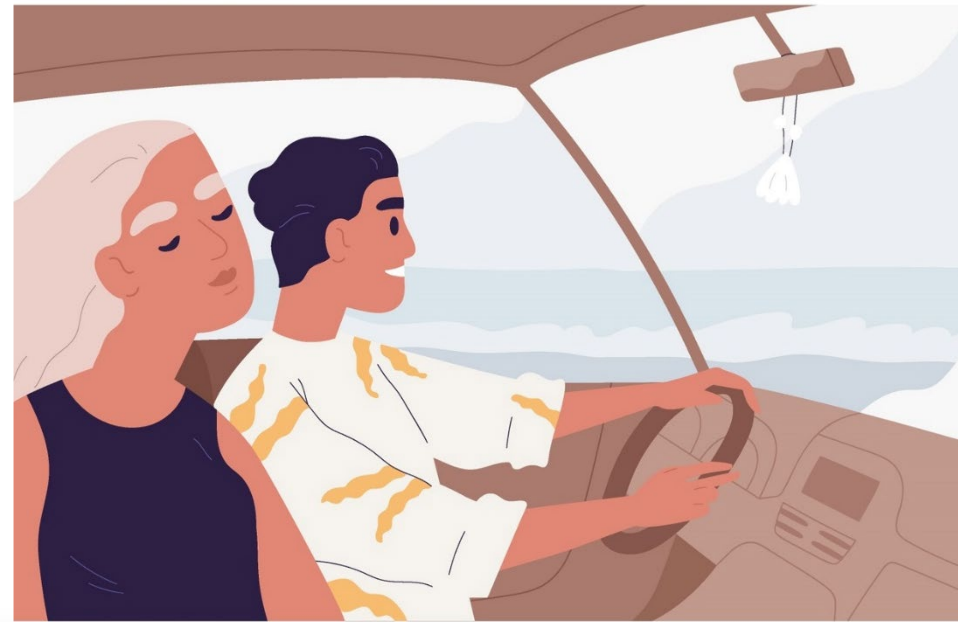
HSAG HEALTH SERVICES ADVISORY GROUP

Social Driver: Transportation Needs

Sample question: In the past 12 months, has lack of transportation kept you from medical appointments, non-medical appointments, work, or from getting your medicines or things that you need?

a) Yes

b) No



HSAG HEALTH SERVICES ADVISORY GROUP

Social Driver: Utility Difficulties

Sample question: In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home.

a) Yes
b) No
c) Already shut off

HSAG HEALTH SERVICES ADVISORY GROUP

Social Driver: Interpersonal Safety

Sample question: How often does anyone, including family and friends, physically hurt you?

a) Never
b) Rarely
c) Sometimes
d) Fairly often
e) Frequently

innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

CMS Social Needs Screening Tool

The Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

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

Transportation

5. **In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**[6]
   - ☐ Yes
   - ☐ No

Utilities

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?**[7]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. [8]

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

CMS. The AHC Health-Related Social Needs Screening Tool.
innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Example: PRAPARE® (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences)

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	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)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
   Street:______________________________
   City, State, Zip code: ___________________

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

13. 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.

____

	I choose not to answer this question

14. 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	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

15. 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 or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that 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		1 or 2 times a week
	3 to 5 times a week		5 or more times a
	I choose not to answer this question		

17. 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

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this

19. Are you a refugee?

	Yes		No		I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

The PRAPARE® social drivers of health assessment screening tool and implementation/action toolkit was developed and owned by the National Association of Community Health Centers (NACHC), in collaboration with the Association of Asian Pacific Community Health Organization (AAPCHO), the Oregon Primary Care Association (OPCA), and the Institute for Alternative Futures (IAF). PRAPARE® and its resources are proprietary information of NACHC and its partners intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part or whole without prior written consent from NACHC. For more information, visit www.prapare.org

Screening for Social Drivers of Health Measure

CMS New Measure #2

Assesses whether a hospital implements screening of all patients that are 18 years or older at time of admission for health-related social needs.

- This measure requires that patients be screened for all five health-related social needs.
  - Food insecurity
  - Housing instability
  - Transportation needs
  - Utility difficulties
  - Interpersonal safety

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

What Data Points do Hospitals Have to Collect to Report on This Measure?

Numerator: The number of inpatients admitted to the hospital, 18 years or older at time of admission, and who are screened for **each of the HRSNs.**

Denominator: The total number of patients who are admitted to the hospital, 18 years or older on the day they are admitted.

Patients who opt out of screening are excluded from the denominator.

HSAG HEALTH SERVICES ADVISORY GROUP

CMS Reporting Periods

CY 2023	CY 2024	CY 2025	CY 2026
Voluntary reporting of measure	Mandatory reporting on an annual basis	Mandatory reporting on an annual basis	Payment Determination

- Hospitals will follow established annual structural measure submission and reporting requirements.
- Due to variability across hospital settings and the population your serve, CMS has allowed hospitals flexibility with selection of tools to screen patients.

CY = calendar year

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

Screening for Social Drivers of Health Measure

CMS New Measure #3

This is a structural measure that provides information on the following:

- Percent of patients admitted for an inpatient hospital stay
- 18 years or older on date of admission
- Screened for an HRSN
- Who screen positive for **1 or more** of the HRSNs
  - Food insecurity
  - Housing instability
  - Transportation needs
  - Utility difficulties
  - Interpersonal safety

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

What Data Points Do Hospitals Have to Collect to Report on This Measure? (cont.)

Numerator: The number of inpatients admitted to the hospital, 18 years or older at time of admission, and who are screened for each of the 5 social drivers and who **screen positive for having a need in 1 or more of the 5 HRSNs—calculated separately, 1 measure per social risk.**

Denominator: The total number of patients who are admitted to the hospital, 18 years or older on the day they are admitted, and **are screened for an HRSN**.

HSAG HEALTH SERVICES ADVISORY GROUP

CMS Reporting Periods

CY 2023	CY 2024	CY 2025	CY 2026
Voluntary reporting of measure	Mandatory reporting on an annual basis	Mandatory reporting on an annual basis	Payment Determination

Hospitals will report this measure as 5 separate rates.

- This measure is intended to provide information to hospitals on the level of unmet socials needs among patients served, and not necessarily for comparison between hospitals.
- Hospitals will follow established annual structural measure submission and reporting requirements.

Submission of CMS Metrics

Information on how data will be submitted is not available at this time.

HSAG HEALTH SERVICES ADVISORY GROUP

What Are Z Codes?

- ICD-10-CM codes:

  Report social, economic, and environmental determinants known to affect health and health-related outcomes.

- Z codes:

  Tool for identifying a range of issues related, but not limited, to:

  - Education and literacy; employment; housing; obtaining adequate amounts of food or safe drinking water; and occupational exposure to toxic agents, dust, or radiation.

- Z codes can be used in any healthcare setting.

CMS. Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019. www.cms.gov/files/document/z-codes-data-highlight.pdf

How Are Z Codes Documented?

- Describe problems or risk factors related to SDOH.
- Should be assigned when information is documented.
- Assign as many SDOH codes as necessary.
- Assign only when the documentation specifies that the patient has an associated problem or risk factor.
- Codes assigned may be based on medical record documentation from:
  - Clinicians
  - Social workers
  - Nurses
  - Case managers
  - Community health workers
  - Patient self-reported documentation signed off by clinician or provider

www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf

ICD-10-CM Categories Z Codes

Code Category	Description	Number of Sub-Codes
Z55	Problem R/T education and literacy	8
Z56	Problems R/T employment and unemployment	12
Z57	Occupational exposure to risk factors	12
Z58	Problems R/T physical environment	12
Z59	Problems R/T housing and economic circumstances	23
Z60	Problems R/T social environment	7
Z62	Problems R/T upbringing	25
Z63	Other problems R/T primary support group, including family circumstances	15
Z64	Problems R/T certain psychosocial circumstances	3
Z65	Problems R/T other psychosocial circumstances	8

www.icd10data.com/ICD10CM/Codes/Z00-Z99/Z55-Z65

Using Z Codes in Your Facility

USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- 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.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- **Identify individuals'** social risk factors and unmet needs.
- **Inform health care** and services, follow-up, and discharge planning.
- **Trigger referrals** to social services that meet individuals' needs.
- **Track referrals** between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

CMS

CMS. Z Codes Infographic, 2022. www.cms.gov/files/document/z-codes-infographic.pdf

HSAG HEALTH SERVICES ADVISORY GROUP

Using Z Codes in Your Facility (cont.)

USING SDOH Z CODES

Can Enhance Your Quality Improvement Initiatives

Health Care Administrators

Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals

Follow the ICD-10-CM coding guidelines.[3]

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.[4]
- Coding team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code Categories

- **Z55** – Problems related to education and literacy
- **Z56** – Problems related to employment and unemployment
- **Z57** – Occupational exposure to risk factors
- **Z58** – Problems related to physical environment
- **Z59** – Problems related to housing and economic circumstances
- **Z60** – Problems related to social environment
- **Z62** – Problems related to upbringing
- **Z63** – Other problems related to primary support group, including family circumstances
- **Z64** – Problems related to certain psychosocial circumstances
- **Z65** – Problems related to other psychosocial circumstances

This list is subject to revisions and additions to improve alignment with SDOH data elements.

[3] https://www.cms.gov/medicare/icd-10/2022-icd-10-cm
[4] https://www.cdc.gov/nchs/icd/icd-10-cm.htm

Revision Date: June 2022

go.cms.gov/omh

CMS. Z Codes Infographic, 2022. www.cms.gov/files/document/z-codes-infographic.pdf

Key Concepts

- CMS metrics screen for food, housing, transportation, utilities, and interpersonal safety.
- Hospitals screen admitted patients ages 18+ for health-related social needs.
  - Metric 2: numerator is number patients screened; denominator is total number of patients admitted.
  - Metric 3: numerator is number of patients who screen positive for a social risk; denominator is total number patients screened.
- Using Z codes to document SDOH in the medical record can identify other issues, such as literacy, employment, and occupational exposure to toxins.

HSAG HEALTH SERVICES ADVISORY GROUP

Join Us for the Entire Health Equity Quickinar Series: 2nd and 4th Thursdays

Recordings, slides, and resource links are posted for on-demand access after every session.

7. Culturally Competent Data Training

7. Culturally Competent Data Training

Thursday, April 13, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT

Objectives:

- Identify the importance of culturally competent training for accuracy of REaL and social driver data.
- Discuss the importance of crucial conversations in engaging patients in reporting REaL data and social driver data.
- Identify points of data collection throughout the hospital process.

1. Health Equity, Hospitals, and CMS Reporting
2. Engaging Leadership in Health Equity
3. Health Equity as a Strategic Priority
4. Collection and Validating REaL Data
5. Social Determinants and Social Drivers of Health
6. Screening for Social Drivers
7. Culturally Competent Data Training
8. Analysis and Stratification of Health Equity Data
9. Health Equity Interventions
10. Best Practices in Health Equity Interventions
11. Community Paramedicine
12. Identifying Community Health Disparities
13. Community Engagement—Health Equity

www.hsag.com/health-equity-quickinars

Check out the Patient and Family Engagement (PFE) Quickinars: 1st and 3rd Thursdays

Recordings, slides, and resource links are posted for on-demand access after every session.

5. PFE to Prepare for Hospital Discharge

Engaging Patients and Family to Prepare for Hospital Discharge

Thursday, April 6, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT

Objectives:

- Demonstrate methods of assessing patient social needs prior to discharge.
- Summarize the concept of discharge planning beginning at admission.
- Review how to use checklists to prepare patient for discharge.
- Refer to care coordination quickinars for more information on health literacy.

1. Intro to PFE
2. Achieving Patient/Family Centered Care
3. Preparing for PFE Programs
4. PFE to Prepare for Hospital Admission
5. PFE to Prepare for Hospital Discharge
6. Role of PFE in Readmission Prevention
7. Bedside Hand Off to Improve Patient Outcomes
8. Adverse Event Transparency
9. Role of the PFE Advisor
10. Selecting/Training/Engaging Advisors
11. PFE in Critical Access & Small Rural Hospitals
12. PFE in Acute Care Hospitals

www.hsag.com/pfe-quickinars

QUESTIONS?

Thank you!

hospitalquality@hsag.com

This material was prepared by Health Services Advisory Group (HSAG), a Hospital Quality Improvement Contractor (HQIC) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. XS-HQIC-DIS-03132023-01