Health Equity Quickinar Series
Session 6

Screening for Social Drivers of Health
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.
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.
What Are the CMS Data Metrics for Social Drivers?

Health-Related Social Needs (HRSNs)

• Food insecurity
• Housing instability
• Transportation needs
• Utility difficulties
• Interpersonal safety
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
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
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
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
Sample question: How often does anyone, including family and friends, physically hurt you?

a) Never
b) Rarely
c) Sometimes
d) Fairly often
e) Frequently
### 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?**
   - [ ] 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?**
   - [ ] 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.

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - [ ] Never 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?**
   - [ ] 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?**
   - [ ] 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.

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

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

<table>
<thead>
<tr>
<th>Personal Characteristics</th>
<th>8. Are you worried about losing your housing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>I choose not to answer this question</td>
<td>I choose not to answer this question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Money &amp; Resources</th>
<th>9. What address do you live at?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street:</td>
<td>City, State, Zip code:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. What is the highest level of school that you have finished?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school degree</td>
</tr>
<tr>
<td>More than high school</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family &amp; Home</th>
<th>11. What is your current work situation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>Part-time or temporary work</td>
</tr>
<tr>
<td>Full-time work</td>
<td>Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver)</td>
</tr>
<tr>
<td>I choose not to answer this question</td>
<td>I choose not to answer this question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social and Emotional Health</th>
<th>12. What is your main insurance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>None/uninsured</td>
<td>Medicaid</td>
</tr>
<tr>
<td>CHIP Medicaid</td>
<td>Medicare</td>
</tr>
<tr>
<td>Other public insurance (not CHIP)</td>
<td>Other Public Insurance (CHIP)</td>
</tr>
<tr>
<td>Private insurance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I choose not to answer this question</td>
</tr>
</tbody>
</table>

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

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.*
## CMS Reporting Periods

<table>
<thead>
<tr>
<th>CY 2023</th>
<th>CY 2024</th>
<th>CY 2025</th>
<th>CY 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary</td>
<td>Mandatory</td>
<td>Mandatory</td>
<td>Payment</td>
</tr>
<tr>
<td>reporting of</td>
<td>reporting on an</td>
<td>reporting on an</td>
<td>Determination</td>
</tr>
<tr>
<td>measure</td>
<td>annual basis</td>
<td>annual basis</td>
<td></td>
</tr>
</tbody>
</table>

- 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

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
**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**.
<table>
<thead>
<tr>
<th>Year</th>
<th>Reporting Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2023</td>
<td>Voluntary reporting of measure</td>
</tr>
<tr>
<td>CY 2024</td>
<td>Mandatory reporting on an annual basis</td>
</tr>
<tr>
<td>CY 2025</td>
<td>Mandatory reporting on an annual basis</td>
</tr>
<tr>
<td>CY 2026</td>
<td>Payment Determination</td>
</tr>
</tbody>
</table>

**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.
Information on how data will be submitted is not available at this time.
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.
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
## ICD-10-CM Categories Z Codes

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

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.
- 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.
- 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

Revision Date: June 2022

2. [https://www.cdc.gov/nchs/icd/icd-10-cm.htm](https://www.cdc.gov/nchs/icd/icd-10-cm.htm)

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.
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.

www.hsag.com/health-equity-quickinmars
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