Hospital Quality Reporting Program

Frequently Asked Questions: Social Drivers of Health (SDOH) Measures

April 2024

SPECIFICATIONS AND CALCULATIONS

1. **Where can I find the measure specifications for the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures?**

   Please refer to the measure specifications document on the CMS QualityNet website here.

2. **What are the numerators and denominators of these two measures?**

   Screening for Social Drivers of Health

   Numerator: The number of patients admitted to a PCH who are 18 years or older on the date of admission and are screened for all of the following five health related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their PCH stay.

   Denominator: The number of patients who are admitted to a PCH and who are 18 years or older on the date of admission.

   Denominator Exclusions: The following patients can be excluded from the denominator:

   (1) patients who opt-out of screening for any reason; and (2) patients who are themselves unable to complete the screening during their PCH stay and have no legal guardian or caregiver able to do so on the patient's behalf during their inpatient stay. Additionally, patients who expire during the PCH stay are excluded.

   Screen Positive Rate for Social Drivers of Health

   Numerator: The number of patients admitted for a PCH stay who are 18 years or older on the date of admission, who were screened for all five HRSNs, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately for each HRSN): food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety.

   Denominator: The number of patients admitted for a PCH stay who are 18 years or older on the date of admission and are screened for all of the following five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their PCH stay.

   Denominator Exclusion: The following patients can be excluded from the denominator:

   1) Patients who opt-out of screening for any reason; and 2) patients who are themselves unable to complete the screening during their PCH stay and have no caregiver able to do so on the patient's behalf during their PCH stay. Additionally, patients who expire during the PCH stay are excluded.

3. **Is "opt-out" synonymous with refused? What are examples of other reasons for opting out? If the PCH actually screens the patient for all five HSRNs but the patient refuses to answer, do we exclude the patient from the denominator? Is it allowable to continue to include them in both the SDOH-1 numerator and denominator since we performed the screening? If the PCH actually screens the patient for all five HSRNs and answers some of the HSRNs but refused to answer the others, are they excluded from the denominator?**

Yes, in this context**,** opt-out could mean refused or that the patient declined to answer. If the patient or authorized representative declines to answer one or more questions related to an HRSN**,** the patient can be excluded from the denominator of the Screening for Social Drivers of Health measure. This would then also exclude them from the Screen Positive Rate for Social Drivers of Health measure for all HRSNs. If the patient declines to answer or opts out of screening, they should not be screened.

Additionally, if the patient is medically unable to respond or has no legal guardian or caregiver able to respond on the patient's behalf, the patient would be excluded from the denominator of the Screening for Social Drivers of Health measure.

4. **Would the setting in which the patient was admitted from or discharged to exclude the patient from the denominator? For example, if the patient was admitted from and discharged to a nursing home would they be excluded?**

   All patients, regardless of where they were admitted from or discharged to, should be included in the denominator if the patient was admitted to a PCH who was 18 years or older on the date of admission, unless a patient meets one or more of the exclusion criteria.

5. **What is the rationale for including patients who are admitted from a nursing home or long-term care facility? What is the expectation if a patient screens positive for any of the HRSNs?**

   When patients are admitted to the PCH for inpatient care, there is substantial opportunity to screen for HRSNs and include relevant community services referrals as part of discharge planning. These measures will help providers identify patients with unmet HRSNs irrelevant of their living situation. PCHs will be able to implement and assess quality improvement efforts that address patients' unmet social needs by connecting admitted patients with unmet social needs to local community resources to support safe discharge and improved health outcomes.

   Patients discharged or transferred to congregate living settings should be provided with HRSN screening results to enable professionals providing services to develop person centered plans to address ongoing needs.

6. **How is the Screening for Social Drivers of Health measure calculated?**

   The Screening for Social Drivers of Health measure is calculated by dividing the total number of PCH inpatients who are 18 and older and screened for all five health HRSNs by the total number of patients admitted to a PCH who are 18 or older at the time of admission.

7. **How is the Screen Positive Rate for Social Drivers of Health measure calculated?**

   The Screen Positive Rate for Social Drivers of Health measure will be calculated as five separate rates. The Screen Positive Rate for Social Drivers of Health measure uses the numerator of the Screening for Social Drivers of Health measure as the denominator.

Rate of PCH Inpatients who Screen Positive for Food Insecurity	Number of PCH inpatients who screened positive for food insecurity / total number of PCH inpatients screened for all five HRSNs
Rate of PCH Inpatients who Screen Positive for Housing Instability	Number of PCH inpatients who screened positive for housing instability / total number of PCH inpatients screened for all five HRSNs
Rate of PCH Inpatients who Screen Positive for Transportation Needs	Number of PCH inpatients who screened positive for transportation needs / total number of PCH inpatients screened for all five HRSNs
Rate of PCH Inpatients who Screen Positive for Utility Difficulties	Number of PCH inpatients who screened positive for utility difficulties / total number of PCH inpatients screened for all five HRSNs
Rate of PCH Inpatients who Screen Positive for Interpersonal Safety	Number of PCH inpatients who screened positive for interpersonal safety / total number of PCH inpatients screened for all five HRSNs

8. For example, how would the following be calculated?

There are 100 total patients who are admitted to the PCH in a given year who are 18 or older at the time of admission. Ninety of those patients were screened for all five HRSNs. Ten were only screened for some HRSNs or not screened at all.

The Screening for Social Drivers of Health measure for this PCH would be calculated as: 90 / 100 = 90% of PCH inpatients 18 or older at time of admissions were screened for all five HRSNs. If no exclusions are applicable, the 10 patients who were only screened for some HRSNs or not screened at all should be included in the denominator, but not the numerator.

Of the 90 patients who were screened for all five HRSNs: 9 screened positive for food insecurity, 9 screened positive for housing instability, 5 screened positive for transportation needs, 20 screened positive for utility difficulties, and 5 screened positive for interpersonal safety.

The Screen Positive Rate for Social Drivers of Health measure would be calculated as follows for each HRSN:

Rate of PCH Inpatients who Screen Positive for Food Insecurity	9/90 = 10%
Rate of PCH Inpatients who Screen Positive for Housing Instability	9/90 = 10%
Rate of PCH Inpatients who Screen Positive for Transportation Needs	5/90 = 6%*
Rate of PCH Inpatients who Screen Positive for Utility Difficulties	20/90 = 22%*
Rate of PCH Inpatients who Screen Positive for Interpersonal Safety	5/90 = 6%

*Percentages will be rounded to nearest full percent.

9. What is the time frame for "at time of admission?" Is it collected within one hour, 24 hours, or anytime during the episode of care?

Screening can occur any time during the PCH admission prior to discharge.

10. How frequently should a PCH screen an individual patient? For example, if a patient comes in today, was assessed for the health-related social needs (HRSNs), and comes back two months later, does a PCH assess this person again? For the patient to count toward the numerator, does the PCH screen the patient on the current visit? Could the screening of the patient during a prior visit count towards the numerator?

Screening should occur during each PCH stay. For patients frequently admitted to the PCH, for example, due to chronic health conditions, the PCH could confirm the current status of any previously reported HRSNs and inquire about other HRSNs not previously reported. In addition, if this information has been captured in the electronic health record (EHR) in the outpatient setting prior to repeat PCH admission, it could be included in PCH reporting of numerator and denominator data, during the measure's reporting period.

Patients should be screened during every admission, but only unique patients should be included in any one reporting period (year). If a patient has multiple admissions in the year, the most recent result (i.e., the result closest to the reporting period) should be submitted.

For example, if the patient were admitted, screened, and discharged in May 2023 and then admitted, screened, and discharged in December 2023, the results of the December 2023 admission would be used for the CY 2023 reporting period.

11. Does the population use the admission date or discharge date? For example, if a patient was admitted on 11/23/2023 and discharged on 1/3/2024, do we include that patient for CY 2023 or CY 2024?

As noted in the FY 2024 IPPS/LTCH PPS final rule, screening can occur at any point during the PCH stay. In order to not count patients twice for the same admission if the year changes during the PCH admission, we recommend PCHs use discharge date.

For example, in the above scenario, the patient would be counted towards CY 2024, not CY 2023.

12. Will CMS allow sampling for these measures, or will PCHs need to include all patients who are admitted to a PCH and who are 18 years or older on the date of admission?

PCHs will report these data in aggregate. The measure is not sampled. The measure denominator consists of the total number of patients who are admitted to a PCH and who are 18 years or older on the date of admission.

The following patients can be excluded from the denominator: (1) patients who opt-out of screening for any reason; and (2) patients who are themselves unable to complete the screening during their inpatient stay and have no legal guardian or caregiver able to do so on the patient's behalf during their PCH stay. Additionally, patients who expire during the PCH stay are excluded.

13. Can the PCH opt-out or note that it was unable to obtain a response for a specific domain/question, or does that need to be at the overall HRSN documentation level? Would either suffice as an exclusion? Would we exclude a patient for housing instability, but not food insecurity?

A "PCH" is not able to opt-out. A patient can be excluded from the denominator of both measures if: 1) the patient opts-out of screening for any reason; and 2) if the patient themselves is unable to complete the screening during their PCH stay and have no caregiver able to do so on the patient's behalf during their PCH stay. Additionally, patients who expire during the PCH stay are excluded.

If a patient opts-out of screening for one or more of the HRSNs, they can be excluded from the denominator of the Screening for Social Drivers of Health measure. This would then also exclude them from the Screen Positive Rate for Social Drivers of Health measure for all HRSNs.

SUBMISSIONS AND REPORTING

14. What is the reporting period for these measures?

CMS will require reporting of the SDOH measures on an annual basis. The annual submission period for these measures is from July 1 through August 15*.

For the voluntary CY 2024 reporting period (i.e., January 1, 2024 – December 31, 2024), PCHs will be able to report these measures in CMS' Hospital Quality Reporting (HQR) System from July 1, 2024, through August 18*, 2025.

Mandatory reporting will begin with the CY 2025 reporting period (i.e., January 1, 2025 – December 31, 2025), And PCHs will be able to report these measures in the HQR System from July 1, 2026 through August 17*, 2026.

15. Is the requirement to annually enter the aggregate numerator and denominator for each measure?

Yes, the requirement is to report the numerators for both measures and the denominator for the Screening for Social Drivers of Health measure. The data reported should be aggregated (i.e., totaled) for the PCH. The Screen Positive Rate for Social Drivers of Health measure uses the numerator of the Screening for Social Drivers of Health measure as the denominator. See questions four and five above for an example. The HQR System will calculate the rate for each measure based on the aggregated numerators and denominator that are reported.

16. Will PCHs enter information into the web-based section, within the HQR System, during the voluntary reporting period? Does the window to enter these data start in June with a deadline of August 15, 2025*? Also, since this is voluntary, do we activate anything in this section within the HQR System or will you automatically provide the voluntary web-based form inside the web-based section?

PCHs will be able to access the SDOH measures data form, in the HQR system, by clicking on Data Submission under the Dashboard, on the left-hand side of the HQR homepage, and then clicking on Structural Measures. Additional information will be forthcoming prior to the start of the submission period on July 1, 2025. For the CY 2024 voluntary reporting period, PCHs will be able to report these measures in the HQR System from July 1, 2025, through August 18, 2025*. The data form will be available for all PCHs to voluntarily enter the data.

*CMS reporting deadlines are customarily on the 15th day of the respective month. If the 15th day is a Friday, Saturday, Sunday, or federal holiday, the deadline date is shifted to the next business day.

17. When documenting by exception, nurses and other clinicians only document an issue if it exists. We generally do not document "none" if a patient had no issues with food insecurity, housing instability, transportation needs, paying for utilities, and/or interpersonal safety. Is this acceptable, or do we need to document that the issue exists or that the issue doesn't exist when screening patients and when preparing to build our reports?

Documentation must reflect that the patient was screened for all five HRSNs, as well as if a patient screened positive for one or more of the HRSNs. The two measures require that PCHs submit the number of patients screened for all five HRSNs, the number of patients admitted to the PCH who are 18 or older at the time of admission, and the number of patients who screened positive for each of the five HRSNs who were screened for all five HRSNs.

If a PCH is able to accurately submit those aggregate numbers from the documentation method outlined in the question above, it would meet the measure requirement.

SCREENING AND SCREENING TOOLS

18. What questions are required for the Screening for Social Drivers of Health and the Screen Positive Rate for Social Drivers of Health measures? I understand we have to report on the five HRSNs. However, what questions are required under each topic?

Due to variability across PCH settings and the populations they serve, and recognizing that some PCHs may be implementing screenings for the first time for one or more of the

HRSNs that are part of these measures, CMS is allowing PCHs flexibility with selection of tools to screen patients for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. CMS is not requiring the use of specific questions for each HRSN.

CMS suggests PCHs refer to evidence-based resources for comprehensive information about the most widely used HRSN screening tools. For example, the Social Interventions Research and Evaluation Network (SIREN) website, housed at the Center for Health and Community at the University of California, San Francisco, contains descriptions of the content and characteristics of various tools, including information about intended populations, completion time, and number of questions. Another example is the Accountable Health Communities Health-Related Social Needs (ACH-HRSN) Screening Tool (refer to Question 19). The AHC-HRSN is a 19-item screening tool, with 16 supplement questions, to identify patient needs that can be addressed through community services in four domains (economic stability, social and community context, neighborhood and physical environment, and food.)

CMS has noted it anticipates additional emphasis on standardized and validated screening instruments in future versions of these measure. PCHs are encouraged to prioritize screening tools that have undergone adequate testing to ensure they are accurate and reliable.

19. If we use the AHC-HRSN Screening Tool as our validated tool, can we only use the first 10 questions?

Yes, the ten questions included in the AHC HRSN Screening Tool Core Questions tool would meet the requirement for the measure specifications. There are additional questions in the AHC HRSN Screening Tool Supplemental section, but those are not required to meet the measure specifications.

Additional information can be found on the CMS Innovation Center's Accountable Health Communities Model webpage, the Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool, and the Accountable Health Communities Health-Related Social Needs Screening Tool Citation and Notification Information.

20. Are we able to use the International Classification of Diseases (ICD)-10 Social Determinants of Health Z codes to capture this information? For example, if the Uniform Billing (UB)-04 included the ICD-10 code "Z59.62 Unable to pay for utilities," can we utilize that code?

If the use of this code means that the PCH has screened for that HRSN and that patient has screened positive for it, PCHs could use Z codes in this way. For more information about using Z codes, the CMS Office of Minority Health recently released a new Z code infographic: Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes (2023). This resource aims to assist providers with understanding and using Z codes to improve the quality and collection of health equity data.

21. We have already implemented SDOH screening tools in our ambulatory setting. Can we use a tool that is used in the ambulatory setting for a patient admitted as an inpatient? Does the screening need to occur during the inpatient admission? If we can use an outpatient screening, is there a specific timeframe to perform that screening, or is that up to the hospital?

If the tool mentioned meets the measure criteria, including the five specified HRSNs, it can be used in the PCH setting.

The measure specifies that PCHs should screen all eligible patients (patients 18 years or older on the date of admission). For example, for patients frequently admitted to the PCH due to chronic health conditions, the PCH could confirm the current status of any previously reported HRSN and inquire about other HRSNs not previously reported.

In addition, if this information has already been captured in the EHR in the outpatient setting prior to the PCH admission, it could be included in PCH reporting of numerator and denominator data, during the reporting period. Otherwise, there is no specific timeframe as to when the outpatient screening would occur relevant to the PCH admission.

22. Is it acceptable to reduce the number of questions in the validated tool to collect data, as long as you ask one in each of 5 categories?

To report on this measure to CMS, PCHs need to provide: (1) the number of inpatients admitted to the PCH who are 18 years or older at time of admission and who are screened for all 5 of the five HRSNs: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety; and (2) the total number of patients who are admitted to the PCH who are 18 years or older on the date they are admitted.

23. Are we able to use information (such as race and ethnicity) documented in other places, such as the medical record or face sheet (not in the screening tool)?

Race, ethnicity, and other demographic information are not required to be reported to CMS for the SDOH measures. Note, the Hospital Commitment to Health Equity measure includes attestation statements about the collection of patient demographic information, including self-reported race and ethnicity, and/or social determinant of health information.

24. Are there recommended value sets that can be used to identify the data elements (HRSNs)?

CMS is not recommending specific value sets at this time.

25. When will the SDOH measures be publicly reported?

The SDOH measures will be publicly reported beginning with the CY 2025 reporting period (January 1, 2025 through December 31, 2025) and will be included in the July 2027 public reporting release.