Hospital Quality Reporting Program

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

January 2025

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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.

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

   Screening for Social Drivers of Health

   Numerator: The number of patients admitted to an inpatient hospital stay 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 hospital inpatient stay.

   Denominator: The number of patients who are admitted to a hospital inpatient stay 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 inpatient 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 inpatient stay are excluded.

   Screen Positive Rate for Social Drivers of Health

   Numerator: The number of patients admitted for an inpatient hospital 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 an inpatient hospital 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 hospital inpatient 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 inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay. Additionally, patients who expire during the inpatient stay are excluded.

3. **Is "opt-out" synonymous with refused? What are examples of other reasons for opting out? If the hospital 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 hospital actually screens the patient for all five HSRNs and the patient 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 an inpatient hospital stay 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 hospital 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. Hospitals 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 hospital inpatients who are 18 and older and screened for all five health HRSNs

by the total number of patients admitted to a hospital inpatient stay 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 Hospital Inpatients who Screen Positive for Food Insecurity	Number of hospital inpatients who screened positive for food insecurity / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Housing Instability	Number of hospital inpatients who screened positive for housing instability / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Transportation Needs	Number of hospital inpatients who screened positive for transportation needs / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Utility Difficulties	Number of hospital inpatients who screened positive for utility difficulties / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Interpersonal Safety	Number of hospital inpatients who screened positive for interpersonal safety / total number of hospital 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 hospital 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 hospital would be calculated as: 90 / 100 = 90% of hospital 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 Hospital Inpatients who Screen Positive for Food Insecurity	9/90 = 10%
Rate of Hospital Inpatients who Screen Positive for Housing Instability	9/90 = 10%
Rate of Hospital Inpatients who Screen Positive for Transportation Needs	5/90 = 6%*
Rate of Hospital Inpatients who Screen Positive for Utility Difficulties	20/90 = 22%*
Rate of Hospital 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 hospital admission prior to discharge.

10. **How frequently should a hospital 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 hospital assess this person again? For the patient to count toward the numerator, does the hospital 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 hospital stay. For patients frequently admitted to the hospital, for example, due to chronic health conditions, the hospital 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 hospital admission, it could be included in hospital 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 2024 and then admitted, screened, and discharged in December 2024, the results of the December 2024 admission would be used for the CY 2024 reporting period.

11. **Does the population use the admission date or discharge date? For example, if a patient was admitted on 11/23/2024 and discharged on 1/3/2025, do we include that patient for CY 2024 or CY 2025?**

As noted in the FY 2023 IPPS/LTCH PPS final rule, screening can occur at any point during the hospital inpatient stay. In order to not count patients twice for the same admission if the year changes during the hospital admission, we recommend hospitals use discharge date. For example, in the above scenario, the patient would be counted towards CY 2025, not CY 2024.

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

Hospitals 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 hospital inpatient stay 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 inpatient stay. Additionally, patients who expire during the inpatient stay are excluded.

13. Can the hospital 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 "hospital" 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 inpatient stay and have no caregiver able to do so on the patient's behalf during their inpatient stay. Additionally, patients who expire during the inpatient 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 April 1 through May 15.
For example, for the mandatory CY 2024 reporting period (i.e., January 1, 2024 – December 31, 2024), hospitals will report these measures in CMS' Hospital Quality Reporting (HQR) System from April 1, 2025, through May 15, 2025.

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 hospital. 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 hospitals enter information into the web-based section, within the HQR System? Does the window to enter these data start in March with a deadline of May 15th?**

    Hospitals 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 the Structural Measures tab. For example, for the CY 2024 mandatory reporting period, hospitals will be able to report these measures in the HQR System from April 1, 2025, through May 15, 2025.

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. 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 hospitals submit the number of patients screened for all five HRSNs, the number of patients admitted to the hospital 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 hospital 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? What questions are required under each topic?**

    Due to variability across hospital settings and the populations they serve and recognizing that some hospitals may be implementing screenings for the first time for one or more of the HRSNs that are part of these measures, CMS is allowing hospitals flexibility with selection of tools to screen patients. CMS is not requiring the use of specific questions for each HRSN.

    CMS suggests hospitals 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.

CMS has noted it anticipates additional emphasis on standardized and validated screening instruments in future versions of these measures. Hospitals 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 hospital has screened for that HRSN and that patient has screened positive for it, hospitals 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 inpatient setting.

The measure specifies that hospitals should screen all eligible patients (patients 18 years or older on the date of admission). For example, for patients frequently admitted to the hospital due to chronic health conditions, the hospital 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 during the reporting period, but prior to hospital admission, it could be included in hospital reporting of numerator and denominator data, during the reporting period.

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, hospitals need to provide: (1) the number of inpatients admitted to the hospital 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 hospital 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 2024 reporting period (January 1, 2024 through December 31, 2024) and will be included in the October 2025 public reporting release.