RQITA
RESOURCE CENTER

Screen Positive Rate for Social Drivers of Health Data Submission Guide

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Introduction

This measure is a quality measure the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) is adopting for use in the Medicare Beneficiary Quality Improvement Project (MBQIP) within the Medicare Rural Hospital Flexibility Program.

This resource is intended to be used by critical access hospital personnel involved in MBQIP and State Flex personnel. This guide is based on currently available information. The information provided and submissions dates are subject to change. For guidance on the Flex Program or MBQIP measures connect with you State Flex Program or the Rural Quality Improvement Technical Assistance (RQITA) Resource Center at RQITA@telligen.com.

Measure Overview

Measure Name: Screen Positive Rate for Social Drivers of Health

Measure Short Name: SDOH-2

MBQIP Domain: Care Coordination

Quality Programs: MBQIP, CMS Inpatient Quality Reporting (IQR) Program

Measure Description

Measure Description: The Screen Positive Rate for Social Drivers of Health Measure provides information on the percent of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, were screened for an HRSN (health-related social needs), and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Measure Rationale for being in MBQIP:

Economic and social factors known as social drivers of health (SDOH) are known to affect health outcomes and costs. Therefore the recognition and measurement of health-related social needs (HRSN) and other health disparities of patients can impact patient care and improve health outcomes. This measure is derived from the Center for Medicare and Medicaid Innovation's Accountable Health Communities (AHC) model and has been tested in large populations across states. The intent of this measure is to help ensure hospitals are considering and addressing social needs in the care they provide to their community.

Relevance for Rural Hospitals:

- Tailored Patient Care: Identifying social drivers of health allows healthcare providers to understand the unique challenges and needs of patients in rural communities so that they are able to tailor care plans. It allows care plans to align with the unique context of each patient's life (transportation, housing, etc.). It allows for collaboration with patient and clinicians to work together to adjust care plans to accommodate social needs.
- Compassionate Care: When we inquire effectively about health-related social needs or social drivers of health, it should be done in a way that is compassionate, discreet, and non-judgmental. It may be simply that our patients see that we want to know about their lives. We

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don't force them to raise awkward explanations about what's going on. We don't assume that everything's OK at home, but rather enquire by compassionately raising it ourselves.

- Preventive Interventions: Screening for social drivers of health can help identify potential risk factors early on, allowing healthcare providers to intervene with preventive measures.
- Reduced Health Disparities: Rural communities often face greater health disparities due to limited access to healthcare services and resources. Screening for social drivers of health can ensure all patients receive equitable care.
- Cost Savings: Addressing social drivers of health can lead to cost savings in the long run by preventing costly hospital readmissions and complications associated with unmet social needs.
- Community Partnerships: Screening for social drivers of health encourages rural hospitals to collaborate with community organizations and agencies to address the underlying social drivers impacting health.
- Inform Population Health Systems: Collecting information about patients' needs, both those that can be met and those that can't, informs system level work around improving the health of a population. Health care resources like Community Health Needs Assessments, Community Health Improvement Plans, and hospital community benefit spending, not to mention broader public policy initiatives, can be informed by the information collected through screening for health-related social needs and tracking the outcomes of resource referrals or navigation services.

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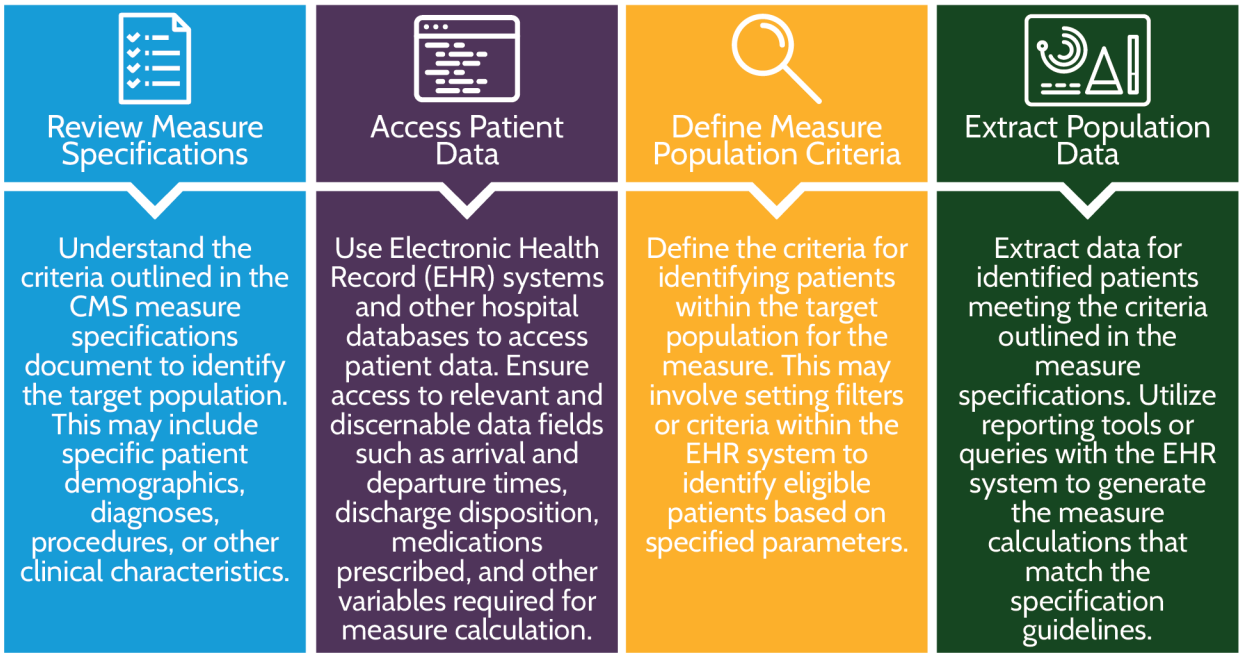
Getting Started

Reporting data for a quality measure for the first time can be a daunting task for hospital staff. Below are actionable first steps hospital quality teams can take for reporting new measures for hospitals.



Best Practices:

Conducting Community Needs Assessment

- Conduct a comprehensive assessment of the social drivers of health prevalent in the local rural community. This can involve engaging with community members, local organizations, public health agencies, and other stakeholders. Non-profit hospitals are required to do a community health needs assessment (CHNA) by the Internal Revenue Service (IRS). Connect with the team members who perform the CHNA in your hospital to use the meaningful data along with the SDOH screening data.

Selecting Screening Tools

- A specific screening tool is not required to be used, but all five areas of health-related social needs must be included. Choose validated screening tools that are appropriate for the rural population and setting. These tools should be brief, easy to administer, and sensitive to the social drivers commonly affecting rural residents. Consider factors such as literacy levels, cultural sensitivity, and language preferences when selecting screening tools. Ensure engagement with multiple teams when selecting a tool. Consider engagement with the social services department to recommend a screening tool and that it is approved by the hospital clinical leadership team.

Integrating Screening into Workflow

- Integrate the screening process into routine clinical workflows to ensure that it becomes a standard part of patient care. Determine the staff members responsible for screening and the screening process. This may involve training providers and staff on how to administer screening tools, documenting in electronic health records (EHRs) for easy reference when

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reporting this measure, and establishing protocols for follow-up and referrals. Ensure Results of screenings are incorporated into care plans with healthcare providers. Healthcare teams should understand the unique challenges and needs of the patient so they are able to adjust care plans to meet to needs.

Providing Training and Education

- Provide training and education for providers and staff on the importance of addressing social drivers of health and how to effectively communicate with patients about these sensitive topics. Encourage a non-judgmental and empathetic approach to screening and addressing social needs.

Collaborating with Community Partners

- Forge partnerships with community organizations, local agencies, and social service providers to establish referral pathways for patients in need of support. Develop a network of resources and services that can address the identified social needs of patients, including transportation assistance, food banks, housing assistance programs, employment services, and mental health support. If your community lacks organizations to address social needs screening information can be used to advocate for increased social services in your area to state agencies such as the State Office of Rural Health, county departments of health, or other state legislative bodies.

Data Collection and Evaluation

- Collect data on the outcomes of screening efforts, including the prevalence of social drivers of health among patients, referral rates, and the impact of interventions on health outcomes and healthcare utilization. Use this data to evaluate the effectiveness of screening programs, identify areas for improvement, and advocate for resources to address social needs.

Patient Engagement and Empowerment

- Involve patients in decision-making about referral options and care plans. Empower patients to advocate for their own social needs and provide them with information about available resources and support services.

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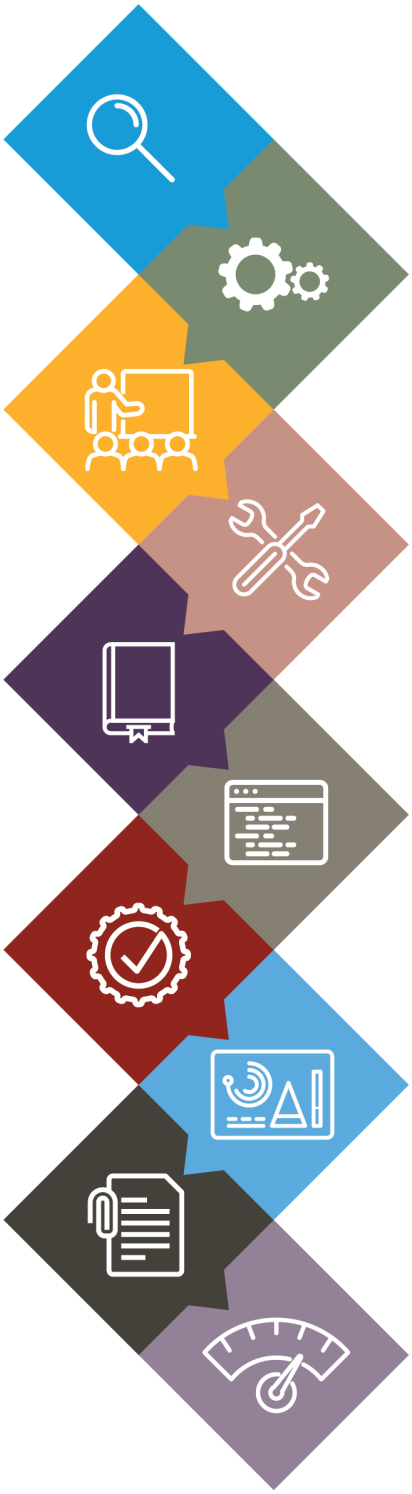
Data Collection Details

How to collect data in the hospital

Collecting data for a measure involves step-by-step processes from data collection to quality improvement. Consider the following steps for implementation.



Step 1: Identify measure population

Step 2: Configure EHR system to capture and report data or decide to capture the information manually

Step 3: Train staff on importance of measures and accurate reporting in EHR

Step 4: Implement Clinical Decision Support (CDS) tools to prompt capturing necessary data

Step 5: Standardize documentation practices with templates, order sets and measure guidelines

Step 6: Utilize structured data entry

Step 7: Monitor data quality with data validation checks quarterly

Step 8: Generate reports quarterly (and annually)

Step 9: Submit data to CMS according to timelines

Step 10: Monitor progress toward performance goals

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Measure Reporting Details

The following are data elements for the measure necessary for reporting the measure and collecting data. For more detailed data refer to the measure specifications.

Measure Encounter Period: This measure is reported annually reflecting calendar year (January 1, 20XX – December 31, 20XX) encounter period.

Measure Submission Deadline: This measure is submitted annually May 15 of each year for data from the previous year. Data submission deadlines on a federal holiday or weekend (Saturday or Sunday) will default to the first business day thereafter in this document where applicable.

Measure Reporting Platform: This measure is submitted annually in the Hospital Quality Reporting (HQR) secure portal.

Measure Population: The number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission.

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 HRSN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): 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 HRSN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

Exclusions:

1. Patients who opt- out of screening
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.
3. Patients who expire during the inpatient stay.

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Reporting the Data

The steps for reporting this measure into the Hospital Quality Reporting (HQR) platform are detailed below. A video tutorial is also available through the Centers for Medicare & Medicaid Services (CMS) YouTube webpage HQR Playlist.

To report on this measure, hospitals will provide:

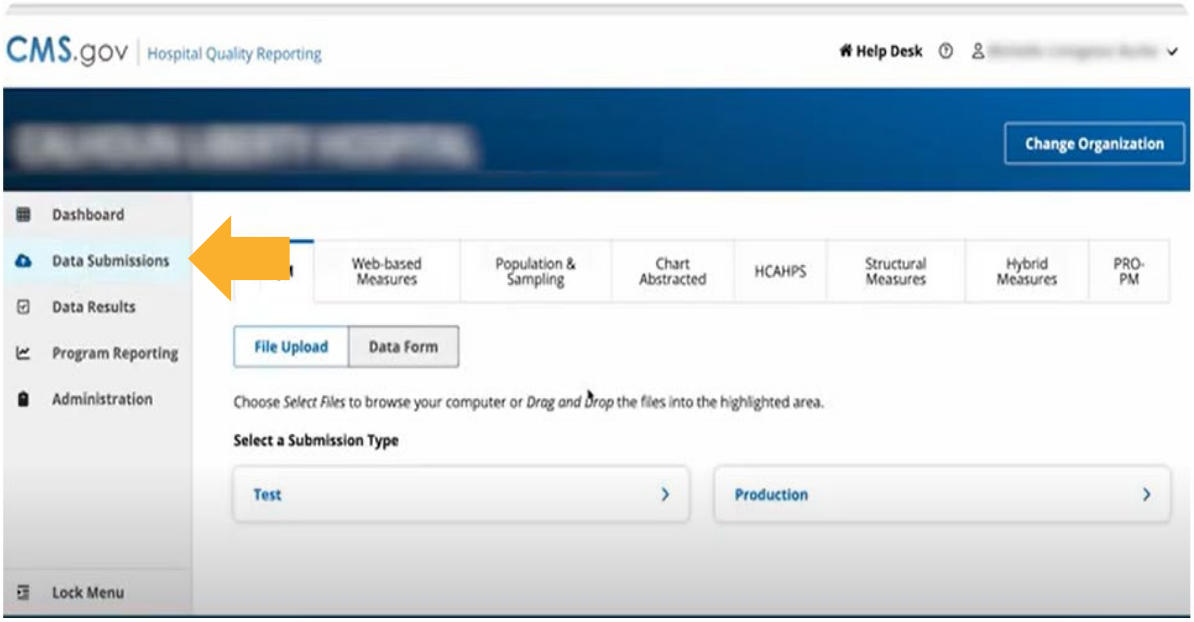
1. The number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability,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

and

2. The total 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 HRSN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay.

To report this measure, hospitals will begin by logging into the Hospital Quality Reporting Secure Portal.

1. From dashboard, go to navigation menu on the left side of the screen.
2. Select 'Data Submissions' on the left.



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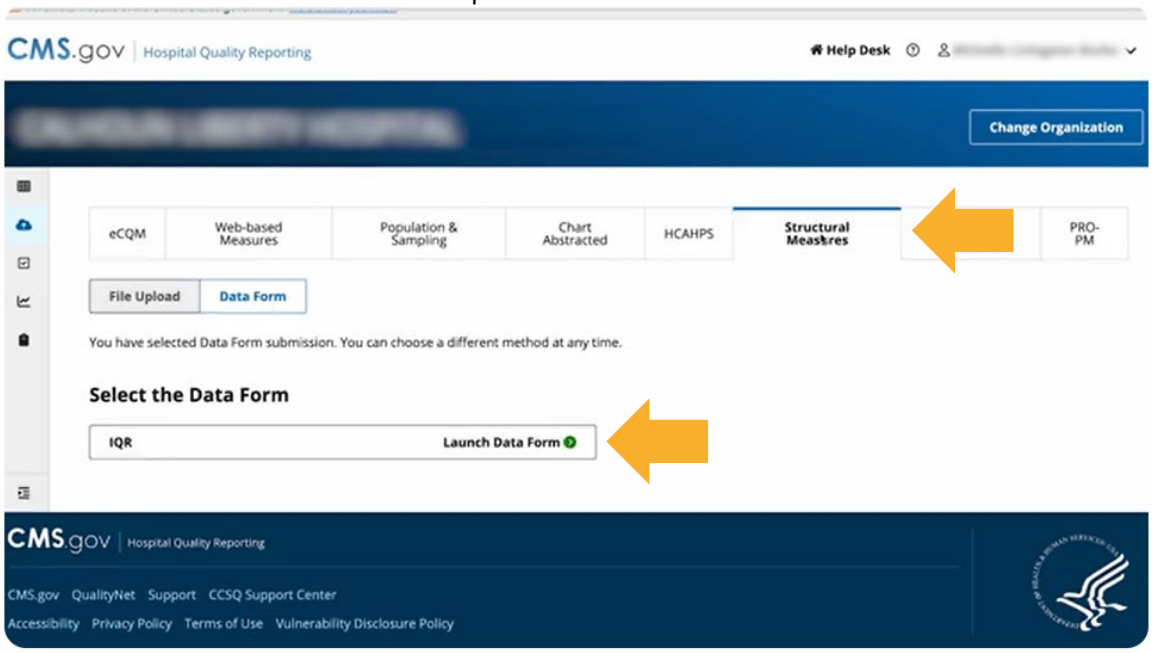
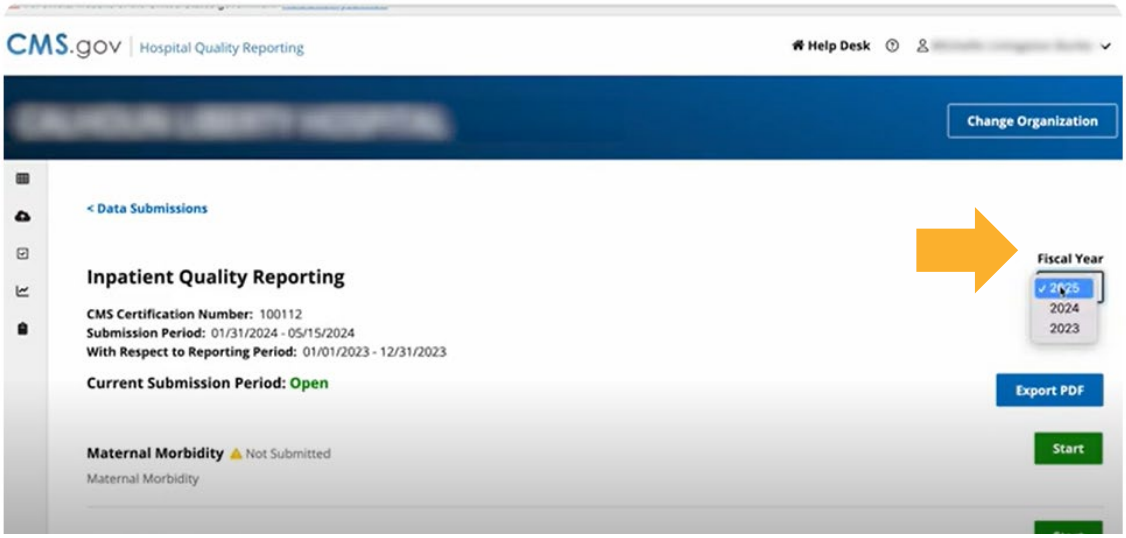
3. Select ‘Structural Measures’ tab on the top. Then ‘Launch Data Form’.



4. Select the Fiscal Year you want to report data for. The Fiscal Year is two years after the Calendar Year for encounter dates you are submitting. The data is collected during the Calendar Year, then typically submitted the following year, and the payment is given in the Fiscal Year.

   For example, the data collected during CY (Calendar Year) January 1, 2023–December 31, 2023, will be submitted during the April 1, 2024–May 15, 2024 Submission Period. If there would be an APU (Annual Payment Update) for the data, it would be paid in the FY (Fiscal Year) 2025 so you would select ‘Fiscal Year 2025’ for this submission.



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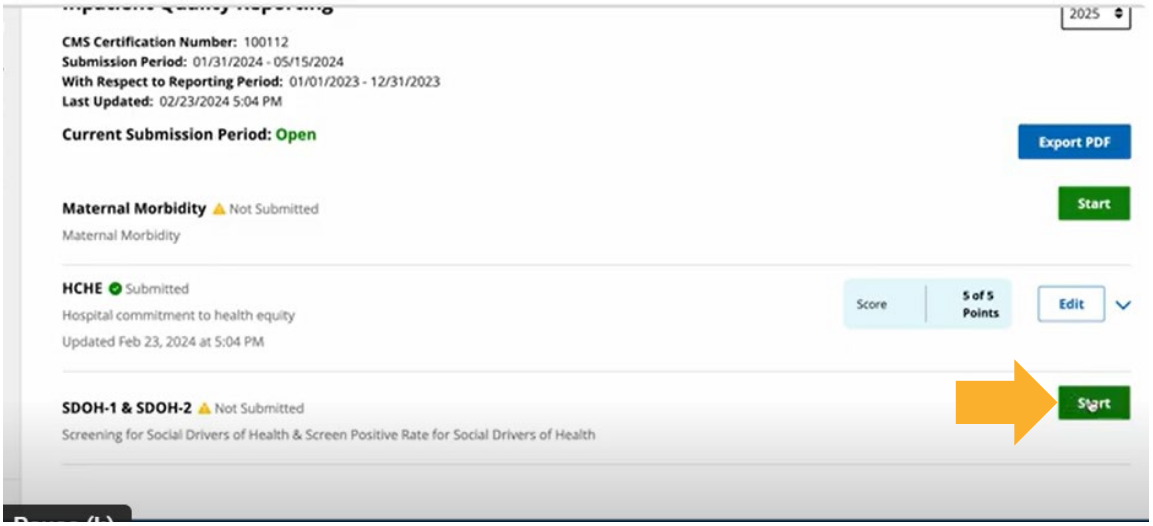
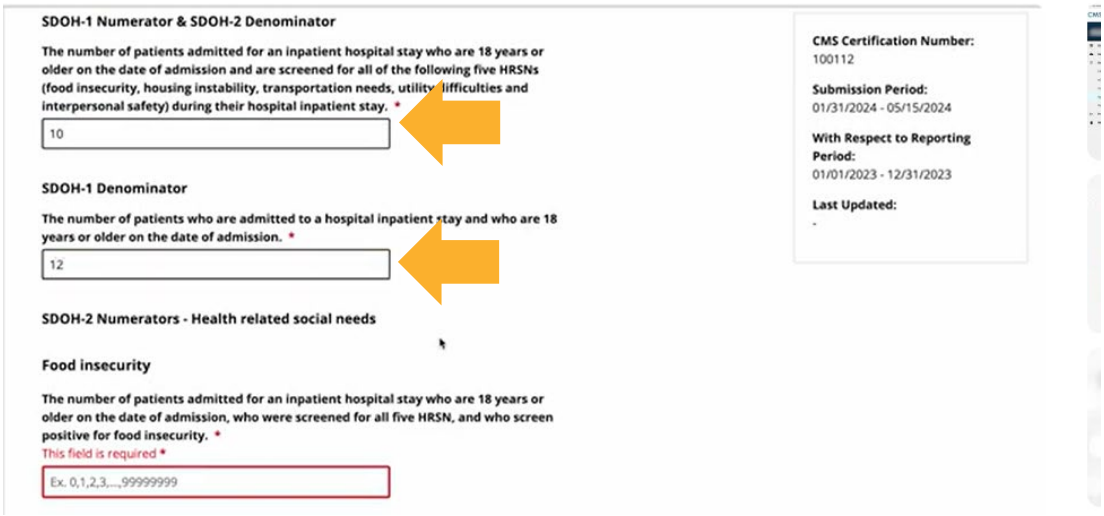
5. Select ‘Start’ to the right of SDOH measures.



6. Enter in the SDOH-1 Numerator and Denominator if you have not already done so. Refer to the Data Submission Guide for Screening for Social Drivers of Health for data element details.

   Remember: The numerator for SDOH-1 is 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 HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay. The denominator for SDOH-1 is the number of patients who are admitted to a hospital inpatient stay and who are 18 years or older on the date of admission. Although you may be submitting data for SDOH-2 the numerator for SDOH-1 is utilized for SDOH-2.



NOTE: After completing this step, you have entered data for SDOH-1.

To enter SDOH-2 data, proceed to the next step:

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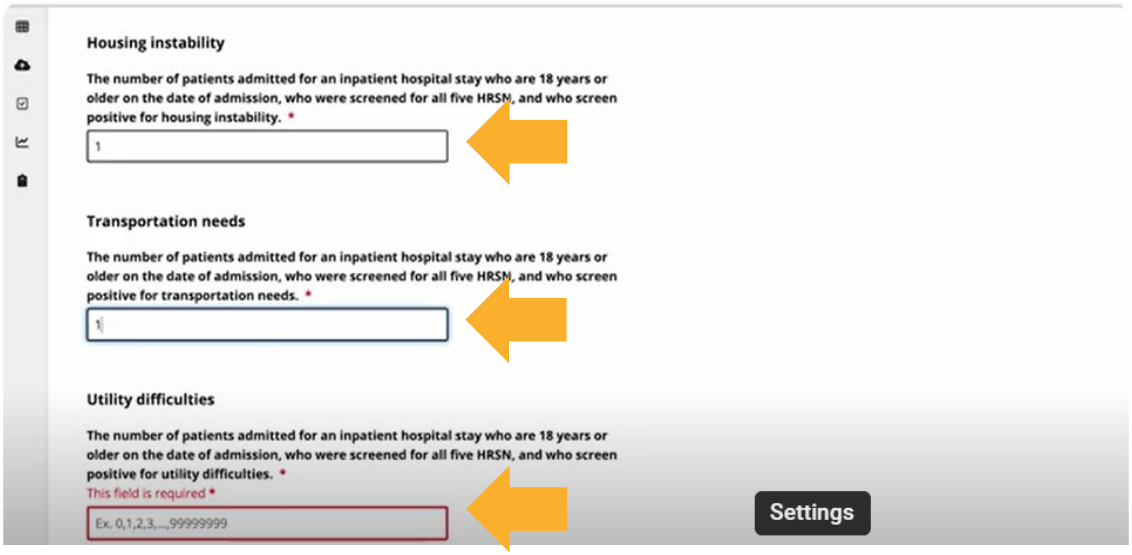
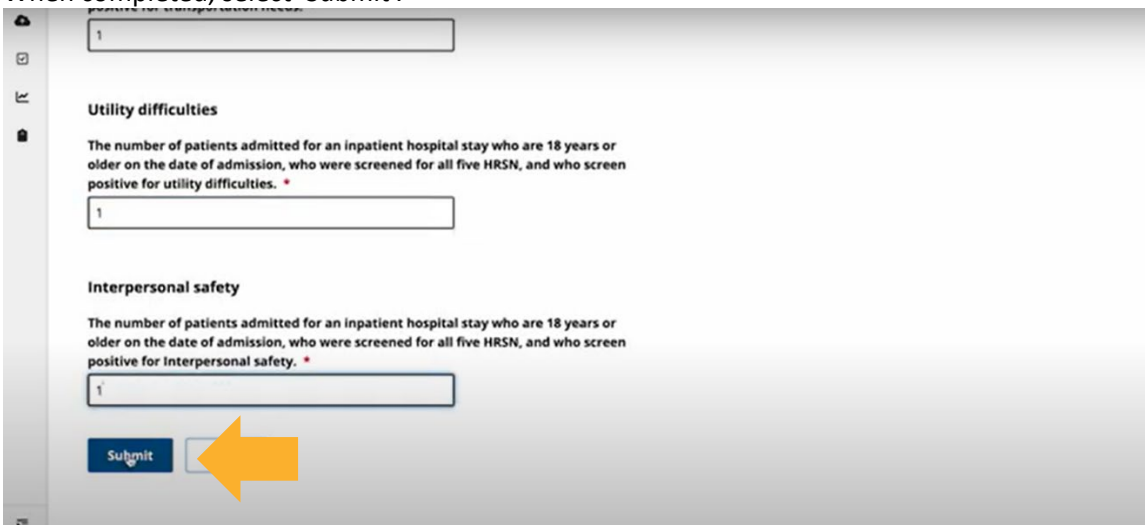
7. Enter SDOH-2 numerators for each of the health-related social needs. Remember SDOH-2 numerator is the number of patients admitted for an inpatient hospital stay who are 18 years or older on the date of admission, who were screened for all five HRSN, **and** who screen positive for having a need in one or more of the following five HRSNs (calculated separately): Food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety.

   You will have a numerator (or the count of those who screened positive) for **each** of the five health-related social needs.

   For this measure, you do not need to enter denominators for SDOH-2 as the SDOH-1 numerator is used and will automatically populate as the SDOH-2 denominator.



8. When completed, select 'Submit'.



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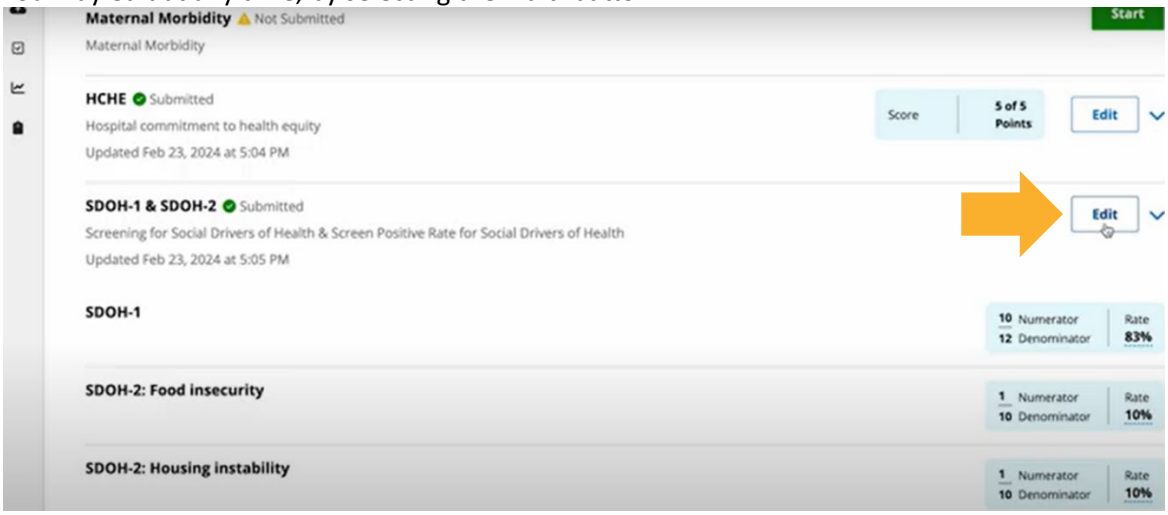
9. Here you will see the numerator, denominator, and rate for each of the SDOH measures.

10. You may edit at any time, by selecting the 'Edit' button.



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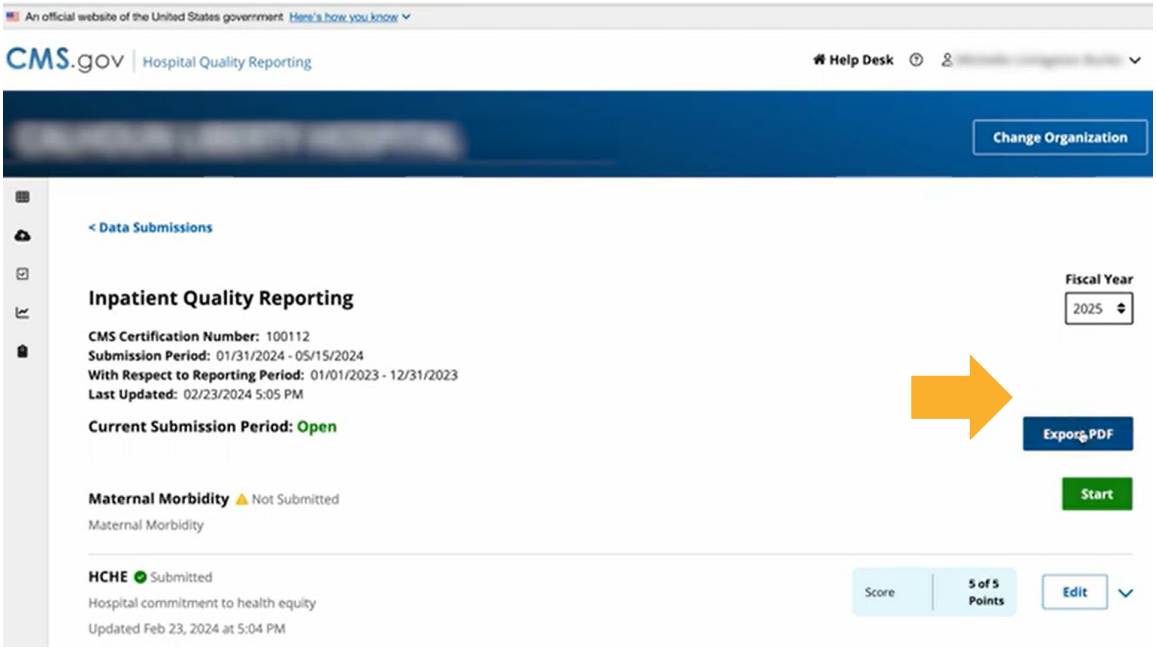
11. To download a report, select the 'Export PDF' button. This is recommended in order to have confirmation of submission for your own records.



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Additional Resources

YouTube Video Tutorial – How to Submit HCHE and SDOH data - CMS Hospital Quality Reporting (HQR)

SDOH Measure Specifications and FAQs – QualityNet

Screening Tools

A specific screening tool is not required to be used, but all areas of health-related social needs must be included.

UCSF Sirenetwork Social Needs Screening Tool Comparison Table compares various screening tools. Rural Health Information Hub Tools to Assess and Measure SDOH Provides and overview of select SDOH screening tools.

CMS Measures Management System Equity-Related Screening Tools contains options for equity and SDOH screening tools.

AHRQ SDOH & Practice Improvement contains screening tools and implementation tools to help healthcare organizations address SDOH

General Resources to Address Social Drivers of Health Positive Screenings

211 Helpline Center (United Way)
Offers community information and referrals to social services, including transportation options, for everyday needs and in times of crisis
Dial 211 from any phone 24 hours a day, 7 days a week.
www.211.org

FindHelp.org
Provides information on local services, including transportation, by zip code.
https://www.findhelp.org/

Community Action Agencies Across America
State by state network of Community Agencies that serve low-income and poor. Services may include help with emergency assistance, food and nutrition, adult basic education and employment, housing, money management, and transportation.
https://communityactionpartnership.com/?option=com_spreadsheets&view=search&spreadsheet=cap&Itemid=188

Eldercare and Area Agencies on Aging
(AAAs)
AAAs help adults with disabilities and older adults and their caregivers find support and local services, including local programs and agencies that provide transportation services.
1-800-677-1116
Monday – Friday, 9:00 AM to 8:00 PM ET
https://eldercare.acl.gov/Public/Index.aspx

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