Addressing Social Determinants of Health (SDOH) in Hospital Patients

TMF Health Quality Institute

Presented for Texas NMDOH Consortium

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Meet the Speaker

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About the Hospital Quality Improvement Contract (HQIC)

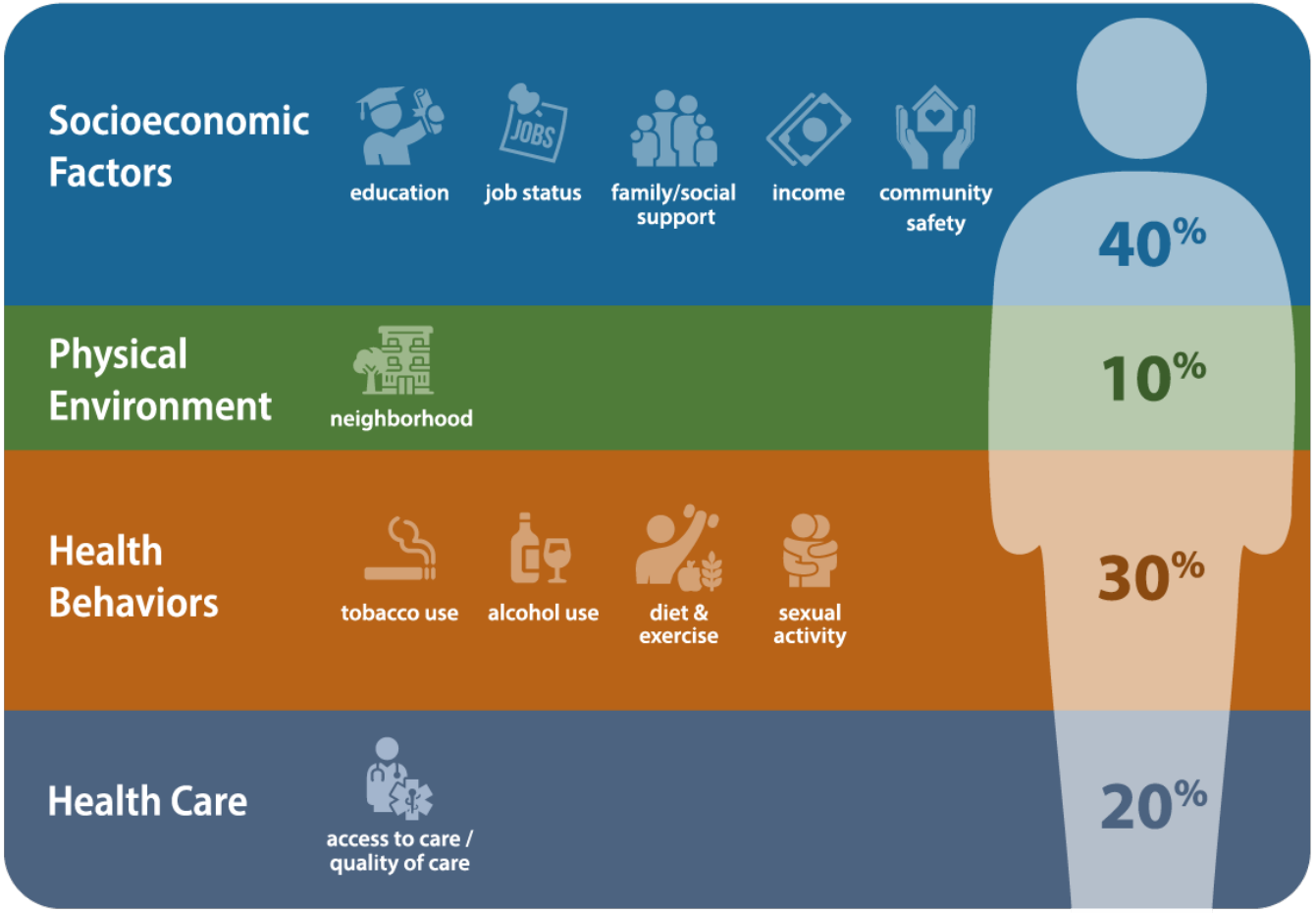
- Arkansas
- Minnesota
- Mississippi
- Missouri
- Oklahoma
- Texas
- Northern Mariana Islands
- Puerto Rico
- U.S. Virgin Islands

The Centers for Medicare & Medicaid Services (CMS) contracted with TMF to work with qualifying hospitals participating in the HQIC program, which spanned from September 2020 to September 2024, to reduce all-cause patient harm and readmissions in rural, medically underserved and vulnerable populations.

Introduction/Background

- Social determinants of health (SDOH) or non-medical drivers of health (NMDOH) have been found to play major roles in the health of populations.
- BMC Public Health October 2021 study: NMDOH contributed to nearly 80% of the reasons for rehospitalization, with 10%-15% potentially preventable.
- Beginning Jan. 1, 2024, CMS requires all hospitals in the Inpatient Quality Reporting (IQR) program to submit two new SDOH measures: **SDOH-1** and **SDOH-2**.

What Affects Our Health?



Data source: American Hospital Association (AHA) and Institute for Clinical Systems Improvement, "Social Determinants of Health Series: Promoting Healthy Behaviors"

Five Domains of SDOH Screening

- CMS identifies five NMDOH domains for SDOH screening:
  1) Food Insecurity
  2) Housing Instability
  3) Transportation Needs
  4) Utility Difficulties
  5) Interpersonal Safety

- Learn more in TMF's first SDOH video.

- American Hospital Association (AHA) Social Determinants of Health Series – reports, case studies, webinars, videos

Goals of CMS SDOH Measures

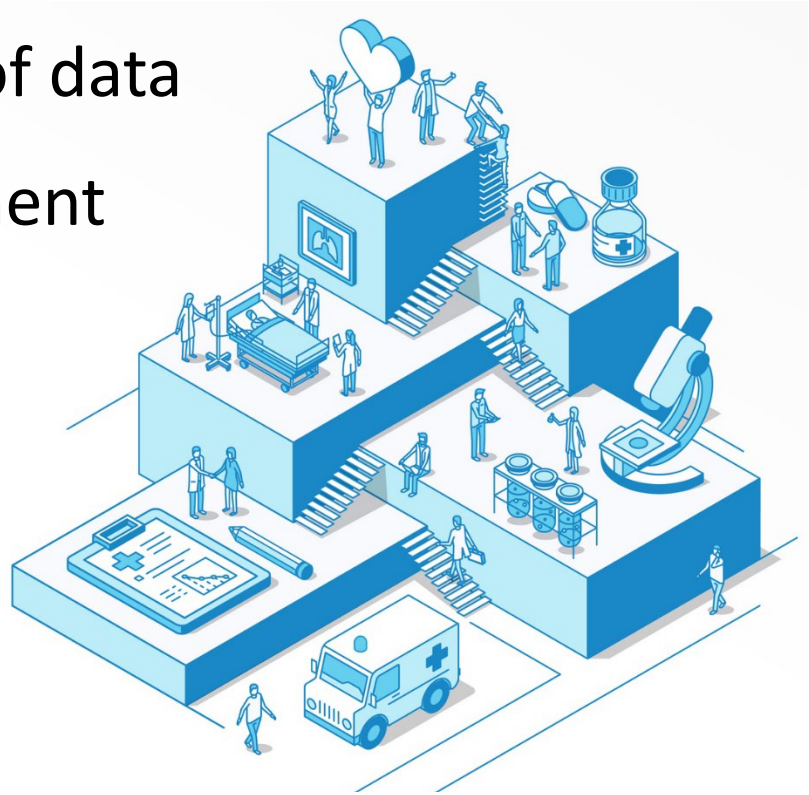
- **Primary Goal**
  - All hospitals collect patient-level social risk factor data:
    - Create meaningful collaboration between health care providers and community-based organizations
- **Secondary Goal**
  - Use data gathered to stratify patient risk and hospital performance rates.

The SDOH Measures

- **SDOH-1**: Screening for Social Drivers of Health
  - All patients admitted to hospital ages 18 and older who were screened for social drivers of health
- **SDOH-2**: Screen Positive Rate for Social Drivers of Health
  - How many of those admitted adult patients screened identified as having one or more social risk factors?

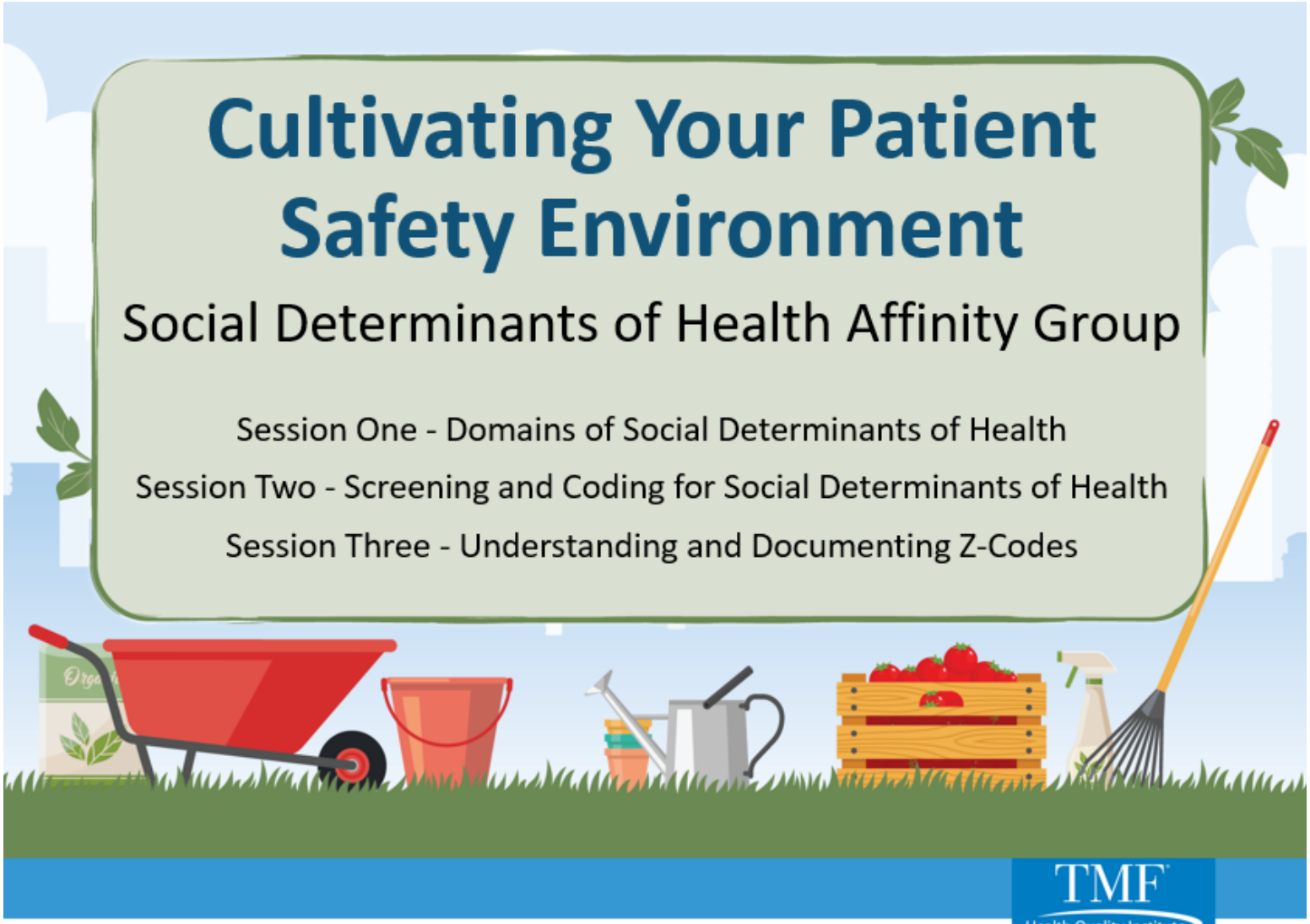
Data Journey to Improved Outcomes

- Consistent internal review of data
- Identify areas for improvement
- Focus improvement efforts
- Develop targeted solutions
- Track progress

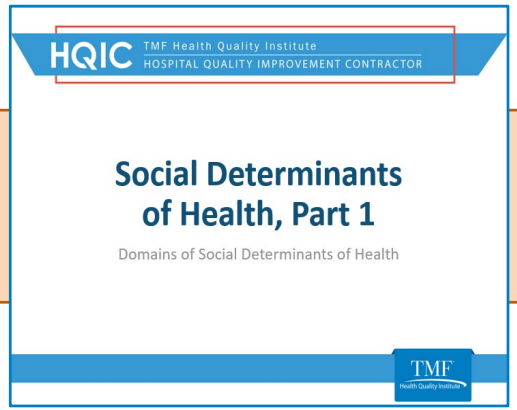


Affinity Groups

- Defined as “group of people who share a common interest, background or goal”
- One group meets monthly over three months (September – November)
- Discuss challenges, barriers and successful actions to reduce readmissions in hospitals
- Explore strategies to reduce readmissions
- Share tools and resources to reduce readmissions

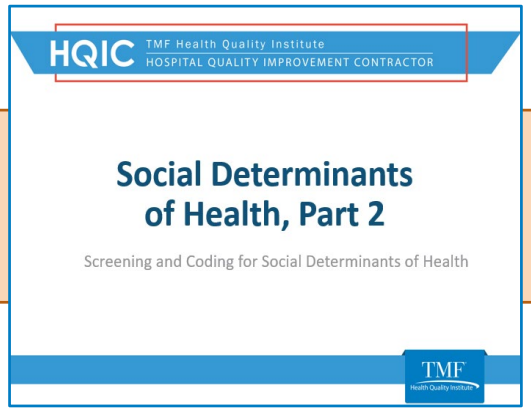

Cultivating Your Patient Safety Environment
Social Determinants of Health Affinity Group
Session One - Domains of Social Determinants of Health
Session Two - Screening and Coding for Social Determinants of Health
Session Three - Understanding and Documenting Z-Codes
TMF Health Quality Institute

Affinity Group Videos



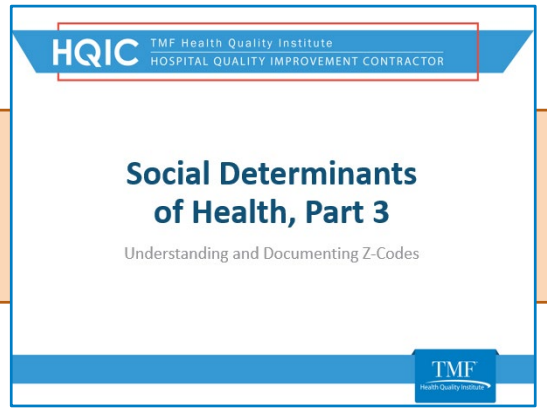
Video 1:

Domains of SDOH



Video 2:

Screening and Coding SDOH



Video 3:

Documenting Z Codes

Affinity Group Structure

Designated staff

- Facilitator
- Subject matter expert (SME)
- Chat monitor
- Chat poster
- Note taker

Sessions not recorded to encourage sharing

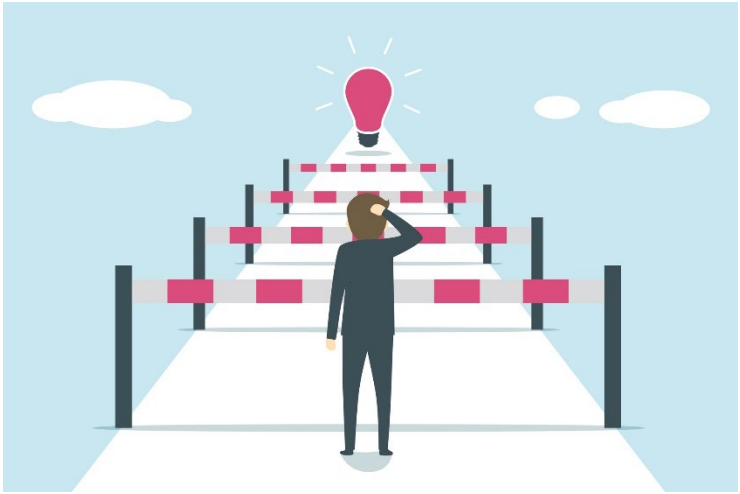
Hospitals with success in topic area identified to speak during sessions

Open discussion and networking between attendees

Post-event email sent to registrants with Q&A and resources

Challenges and Barriers

- Lack of definitions for SDOH
  - Gravity Project
- Lack of effective screening tools
- Absence of operational processes
- Workflow of coders
- Unfamiliarity with social needs of community
- Lack of clarity regarding who can document



Affinity Group in Action: Case Study in Culture and Language

Small, critical access hospital in southern Texas:

- Challenges:
  - Lack of effective screening tools
  - Absence of operational processes
  - Unfamiliarity with social needs of community

> ***"The webinar series reminded us to think about our patients' backgrounds and determine how we can offer care and services that meet their cultural and language needs."***
>
> — Chief Nurse

- Solutions
  - Organizational assessment, education to staff on resources available
  - Screening of patients for language preferences
  - Development of a Language Access Plan (CMS)

Screening Tools

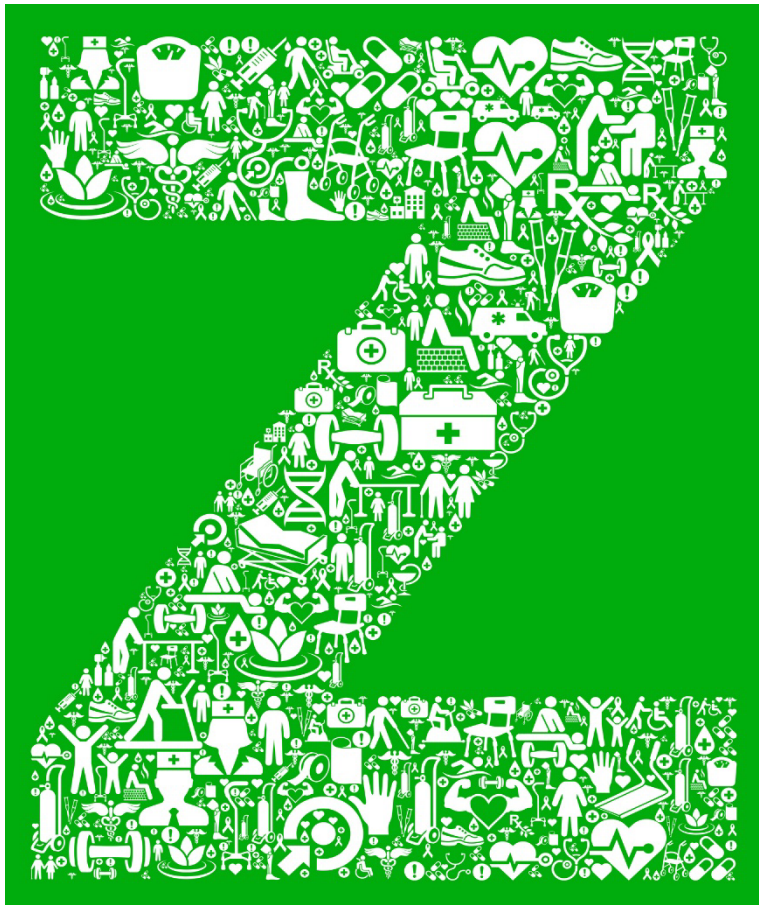
- CMS recommends The Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool:
  - Outlines questions to put into a form for patients to complete; it is recommended, not required. Other tools could be used if they gather the necessary information.
- CMS created AHC-HRSN screening tool to use in the AHC Model.
- Evidence shows that if providers deal with unmet HRSN, the harm they cause can be reversed.
- Original AHC-HRSN tool covered only the five domains of screening in 10 questions:
  - Newest version adds questions in eight supplemental domains

Documentation

- Embed a screening tool into the electronic health record (EHR) for greatest accuracy:
  - Each response to a question is a discrete field, including “Opt Out”
  - Allows quality improvement staff to query the report from the EHR
- If included in EHR, clinicians and case management staff can use the information to:
  - Make clinical decisions
  - Integrate Social Determinants of Health into EHR
  - Allow discharge planning to include referrals to community agencies
  - Decrease acute care admissions and readmissions
  - Cut Acute Care Usage

Introduction to Z Codes

- What are **Z codes**?
  - A subset of CMS ICD-10-CM codes
  - Used to report social, economic and environmental determinants of health (NMDOH) that impact health and health-related outcomes
  - Data is critical to improvement efforts
- Why is this important?
  - NMDOH are known to have greater influence over an individual's health than genetic factors or health care access.



Affinity Group Benefits

Benefits to Hospitals:

- Networking with similar hospitals
- Share policies, resources, etc.
- Connect with a quality improvement specialist for individual technical assistance after session

Benefits to TMF:

- Identify hospitals with best practices and difficulties
- Actively work with hospitals to reduce patient harm
- Increase topic-specific knowledge among TMF team

Results: Feedback

461 Clicks

- **Part 1**: ***Domains of SDOH***

375 Clicks

- **Part 2**: ***Screening and Coding for SDOH***

415 Clicks

- **Part 3**: ***Understanding and Documenting Z Codes***

Screening Tools

- Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool (PDF), CMS
- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) Tool
  - Download in preferred language: https://prapare.org/the-prapare-screening-tool
- Social Needs Screening Tool (PDF), American Academy of Family Physicians (AAFP)
  - Similar to the AHC-HRSN tool, with same format

American Hospital Association (AHA) Resources

- SDOH guides:
  - Food Insecurity and the Role of Hospitals
  - Housing and the Role of Hospitals
  - Transportation and the Role of Hospitals
- Screening for Social Needs: Guiding Care Teams to Engage Patients (PDF)
- SDOH curriculum for clinicians: Virtual Expedition Modules

Thank You

TMF Health Quality Institute
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