Health-Related Social Needs (HRSN)

Session 1: HRSN Measure Overview
September 13, 2023

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- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

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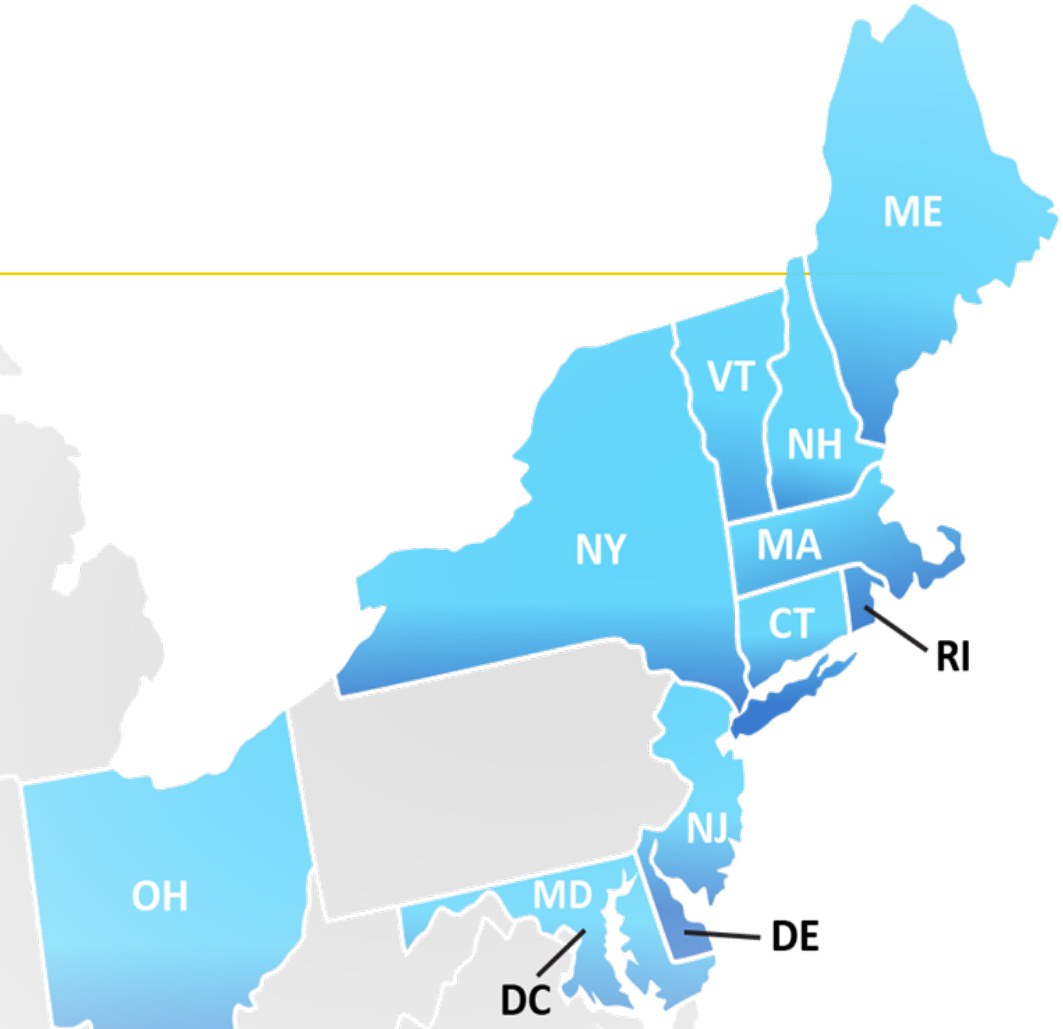

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- A federally funded Medicare Hospital Quality Improvement
  Contractor (HQIC) in 12 states
- IPRO collaborates with several organizations to reach hospitals.

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- Kentucky Hospital Association
- Qlarant

- Q3 Health Innovation Partners
- Superior Health Quality Alliance

American Institutes for Research (AIR)

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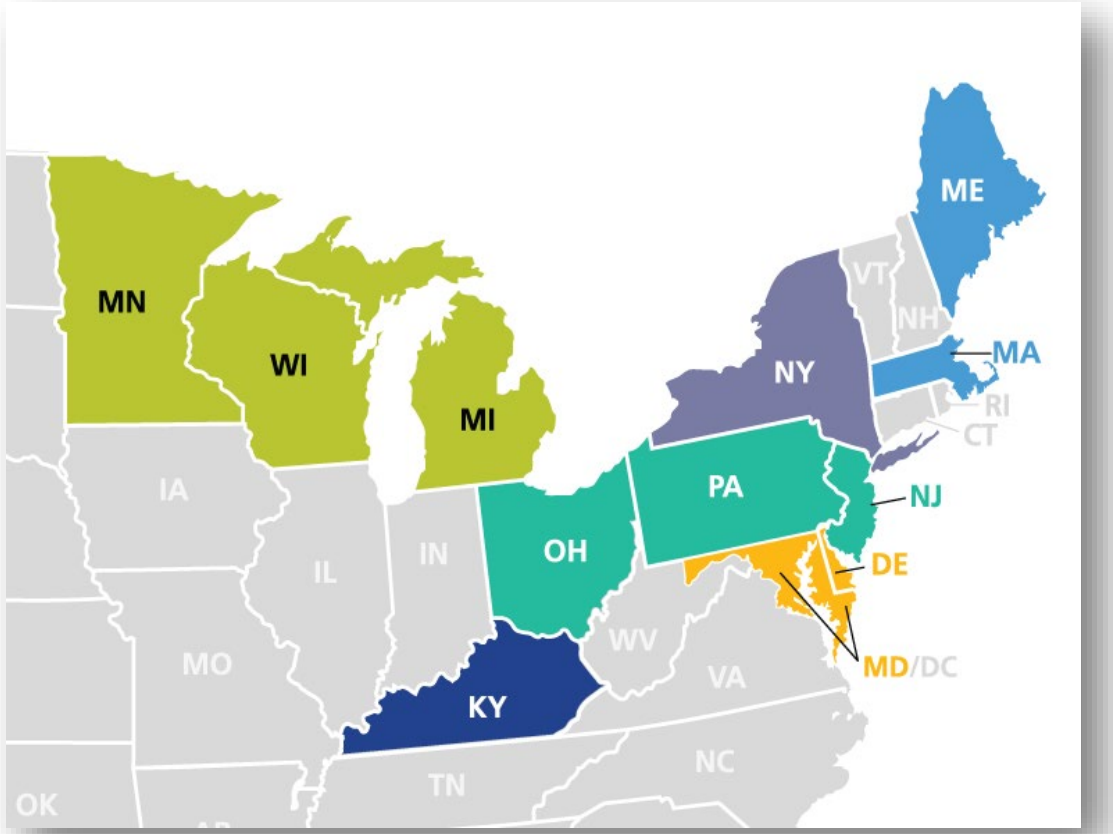

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Introductions

Share your **name**, **title**, **organization,** and response to:

What is your favorite Fall activity?

Today's Session Objectives

- Review Series Schedule and Topics
- Overview of HRSN – What Are They?
- The HRSN Measure – What Are the Requirements?
- Discussion of Challenges Capturing HRSN

HSRN Series

Date	Time	Topic
9/13/2023	12:00 – 12:45 PM ET	Reviewing HRSN & the HRSN Measure
10/11/2023	12:00 – 12:45 PM ET	Training Providers and Staff to Screen for HRSN and Educating Patients
11/8/2023	12:00 – 12:45 PM ET	Incorporating Screening Tools into the Workflow
12/13/2023	12:00 – 12:45 PM ET	Using Z-Codes to Capture HRSN
1/10/2024	12:00 – 12:45 PM ET	Connecting with CBOs to Close the Referral Loop
2/14/2024	12:00 – 12:45 PM ET	Involving Patients, Families, and Communities to Help Improve HRSN Screening and Referrals

To Register:
https://ipro.webex.com/webappng/sites/ipro/webinar/webinarSeries/register/6b18cc607cd74404b38127444d16962d

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Health-Related Social Needs

Health-Related Social Needs are an “individual’s unmet, adverse social conditions that contribute to poor health.”

They are a result of underlying social determinants of health – “the conditions in which people are born, grow, work, live, and age.”

They can account for up to **50 percent of health outcomes** – hence the need to address them.

The Semantics Can be Confusing

Term	Definition
Social Determinants of Health	Social factors that give health benefits to some populations but can cause harm to others, such as economic stability, access to health care.*
Social Risk Factors	Adverse social conditions associated with poor health, such as food insecurity and housing instability, that result from SDOH impact.**
Social Needs	The social risk factor(s) that an individual identifies and prioritizes for intervention using shared-decision making.**
Social Drivers of Health & Health-Related Social Need	CMS terms synonymous with social risk factors.
Sociodemographic Data	Encompasses race, ethnicity, language, disability status, SOGI, social risk factors…any data collected about a patient to help better serve them.

* https://www.healthaffairs.org/content/forefront/talking-social-determinants-precision-matter
** https://www.milbank.org/quarterly/articles/meanings-and-misunderstandings-a-social-determinants-of-health-lexicon-for-health-care-systems/

HCHE Structural Measure

Hospital Commitment to Health Equity

Measure ID: HCHE

- CY 2023 Reporting Period
- CY 2025 Payment Determination
- Structural measure that assesses a hospital's commitment to health equity using five domains of competencies:
  - Equity is a Strategic Priority
  - Data Collection
  - Data Analysis
  - Quality Improvement
  - Leadership Engagement
- Each domain is worth one point, for a total of five possible points
- Hospitals must attest to all of the elements of a domain to receive the point
- CMS will publicly report the scores for this measure

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

Social Drivers of Health Process Measures

Screening for Social Drivers of Health

Measure ID: HCHE

- CY 2023 Voluntary Reporting
- CY 2024 Mandatory Reporting
- CY 2026 Payment Determination
- Assesses if a hospital screens patients 18 years or older for health-related social needs (HRSNs) at time of admission
- Patients must be screened for five HRSNs:
  - Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- Hospitals can choose the screening tool
- Numerator: number of patients admitted to an inpatient hospital who are 18 years or older on the date of admission screened for all five HRSNs
- Denominator: number of patients 18 years or older on the date of admission admitted to the hospital

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

Social Drivers of Process Measures

Screen Positive Rate for Social Drivers of Health

Measure ID: SDOH-2

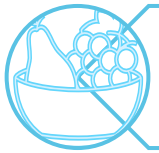
- CY 2023 Voluntary Reporting
- CY 2024 Mandatory Reporting
- CY 2026 Payment Determination
- Structural measure tracks
  - % of patients admitted for inpatient hospital stay 18 years or older
  - Screened for an HRSN and screen positive for one or more of the five HRSNs
- Numerator: number of patients admitted for inpatient hospital stay 18 years or older who were screened for an HRSN, and who *screen positive* for one or more
- Denominator: number of patients admitted for inpatient hospital stay 18 years or older and are screened for an HRSN during their hospital inpatient stay

https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/hospital-inpatient-quality-reporting-iqr-program/2022-events/iqr9122/

Health-Related Social Needs

Housing

- At risk of being behind on housing payment, multiple moves, or eviction
- Living in a place not meant for human habitation



Food

- Limited/uncertain access to adequate food

Utilities

- Limited/uncertain access to home utilities e.g., water, electricity

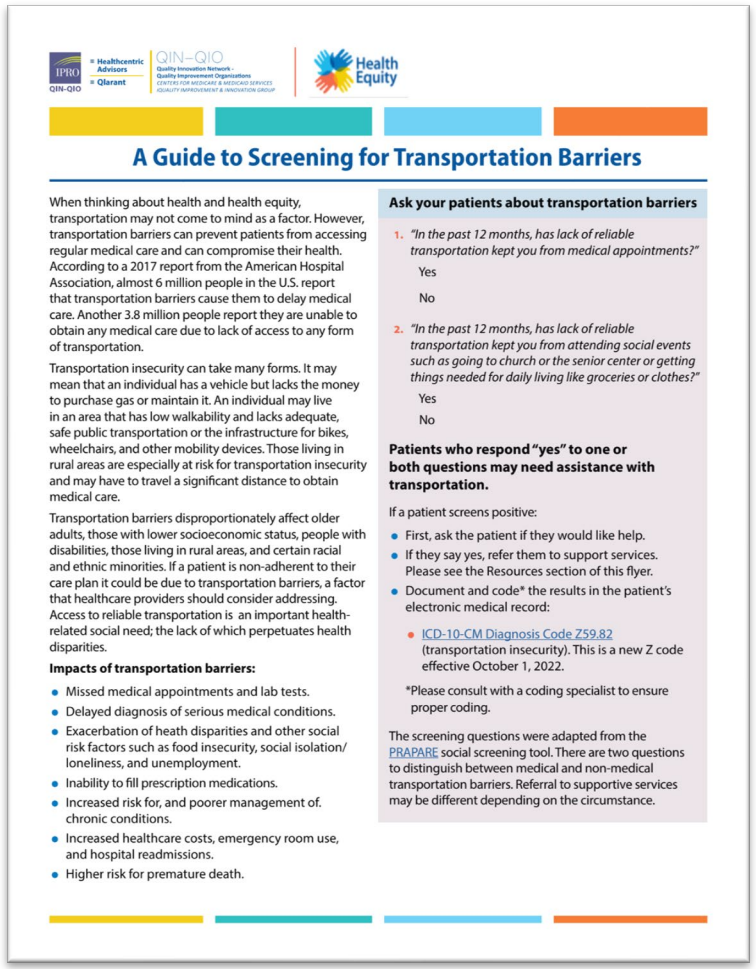
Transportation

- Inability to move from place to place in a safe and timely manner

Safety

- Concern about safety or violence from family/friends

Screening for Health-Related Social Needs



A Guide to Screening for Transportation Barriers

When thinking about health and health equity, transportation may not come to mind as a factor. However, transportation barriers can prevent patients from accessing regular medical care and can compromise their health. According to a 2017 report from the American Hospital Association, almost 6 million people in the U.S. report that transportation barriers cause them to delay medical care. Another 3.8 million people report they are unable to obtain any medical care due to lack of access to any form of transportation.

Transportation insecurity can take many forms. It may mean that an individual has a vehicle but lacks the money to purchase gas or maintain it. An individual may live in an area that has low walkability and lacks adequate, safe public transportation or the infrastructure for bikes, wheelchairs, and other mobility devices. Those living in rural areas are especially at risk for transportation insecurity and may have to travel a significant distance to obtain medical care.

Transportation barriers disproportionately affect older adults, those with lower socioeconomic status, people with disabilities, those living in rural areas, and certain racial and ethnic minorities. If a patient is non-adherent to their care plan it could be due to transportation barriers, a factor that healthcare providers should consider addressing. Access to reliable transportation is an important health-related social need; the lack of which perpetuates health disparities.

Impacts of transportation barriers:

- Missed medical appointments and lab tests.
- Delayed diagnosis of serious medical conditions.
- Exacerbation of heath disparities and other social risk factors such as food insecurity, social isolation/ loneliness, and unemployment.
- Inability to fill prescription medications.
- Increased risk for, and poorer management of. chronic conditions.
- Increased healthcare costs, emergency room use, and hospital readmissions.
- Higher risk for premature death.

Ask your patients about transportation barriers

1. *"In the past 12 months, has lack of reliable transportation kept you from medical appointments?"*
   Yes
   No
2. *"In the past 12 months, has lack of reliable transportation kept you from attending social events such as going to church or the senior center or getting things needed for daily living like groceries or clothes?"*
   Yes
   No

Patients who respond "yes" to one or both questions may need assistance with transportation.

If a patient screens positive:

- First, ask the patient if they would like help.
- If they say yes, refer them to support services. Please see the Resources section of this flyer.
- Document and code* the results in the patient's electronic medical record:
  - ICD-10-CM Diagnosis Code Z59.82 (transportation insecurity). This is a new Z code effective October 1, 2022.

*Please consult with a coding specialist to ensure proper coding.

The screening questions were adapted from the PRAPARE social screening tool. There are two questions to distinguish between medical and non-medical transportation barriers. Referral to supportive services may be different depending on the circumstance.

A Guide to Screening Patients for Food Insecurity

Access to healthy, quality food can help individuals achieve and maintain optimal health. The connection between nutritious food and a healthy, active life are well documented and supported by robust scientific study. But due to food insecurity, many people lack access to adequate food.

According to the U.S. Department of Agriculture (USDA), 1 in 8 people – or 38 million Americans – were food insecure in 2020. The USDA defines food insecurity as a household-level economic and social condition of limited or uncertain access to adequate food. Hunger is an individual-level physiological condition that can result from food insecurity.

Impacts of food insecurity:

- Associated with some of the most costly and preventable diseases in the U.S.
- Exacerbates health disparities, especially for racial/ ethnic minorities.
- Increases the risk of malnutrition.
- Increases likelihood of skipping or underuse of prescribed medications.
- Increases the risk for mental health conditions.
- Contributes to higher healthcare costs.

Healthcare providers can play an important role in identifying and addressing food insecurity. Screen all patients and refer those who need help.

The recommendation is that you screen all patients for food insecurity

Use the validated Hunger Vital Sign™ two-question screening tool to screen your patients for food insecurity:

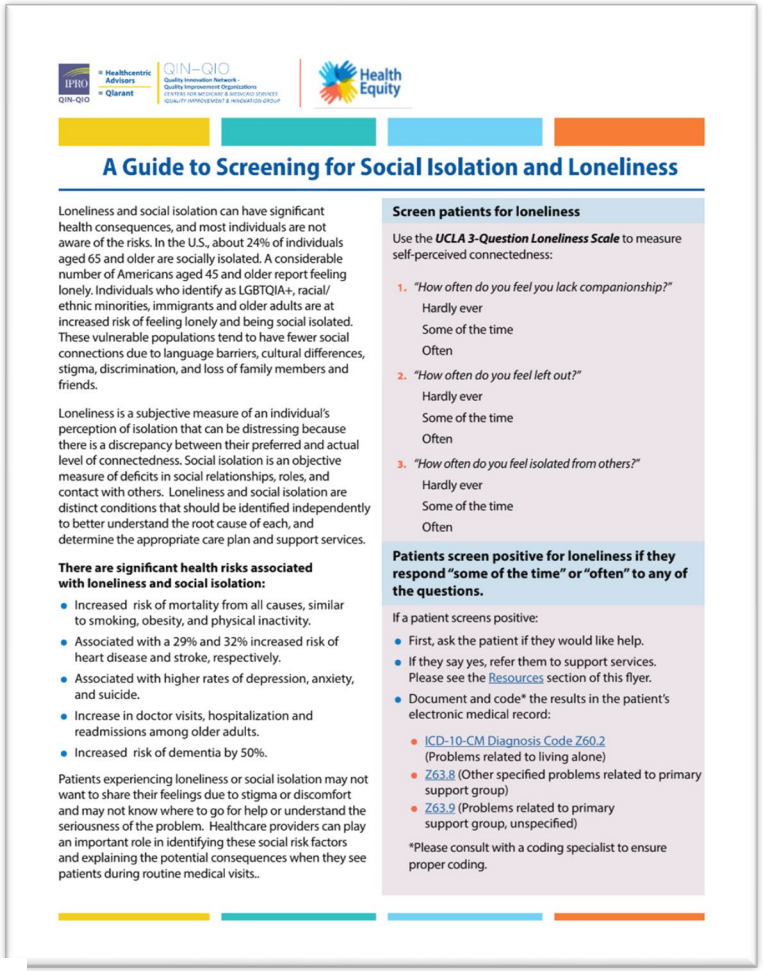
1. "Within the past 12 months, we worried our food would run out before we got money to buy more."
   Often True Sometimes True
   Never True Refused/Don't Know
2. "Within the past 12 months, the food we bought just didn't last and we didn't have money to get more."
   Often True Sometimes True
   Never True Refused/Don't Know

Patients screen positive for food insecurity if they respond "often true" or "sometimes true" to either or both statements.

If a patient screens positive:

- First, ask the patient if they would like help.
- If they say yes, refer them to support services. Please see the Resources section of this flyer.
- Document and code* the results in the patient's electronic medical record:
  - ICD-10-CM Diagnosis Code Z59.41 (Food insecurity)

*Please consult with a coding specialist to ensure proper coding of patient conditions.



A Guide to Screening for Social Isolation and Loneliness

Loneliness and social isolation can have significant health consequences, and most individuals are not aware of the risks. In the U.S., about 24% of individuals aged 65 and older are socially isolated. A considerable number of Americans aged 45 and older report feeling lonely. Individuals who identify as LGBTQIA+, racial/ ethnic minorities, immigrants and older adults are at increased risk of feeling lonely and being social isolated. These vulnerable populations tend to have fewer social connections due to language barriers, cultural differences, stigma, discrimination, and loss of family members and friends.

Loneliness is a subjective measure of an individual's perception of isolation that can be distressing because there is a discrepancy between their preferred and actual level of connectedness. Social isolation is an objective measure of deficits in social relationships, roles, and contact with others. Loneliness and social isolation are distinct conditions that should be identified independently to better understand the root cause of each, and determine the appropriate care plan and support services.

There are significant health risks associated with loneliness and social isolation:

- Increased risk of mortality from all causes, similar to smoking, obesity, and physical inactivity.
- Associated with a 29% and 32% increased risk of heart disease and stroke, respectively.
- Associated with higher rates of depression, anxiety, and suicide.
- Increase in doctor visits, hospitalization and readmissions among older adults.
- Increased risk of dementia by 50%.

Patients experiencing loneliness or social isolation may not want to share their feelings due to stigma or discomfort and may not know where to go for help or understand the seriousness of the problem. Healthcare providers can play an important role in identifying these social risk factors and explaining the potential consequences when they see patients during routine medical visits..

Screen patients for loneliness

Use the ***UCLA 3-Question Loneliness Scale*** to measure self-perceived connectedness:

1. *"How often do you feel you lack companionship?"*
   Hardly ever
   Some of the time
   Often
2. *"How often do you feel left out?"*
   Hardly ever
   Some of the time
   Often
3. *"How often do you feel isolated from others?"*
   Hardly ever
   Some of the time
   Often

Patients screen positive for loneliness if they respond "some of the time" or "often" to any of the questions.

If a patient screens positive:

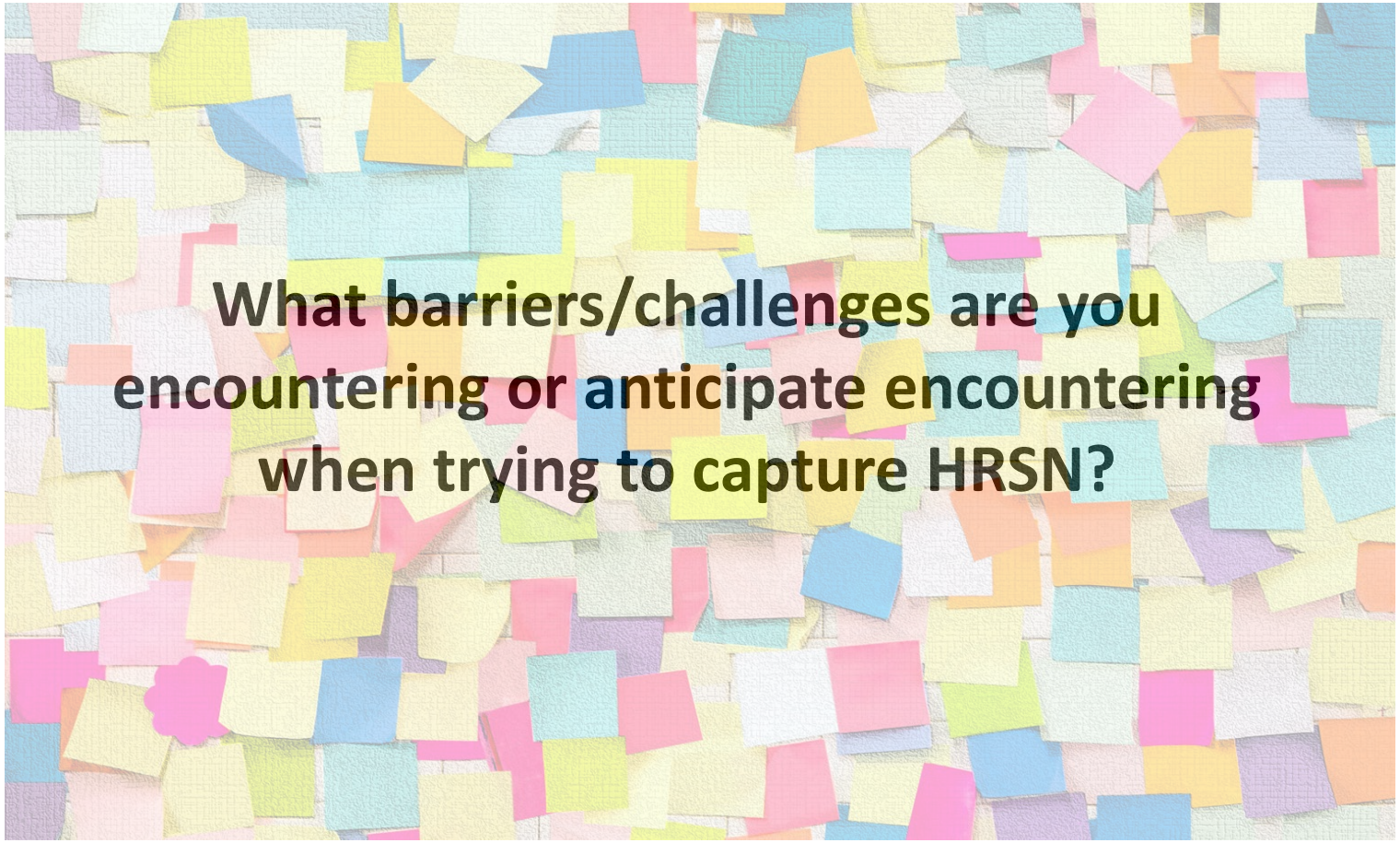
- First, ask the patient if they would like help.
- If they say yes, refer them to support services. Please see the Resources section of this flyer.
- Document and code* the results in the patient's electronic medical record:
  - ICD-10-CM Diagnosis Code Z60.2 (Problems related to living alone)
  - Z63.8 (Other specified problems related to primary support group)
  - Z63.9 (Problems related to primary support group, unspecified)

*Please consult with a coding specialist to ensure proper coding.

Polling Question: Screening for HRSN

Which of these HRSN does your organization currently screen for?

Barriers/Challenges to Capturing HRSN



Health Equity SMEs

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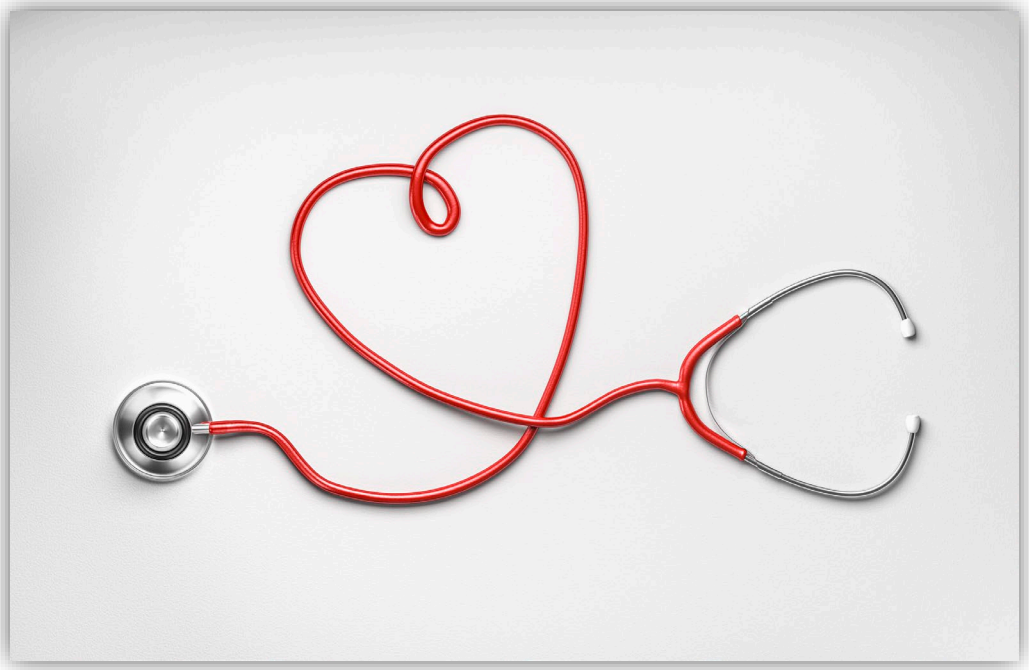
Thank You

Thank you for your continued partnership and commitment to health equity.



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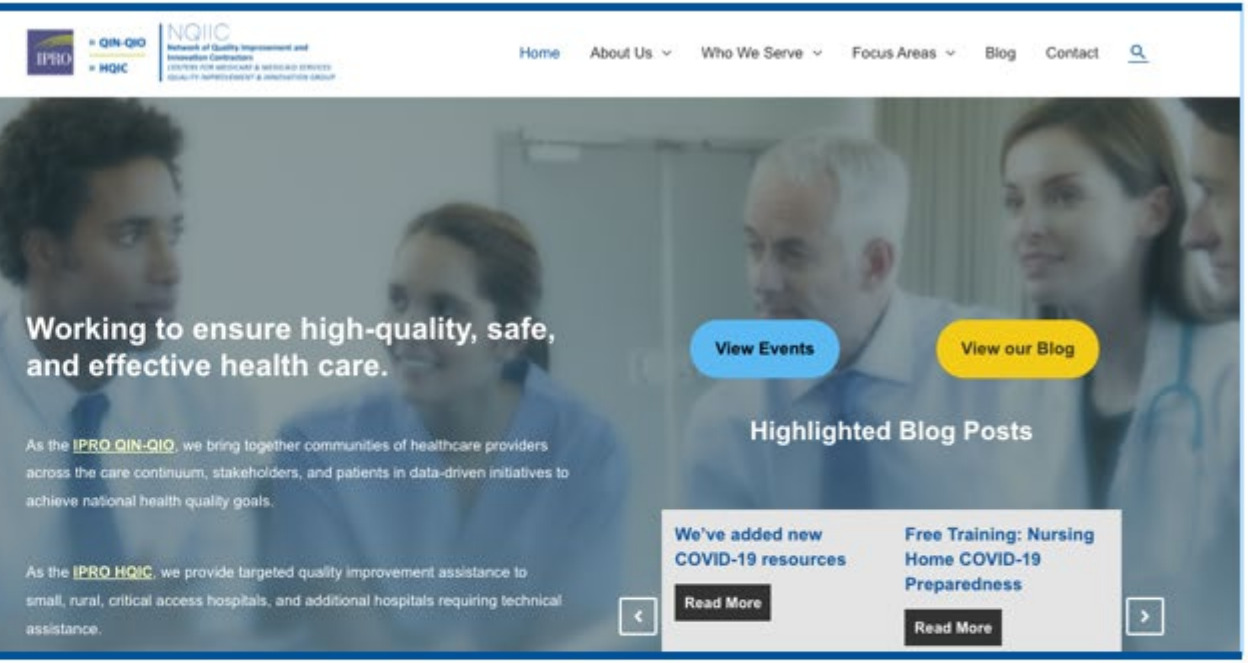

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