# Quick Start Guide:
# Screening for Social Determinants of Health

The FY2023 IPPS/LTCH final rule states that hospitals participating in the Hospital Inpatient Quality Reporting Program will be required to report on two new measures: Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health in CY2024. Screening for Social Drivers measures whether a hospital implements screening for all inpatients 18 years or older for five health-related social needs (HRSN): food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety. The Screen Positive Rate for Social Drivers of Health measures the percent of inpatients who were screened for an HRSN and screened positive for at least one of the five HRSNs. With these new requirements, it is imperative that hospitals begin to explore how they can incorporate social determinants of health documentation and interventions into routine care.

## Overview

Social determinants of health (SDOH) are the social, economic and environmental conditions that contribute to one's quality of life and health outcomes. Whether related to a lack of access to healthy food, reliable transportation or safe neighborhoods, it's important to systematically collect and document patients' SDOH to reduce disparities in healthcare. Collecting this data allows providers to tailor treatment plans to patients' unique needs, leading to increased patient-provider satisfaction and treatment plan adherence. Emerging evidence also shows that addressing social needs can lower healthcare utilization and costs as well as improve patient health, therefore it is crucial for hospitals and health systems to incorporate SDOH screening into clinical workflows. Following are tips and resources to get started.

## General Tips

- **Identify a SDOH Clinical Champion.** Designate a trusted health equity advocate as the central point person to coordinate screening efforts. This person can be responsible for leading a team who advocates for the initiative; reviewing available SDOH screening options and recommending the best fit for your patient population; providing suggestions for workflows on when best to screen; customizing existing screening tools; providing educational materials and coordinating trainings for staff; and being the point person for any issues that arise. Potential roles for the SDOH champion include the population health team, care coordination team or community outreach team.

- **Start Small:** Take a targeted approach. Screen a limited population, then scale upwards (e.g., focus on patients receiving behavioral health services, high-risk patients with comorbidities, or with less-emergent emergency department patients). Start small, pilot and expand what works. Choose a tool to conduct social needs screenings or start by screening for only one or two social needs at a time. Starting small provides time to make adjustments



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where necessary, such as to the screening tool itself, or the methods used for collecting data from patients (e.g., self-administered vs. staff-administered screenings, on-site vs. at-home screening in the patient portal).

- **Experiment with Different Workflows.** Maintain flexibility about workflows to align with clinical needs and interests. Encourage collaborations between the SDOH champion and clinical staff to design an optimal least-burdensome workflow. Once a workflow has been developed, begin by incorporating it with a limited group of staff, such as a specific department. This will enable your team to refine the screening process and address any challenges before expanding to the larger patient population.

- **Make Staff Aware of Reporting Requirements.** Evidence shows that clinical staff are more motivated to complete data collection when made aware that it is a requirement. Inform your staff of the two new measures in the FY2023 IPPS/LTCH final rule, the Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health measures. Although these are voluntary for CY2023, reporting on these measures will become mandatory on an annual basis beginning with the CY2024 reporting period.

## Screening Tools

- **Screening and Using Data to Address Social Determinants Learning Module:** This module reviews how to determine the best option to screen for SDOH, address identified needs and use the data to address health disparities.

- **Social Needs Screening Tools:** This resource provides a list of ten available screening tools as well as community resource databases.

- **Social Needs Screening Tool Comparison Table:** The table summarizes characteristics of several of the most widely-used social health screening tools to facilitate comparisons, including information about the intended population or setting, total number of questions, social health domains covered and domain-specific measures used.

## Incorporating SDOH into Workflows

- **Integrating Social Determinants of Health Screenings in Your Workflow Learning Module:** This module examines how to integrate screening for SDOH into the everyday workflow.

- **Plan Do Study Act Worksheet**

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## Other Resources

### What are the Social Determinants of Health?

- **Overview of Social Determinants of Health Learning Module**: This module explores what the social determinants of health are, how they can impact your patient's health and how the SDOH relates to health equity and health disparities.

- **AHA Societal Factors that Influence Health, A Framework for Hospitals**: A framework to guide hospitals' strategies to address the social needs of their patients, social determinants and systemic causes to inequities.

- **Addressing Social Determinants of Health in Hospitals**: This resource shares hospitals' and health systems' current health-related social needs activities and investments, as well as their potential future efforts.

### Using Z Codes

- **Using Z Codes to Capture Social Determinants of Health Learning Module**: This module explains what Z codes are, why collecting this data is important, and who on the patient's care team can capture and document the information.

- **Using Z Codes, the SDOH Data Journey to Better Outcomes**: This infographic describes the journey of SDOH from data collection, documentation, mapping SDOH data to Z codes and reporting findings. It includes resources and guides for healthcare administrators, the health care team and coding professionals.

- **ICD-10-CM Coding for Social Determinants of Health**: This resource provides information on how Z codes can be used to capture social needs information, coding guidance and additional tools and resources for hospitals, health systems and clinicians.

### General Resources

- **Social Determinants of Health General Resources**



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