**Social Drivers of Health measures for Hospital Inpatient Quality Program (IQR) from Final IPPS Rule, August 2022**

On August 1 2022, CMS adopted the first-ever social risk quality measures as part of the final FY23 Hospital Inpatient Prospective Payment System rule. The two social risk measures, which are part of the pay-for-reporting Hospital Inpatient Quality Reporting (IQR) Program, include 'Screening for Social Drivers of Health' -- the percent of patients screened for food, housing, transportation, utility, and interpersonal safety needs, and 'Screen Positive Rate for Social Drivers of Health' -- the percent screening positive among those screened. Reporting of these measures is optional for CY 2023 and required starting in CY 2024. Measure specifications are below.

The text below comes from the final IPPS rule published August 1, 2022: https://public-inspection.federalregister.gov/2022-16472.pdf.

**Screening for Social Drivers of Health**
(p.1220 in the final rule (see link above))

"Cohort
The Screening for Social Drivers of Health measure assesses the total number of patients, aged 18 years and older, screened for social risk factors (specifically, food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) during a hospital inpatient stay. The measure cohort includes patients who are admitted to an inpatient hospital stay and are 18 years or older on the date of admission.

Numerator
The numerator consists of 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[561] of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their hospital inpatient stay.

Denominator
The denominator consists of the 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 will be excluded from the denominator: (1) Patients who opt-out of screening; 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.

Measure Calculation
The Screening for Social Drivers of Health measure will be calculated as the number of patients admitted to an inpatient hospital stay who are 18 years or older on the date of admission screened for all[562] five HRSNs (food insecurity, housing instability, transportation needs, utility

difficulties, and interpersonal safety) divided by the total number of patients 18 years or older on the date of admission admitted to the hospital.

Data Submission and Reporting

We are finalizing voluntary reporting of the Screening for Social Drivers of Health measure beginning with the CY 2023 reporting period, followed by mandatory reporting on an annual basis beginning with the CY 2024 reporting period/FY 2026 payment determination and for subsequent years.

Due to variability across hospital settings and the populations they serve, we are allowing hospitals flexibility with selection of tools to screen patients for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
Potential sources of these data could include, for example, administrative claims data, electronic clinical data, standardized patient assessments, or patient-reported data and surveys. Multiple screening tools exist and many hospitals already have screening tools integrated into their electronic health records (EHRs). We suggest hospitals refer to the Social Interventions Research and Evaluation Network (SIREN) website, for example, for comprehensive information about the most widely used HRSN screening tools.[563,564] SIREN contains descriptions of the content and characteristics of various tools, including information about intended populations, completion time, and number of questions.

We note that providers participating in the Hospital IQR Program must use certified EHR technology (CEHRT) that has been certified to the 2015 Edition of health IT certification criteria under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program, and extraction of structured data from a certified EHR can make the data more accessible for utilization and submission for quality measurement reporting (86 FR 45383). Use of certified health IT can also support capture of HRSN information in an interoperable fashion so that this data can be shared across the care continuum to support coordinated care. For instance, in the 2020 ONC 21st Century Cures Act final rule, ONC adopted a new framework for the core data set which certified health IT products must exchange, called the United States Core Data for Interoperability (USCDI) (85 FR 25669). Version 2 of the USCDI, published in July 2021, included new data classes for social determinants of health (SDOH). These include standards to capture SDOH Problems/Health Concerns, SDOH Interventions, SDOH Goals, and SDOH Assessments. ONC recently published USCDI Version 3, which maintains the SDOH elements in Version 2 while adding additional data elements.[565] While adoption of USCDI Version 2 is not a requirement for ONC Health IT Certification at this time, under ONC's Standards Version Advancement Process,[566] developers of certified health IT may upgrade their certified health IT products to USCDI Version 2 to support the availability of information about social drivers of health. Version 3 will also be considered under the SVAP process.

Additional stakeholder efforts are underway to expand capabilities to capture additional social determinants of health data elements include initiatives such as the Gravity Project[567] to identify and harmonize social risk factor data for interoperable electronic health information exchange. We note these various efforts and encourage use of tools that will meet information exchange standards and facility interoperability. We also encourage providers to identify and utilize tools

that rely on standards-based approaches to data collection and utilization to support interoperability of these data.

Hospitals are required to submit information for structural measures once annually using a CMS-approved web-based data collection tool available within the Hospital Quality Reporting (HQR) System (previously referred to as the QualityNet Secure Portal). We refer readers to section IX.E.10. of the preamble of this final rule (Form, Manner, and Timing of Quality Data Submission) for more details on our previously finalized data submission and deadline requirements across measure types, and specifically, section IX.E.10.i. for our data and submission requirements for structural measures."

**Screen Positive for Social Drivers of Health**
(p.1253 in the final rule (see link above))

"Cohort
The Screen Positive Rate for Social Drivers of Health is a structural measure that provides information on the percent of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, were screened for an HRSN, and who screen positive for one or more of the following five HRSNs: Food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety.

Numerator
The numerator consists of 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 an 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 denominator consists of 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 an HRSN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their hospital inpatient stay. The following patients will be excluded from the denominator: 1) Patients who opt-out of screening; 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.

Measure Calculation
The result of this measure will be calculated as *five separate rates.* Each rate is derived from the number of patients admitted for an inpatient hospital stay and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

Data Submission and Reporting

We are finalizing voluntary reporting of the Screen Positive Rate for Social Drivers of Health measure beginning with the CY 2023 reporting period, followed by mandatory reporting on an annual basis, beginning with the CY 2024 reporting period/FY 2026 payment determination and for subsequent years.

Hospitals are required to submit information for structural measures once annually using a CMS-approved web-based data collection tool available within the HQR System. We refer readers to section IX.E.10. (Form, Manner, and Timing of Quality Data Submission) of the preamble of this final rule for more details on our previously finalized data submission and deadline requirements across measure types, and specifically, section IX.E.10.i. for our data and submission requirements for structural measures."

Footnotes:

561 In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28502), we stated "one or all of the following five HRSNs." We have updated the preamble of the final rule in this instance to state "all five HRSNs" as per the measure specifications and in alignment with the language throughout the preamble.

562 In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28502), we stated "one or all of the following five HRSNs." We have updated the preamble of the final rule in this instance to state "all five HRSNs" as per the measure specifications and in alignment with the language throughout the preamble.

563 Social Interventions Research & Evaluation Network. (2019). Social Needs Screening Tool Comparison Table. Available at: https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison. Accessed January 18, 2021.

564 The Social Interventions Research and Evaluation Network (SIREN) at University of California San Francisco was launched in the spring of 2016 to synthesize, disseminate, and catalyze research on the social determinants of health and healthcare delivery.

565 Office of the National Coordinator for Health IT. (2022). United States Core Data for Interoperability, Version 3 (July 2022). Available at: https://www.healthit.gov/isa/sites/isa/files/2022-07/USCDI-Version-3-July-2022-Final.pdf

566 Office of the National Coordinator for Health IT. (2022). Standards Version Advancement Process. Available at: https://www.healthit.gov/topic/standards-version-advancement-process-svap

567 See https://thegravityproject.net/.