ALLIANT HEALTH SOLUTIONS | SORH State Office of Rural Health
A Division of the Georgia Department of Community Health

GA FLEX Health Equity Improvement Project Monthly Meeting

December 17, 2024

Agenda

- Welcome
- Discuss Domain 2 Data Collection
- Introduce Domain 3 Data Analysis
- Progress, Not Perfection: A Discussion of SDOH Data Collection and Coding
- Group Discussion: Barriers and Opportunities
- Next Session
- Wrap Up

GA FLEX Health Equity Leads

Karen Holtz, MT (ASCP), MS, CPHQ
Education Lead
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Karen has over 20 years experience in leading performance improvement programs as well as providing advisory services to hospitals. She recently led the Learning and Action Networks (LANs) in the Hospital Quality Improvement Contractor (HQIC) program. Karen holds a master's degree in healthcare management from the University of Pittsburgh.

Melody "Mel" Brown, MSM
State Quality Manager - Georgia
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Melody has over 40 years of health care experience, including varied roles at Alliant Health Solutions, where she works on the CMS contract for the Quality Innovation Network-Quality Improvement Organization (QIN-QIO). As Georgia's State Quality Manager, her focus is on quality improvement processes and interventions for health care entities throughout the state.

Follow up from the November 26th Webinar

Georgia Pathways for Coverage™

Q. Would a grandparent or relative be eligible?

A. Clarification from DFCS that income eligibility is all dependent on household. Therefore, grandparents would be included as long as they are listed in the case.

Q. Need additional information?

A. Go to www.pathways.georgia.gov website or email Rachel Hood at Georgia.pathways@dch.ga.gov

2024-2029 MBQIP Health Equity Requirements for CAHs

Hospitals will attest to the Hospital Commitment to Health Equity measure via the Hospital Quality Reporting (HQR) system.

Figure 1: Hospital Commitment to Health Equity Measure Attestation Domains

- Each domain is worth one point and hospitals must attest to ALL subcomponent elements of each domain to receive the full point.

CMS Attestation on HCHE Measure Domain 2

Domain 2: Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities.

Hospitals are encouraged to collect social drivers of health data electronically and use tools that have undergone validity and reliability testing. Domain 2's sub-domains of 2a, 2b, and 2c are defined further in Text Box 2.

2A. Our hospital collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on the majority of our patients.

A wide range of demographic and social drivers of health information qualifies for data collection, including but not limited to:

- Self-reported race and ethnicity
- Socioeconomic status
- Being a member of a religious minority
- Living with a disability
- Living in a rural area
- Language proficiency
- Health literacy
- Access to primary care/usual source of care
- Housing status or food security
- Access to transportation

2B. Our hospital has training for staff in culturally sensitive collection of demographics and/or social determinant of health information.

The purpose of this question is to ensure hospitals provide guidance or training to staff on how to collect this information in a patient-centered manner.

2C. Our hospital inputs demographic and/or social determinant of health information collected from patients in structured, interoperable data elements using a certified EHR technology.

No additional clarification is provided for this attestation sub-domain.

https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf

MBQIP 2025 Core Measure Set and CMS Attestation on SDOH Screening

Measure 2		Measure 3	
Screening for Social Drivers of Health Measure		**Screen Positive Rate for Social Drivers of Health Measure**	
• Food insecurity • Housing instability • Transportation needs • Utilities difficulties • Interpersonal safety		• Food insecurity • Housing instability • Transportation needs • Utility difficulties • Interpersonal safety	
Numerator	Number of patients who were screened for **one or all** social drivers	Numerator	Number of patients who screened positive for each driver
Denominator	Number of patients 18 or older admitted as an inpatient	Denominator	Number of patients 18 or older admitted as an inpatient and screened for social drivers

- The screening rate (*in blue*) is one rate, but the screen positive rate (*in green*) will result in five unique rates for each of the five categories of social drivers of health.
- **Exclusion Criteria:**
  - Patients who opt out of screening
  - Patients unable to complete the screening and have no legal guardian or caregiver to do the screening on their behalf or patients who died during admission.
- **Reporting period for this data:**
  - CY2024 Mandatory Reporting (submission period is April 1, 2025, to May 15, 2025)
  - FY2026 Payment Determination

Reporting: *Annual numerator and denominator submission through Hospital Quality Reporting (HQR) platform via web-based data form.*

Frequently Asked Questions – Domain 2

8. What is the definition of "majority" for data collection?
Hospitals may affirmatively attest to Domain 2A if they are collecting demographic information, including self-reported race and ethnicity, and/or social drivers of health information on a number or percentage equaling more than half of the patients in a hospital.

9. What demographic and/or social drivers of health variables need to be collected?
The Hospital Commitment to Health Equity measure allows for flexibility in data collection. A wide range of demographic and social drivers of health information qualify as data collection for this measure. Hospitals should collect demographic and social driver of health information on a majority of patients served in their hospital.

Please refer to sub-domain 2A in the *Attestation Guidance for the Hospital Commitment to Health Equity Measure* document for detailed information and examples of qualifying data collection activities for this measure, and a selection of resources on best practices to advance health equity at your hospital(s). This resource can be found on QualityNet (https://qualitynet.cms.gov) at: Hospitals-Inpatient > Hospital Inpatient Quality Reporting (IQR) Program > IQR Measures > Web-Based Data Collection

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

Frequently Asked Questions – SDOH Measures

7. How is the Screen Positive Rate for Social Drivers of Health measure calculated?

The Screen Positive Rate for Social Drivers of Health measure will be calculated as five separate rates. The Screen Positive Rate for Social Drivers of Health measure uses the numerator of the Screening for Social Drivers of Health measure as the denominator.

Rate of Hospital Inpatients who Screen Positive for Food Insecurity	Number of hospital inpatients who screened positive for food insecurity / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Housing Instability	Number of hospital inpatients who screened positive for housing instability / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Transportation Needs	Number of hospital inpatients who screened positive for transportation needs / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Utility Difficulties	Number of hospital inpatients who screened positive for utility difficulties / total number of hospital inpatients screened for all five HRSNs
Rate of Hospital Inpatients who Screen Positive for Interpersonal Safety	Number of hospital inpatients who screened positive for interpersonal safety / total number of hospital inpatients screened for all five HRSNs

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

Frequently Asked Questions – SDOH Measures

For example, how would the following be calculated?

- There are a total of 100 patients admitted to the hospital in a given year who are 18 or older at the time of admission. Ninety (90) of those patients were screened for all five HRSNs. Ten (10) were only screened for some HRSNs or not screened at all.

- The Screening for Social Drivers of Health measure for this hospital would be calculated as: 90 / 100 = 90% of hospital inpatients 18 or older at time of admissions were screened for all five HRSNs. If no exclusions are applicable, the 10 patients who were only screened for some HRSNs or not screened at all should be included in the denominator, but not the numerator.

- Of the 90 patients who were screened for all five HRSNs:
  - 9 screened positive for food insecurity
  - 9 screened positive for housing instability
  - 5 screened positive for transportation needs
  - 20 screened positive for utility difficulties
  - 5 screened positive for interpersonal safety

The Screen Positive Rate for Social Drivers of Health measure would be calculated as follows for each HRSN:

Social Driver of Health (SDOH)	Rate
Rate of hospital inpatients who screen positive for food insecurity	9/90 = 10%
Rate of hospital inpatients who screen positive for housing instability	9/90 = 10%
Rate of hospital inpatients who screen positive for transportation needs	5/90 = 6%
Rate of hospital inpatients who screen positive for utility difficulties	20/90 = 22%
Rate of hospital inpatients who screen positive for interpersonal safety	5/90 = 6%

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

CMS Attestation on HCHE Measure Domain 3

Domain 3: Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities.

Domain 3 has only one sub-domain (3a) which is defined further in Text Box 3 below.

Text Box 3: Guidance for Attesting to Domain 3 Data Analysis

3A. Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.

The purpose of measure stratification is to understand if certain patient groups are receiving better care. Stratification in this case refers to examining quality measure results by subgroups of patients to identify important gaps in quality between patient groups.

Hospitals may develop stratification metrics for priority populations (as defined by your organization e.g., by race and ethnicity, economic burden, etc.) and monitor results on these metrics using existing internal quality dashboards.

CMS expects hospitals to identify equity gaps by providing stratified measure information based on either outcome quality measures or process of care measures; this means providing measure scores for priority populations or the gap in score between two groups.

https://qualitynet.cms.gov/files/6481de126f7752001c37e34f?filename=AttstGdnceHCHEMeas_v1.1.pdf

Data Analysis Components

- Key performance outcome (or process of care measure), e.g., 30-day readmissions
- Stratify priority population
  - REaL, e.g., race
  - SDOH, e.g., transportation
- Display equity gaps in dashboard or current way of internal review of quality measures and performance

Frequently Asked Questions - Domain 3

11. Does CMS require results to be reported on a specific "performance dashboard"?
CMS does not require reporting on a specific performance dashboard for this measure. Hospitals can utilize their existing internal quality dashboards. The evolution and maturity of a hospital's data collection tools and processes may lead to new and or enhanced dashboards. As with any strategic initiative, results should be available in the same fashion that hospital staff, leaders, clinicians and quality experts are currently reviewing quality measures and performance internally.

12. Do hospitals need to stratify all key performance indicators or just some?
The purpose of measure stratification is to understand if certain patient groups are receiving better care. Stratification in this case refers to examining quality measure results by subgroups of patients to identify important gaps in quality between patient groups. Hospitals may develop stratification metrics for priority populations (as defined by your organization) and monitor results on internal quality dashboards. CMS expects hospitals to identify equity gaps by providing stratified measure information based on either outcome quality measures or process of care measures; this means providing measure scores for priority populations or the gap in score between two groups.

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

Hospital Quality Reporting (HQR) Data Submission and Timeline

15. How will hospitals submit their attestation into the Hospital Quality Reporting (HQR) System?

Hospitals will attest to the Hospital Commitment to Health Equity measure via the HQR system available to authorized users. The measure includes five attestation-based domains of commitment, comprised of several "yes" / "no" sub-questions. Hospitals may attest "yes" for each sub-question where they meet the required competencies.

CMS will send out a communication through the Hospital IQR and Improvement ListServ. If you have not already done so, please subscribe to the Hospital IQR and Improvement ListServ on QualityNet (https://www.qualitynet.org/listserv-signup) to receive notifications.

16. When is the data submission deadline for the Hospital Commitment to Health Equity measure?

Hospitals will be able to attest to the Hospital Commitment to Health Equity measure in the HQR Secure Portal from April 1 through May 15 on an annual basis.

Program	Performance Period	Data Submission Deadline	Potential Public Reporting	Payment Determination
IQR	January 1, 2024 – December 31, 2024	May 15, 2025	October 2025	FY2026
IQR	January 1, 2025 – December 31, 2025	May 15, 2026	October 2026	FY2027

https://qualitynet.cms.gov/inpatient/iqr/measures#tab2

Rhonda Spellmeier, KONZA National Network

Rhonda Spellmeier, MBA, BSN, RN
HIE Workflow Specialist
KONZA National Network
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Rhonda earned a BSN in 1996 and has been an RN for over 27 years in critical access health systems in various roles. Those roles have included bedside nursing in med-surg, ER, OB, outpatient, cardiopulmonary rehab, swing bed, and case management. Additionally, she has served as a nurse manager, clinical IT analyst, and chief nursing officer.

Ultimately, after earning an MBA, she began to focus on bridging the gap between clinicians and health IT in hopes of improving patient outcomes and clinician and patient satisfaction. Rhonda has been actively involved in many successful quality improvement initiatives throughout her career with a recurrent theme of workflow analysis and the impact it has on outcome success.

KONZA NATIONAL NETWORK

Advancing health information sharing for better care management, transformative value-based payment models and actionable data analytics to improve patient outcomes

- Private, Non-Profit
- Provider-Led, Provider Governed
- Designated QHIN (Dec. 2023)
- Operate 10 HIEs across 10 states with regional and national presence
- High Quality Data: Largest Validated Clinical Data Stream under the NCQA DAV program with 333 DAV-Accredited sites
- Highest Level of Data Security: EHNAC HIEAP Accreditation & HITRUST R2 Certification

Objectives

- Define Social Determinants of Health and Health Related Social Needs
- Identify components of a successful HRSN program
- Define Z-Codes and their importance in SDOH data collection
- Identify available resources

Implementing system-wide programs can be overwhelming and often results in focus on perfection of the end product rather than making step-wise, intentional, long-term progress. During today's webinar, we will briefly review the components of an HRSN/SDOH program and provide guidance and resources for the data collection and mapping portion of the HRSN/SDOH program. Actionable steps and vetted resources will be included so you can take this information back to your team and utilize what is relevant for your SDOH journey.

Understanding HRSN and SDOH

The term "health-related social needs" is sometimes used interchangeably with Social Determinants of Health (SDOH).

SDOH refers to the conditions in which people are born, grow, work, live, and age that are shaped by the distribution of money, power and resources and impacted by factors such as institutional bias, discrimination, racism, and more.

HRSN refers to the social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They include things such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more.

HRSN is a result of the SDOH. An unequal distribution of SDOH is the root cause of HRSNs at the individual level.

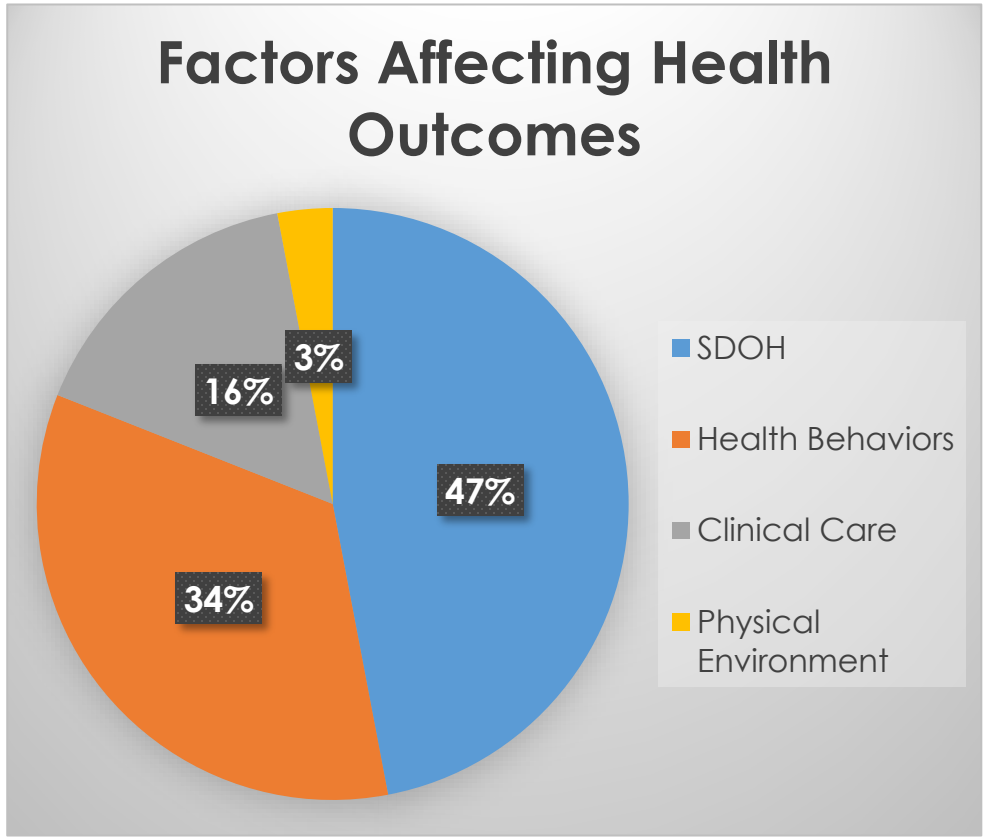
We can't always fix the SDOH, but we CAN take steps to address the resulting health-related social needs.

Polling Question #1

1. **Has your hospital implemented a formal HRSN/SDOH screening process?**

   A. Yes, in place
   B. Not yet, in progress
   C. No
   D. Don't know

Why is an HRSN program important?



Overall Reduction in Healthcare Cost

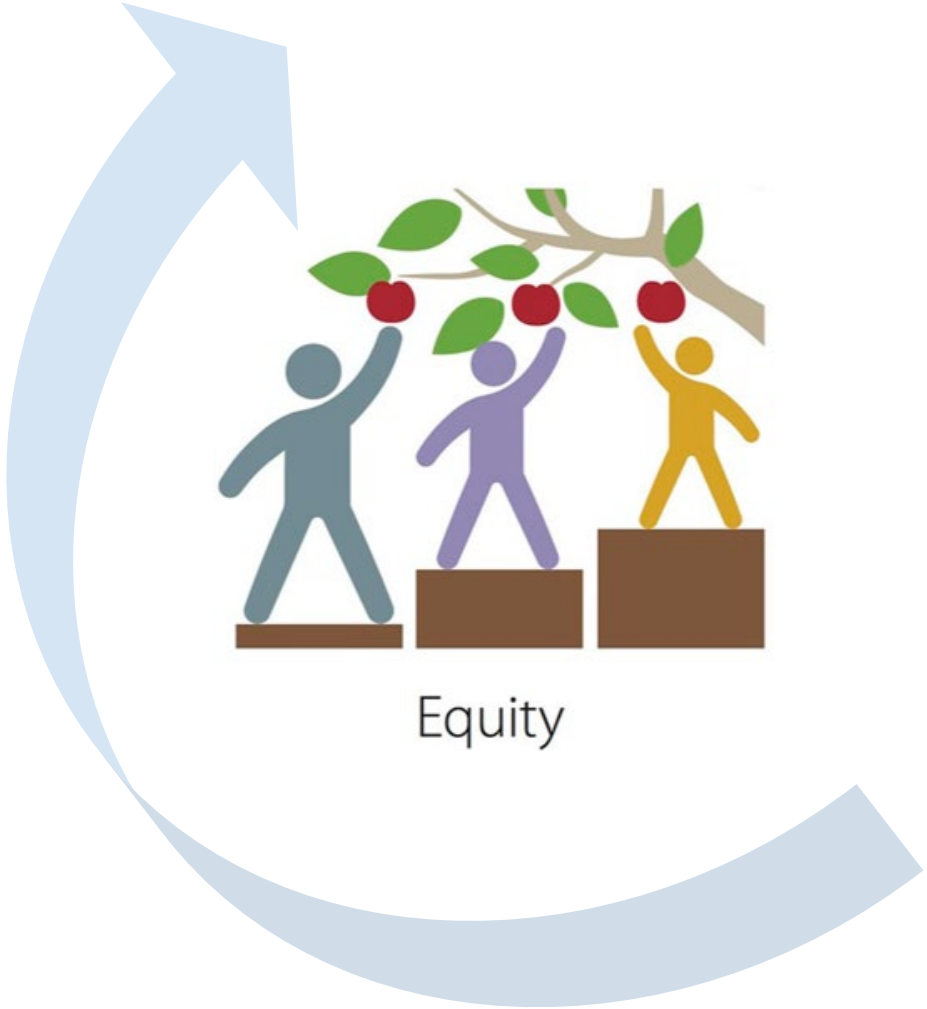
- Payer
  - CMS Hospital Commitment to Health Equity
  - SHIP, Flex
  - Value Based Payment
  - Appropriate allocation of resources

Improved Outcomes

- Quality Programs
  - Promoting Interoperability
  - IQR
  - HQIC, HQIN
  - State Specific Programs
- Population Health
- Community Needs Assessment

And it's the right thing to do for our patients.

The Five Domains of an HRSN Program



- Strategic Planning
- **Data Collection/Validation**
- Data Analysis
- Quality Improvement
- Leadership Engagement

Data Collection - Gap Assessment as part of Strategic Planning

Does your hospital use a self-reporting methodology to collect demographic data from the patient and/or caregiver?
Examples include REaL, SOGI, and SDOH data

- Consider running reports out of your EHR to determine if codes Z55-65 are being used
- Consider manual chart abstraction if reporting tools not available within your EHR to review "notes" for documentation
- Consider partnering with your Health Information Exchange for a data review of SDOH elements
- Consider evaluating claims data for presence of Z-Codes

This is the time to engage <u>all</u> your internal stakeholders.
This is not the time to design or implement solutions.

Polling Question #2

2. Has your hospital implemented a formal process for assigning Z Codes to an encounter?

A. Yes, in place
B. Not yet, in progress
C. No
D. Don't know

Z-Codes as an SDOH Tool

Using a standardized approach is important for:

- ❑ Meeting the needs of patients by appropriately screening for the right services and referrals
- ❑ Allows for streamlined Z-Code assignment
- ❑ Identifying population health-related trends that may be tackled through nontraditional, system-wide relationships beyond the hospital and clinic
- ❑ Aggregate data across patient populations to determine how to focus an SDOH strategy
- ❑ Match program scope and staffing based on population needs
- ❑ Supporting policy/payment reforms that include appropriate adjustments for SDH
- ❑ Enabling system-wide research and evaluating outcomes of interventions

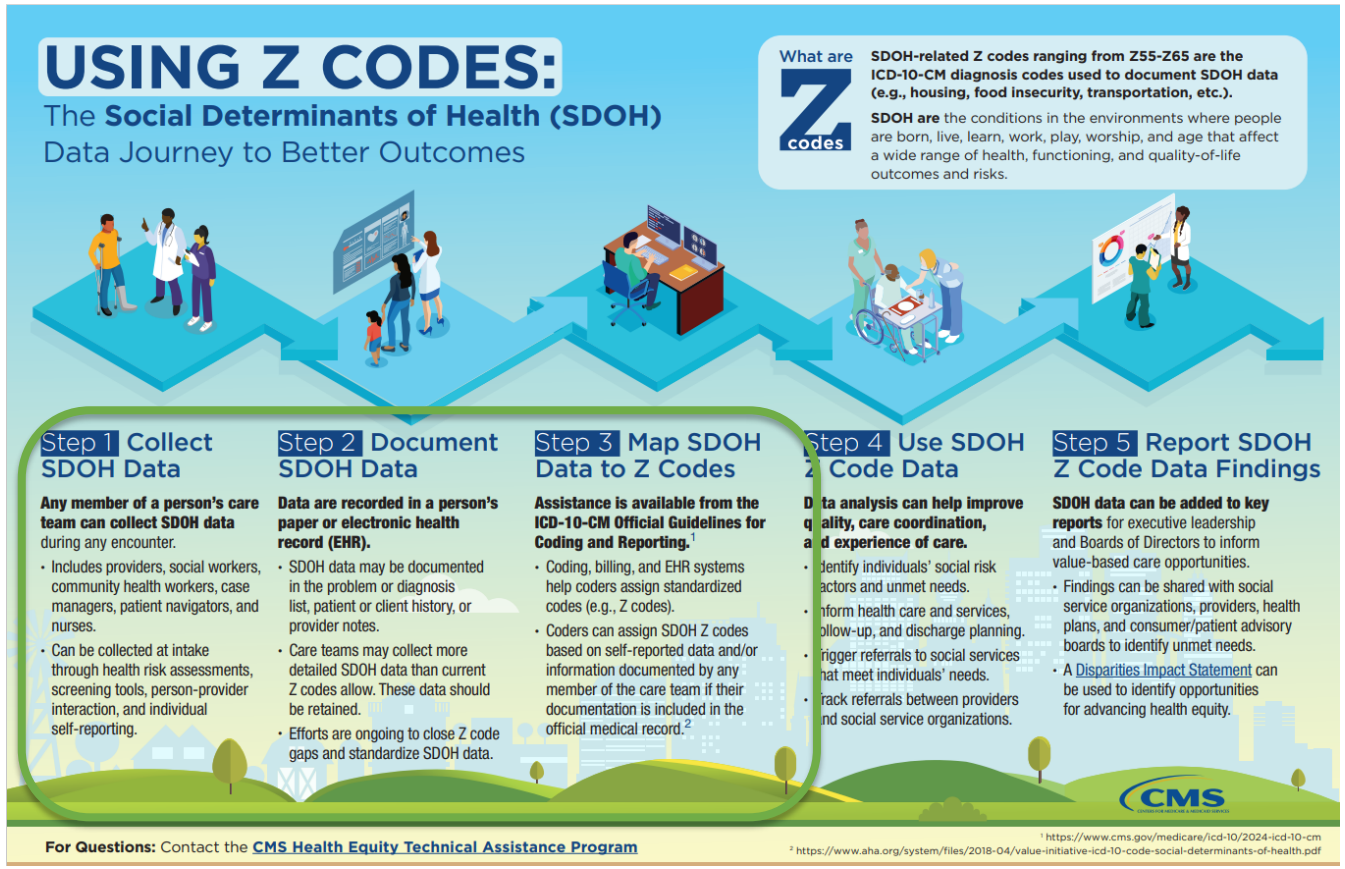
Why Z-Codes?

- ❑ Have been available since 2015-16
- ❑ Allows a structured format for mapping documentation to a problem
- ❑ Supports automated analysis and reporting for quality programs
- ❑ Analysis can be used in Community Needs Assessments
- ❑ Allows for implementation without an EHR build (unlike Snomed or LOINC mapping)
- ❑ Can be used by coding professionals without physician approval if supporting documentation is present (Since 2018)
- ❑ Are Interoperable and shareable across multiple organizations, including your Health Information Exchange

Barriers to Using Z-Codes

- ❑ Lack of structured, consistent data collection and documentation in patient record
- ❑ Lack of clear organizational goals regarding health equity
- ❑ Lack of workflow development
- ❑ Lack of education, training, understanding by stakeholders
- ❑ Lack of resources to address more data collection requirements
- ❑ Lack of data collection/code mapping in EHR
- ❑ Lack of confidence and organizational authority to assign codes
- ❑ Lack of processes for resolving Z Codes in problem list when appropriate
- ❑ Lack of "solutions" to positive screens

Using Z Codes - Best Practices



www.cms.gov/files/document/zcodes-infographic.pdf

Data Collection:

- Determine who, when, what and how screenings will occur
  - Any clinician can perform SDOH assessment
  - Patients can self-report

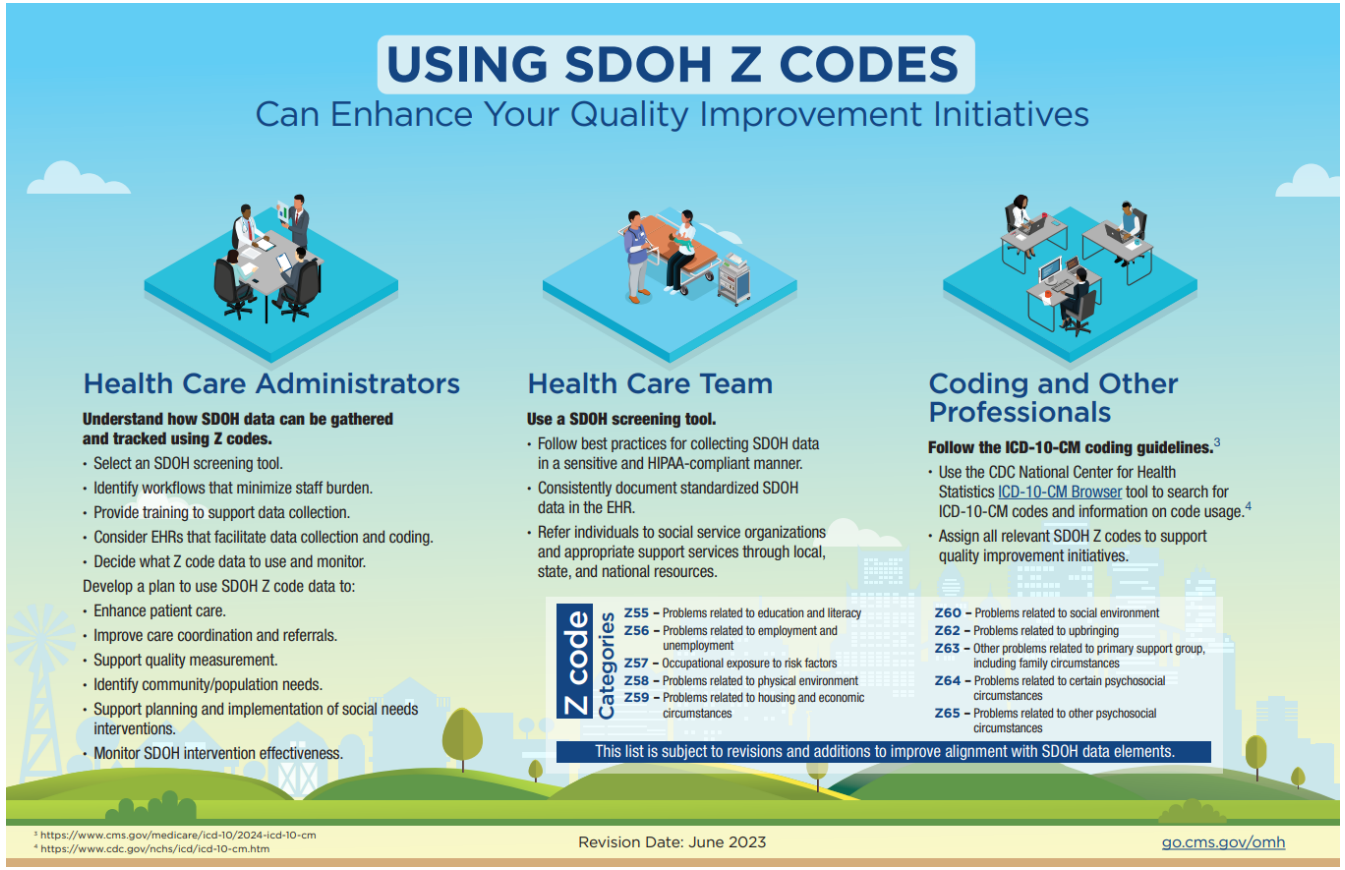
Data Documentation:

- Data may be documented in the problem list, history, provider/nurses/SS notes, structured screening tool to provide support for coders
- Implement an EHR based screening tool (i.e. PRAPARE, ACH HRSN Proprietary)
  - Ideally build with associated SNOMED, LOINC, Z Code and orders
- If no electronic-based tool, use paper forms and scan into EHR.
  - Track completed screenings and positive results for quality reporting

Map SDOH Data to Z Codes

- EHR coding modules configured with updated SDOH Z-Codes
- Utilize crosswalk of codes to screening results
- Educate coding staff
- Where to find supporting documentation
- Evaluate usage and provide feedback
- Allow for extra time to code!

Using Z Codes - Team Roles



www.cms.gov/files/document/zcodes-infographic.pdf

Administrators

- GAP Assessment revisited annually with ongoing internal quality programs (i.e. PDSA cycles) more frequently (i.e. monthly or quarterly)
- Ensure resources for education, EHR builds and collaboration with external organizations
- Assess for and address internal and systemic bias
- Educate your community and patients on your HRSN initiatives!
- Include in your Policies and Procedures

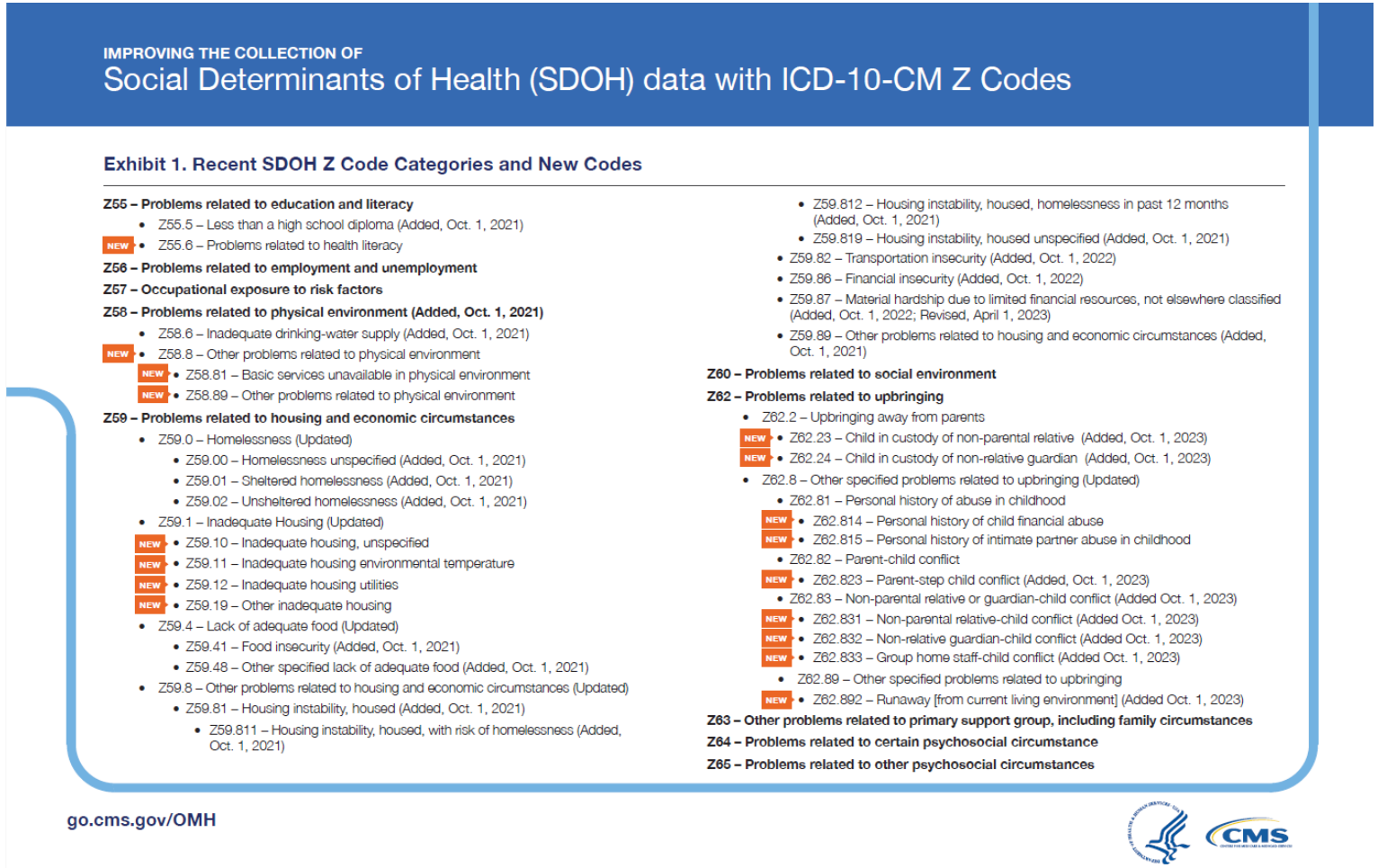
Health Care Team

- Keep workflows practical.
  - Can the screening tool be incorporated into existing assessment workflows
  - Consider starting with one area and moving to others as you hone the process
- If you don't have an EHR screening tool, use a paper form
  - Keep a running log of patient's screened and if they have a positive screening. This will help with reporting
- If a Z-code is added to the problem list by a Provider, be aware of its need to be maintained as a problem

HIM and Coders

- Provide feedback to the clinical team leadership about documentation
- Be aware a Z-code program will add time to the coding process
- There may not be an exact Z-code for every scenario

ICD-10-CM Z Codes



IMPROVING THE COLLECTION OF
Social Determinants of Health (SDOH) data with ICD-10-CM Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy
- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- NEW • Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)
- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)
- NEW • Z58.8 – Other problems related to physical environment
  - NEW • Z58.81 – Basic services unavailable in physical environment
  - NEW • Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances
- Z59.0 – Homelessness (Updated)
  - Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)
  - Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)
  - Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
- Z59.1 – Inadequate Housing (Updated)
  - NEW • Z59.10 – Inadequate housing, unspecified
  - NEW • Z59.11 – Inadequate housing environmental temperature
  - NEW • Z59.12 – Inadequate housing utilities
  - NEW • Z59.19 – Other inadequate housing
- Z59.4 – Lack of adequate food (Updated)
  - Z59.41 – Food insecurity (Added, Oct. 1, 2021)
  - Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)
- Z59.8 – Other problems related to housing and economic circumstances (Updated)
  - Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)
    - Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)
    - Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
    - Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)
  - Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)
  - Z59.86 – Financial insecurity (Added, Oct. 1, 2022)
  - Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)
  - Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing
- Z62.2 – Upbringing away from parents
  - NEW • Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
  - NEW • Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- Z62.8 – Other specified problems related to upbringing (Updated)
  - Z62.81 – Personal history of abuse in childhood
    - NEW • Z62.814 – Personal history of child financial abuse
    - NEW • Z62.815 – Personal history of intimate partner abuse in childhood
  - Z62.82 – Parent-child conflict
    - NEW • Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)
  - Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)
  - Z62.89 – Other specified problems related to upbringing
    - NEW • Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

go.cms.gov/OMH

CMS

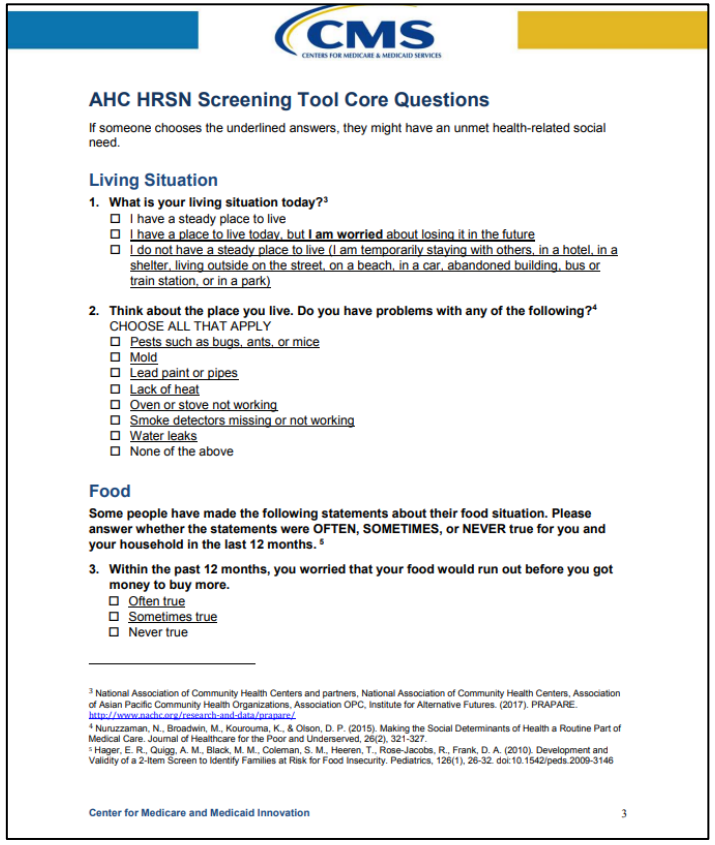
www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

ICD-10 codes are updated every April and October.

- Educate staff on newly added codes
- Evaluate updated codes for inclusion in your EHR
- Update Crosswalks
- Discuss updates with clinical team to determine if screens need updated as well
- View new codes at CDC website

Screening Tool Resources

Documentation is required to assign SDOH Z-Codes.



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

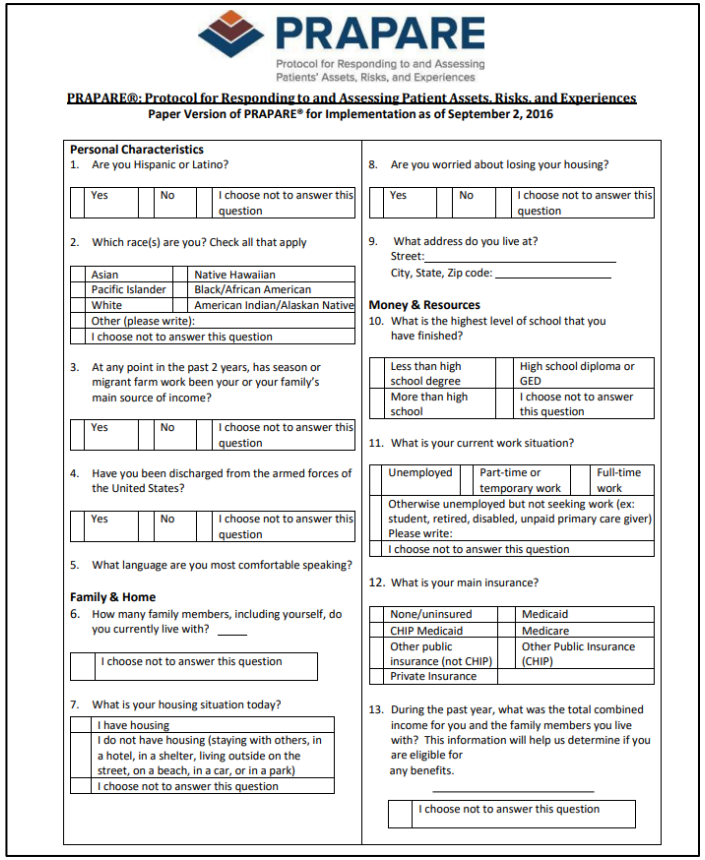
3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

[3] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/
[4] Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.
[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

Center for Medicare and Medicaid Innovation 3

https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

Not sure what to pick? Go to Social Needs Screening Tool Comparison Table | SIREN (ucsf.edu)
For access to a table comparing tools



PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?
   ☐ Yes ☐ No ☐ I choose not to answer this question

2. Which race(s) are you? Check all that apply
   ☐ Asian ☐ Native Hawaiian
   ☐ Pacific Islander ☐ Black/African American
   ☐ White ☐ American Indian/Alaskan Native
   ☐ Other (please write):
   ☐ I choose not to answer this question

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
   ☐ Yes ☐ No ☐ I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?
   ☐ Yes ☐ No ☐ I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? ____
   ☐ I choose not to answer this question

7. What is your housing situation today?
   ☐ I have housing
   ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
   ☐ I choose not to answer this question

8. Are you worried about losing your housing?
   ☐ Yes ☐ No ☐ I choose not to answer this question

9. What address do you live at?
   Street:_____
   City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?
    ☐ Less than high school degree ☐ High school diploma or GED
    ☐ More than high school ☐ I choose not to answer this question

11. What is your current work situation?
    ☐ Unemployed ☐ Part-time or temporary work ☐ Full-time work
    ☐ Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:
    ☐ I choose not to answer this question

12. What is your main insurance?
    ☐ None/uninsured ☐ Medicaid
    ☐ CHIP Medicaid ☐ Medicare
    ☐ Other public insurance (not CHIP) ☐ Other Public Insurance (CHIP)
    ☐ Private Insurance

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.
    _____
    ☐ I choose not to answer this question

PRAPARE-English.pdf

Guiding Principles for Social Needs Screenings

Table 1. Guiding Principles for Social Needs Screenings

Empathy. The ability to understand and share the feelings of another.	Empathy builds connections between clinicians and their patients to better understand their life circumstances and emotions. It allows the clinician to listen and react nonjudgmentally to the patient's challenges.
Respect. Regard for the feelings, wishes, rights or traditions of others.	Demonstrate respect by considering patients' willingness to share their challenges related to socioeconomic risk factors. Asking patients about their priorities demonstrates respect for their wishes and goals.
Autonomy. The right of patients to make independent decisions about their care.	Respect individual autonomy to make decisions about what social support they want to accept. The patient's choice is critical in seeking his or her buy-in for the screening process and any subsequent actions.
Trust. The reassuring feeling of confidence in the clinician.	Build trust with patients to reduce the barriers discussed above; this enables a clinician to gain insight into a patient's life circumstances and priorities, and elicit their on-going input on their health status and social needs. Key traits related to trust include competence, compassion, privacy, confidentiality, reliability and communication.[10]
Dignity. Sense of self-respect.	Recognize patients as an equal, value their needs, inform them about their medical diagnoses and social risk, recommend treatment, but give them the right to make decisions.
Collaboration. Working with someone to create an outcome.	Partner and foster relationships with community stakeholders to develop strategies that meet the unique social needs of patients and community members.
Support. The act of helping or assisting someone.	Show support by valuing patients' priorities, giving them time to comprehend their health and social needs, and respecting their decision to seek help, based on their preferences.
Sensitivity. An appreciation of others' feelings.	Recognize the sensitivities associated with individuals being asked to share their deepest concerns. Build a safe environment for patients to share their life circumstances.
Cultural Competence. Being respectful and responsive to the health beliefs and practices of diverse population groups.	Recognize the diversity of the community and establish a culture where clinicians acknowledge that societal norms and attitudes towards health are grounded in culture. Leverage this openness to empower individuals to address their health and social needs in a culturally appropriate manner.
Community-engaged. The process of working collaboratively with community groups and members to address issues that impact the well-being of those groups.	Prioritize engaging patients and the community the hospital services by partnering with community organizations and listening to the life experiences of community members to gain insight on community needs as well as assets.

Source: American Hospital Association, 2019.

Table 2. Skills for Engaging in Sensitive Conversations

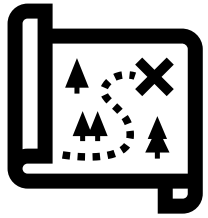
Approach	Description
Cultural Competency. The ability to interact effectively with people from different cultures.	Cultural competency training helps care team members increase their sensitivity to cultural diversity, reduce language barriers and build understanding for life experiences that shape a person's identity.[12]
Motivational Interviewing. Counseling method that helps people resolve challenges and find the internal motivation to change their behavior.	Motivational interviewing empowers patients to take control of their own health and behaviors by setting goals based on their wishes and current circumstances.[13]
Active Listening. Technique where the listener fully concentrates, understands, responds and remembers what is being said.	Active listening teaches providers how to properly listen to what patients are saying, identify any underlying hesitance and in return ask leading, open-ended, closed-ended and reflective questions related to their challenges.
Empathic Inquiry. The technique that integrates motivational interviewing and trauma-informed care to facilitate collaboration and emotional support.	Empathic inquiry trains care team members to connect with patients, increase relatability and suggest nonjudgmental approaches to improve health.
Asset-based. An approach to care that focuses on the individual's strengths and potentials.	Recognize that, alongside having needs, patients and communities have many assets that can be leveraged to address their social needs. An asset-based approach allows the provider-patient conversation to be reframed from a focus on deficits to connecting with their strengths, interests and areas the patient fiends meaningful. At the community level, an asset-based approach helps identify, partner with and leverage resourceful organizations such as schools, community-based or faith-based organizations, government, local businesses, etc., and people in the community to collectively build on existing resources and form new community connections.
Trauma-informed. A framework that involves understanding and responding to behaviors/actions and needs as a result of trauma.	Trauma-informed care is a holistic approach of treating a patient, where it is assumed that each individual has a history of trauma and coping mechanisms. Integrate questions and practices that are trauma-sensitive to increase resiliency and build a culture that supports personalized patient care.[14]

Source: American Hospital Association, 2019.

screening-for-social-needs-tool-value-initiative-rev-9-26-2019.pdf (aha.org)

Z-Code Mapping and Crosswalks

Housing Instability				
AHC Question (and LOINC code)	**Answer**	**ICD-10-CM**	**SNOMED CT**	**Exact Q-A**
What is your living situation today? (71802-3)	I have a place to live today, but I am worried about losing it in the future	Z59.819 Housing instability, housed unspecified	1156191002 |Housing instability (finding)	Yes
	With more questioning…			
		Z59.819 Housing instability, housed unspecified	1156193004 |Housing instability due to frequent change in place of residence (finding)	No
		Z59.819 Housing instability, housed unspecified	1156195006 |Housing instability due to being behind on payments for place of residence (finding)	No
		Z59.819 Housing instability, housed unspecified	1187272007 |Housing instability due to housing cost burden (finding)	No
		Z59.819 Housing instability, housed unspecified	1156196007 |Housing instability due to threat of eviction (findin	No
		Z59.811 Housing instability, housed, with risk of homelessness	1156192009 |H instability due t risk of homeles (finding)	
		Z59.812 Housing instability,	1156194005 |H	



PRAPARE Question	PRAPARE Response	ICD-10 z-code
What is your housing situation today?	I have housing	
	I do not have housing (staying with others, in a hotel, on the street, in a shelter)	**Z59.0 Homelessness**
What is the highest level of school that you have finished?	Less than high school degree	**Z55.3 Underachievement in school**
	High school diploma or GED	
	More than high school	
What is your current work situation?	Unemployed and seeking work	**Z56.0 Unemployment, unspecified**
	Part-time work	
	Full-time work	
	Otherwise unemployed but not seeking work	
Percent of federal poverty level (FPL)	100% or below	**Z59.5 Extreme poverty**
	101-150%	**Z59.6 Low-income**

Domains	Social Risk Factors	ICD-10-CM
What is your current housing situation?	Sheltered homelessness	Z59.01
	Unsheltered homelessness	Z59.02
	Risk of homelessness (imminent)	Z59.811
	Housed, homeless in past 12 mos.	Z59.812
	Other housing problems (e.g., financial)	Z59.89
What is your education level?	Less than high school diploma	Z55.5
What is your employment situation?	Change of job	Z56.1
	Threat of job loss	Z56.2
	Stressful work schedule	Z56.3
	Discord with boss and co-workers	Z56.4
	Uncongenial work environment	Z56.5
	Physical and mental strain	Z56.6
	Sexual harassment on the job	Z56.81
What is your household income level?*	Extreme poverty	Z59.5
	Low income	Z59.6
Are you able to afford food?	Food insecurity	Z59.41

Resources for Social Risk Coding in Care Settings - Gravity Project - Confluence (hl7.org)

HRSN-Screening-Crosswalk.pdf

Coding SDOH Takes Practice - AAPC Knowledge Center

ICD-10 Z-Codes for Social Determinants of Health (healthleadsusa.org)

PRAPARE-Data-Documentation-Quick-Sheet.pdf

Polling Question #3

3. Has your hospital implemented an audit process for Z Code use?

A. Yes, in place
B. Not yet, in progress
C. No
D. Don't know

Data Collection/Validation

Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities.

Race/Ethnicity/Language or REaL Data collected in structured format (ask questions)

https://www.youtube.com/watch?v=8EROTqmL-cY

Simple Strategies for Collecting REAL Data (hqin.org)

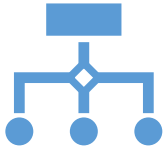
Collection of patient level structured data (ask even more questions)

The AHC Health-Related Social Needs Screening Tool (cms.gov)

ifdhe_real_data_toolkit_1.pdf (aha.org)

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

https://www.nachc.org/research-and-data/prapare/toolkit/



Qualifying, validating and sharing collected data (structured is best)

USING Z CODES (cms.gov)

SDoH Z Codes: How it Took a Village to Cleared the Confusion – ICD10monitor (medlearn.com)

Resources for Social Risk Coding in Care Settings - Gravity Project - Confluence (hl7.org)

How Health Information Professionals Can Boost SDOH Data Collection (ahima.org)

Resources

1. USING Z CODES (cms.gov) CMS Z-Code Infographic
2. Improving the collection of SDOH data using ICD-10-CM Codes
3. Resources For Implementation - Gravity Project - Confluence (hl7.org) Confluence Resources for Implementation
4. value-initiative-icd-10-code-sdoh-0418.pdf (codingclinicadvisor.com) AHA ICD-10 Coding for SDOH (2018)
5. Quick Start Guide (hqin.org) Health Quality Innovation Network to address Health Equity Measure
6. Disparities Impact Statement (cms.gov) Tool for taking action after Gap Assessment
7. Coding SDOH Takes Practice - AAPC Knowledge Center
8. ifdhe_real_data_toolkit_1.pdf (aha.org) With links to many other resources
9. ICD-10-CM Official Guidelines for Coding and Reporting FY 2024

Polling Question #4 and Group Discussion

4. What are your barriers to using Z Codes? *Select all that apply.*

Barriers to Using Z-Codes

- ❑ Lack of structured, consistent data collection and documentation in patient record
- ❑ Lack of clear organizational goals regarding health equity
- ❑ Lack of workflow development
- ❑ Lack of education, training, understanding by stakeholders
- ❑ Lack of resources to address more data collection requirements
- ❑ Lack of data collection/code mapping in EHR
- ❑ Lack of confidence and organizational authority to assign codes
- ❑ Lack of processes for resolving Z Codes in problem list when appropriate
- ❑ Lack of "solutions" to positive screens

Opportunities:

Next Steps

1. Discuss barriers and opportunities for data collection and use of Z codes with hospital team.

2. If any hospital has used their Community Health Needs Assessment (CHNA) in data analysis and would like to share on January 28 session, please email Karen.Holtz@allianthealth.org.

Next Session

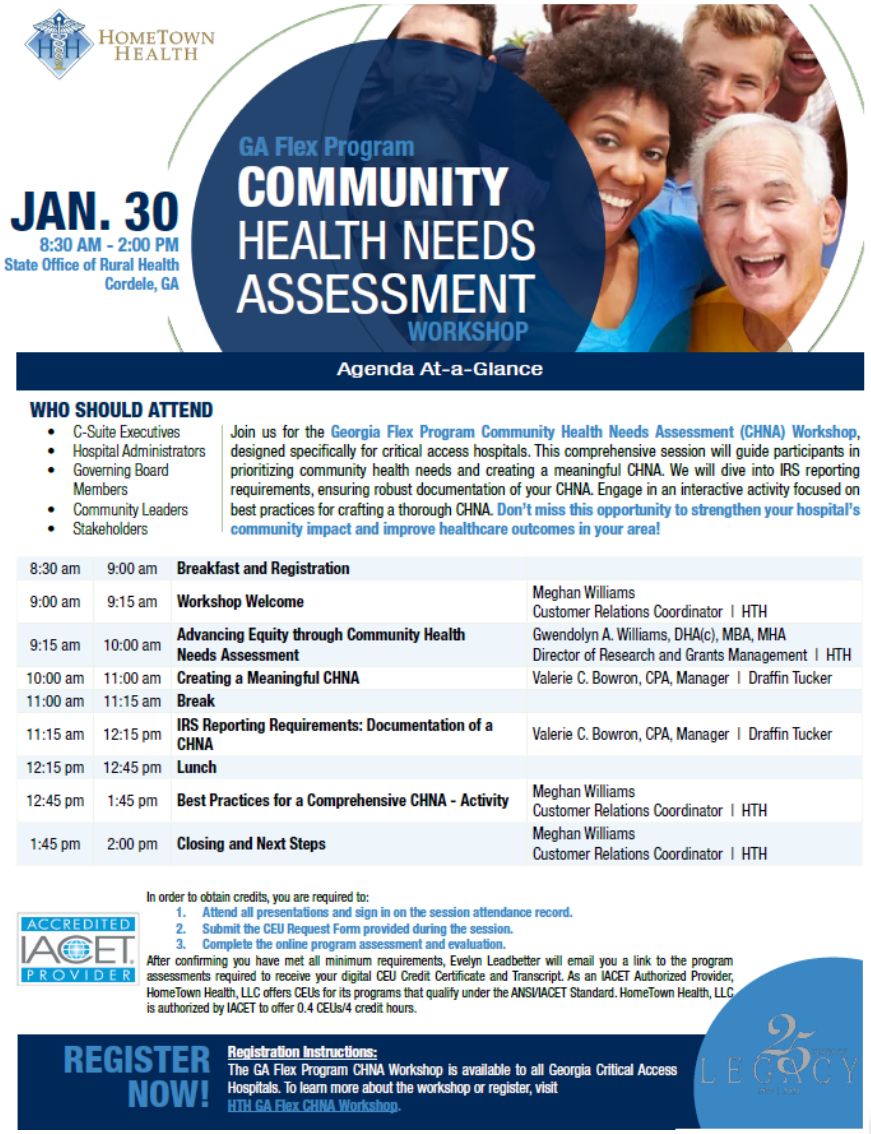
Community Health Needs Assessment

Tuesday, January 28, 2025

10 - 11 a.m. ET

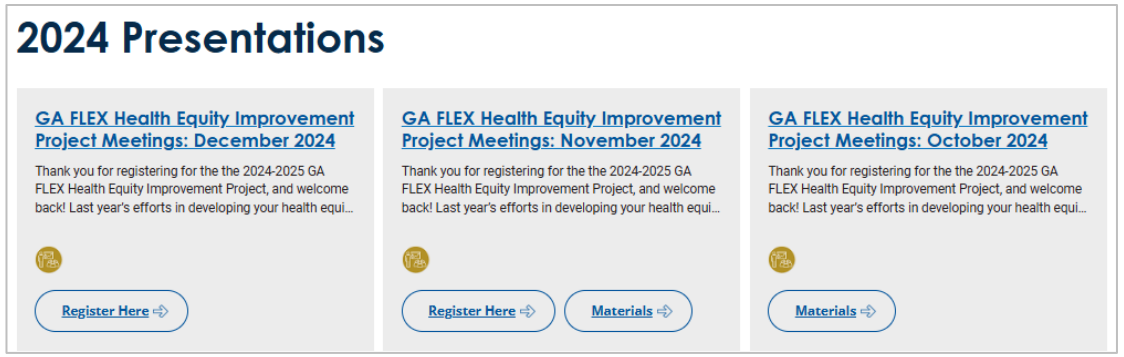
Gwendolyn A. Williams, DHA(c), MBA, MHA
Director of Research & Grants Management
HomeTown Health, LLC

HomeTown Health is hosting CHNA for GA Flex hospitals on January 30



Alliant Health Website and GA Flex Resources

https://quality.allianthealth.org/ga-flex/




Questions?
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State Office of Rural Health
A Division of the Georgia Department of Community Health