HEDIS® MY 2024 TIPS (To Improve Performance Sheet): Social Need Screening and Intervention (SNS-E)

Importance of the Quality Measure

It is widely acknowledged that social determinates of health (SDOH) directly influence a person's health status. SDOH includes factors such as income, education, employment, housing, transportation, race, and gender, which are influenced by the distribution of money, power, and resources.[1] Addressing SDOH needs is fundamental for improving health and reducing inequities. NCQA implemented a new HEDIS® measure in MY 2024, *Social Need Screening and Intervention* (SNS), as part of an organization-wide effort to advance health equity and encourage accountability for addressing food, housing, and transportation needs of patients.[2] SDOH can affect the health and quality of life of your patients. By identifying and addressing these barriers, either directly or through timely referrals, you can help improve health outcomes for your patients.

Did You Know?

- In 2022, 12.8% of U.S. households were food insecure or unable to acquire enough food to feed their families due to lack of finances or other resources at some time during 2022. This rate grew significantly higher from 10.2% in 2021.[3]
- The U.S. Department of Housing and Urban Development's (HUD) 2023 Worst Case Housing Needs Report found that 8.53 million households were classified as having worst-case housing needs (very low-income renters who pay more than half their income in rent, live in severely inadequate conditions, or both) with almost a third of those households containing children.[4]
- According to the U.S. Dept. of Transportation, having access to public transportation is important for people who are unable to drive, are members of low-income households, have children, are individuals with disabilities, and who are older adults. Safe, accessible transport is vital for improving health, preventive healthcare, employment, and educational opportunities to improve economic well-being.[5]

Quality Measure Description

The percentage of members (all ages) who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention within one month if they screened positive.

References

[1] World Health Organization. (2023). Social Determinates of Health. Retrieved from https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[2] NCQA. (2022). Proposed New Measure for HEDIS® Measurement Year (MY) 2023: Social Needs Screening and Intervention (SNS-E). Retrieved from https://www.ncqa.org/wp-content/uploads/2022/02/04.-SNS-E.pdf

[3] U.S. Department of Agriculture. (October 2023). Food Security in the U.S. Key Statistics & Graphics. Retrieved from: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/key-statistics-graphics.aspx#foodsecure

[4] U.S. Department of Housing and Urban Development. Office of Policy Development and Research. (May 2023). Worst Case Housing Needs 2023 Report to Congress. Retrieved from: https://www.huduser.gov/portal//portal/sites/default/files/pdf/Worst-Case-Housing-Needs-2023.pdf

[5] U.S Department of Transportation. Connectivity. Retrieved from https://www7.transportation.gov/mission/health/connectivity

NCQA Definitions

Food Insecurity	Uncertain, limited, or unstable access to food that is adequate in quantity and in nutritional quality; culturally acceptable; safe; and acquired in socially acceptable ways.
Housing Instability	Currently consistently housed but experiencing any of the following circumstances in the past 12 months: being behind on rent or mortgage, multiple moves, cost burden or risk of eviction.
Homelessness	Currently living in an environment that is not meant for permanent human habitation (e.g., cars, parks, sidewalks, abandoned buildings, on the street), not having a consistent place to sleep at night, or because of economic difficulties, currently living in a shelter, motel, temporary or transitional living situation.
Housing Inadequacy	Housing does not meet habitability standards.
Transportation Insecurity	Uncertain, limited or no access to safe, reliable, accessible, affordable, and socially acceptable transportation infrastructure and modalities necessary for maintaining one's health, well-being, or livelihood.

If you are an NCQA PCMH recognized practice, you must collect data on SDOH and use the information to continuously enhance care systems and community connections to systematically address needs. Below you will find the NCQA PCMH (Version 9) criteria related to SDOH that must be met.

KM 02 (CORE) COMPREHENSIVE HEALTH ASSESSMENT	KM 21 (CORE) COMMUNITY RESOURCE NEEDS
G. Collects information on social determinants of health: conditions in a patient's environment where people live, learn, work, and play that affect a wide range of health, functioning, and quality-of-life outcomes and risks.	The practice identifies needed resources by assessing collected population information. It may assess SDOH, predominant conditions, emergency department usage and other health concerns to prioritize community resources (e.g., food banks, support groups) that support the patient population.

Quality Improvement Opportunities

- Evaluate all patients for SDOH needs.
- Assess EHR capabilities to flag for SDOH assessment and build-in screening tools.
- Document and code all claims appropriately.
- Make referrals when appropriate to 2-1-1, or the Community Health Network of Connecticut, Inc.®. (CHNCT) Care Management (CM) program.

Tools & Resources for Healthcare Professionals

- Agency for Healthcare Research and Quality, Identifying and Addressing Social Needs in Primary Care Settings: https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/tools-and-materials/social-needs-tool.pdf
- CT WIC Program Information for Medical Providers: https://portal.ct.gov/DPH/WIC/Medical-Providers

Resources for Patients & Families

- Connecticut 2-1-1, a one-stop service that can help people find the local resources they need. You or your patient can dial 2-1-1 or visit www.211ct.org.
- Information for HUSKY Health Medicaid members in getting to and from their healthcare appointments is available at https://www.mtm-inc.net/connecticut or by calling 1-855-478-7350
- CT WIC Program: https://portal.ct.gov/DPH/WIC/WIC
- Supplemental Nutrition Assistance Program (SNAP): https://portal.ct.gov/dss/SNAP/Supplemental-Nutrition-Assistance-Program---SNAP

* SDOH Codes

Ensuring that the proper ICD-10 codes are captured on a claim will allow individuals who may need assistance to be identified and connected to the appropriate community resources.

DESCRIPTION	CPT CODES	HCPCS CODES
FOOD INSECURITY	96156, 96160, 96161, 97802, 97803, 97804	S5170, S9470
HOUSING INSTABILITY	96156, 96160, 96161	
HOMELESSNESS	96156, 96160, 96161	
INADEQUATE HOUSING	96156, 96160, 96161	
TRANSPORTATION INSECURITY	96156, 96160, 96161	

FOOD INSECURITY INSTRUMENTS	SCREENING ITEM LOINC CODES	POSITIVE FINDING LOINC CODES
ACCOUNTABLE HEALTH COMMUNITIES (AHC) HEALTH-RELATED SOCIAL NEEDS (HRSN) SCREENING TOOL	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) SOCIAL NEEDS SCREENING TOOL	88122-7	LA28397-0 LA6729-3
	88123-5	LA28397-0 LA6729-3
AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) SOCIAL NEEDS SCREENING TOOL—SHORT FORM	88122-7, 88123-5	LA28397-0 LA6729-3

FOOD INSECURITY INSTRUMENTS	SCREENING ITEM LOINC CODES	POSITIVE FINDING LOINC CODES
HEALTH LEADS SCREENING PANEL® **	95251-5	LA33-6
HUNGER VITAL SIGN™ (HVS)**	88124-3	LA19952-3
PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS' ASSETS, RISKS AND EXPERIENCES [PRAPARE]® **	93031-3	LA30125-1
U.S. HOUSEHOLD FOOD SECURITY SURVEY [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. ADULT FOOD SECURITY SURVEY [U.S. FSS]	95264-8	LA30985-8 LA30986-6
U.S. CHILD FOOD SECURITY SURVEY [U.S. FSS]	95264-8	LA30985-8 LA30986-6
SAFE ENVIRONMENT FOR EVERY KID (SEEK)® **	95400-8 95399-2	LA33-6 LA33-6
WE CARE SURVEY	96434-6	LA32-8
WELLRX QUESTIONNAIRE	93668-2	LA33-6

HOUSING INSTABILITY AND HOMELESSNESS INSTRUMENTS	SCREENING ITEM LOINC CODES	POSITIVE FINDING LOINC CODES
ACCOUNTABLE HEALTH COMMUNITIES (AHC) HEALTH-RELATED SOCIAL NEEDS (HRSN) SCREENING TOOL	71802-3	LA31994-9 LA31995-6
AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) SOCIAL NEEDS SCREENING TOOL	99550-6	LA33-6
CHILDREN'S HEALTH WATCH HOUSING STABILITY VITAL SIGNS™ **	98976-4	LA33-6
	98977-2	≥3
	98978-0	LA33-6
HEALTH LEADS SCREENING PANEL® **	99550-6	LA33-6
PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS' ASSETS, RISKS AND EXPERIENCES [PRAPARE]® **	93033-9	LA33-6
	71802-3	LA30190-5
WE CARE SURVEY	96441-1	LA33-6
WELLRX QUESTIONNAIRE	93669-0	LA33-6

HOUSING INADEQUACY INSTRUMENTS	SCREENING ITEM LOINC CODES	POSITIVE FINDING LOINC CODES
ACCOUNTABLE HEALTH COMMUNITIES (AHC) HEALTH-RELATED SOCIAL NEEDS (HRSN) SCREENING TOOL	96778-6	LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2
AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) SOCIAL NEEDS SCREENING TOOL	96778-6	LA32691-0 LA28580-1 LA32693-6 LA32694-4 LA32695-1 LA32696-9 LA32001-2
NORWALK COMMUNITY HEALTH CENTER SCREENING TOOL (NCHC)	99134-9 99135-6	LA33-6 LA31996-4 LA28580-1 LA31997-2 LA31998-0 LA31999-8 LA32000-4 LA32001-2

TRANSPORTATION INSECURITY INSTRUMENTS	SCREENING ITEM LOINC CODES	POSITIVE FINDING LOINC CODES
ACCOUNTABLE HEALTH COMMUNITIES (AHC) HEALTH-RELATED SOCIAL NEEDS (HRSN) SCREENING TOOL	93030-5	LA33-6
AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) SOCIAL NEEDS SCREENING TOOL	99594-4	LA33-6
AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP) SOCIAL NEEDS SCREENING TOOL—SHORT FORM	89569-8	LA33093-8 LA30134-3
COMPREHENSIVE UNIVERSAL BEHAVIOR SCREEN (CUBS)	89569-8	LA29232-8 LA29233-6 LA29234-4
HEALTH LEADS SCREENING PANEL®1	99553-0	LA33-6
INPATIENT REHABILITATION FACILITY - PATIENT ASSESSMENT INSTRUMENT (IRF-PAI)—VERSION 4.0 [CMS ASSESSMENT]	93030-5	LA30133-5 LA30134-3

TRANSPORTATION INSECURITY INSTRUMENTS	SCREENING ITEM LOINC CODES	POSITIVE FINDING LOINC CODES
OUTCOME AND ASSESSMENT INFORMATION SET (OASIS) FORM—VERSION E—DISCHARGE FROM AGENCY [CMS ASSESSMENT]	93030-5	LA30133-5 LA30134-3
OUTCOME AND ASSESSMENT INFORMATION SET (OASIS) FORM—VERSION E—RESUMPTION OF CARE [CMS ASSESSMENT]	93030-5	LA30133-5 LA30134-3
OUTCOME AND ASSESSMENT INFORMATION SET (OASIS) FORM—VERSION E—START OF CARE [CMS ASSESSMENT]	93030-5	LA30133-5 LA30134-3
PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS' ASSETS, RISKS AND EXPERIENCES [PRAPARE]®**	93030-5	LA30133-5 LA30134-3
PROMIS®**	92358-1	LA30024-6 LA30026-1 LA30027-9
WELLRX QUESTIONNAIRE	93671-6	LA33-6

*Code sets are routinely updated. Please reference the current year's manuals when billing for services. Not all codes listed above are reimbursable. For a list of codes reimbursed by DSS, please refer to the Physician Office and Outpatient Services Fee Schedule on the Connecticut Medical Assistance Program website: www.ctdssmap.com.

**Proprietary; may be cost or licensing requirement associated with use.

Note:

The SNS-E screening numerator counts only screenings that use instruments in the measure specification as identified by the associated LOINC code(s). Allowed screening instruments and LOINC codes for each social need domain are listed above.

Additional Information on HUSKY Health

For information on quality improvement, quality measures, or the programs and services made available through the HUSKY Health program:

- Visit: https://portal.ct.gov/husky, click "**Information for Providers**," then "**Health Measures**" under the "**Reports & Resources**" menu item.
- Email: Quality@chnct.org
- Call: 1.866.317.3301