# Social Need Screening and Intervention (SNS-E) measure

**Please note: The information offered in this flyer is based on HEDIS technical specifications. It is not meant to preclude your clinical judgment.**

The Social Need Screening and Intervention (SNS-E) measure evaluates the percentage of patients who were screened, using prespecified instruments, or assessed by a provider at least once during the measurement period for unmet food, housing and transportation needs and received an intervention corresponding to the positive screen or identified need within 30 days.

## Who is included in the SNS-E measure?

The eligible population for this measure includes any person covered by commercial, Medicaid or Medicare Advantage medical plans.

## Exclusions

- Patients in hospice or using hospice services anytime during the measurement period
- Patients who died anytime during the measurement period
- Medicare-covered patients 66 years of age and older by the end of the measurement period who meet either of the following:
  - Enrolled in an Institutional Special Needs Plan (I-SNP) anytime during the measurement period
  - Living long-term in an institution anytime during the measurement period

## Actions needed for compliance

An intervention corresponding to the type of need identified on or up to 30 days after the date of the first positive screening during the measurement period. Intervention may include any of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.

1. Discuss the significance of health-related social needs (HRSN) and how they relate to your patient's health.
   a. Emphasize the importance of addressing social health barrier(s) to your patient's unique health conditions, needs and overall health journey.
   b. Open the conversation to learn more about your patient's perspective and realities in meeting their health needs.
2. Screen your patients for one or various standardized HRSN to assess the patient for social health challenges.
   a. Acknowledge the situation. Affirm the difficulty of the situation and your awareness of some of the challenges they may be facing, given the social health barrier(s).
   b. Ask if they are willing to accept help and connect with resources for help.
3. Connect patients to resources and support. Visit Humana.findhelp.com to access resources.
4. Track, document and code the screening results in the patient's electronic health record (EHR).
5. Follow up with the patient within one to two months of resource referral.



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## 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, however may have experienced any of the following circumstances in the past 365 days: 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., car, park, sidewalk, abandoned building, 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.

| Food Insecurity Instruments | Screening Item LOINC Codes | Positive Finding LOINC Codes |
|---|---|---|
| Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool | 88122-7, 88123-5 | LA28397-0, LA6729-3 |
| American Academy of Family Physicians (AAFP) Social Needs Screening Tool | 88122-7, 88123-5 | LA28397-0, LA6729-3 |
| American Academy of Family Physicians (AAFP) Social Needs Screening Tool– short form | 88122-7, 88123-5 | LA31994-9, LA31995-6 |
| Health Leads Screening Panel®[1] | 95251-5 | LA33-6 |
| Hunger Vital Sign™1 (HVS) | 88124-3 | LA19952-3 |
| Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®[1] | 93031-3 | LA30125-1 |
| Safe Environment for Every Kid (SEEK)®[1] | 95400-8, 95399-2 | LA33-6 |
| 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 |
| U.S. Household Food Security Survey–Six Item Short Form (U.S. FSS) | 95264-8 | LA30985-8, LA30986-6 |
| We Care Survey | 96441-1 | LA33-6 |
| WellRx Questionnaire | 93669-0 | LA33-6 |

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

| 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 |
| American Academy of Family Physicians (AAFP) Social Needs Screening Tool – short form | 71802-3 | LA31994-9, LA31995-6 |
| Children's Health Watch Housing Stability Vital Signs™[1] | 98976-4<br>98977-2<br>98978-0 | LA33-6<br>≥2<br>LA33-6 |
| Health Leads Screening Panel®[1] | 99550-6 | LA33-6 |
| Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®[1] | 93033-9<br>71802-3 | LA33-6<br>LA30190-5 |
| We Care Survey | 96441-1 | LA33-6 |
| WellRx Questionnaire | 93669-0 | LA33-6 |

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| 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 |
| American Academy of Family Physicians (AAFP) Social Needs Screening Tool – short form | 96778-6 | LA31996-4, LA28580-1, LA31997-2, LA31998-0, LA31999-8, LA32000-4, LA32001-2 |
| Norwalk Community Health Center Screening Tool (NCHC) | 99134-9<br>99135-6 | LA33-6<br>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 | 99594-4 | 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) | 101351-5 | LA30133-5, LA30134-3 |
| Outcome and assessment information set (OASIS) form—version E—Discharge from Agency (CMS Assessment) | 101351-5 | LA30133-5, LA30134-3 |
| Outcome and assessment information set (OASIS) form—version E—Resumption of Care (CMS Assessment) | 101351-5 | LA30133-5, LA30134-3 |
| Outcome and assessment information set (OASIS) form—version E—Start of Care [CMS Assessment] | 101351-5 | LA30133-5, LA30134-3 |
| Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®[1] | 93030-5 | LA30133-5, LA30134-3 |
| PROMIS®[1] | 92358-1 | LA30024-6, LA30026-1, LA30027-9 |
| WellRx Questionnaire | 93671-6 | LA33-6 |

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The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.



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