

HEDIS MEASURE OVERVIEW

Social Need Screening and Intervention (SNS-E)

Please note: The information offered in this flyer is based on Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. It is not meant to preclude your clinical judgment.

Measure description

The Social Need Screening and Intervention (SNS-E) measure evaluates the percentage of patients 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 if they screened positive. Six rates are reported:

- Food screening: the percentage of patients screened for food insecurity
- Food intervention: the percentage of patients who received a corresponding intervention within 30 days (one month) of screening positive for food insecurity
- Housing screening: the percentage of patients screened for housing instability, homelessness or housing inadequacy
- Housing intervention: the percentage of patients who received a corresponding intervention within 30 days (one month) of screening positive for housing instability, homelessness or housing inadequacy
- Transportation screening: the percentage of patients screened for transportation insecurity
- Transportation intervention: the percentage of patients who received a corresponding intervention within 30 days (one month) of screening positive for transportation insecurity

Who is included in the SNS-E measure?

The eligible population for this measure includes patients of all ages.

Exclusions

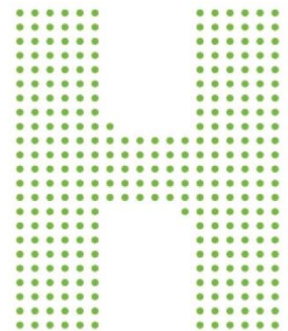
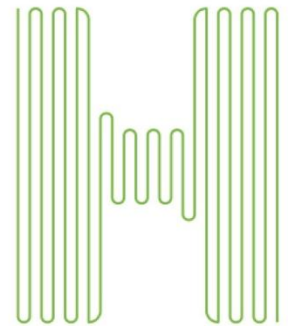
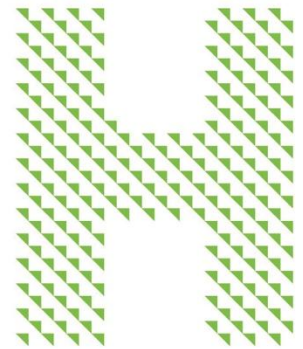
- Patients in hospice or using hospice services anytime during the measurement period
- Patients who die anytime during the measurement period
- Medicare-covered patients 66 years of age and older by the end of the measurement period who meet either of the following:
 - Enrolled in an Institutional Special 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; both the screening and intervention must be documented and coded.

Intervention may include any of the following categories: adjustment, assistance, assessment, coordination, counseling, education, evaluation of eligibility, evaluation/assessment, provision or referral.

A validated and prespecified screening tool must be utilized for the screening to address the measure. Examples of such tools are below. Use of screening instruments is documented via Logical Observation Identifiers Names and Codes (LOINC) codes.



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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) for 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](https://www.humana.com/findhelp) to access resources.

4 Track, document and code the screening results with the appropriate intervention/resource referral in the patient's electronic health record (EHR).

5 Follow up with patient within one to two months of intervention/resource referral.

For the Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool, visit www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf.

For the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)[®] tool, visit <https://prapare.org/the-prapare-screening-tool/>.

For more information on coding this measure, visit <https://apps.humana.com/marketing/documents.asp?file=5429073>.



There are many standardized, validated HRSN screening tools available, such as the [Accountable Health Communities \(AHC\) Health-Related Social Needs Screening Tool](#), built by the Centers for Medicare & Medicaid Services (CMS). Some EHRs have enhancements that integrate the HRSN screening tool as an assessment. Another screening tool is the [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE\)[®]](#).

Information regarding inclusion, compliance and exclusions for this measure were sourced from the HEDIS Measurement Year 2025: Volume 2: Technical Specifications for Health Plans report.

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