



# Social determinants of health: screening tools update

## Covering: HEDIS Social Needs Survey (SNS-E) Oregon Quality Incentive Metric (QIM) SDOH Metric D-SNP Health Risk Assessment Questionnaire

Currently, the HEDIS SNS-E, Oregon QIM SDOH Metric, and D-SNP Health Risk Assessment Questionnaire all require that specific tools be used to screen for three SDOH: food, housing, and transportation.

To help providers choose from among the many screening tools available, and to assist with any Electronic Health Record (EHR) builds, we’ve identified three common tools (below) approved by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) that include questions covering all three required domains. We’ve also provided additional information on each tool in this document, along with a list of other approved tools.

### Common screening tools with required questions for Oregon Medicaid SDOH Metric QIM, HEDIS SNS-E, and D-SNP Health Risk Assessment Questionnaire

| Adult screening tools <sup>2</sup>                                                                              | Food insecurity | Housing insecurity | Transportation insecurity |
|-----------------------------------------------------------------------------------------------------------------|-----------------|--------------------|---------------------------|
| <u>Accountable health communities (AHC)</u> <sup>3</sup>                                                        | ✓               | ✓                  | ✓                         |
| <u>WellRx questionnaire</u>                                                                                     | ✓               | ✓                  | ✓                         |
| <u>Protocol for responding to and assessing patients’ assets, risks, and experiences (PRAPARE)</u> <sup>3</sup> | ✓               | ✓                  | ✓                         |

<sup>1</sup> Health plans typically conduct the screening for D-SNP.  
<sup>2</sup> Adult screening tools may be used in pediatric populations.  
<sup>3</sup> Tool is available in Connect Oregon.

Social determinants of health (SDoH), such as food, housing, and transportation insecurity, significantly affect health outcomes. Screening for them and providing referrals or assistance to address positive findings is becoming standard healthcare practice.

Reflecting this, metric stewards, including the NCQA and state Medicaid agencies, now have metrics designed to help address SDoH. Additionally, SDoH screening is required by CMS for vulnerable populations who qualify for Medicare Dual Special Needs Programs (D-SNP<sup>1</sup>).



Continued >

## Common screening tools: SDoH questions

| Approved screening tools                                                                           | Food insecurity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Housing insecurity <sup>1</sup>                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Transportation insecurity                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u>Accountable health communities (AHC)</u>                                                        | <p>Within the past 12 months, you worried that your food would run out before you got money to buy more.</p> <p><input type="checkbox"/> Often true<br/> <input type="checkbox"/> Sometimes true<br/> <input type="checkbox"/> Never true</p> <p>Within the past 12 months, the food you bought didn't last, and you didn't have money to get more.</p> <p><input type="checkbox"/> Often true<br/> <input type="checkbox"/> Sometimes true<br/> <input type="checkbox"/> Never true</p>                                                                                                        | <p>What is your living situation today?<sup>2</sup></p> <p><input type="checkbox"/> I have a steady place to live<br/> <input type="checkbox"/> I have a place to live today, but I am worried about losing it in the future<br/> <input type="checkbox"/> 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)</p> | <p>In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>                                                                                                                                                                                                                                                       |
| <u>WellRx questionnaire</u>                                                                        | <p>In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>                                                                                                                                                                                                                                                                                                                                                                                            | <p>Are you homeless or worried that you might be in the future?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>                                                                                                                                                                                                                                                                                                                                              | <p>Do you have trouble finding or paying for a ride?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>                                                                                                                                                                                                                                                                                                                                                                    |
| <u>Protocol for responding to and assessing patients' assets, risks, and experiences (PRAPARE)</u> | <p>In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.</p> <p><input type="checkbox"/> Food<br/> <input type="checkbox"/> Clothing<br/> <input type="checkbox"/> Utilities<br/> <input type="checkbox"/> Child care<br/> <input type="checkbox"/> Medicine or any healthcare (medical, dental, mental health, vision)<br/> <input type="checkbox"/> Phone<br/> <input type="checkbox"/> Other (please write) _____</p> <p><input type="checkbox"/> I choose not to answer this question</p> | <p>What is your housing situation today?</p> <p><input type="checkbox"/> I have housing<br/> <input type="checkbox"/> 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)<br/> <input type="checkbox"/> I choose not to answer this question</p>                                                                                                                                             | <p>Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.</p> <p><input type="checkbox"/> Yes, it has kept me from my medical appointments<br/> <input type="checkbox"/> Yes, it has getting kept me from nonmedical meetings, appointments, work, or from getting things that I need<br/> <input type="checkbox"/> No<br/> <input type="checkbox"/> I choose not to answer this question</p> |

<sup>1</sup> Housing Inadequacy not included

<sup>2</sup>Time frames can be altered as needed

## Other approved tools

### HEDIS SNS-E Metric (listed by question)

#### Food insecurity instruments

- [Hunger Vital Sign<sup>1</sup> \(HVS\)](#)
- [Safe Environment for Every Kid \(SEEK\)<sup>®</sup>](#)
- [U.S. Adult/Child/Household Food Security Surveys \(multiple surveys\)](#)
- [We Care \(BMC Thrive\)](#)

#### Housing instability and homelessness instruments

- [Children's Health Watch Housing Stability Vital Signs<sup>™</sup>](#)
- [We Care \(BMC Thrive\)](#)

#### Transportation insecurity instruments

- [CMS OASIS \(various tools\)](#)
- [Inpatient Rehabilitation Facility Patient Assessment Instrument \(IRF-PAI\)](#)
- [PROMIS](#)



#### Medicaid SDoH QIM

Please scan this code for the current list of OHA-approved screening tools

[Oregon.gov/oha/hpa/dsi-tc/pages/social-needs-screening-tools.aspx](https://Oregon.gov/oha/hpa/dsi-tc/pages/social-needs-screening-tools.aspx)

## Codes by common tool for screening, positive finding, and intervention

### Screening and positive finding codes

| Common approved screening tools                                                                             | Food insecurity LOINC codes |                       | Housing instability/homelessness LOINC codes <sup>1</sup> |                        | Transportation insecurity LOINC codes |                        |
|-------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------|-----------------------------------------------------------|------------------------|---------------------------------------|------------------------|
|                                                                                                             | Screening                   | Positive finding      | Screening                                                 | Positive finding       | Screening                             | Positive finding       |
| <a href="#">Accountable Health Communities (AHC)</a>                                                        | 88122-7<br>88123-5          | LA28397-0<br>LA6729-3 | 99550-6<br>71802-3 (short)<br>71802-3                     | LA31994-9<br>LA31995-6 | 93030-5                               | LA33-6                 |
| <a href="#">WellRx Questionnaire</a>                                                                        | 95251-5                     | LA33-6                | 99550-6                                                   | LA33-6                 | 99553-0                               |                        |
| <a href="#">Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)</a> | 93031-3                     | LA30125-1             | 93033-9<br>71802-3                                        | LA33-6<br>LA30190-5    | 93030-5                               | LA30133-5<br>LA30134-3 |

### Intervention codes

| SDoH intervention (procedure) codes | CPT codes   | Select SNOMED codes |            |            |            |            |            |
|-------------------------------------|-------------|---------------------|------------|------------|------------|------------|------------|
| Food insecurity                     | 96156 97802 | 1759002             | 308440001  | 710925007  | 1002223009 | 1004109000 | 1230338004 |
|                                     | 96160 97803 | 61310001            | 385767005  | 711069006  | 1002224003 | 1004110005 | 1162436000 |
|                                     | 96161 97804 | 103699006           | 710824005  | 713109004  | 1002225002 | 1148446004 |            |
| Housing insecurity/Homelessness     | 96156       | 308440001           | 1148446004 | 1148814008 | 1156869006 | 1230338004 |            |
|                                     | 96160       | 710824005           | 1148447008 | 1148817001 | 1162436000 |            |            |
|                                     | 96161       | 711069006           | 1148812007 | 1148818006 | 1162437009 |            |            |
| Transportation                      | 96156       | 308440001           | 1148446004 |            |            |            |            |
|                                     | 96160       | 710824005           | 1162436000 |            |            |            |            |
|                                     | 96161       | 711069006           | 1230338004 |            |            |            |            |

<sup>1</sup> Housing Inadequacy questions are not included

**SDoH screening and referral declines**

Patients who decline SDoH screening or referral are not included as denominator exceptions for the HEDIS SNS-E metric, so there are no associated codes for such patients in the tables. These exceptions *are* included in the QIM metric. As of December 2024, the Oregon Health Authority had not provided guidance regarding codes to use for declinations. Due to this, PacificSource has selected the two declination codes listed below. Providers can map these codes to EHR screening and/or intervention declinations to remove members from the QIM metric denominator.

**Declination codes**

| SDoH declination codes | LOINC codes |
|------------------------|-------------|
| Decline to answer      | LA27922     |
| Patient refused        | LA10058-8   |

