

Measure Description

The percentage of members who were screened, using prespecified instruments, at least once during the measurement period (January 1 – December 31) for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.

- **Food Screening:** The percentage of members who were screened for food insecurity between January 1 and December 1 of the measurement period.
- **Food Intervention:** The percentage of members who received a corresponding intervention within 1 month (31 days total) of screening positive for food insecurity.
- **Housing Screening:** The percentage of members who were screened for housing instability, homelessness or housing inadequacy between January 1 and December 1 of the measurement period.
- **Housing Intervention:** The percentage of members who received a corresponding intervention within 1 month (31 days total) of screening positive for housing instability, homelessness, or housing inadequacy.
- **Transportation Screening:** The percentage of members who were screened for transportation insecurity between January 1 and December 1 of the measurement period.
- **Transportation Intervention:** The percentage of members who received a corresponding intervention within 1 (31 total days) month of screening positive for transportation insecurity.

Eligibility: Any age member for any line of business.

Product Lines: Commercial, Medicaid, Medicare, Exchange

Codes Included in the Current HEDIS® Measure

Description	Code
Food Insecurity Procedures	CPT: 96156, 96160, 96161, 97802-97804 HCPCS: S5170, S9470
Homelessness Procedures, or Housing Instability Procedures, or Inadequate Housing Procedures, or Transportation Insecurity Procedures	CPT: 96156, 96160, 96161

Codes to Identify Eligible Screening Instruments and Positive Findings

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
American Academy of Family Physicians (AAFP) Social Needs Screening Tool	88123-5	LA28397-0 LA6729-3
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	LA33-6
	95399-2	LA33-6
U.S. Household Food Security Survey [U.S. FSS], U.S. Adult Food Security Survey [U.S. FSS], U.S. Child Food Security Survey [U.S. FSS], U.S. Household Food Security Survey–Six-Item Short Form [U.S. FSS]	95264-8	LA30985-8 LA30986-6
We Care Survey	96434-6	LA32-8
WellRx Questionnaire	93668-2	LA33-6

¹Proprietary; 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
Children's Health Watch Housing Stability Vital Signs™1	98976-4	LA33-6
	98977-2	≥3
	98978-0	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	LA33-6
	71802-3	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
Norwalk Community Health Center Screening Tool [NCHC]	99134-9 99135-6	LA33-6 LA31996-4 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 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
Outcome and assessment information set (OASIS) form	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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Ways Providers can Improve HEDIS® Performance

- Screen patients during visits for food insecurity, housing instability, homelessness, housing inadequacy and transportation insecurity using prespecified instruments.
 - *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.
- Document in the medical record the screening encounter date and the corresponding intervention if the member screened positive. Help members find free or low-cost resources for basic needs (i.e., housing, food, clothing, job training, and more) in their community at www.MolinaHelpFinder.com.
- An intervention may include any of the following intervention categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision, or referral.

Ways Health Plans can Improve HEDIS® Performance

- Screen members during outreach for food insecurity, housing instability, homelessness, housing inadequacy and transportation insecurity using prespecified instruments.
 - *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.

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- 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.

- Ensure your member (and member's family) understands the local community support resources.
- Refer member/family/caregiver for Care Coordination/Case Management.
- Educate providers to utilize standardized screening tools in EMR and appropriate billing to ensure included in electronic measure.
- Connect with local crisis services immediately for an evaluation if a member is experiencing an acute need.

Exclusions

- Members in hospice or using hospice services any time during the measurement year.
- Members who die any time during the measurement year.
- Medicare members 66 years of age and older by the end of the measurement period who meet either of the following:
 - Enrolled in an Institutional SNP (I-SNP) any time during the measurement period.
 - Living long-term in an institution any time during the measurement period, as identified by the LTI flag in the Monthly Membership Detail Data File.

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