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Health-Related Social Needs

Addressing Health-Related Social Needs

Health-Related Social Needs (HRSN) are an individual's unmet, adverse social and economic conditions that negatively affect their health, well-being, and ability to access care. They include:

- Financial strain
- Housing instability
- Food insecurity
- Transportation
- Access to care
- Employment
- Childcare
- Safety issues

HRSN data offers rich insights into external conditions impacting health — an especially important consideration in underserved populations that may require complex care.

Benefits of Identifying HRSN for Providers

Providers should aim to improve health, quality and financial outcomes of patients by identifying and beginning to address barriers. **Patients with unaddressed social needs are more likely to miss medical appointments.**

No-shows impact not only patient health, but present missed opportunities for provider reimbursement, contribute to lower utilization, and diminish quality measure scores.

HRSN data integration has been shown to improve readmission management, communication between patient and provider, care coordination and overall patient experience.

Steps to Achieving Success

1. Adopt or Develop a Screening Tool

A screening tool is the first step in capturing HRSN data. Practices may develop their own screening tool or adopt an existing tool; **see page 5** of this guide for examples.

2. Define a Workflow

Determine how HRSN screening will function operationally at your practice.

Consider screening opportunities outside of annual/well visits, such as sick visits, vaccination clinics and pediatric visits.

Screening for HRSN does not need to be administered by a physician; a screening can be performed upon check in or while rooming so that it does not disrupt the flow of the visit.

The screening tool can be self-administered on paper or given via an in-person interview. Your practice can also leverage telehealth visits and phone calls to complete screenings.

3. Be Actionable

As part of your practice's HRSN process, develop actionable steps, such as referring patients with a positive screen to local resources.

Utilize a social needs platform, such as PA Navigate for referrals and connections to community organizations.

4. Establish Billing Procedures

Staff should become familiar with diagnosis codes and the submission of claims for both negative and positive screenings. **See page 5** of this guide for a list of ICD-10 codes for positive HRSN screenings.

5. Train and Educate Staff

Create best practices, responsibilities and FAQ resources for staff. These resources should cover general HRSN information and specific information for primary task areas.

Providers should re-examine their HRSN process annually. We encourage providers to develop a system for ongoing evaluation of the screening process, including recognizing and fixing barriers, which can keep the screening process efficient.

SCREENING RESULT	CODING
No Barriers Identified	G9920 only
Barriers Identified	G9919 and all other appropriate diagnosis codes

Tips & Best Practices

- Set a goal of screening each patient for HRSN at least once per calendar year.
- Evaluate your practice's readiness before implementing a HRSN screener. Start small if necessary; screen for one domain, such as food insecurity, that you have resources available to provide to your patients.
- If patient abrasion is a concern, consider a pre-screener or patient support survey. These tools allow patients to define only the needs that are of personal concern to them.
- Minimize administrative burden and mitigate vulnerabilities in your screening process by integrating HRSN into patients' EHR.
- Take advantage of our care gap report available on the provider portal to identify member-level HRSN screening opportunities.
- Communicate expectations, accountability, and responsibility for referrals to your staff.

HRSN SCREENING

ACTION PLAN/REFERRAL

SERVICE DELIVERY

ONGOING INCLUSION IN PATIENT CARE PLAN

FOLLOW-UP

Resources

Website: Visit **hpplans.com/qualityandpopulationhealth** to access resources and information for participating providers.

Social Care Platforms: Visit **findhelp.org** or **PANavigate.org** to search for community resources.

HRSN Diagnosis Codes: **This resource** provides specific screening diagnosis codes and best practices for submission.

Other HRSN Resources

PRAPARE Toolkit: The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help providers collect the data needed to better understand and act on individuals' non-clinical factors of health.

The PRAPARE social needs screening tool is available in 25+ languages. PRAPARE EHR templates exist for EPIC, eClinicalWorks, Cerner, athenaPractice (formerly GE Centricity), NextGen and more, and are freely available to the public.

Health Leads Toolkit: The Health Leads Screening Toolkit combines a patient-centered approach to social needs screening and clinically validated guidelines for integration of HRSN into care delivery.

AAFP Screening Tool: The American Academy of Family Physicians Screening tool can be used by care teams to develop an action plan with patients and help them improve health outcomes.

AHC Screening Tool: CMS' Accountable Health Communities (AHC) HRSN screening tool is designed to inform patients' treatment plans and make referrals to community services.

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PC-420NM-8232