	#814	Screening and Intervention for Health-Related Social Needs (HRSN) ☒ Policy ☐ Standard Operating Procedure

Date of Inception:		8/01/2018	**CEO Approval:**				
Current Approval Date:		08-07-2023	**CMO Approval (If required):**				
Operational Scope:	Board Directors ☐	Admin ☐	PF ☐	CC / QM ☐	Rights ☐	RCM ☐	ERS ☐
H/S ☐	IHS ☐	IT/IDS ☐	Sec / Safety ☐	Environmental ☐	Facilities ☐	☐	Agency ☒

814 Policy

Provider Health supports the whole health and wellness of service participants. Provider recognizes that integrated healthcare includes attention to social factors that can impact a person's overall wellness.

814.1 Purpose

To establish standards and criteria for conducting screening of Health-Related Social Needs screening, including methods to support service participants in accessing necessary community resources.

814.2 Scope

All Provider employees.

814.3 Definitions

Health-Related Social Needs (HRSN) Screening: Per the Center for Medicare and Medicaid Services (CMS), growing evidence supports that unmet social needs such as homelessness, hunger, or environmental safety can have a clinically significant impact on a person's health and wellness. These social needs can often become determinant factors in a person's ability to address other mental health and physical health conditions. Screening and assessing social needs can identify these determinant factors as part of the development of a fully integrated treatment plan.

814.4 Screening for Health-Related Social Needs (HRSN)

A. A Health-Related Social Needs (HRSN) screen, accessed in the electronic health record, is conducted as part of the initial and annual assessment and as clinically indicated or when life circumstances change. Provider utilizes a modified version of the CMS Health-Related Social Needs Screening tool, which assesses HRSN in the areas of health literacy, housing, food and water, utility assistance, transportation, social/family support, safety, employment and legal issues. 1.1 B

B. The HRSN assessment is completed by the member's Case Manager (BHT) and is reviewed and approved by a Licensed Behavioral Health Professional (BHP). 1.1 C

C. The BHMP makes a determination on the need for a Z-Code diagnosis and intervention.

D. Upon diagnosis and a determination that an intervention is needed, the Integrated Clinical Team identifies the needs that the member would like to address. The Service Plan is then automatically updated to include interventions and/or resources that address the needs that the participant chooses to address. Any remaining needs that are not immediately addressed are retained and reviewed with the member to determine whether they would like to address them. 1.1 D

II. Referrals and Resources

A. Provider utilizes the Unite Us referral network and maintains a directory of new community resources and organizations providing supportive services to meet a participant's social needs, including veterans, aging, emergency shelters, literacy, clothing, food and legal/advocacy among others. These are shared with Unite Us as they update their list of resources. As required by the Unite Us Network, Provider has signed written agreements for referral criteria and procedures which are outlined in our Unite Us Workflow.

B. When a participant's HRSN screening results indicate a need for further assessment, evaluation or services, the Care Team Clinical Coordinator and BHMP are notified.

1. If Provider has the resources to support the specific need, then the Care Team makes arrangements to provide the service directly.
2. If it is determined by the Clinical Care Team that the participant may benefit from services, supports or resources not offered by Provider , the Care Team accesses Unite Us, a HRSN platform, to assist the individual in identifying a resource close to their home or offered during hours convenient to their schedule.
3. While any member of the Clinical Care Team may make a resource referral, the Case Manager is generally the person who makes the connection and follows up to see that the service or resource is obtained.
    a. The referring staff member assists the individual in connecting with the service or resource agency by supporting the person in making a phone call to set up an appointment or taking the individual to the agency to obtain the resource if necessary.
    b. Provider schedules transportation or provides a bus pass if needed.
4. Provider has implemented a Referral Satisfaction Survey to obtain member feedback on the services or resources that were provided.