ENHANCING ONCOLOGY MODEL

EOM HEALTH-RELATED SOCIAL NEEDS GUIDE

Version 2.1

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Revision History

Revision #	Revision Date	Description of Change
1.0	1/1/2023	• Initial Version
2.0	11/29/2023	• Section 1: HRSN Requirements and Nationally Recognized Data Collection Tools: Updated to include additional resources available to participants to address social determinants of health. • Section 2: Validated Screening Questions on Food Insecurity, Housing Instability, and Transportation: Updated to include additional information on validated screening tools to collect HRSN data. • Section 3: HRSN Best Practices and Considerations: Updated language to reflect key insights for universal HRSN screening. • Section 4: Addressing HRSNs: Community Referrals and Patient Navigation: Updated. • Section 5: HRSN Resources: Updated with additional HRSN-related literature, case studies, and other informational resources, organized by category: food insecurity, housing instability, and transportation. • Section 6: Additional EOM Resources: Added this section based on updates to Section 5.
2.1	6/28/2024	• Introduction and Important Terminology for Health-Related Social Needs and Social Determinants of Health: Updated • Section 1: HRSN Requirements and Nationally Recognized Data Collection Tools: Updated • Section 2: Validated Screening Questions on Food Insecurity, Housing Instability, and Transportation: Updated • Section 3: HRSN Best Practices and Considerations: Updated • Section 4: Addressing HRSNs: Community Referrals and Patient Navigation: Updated • Section 5: HRSN Resources: Updated • Appendix A: Acronyms and Abbreviations: Added

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Introduction and Rationale for Health-Related Social Needs Screening and Data Collection

This document is designed to guide Enhancing Oncology Model (EOM) participants in the data collection of their beneficiaries' health-related social needs (HRSNs), one of eight required participant redesign activities (PRAs).

EOM is a Center for Medicare & Medicaid Innovation alternative payment model designed to promote high-quality, person-centered care, advance health equity, encourage better care coordination, improve access to care, reduce costs, and improve outcomes for Medicare fee-for-service (FFS) beneficiaries with cancer who receive cancer treatment. EOM builds on lessons from the Oncology Care Model (OCM) and shares certain features with OCM, including episode-based payments that financially incentivize physician group practices (PGPs) to improve care and lower costs. EOM participants are oncology PGPs that prescribe and administer cancer therapy for included cancer types. The model is centered on 6-month episodes of care triggered by receipt of an Initiating Cancer Therapy for an included cancer type. Seven cancer types are included in the model:

- Breast Cancer[1]
- Chronic Leukemia
- Lung Cancer
- Lymphoma
- Multiple Myeloma
- Prostate Cancer[1]
- Small Intestine/Colorectal Cancer

In alignment with the Centers for Medicare & Medicaid Services' (CMS') commitment to reducing health disparities and achieving health equity in CMS quality programs and within Innovation Center models, EOM is dedicated to advancing health equity within all stages of model design, implementation, and evaluation.[2,3]

Advancing health equity requires identifying and addressing HRSNs, which are defined as *adverse social conditions that negatively impact a person's health or health care*, as defined in **Table 1.**

[1] Low-risk breast cancer and low-intensity prostate cancer are not included in EOM. For the purposes of EOM, low-risk breast cancer is defined as breast cancer treated with only long-term oral endocrine chemotherapy; and low-intensity prostate cancer is defined as prostate cancer treated with either androgen deprivation and/or anti-androgen therapy without any other chemotherapy.

[2] Brooks-LaSure, C., Fowler, E., Seshamani, M. & Tsai, D. (2021). Innovation at the Centers for Medicare and Medicaid Services: A Vision for the Next 10 Years. Health Affairs.

[3] Centers for Medicare & Medicaid Services, Office of Minority Health (2021). Paving the Way to Equity: A Progress Report.

There is strong evidence that non-clinical drivers of health contribute to health outcomes and are associated with increased health care utilization and costs.[4,5] Standardizing HRSN screening can also often inform larger, community-wide efforts to ensure the availability and access to community services that are responsive to the needs of CMS beneficiaries.[6]

Table 1. HRSN and SDOH Terminology

Term	Working Definition	Additional Context
Social determinants of health (SDOH)	The conditions in which people are born, grow, live and age, and the wider set of forces and systems shaping the conditions of daily life.[7, 8]	SDOH encompass the structural, systemic, and contextual factors that shape a person's life.[9] These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.[10]
Health-related social needs (HRSNs)	Individual-level, adverse social conditions that negatively impact a person's health or health care.[11]	HRSN screening tools can help capture individual level factors, such as lack of access to transportation for upcoming appointment or financial toxicity associated with costs of cancer therapy.
Drivers of health (DOH)/Social drivers of health	Non-clinical factors known to impact patient outcomes, including socioeconomic status, housing availability, and nutrition, as well as marked inequity in outcomes based on patient demographics such as race and ethnicity, being a member of a minority religious group, geographic location, sexual orientation and gender identity, religion, and disability status.[12]	As part of 2023 Merit-based Incentive Payment System (MIPS) measures, a measure was added for screening for social drivers of health.[13]

[4] Booske, B. C., Athens, J. K., Kindig, D. A., Park, H., & Remington, P. L. (2010). County Health Rankings. http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf

[5] The Commonwealth Fund (2019). Review of Evidence for Health-Related Social Needs Interventions. https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-1-19.pdf

[6] CMS. (2022). A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tools: Promising Practices and Key Insights. https://innovation.cms.gov/media/document/ahcm-screeningtool-companion; Accountable Health Communities Health-Related Social Needs Screening Tool.

[7] U.S. Department of Health and Human Services. (n.d.). Social determinants of health. https://health.gov/healthypeople/priority-areas/social-determinants-health

[8] World Health Organization. (n.d.). Social determinants of health. https://www.who.int/health-topics/social-determinants-of-health

[9] See Footnote 6.

[10] Centers for Disease Control and Prevention. Social Determinants of Health. https://www.cdc.gov/about/priorities/social-determinants-of-health-at-cdc.html?CDC_AAref_Val=https://www.cdc.gov/about/sdoh/index.html

[11] See Footnote 6.

[12] Office of the Assistant Secretary for Planning and Evaluation, Social Drivers of Health. https://aspe.hhs.gov/topics/health-health-care/social-drivers-health

[13] Quality ID #487: Screening for Social Drivers of Health. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_487_MIPSCQM.pdf

Term	Working Definition	Additional Context
Social risk factors	The wide array of non-clinical drivers of health known to negatively impact patient outcomes, including factors such as socioeconomic status, housing availability, and nutrition (among others), often inequality affecting historically marginalized communities on the basis of race and ethnicity, rurality, sexual orientation and gender identity, religion, and disability[14]	While this term is often used interchangeably with "drivers of health," external experts in the field have distinguished between social determinants/drivers of health and social risk factors in this way: social determinants/social drivers are neutral (e.g., income), where social risk factors are "individual-level adverse social determinant[s] (e.g., low income)."[15] Note that belonging to a racial category is not a social risk factor—rather, the social risk factor is the interpersonal and institutional discrimination faced by members of these groups.

Important Terminology for Health-Related Social Needs and Social Determinants of Health

Several terms and definitions are used to discuss the social determinants of health (SDOH), also known as the population- or community-level factors that influence health and quality of life outcomes. CMS has most often referred to individual-level non-clinical needs that are identified through screening in a clinical setting as health-related social needs (HRSNs). For example, while shelter and community safety may be the SDOH, the individual-level HRSN related to housing might be an individual experiencing homelessness or housing insecurity. The term HRSN will be used throughout this guide.

Under the terms of the EOM Participation Agreement (PA), EOM participants are required to implement eight participant redesign activities (PRAs). One PRA required of EOM participants is identifying HRSNs using an HRSN screening tool for their eligible beneficiaries (see Figure 1). HRSNs are the adverse social conditions that negatively impact a person's health or health care. These include challenges in obtaining proper nutrition during cancer treatment, access to transportation for infusion appointments, housing instability, and financial toxicity/concerns due to cost of cancer therapy. They also impact the health and well-being of many Medicare beneficiaries with cancer and pose a risk of exacerbating health disparities. To address this, HRSNs should be identified and mitigated through referrals to community resources and other patient navigation efforts.[16,17]

[14] FY 2023 Inpatient Psychiatric Facilities Prospective Payment System—Rate Update and Quality Reporting—Request for Information Final Rule; 87 FR 46866 (Jul. 29, 2022).

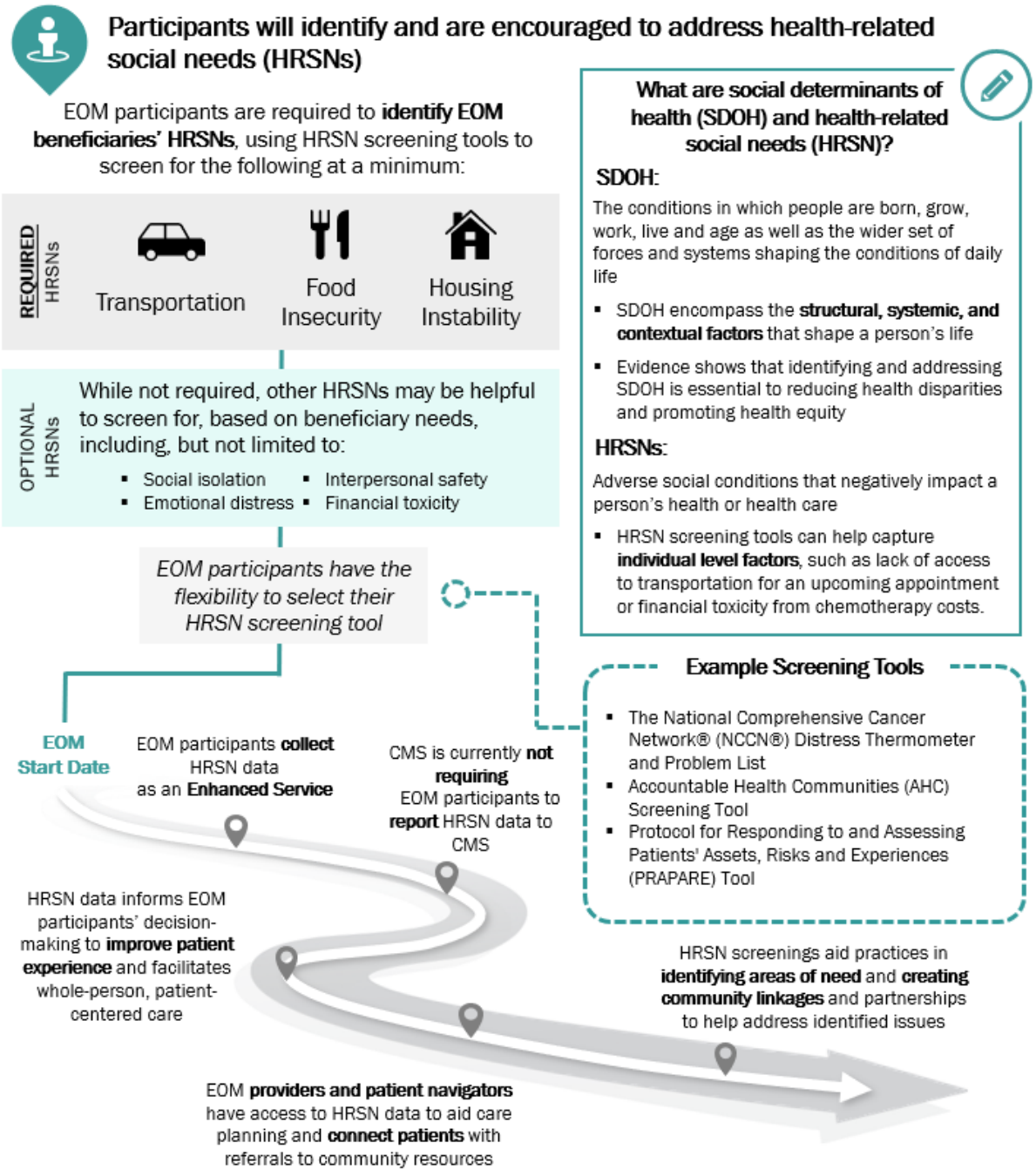
[15] See Footnote 12.

[16] American Association for Cancer Research. (2020). AACR Cancer Disparities Progress Report.

[17] Anderson, J.K.E., Jain, P., Wade, A., Morris, A.M, Slaboda, J.C., Norman, G.J. (2020). Indicators of Potential Health-Related Social Needs and the Association with Perceived Health and Well-Being Outcomes Among Community-Dwelling Medicare Beneficiaries. Quality of Life Research.

For additional information, including evidence-based research and toolkits about the need and utility of screening for HRSNs, **Section 5** provide several publicly available resources related to HRSNs.

Figure 1. Addressing HRSNs as Part of the EOM Enhanced Services[18]



[18] CMS. (2023). EOM Health Equity Strategy Fact Sheet; https://www.cms.gov/priorities/innovation/media/document/eom-healthequity-fs

The rationale for requiring HRSN screening and patient navigation (e.g., referral to services) in EOM includes, but is not limited to:

- Screening identifies risk factors that contribute to poor health outcomes, greater disparities, and higher health care cost and utilization.
- Studies show that most patients believe that information on social needs should be used to improve care.[19]
- Health care providers find value in screening to inform clinical decision making and believe it has the potential to improve patient outcomes. Examples of clinical impacts include, but are not limited to, missed appointments and follow-up due to lack of transportation,[20] poor medication adherence due to food insecurity,[21] and postponed health care and medication due to housing instability.[22] Screening will help providers meet whole-patient needs and advance patient-centered care.[23]
- Screening and referral increase the opportunity to provide multiple types of services to patients.[24]

As terminology continues to evolve in the field, EOM participants may encounter the terms below as they seek to integrate HRSN screening and referral into their practice transformation. The table below provides definitions and context to help EOM participants understand how these terms are used.

The following sections provide more detail about EOM HRSN data collection:

- Model requirements for HRSN screening and recommended tools are described in **Section 1.**
- Sample screening questions are described in **Section 2.**
- HRSN best practices and considerations are described in **Section 3.**
- Addressing HRSNs through community referrals and patient navigation is described in **Section 4.**
- Additional EOM and HRSN resources are listed in **Section 5.**

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[19] De Marchis, E. H., Brown, E., Aceves, B., Loomba, V., Molina, M., Cartier, Y., et al. (2022). State of the Science on Social Screening in Healthcare Settings. SIREN.

[20] American Hospital Association. (2018). Case Study: Denver Health Medical Center Collaborates with Lyft to Improve Transportation for Patients https://www.aha.org/news/insights-and-analysis/2018-03-01-case-study-denver-health-medical-center-collaborates-lyft

[21] Jean-Louis, F. (2023). The Impact Of Food Insecurity On Adult Health & Well-Being: SDoH Series, Part 1. RTI Health Advance. https://healthcare.rti.org/insights/food-insecurity-adult-health#:~:text=Working%2Dage%20adults%20from%20food,those%20in%20food%2Dsecure%20households.

[22] American Hospital Association. (2021). Housing and Health: A Roadmap for the Future. https://www.aha.org/system/files/media/file/2021/03/housing-and-health-roadmap.pdf

[23] See Footnote 24.

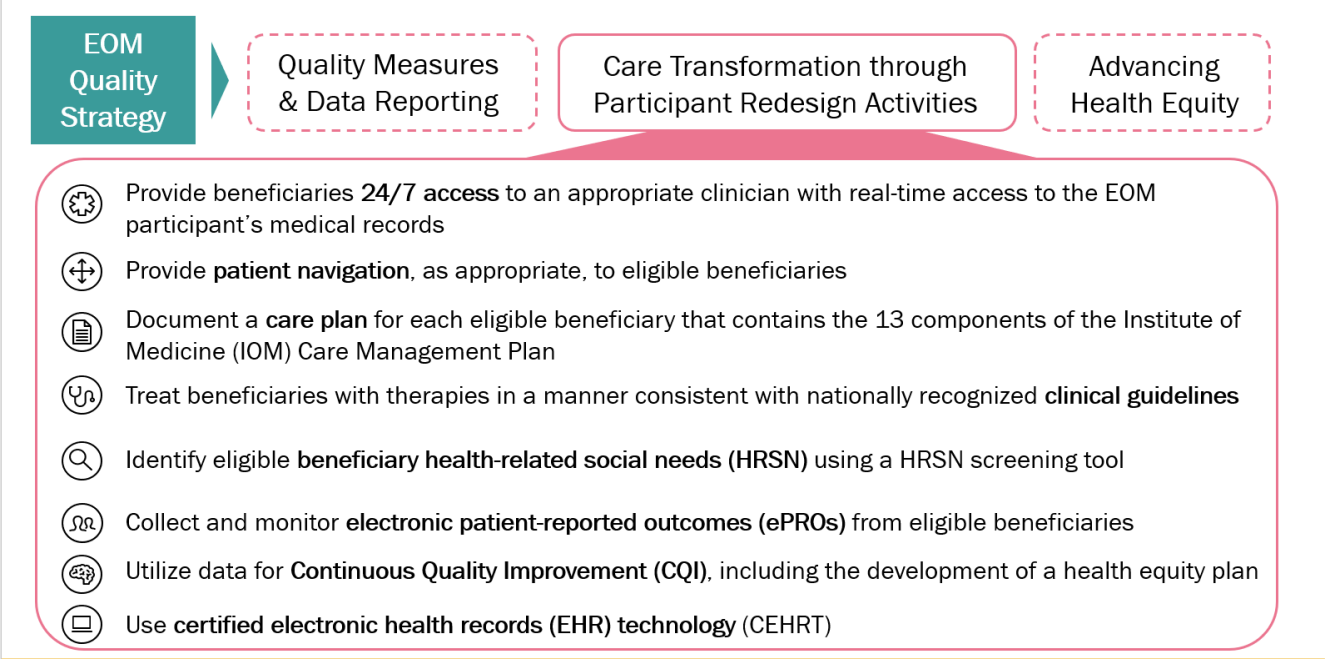
[24] Gottlieb LM, Hessler D, Wing H, Gonzalez-Rocha A, Cartier Y, Fichtenberg C et al. (2024). Revising the Logic Model Behind Health Care's Social Care Investments. Milbank Quarterly.

Section 1: HRSN Requirements and Nationally Recognized Data Collection Tools

1.1 Identifying HRSNs as a Participant Redesign Activity

Under the terms of the PA, EOM participants are required to implement eight PRAs, the first six of which are Enhanced Services (**Figure 2**). Participants can bill for Monthly Enhanced Oncology Services (MEOS) payments to support the implementation of these Enhanced Services for their eligible beneficiaries.

Figure 2. EOM Participant Redesign Activities



One PRA required of EOM participants is the use of established, validated screening tools to collect HRSN data from EOM beneficiaries and to develop a plan for addressing those needs. EOM participants may identify and address subsequent social needs through a combination of patient navigation and care planning activities.

EOM participants will provide patient navigation, as appropriate, to EOM beneficiaries, which may include linking beneficiaries to follow-up services and community resources (e.g., referring eligible beneficiaries to cancer survivor support groups and community organizations that assist with or provide child/elder care, housing, transportation, or financial support). As part of the core elements of patient navigation, EOM participants will also follow up regularly with the beneficiary to ensure they connect with community resource(s) and receive the services they need.

For beneficiaries that are already connected to a community resource, regular follow-up is encouraged as circumstances and needs may change over time, requiring additional or different community services.

EOM participants offer patient navigation services to bridge other gaps in care, such as access to clinical trials and connections to other health specialists or community resources, and to reduce health disparities. EOM participants are encouraged to develop relationships with community partners to accomplish these goals. While every EOM participant's community is different, ideas for community resources include, but are not limited to, state and county public health institutions, social services organizations, places of worship, and other agencies and organizations that serve these communities. Please refer to **Section 5** for additional community resources and **Appendix F** for additional information on core elements of patient navigation.

HHS has released toolkits and guidance to help practices and providers identify community resources. The Administration for Community Living (ACL), within the U.S. Department of Health and Human Services (HHS), funds over 30,000 community-based organizations in every state across the country to support older adults and people with disabilities. This national network serves over 10 million older adults each year, with a focus on high cost, high need populations and equity. A section of their website is dedicated to information and resources on advancing partnerships to align health care and social services, with a primary focus on the community care hub model. Additionally, the Centers for Disease Control and Prevention (CDC) developed a workbook, Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, to address health care inequities. Community-based case studies are included, as well as examples for developing community initiatives to provide equitable care and access.

There are several online resources available for participants to learn more about how to equitably address social determinants of health. In their online resource, Equitably Addressing Social Determinants of Health and Chronic Disease,[25] the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) provides innovative approaches to build healthier communities and reduce health disparities. Some additional health equity resources also include Advancing Health Equity Through the Public Health Workforce;[26] Health Equity in Action: Programs, Policies, and Other Interventions;[27] and Health Equity Science.[28]

[25] Centers for Disease Control and Prevention. (2023). Equitably Addressing Social Determinants of Health and Chronic Diseases. https://www.cdc.gov/health-equity-chronic-disease/social-determinants-of-health-and-chronic-disease.html

[26] Centers for Disease Control and Prevention. (2023). Advancing Health Equity Through Communications. https://www.cdc.gov/health-equity-chronic-disease/health-equity-communications.html

[27] Centers for Disease Control and Prevention. (2023). Health Equity in Action: NCCDPHP Programs and Interventions. https://www.cdc.gov/health-equity-chronic-disease/health-equity-in-action.html

[28] Centers for Disease Control and Prevention. (2023). Health Equity Science. https://www.cdc.gov/health-equity-chronic-disease/health-equity-science.html

1.2 HRSNs to be Collected

EOM participants must screen EOM beneficiaries, at a minimum, for HRSNs in the following domains:

- food insecurity
- transportation
- housing instability

As described in the Participant Agreement (PA) in Article VII and Appendix B, EOM participants are required to screen their EOM beneficiaries and collect HRSN data on the three domains (food insecurity, transportation, and housing instability) within 90 days of the participant start date and to attest annually to CMS that they have implemented each PRA, including HRSN screening, as part of the PRA Attestation.

EOM participants should screen each EOM beneficiary, at a minimum, once each performance period. EOM participants should consider if additional screening is necessary, based on beneficiary need. EOM participants are encouraged to screen for additional HRSNs to meet the needs of their unique population, including, but not limited to, social isolation, difficulty paying for utilities, emotional distress, interpersonal safety, and financial toxicity.

Note: EOM participants are encouraged to use patient-first language with their beneficiaries, for example, "financial toxicity" is a term more commonly used in academic settings, whereas "financial distress" is often used with patients. As described in the EOM Health Equity Plan (HEP) Guide[29], screening for HRSNs is one source of data EOM participants can consider using to support their HEPs by using data for continuous quality improvement (CQI).

For the electronic patient-reported outcomes (ePROs) collection requirement, EOM participants have the option to conduct a full HRSN screening at each E&M visit or to conduct a full HRSN screening once every 6 months. Should a full HRSN screening only be conducted once every 6 months, in order to fulfill the ePROs requirement, the EOM participant should ask the EOM beneficiary at each E&M visit if there have been any changes from the previous visit in their needs around food, transportation, and housing. The EOM participant is encouraged to ask about additional HRSNs as is applicable to their unique beneficiary population.

For more information on how this requirement functions in conjunction with the ePROs requirement, please see the EOM Electronic Patient-Reported Outcomes Guide and the FAQs.

As part of their participation in EOM, practices may be asked to submit documentation, feedback and/or additional information about HRSN screening, as described in the EOM PA in Article VII, Section 7.2 and Appendix B. Should a participant be selected for a monitoring site visit, an EHR audit may be performed as part of the monitoring visit for CMS to validate that HRSN data are being collected. Participants may be asked to share additional information with CMS, such as describing which screening tool(s) they are using and how the data is being collected and documented (e.g., in an excel spreadsheet or in their EHR).

[29] CMS. (2023). EOM 2023 Health Equity Plan Guide. https://www.cms.gov/priorities/innovation/media/document/eom-health-equity-plan

Currently, CMS is not requiring EOM participants to report beneficiary-level HRSN data to CMS. However, as additional standards are developed, CMS may require EOM participants to report HRSN data in later performance periods. Should reporting become required in the future, EOM participants will be notified in a timely manner and this guide will be updated with the technical specifications for practices to interface with the Health Data Reporting (HDR) application and accurately report the data.

Additional resources on these three domains can be found in **Section 5**.

1.3 HRSN Screening Tools

There are non-proprietary and established HRSN screening tools available to EOM participants at no cost. These tools, presented in **Table 2** and listed below, are *examples only—their inclusion here does not constitute an endorsement by CMS or CMS affiliates*. EOM participants have the flexibility to use other HRSN screening tools as they see fit. EOM participants should check with organizations that manage each tool for rules concerning modifications and use.

- Accountable Health Communities (AHC) Screening Tool[30] (See Appendix C)
- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)[31] (See Appendix D)
- The NCCN Distress Thermometer and Problem List[32] (See Appendix E)

Table 2. Established HRSN Screening Tools Available to EOM Participants

HRSN Screening Tools	Description
Accountable Health Communities (AHC) Screening Tool	CMMI created the Accountable Health Communities (AHC) HRSN Screening Tool to use in the AHC Model. The tool helps examine whether identifying and addressing HRSNs of Medicare and Medicaid beneficiaries impacts their total health care costs and improves outcomes.
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE®)	A national standardized patient risk assessment protocol designed to engage patients in assessing and addressing social drivers of health and HRSNs. The PRAPARE tool is available in 25 languages.
The NCCN Distress Thermometer and Problem List*	Free resource to help providers worldwide identify and address the unpleasant experiences that may make it harder to cope with having cancer, its symptoms, or treatment.

[30] CMS secured permissions from the original authors of the screening questions in the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use, copy, modify, publish, and distribute the questions for the AHC Model and CMS use only.

[31] PRAPARE may be licensed for use free of charge by health care providers, managed care plans, institutions, or social service organizations working directly with patients. Please see more information and the End User License Agreement here. Non-end users, including Electronic Health Record vendors, social prescribing tracking platforms, population health analytics tool vendors, and others that wish to embed the PRAPARE screening into an electronic platform for end users, must contact the PRAPARE team to move forward with a licensing agreement.

[32] If your organization would like to use, reproduce, and/or distribute NCCN content for any purpose, please review the applicable information here, log in to NCCN.org, and complete the Permissions Request Form. This link includes specific directions on citing or using the NCCN Distress Thermometer.

*Disclaimer: The NCCN Distress Thermometer and Problem List alone may be insufficient for providers to address beneficiary-level HRSNs. Select questions on the NCCN are limited in their scope. If a provider uses the NCCN and a need is identified, additional follow-up questions and patient discussion may be needed to connect beneficiaries with the appropriate housing, food, or transportation resource.

If an EOM participant is using an HRSN screening tool that is not listed above (this may be more common for screening tools already embedded within EHRs or for HRSN domains outside of food, housing, transportation, interpersonal safety/intimate partner violence, and utilities), the screening tool should:

- Align with Fast Healthcare Interoperability Resources (FHIR) standards and use terminology that aligns with the International Classification of Diseases, Tenth Revision (ICD-10), Logical Observation Identifiers Names and Codes (LOINC), and Systemized Nomenclature of Medicine (SNOMED), in order to enable HRSN data to be shared between different health IT systems, where appropriate, and in accordance with patient privacy laws; ***and***
- Use screening questions that have been assessed for dimensions of validity for the screening domains.
    - EOM participants can check their screening tool/screening questions against a library of screening tools compiled by the Social Interventions Research and Evaluation Network (SIREN).[33]
    - Share the tool and/or questions selected with CMS to inform monitoring efforts.

Participants can choose to administer questions from a screening tool that are pertinent to food insecurity, housing instability, and transportation. HRSN screening can and should be tailored to the screening entities and unique beneficiary needs, staffing model, and other preferences. **Appendix B** provides some additional examples of screening instruments.

[33] SIREN. (2019). Social Needs Screening Tool Comparison Table. Available at https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison.

Section 2: Validated Screening Questions on Food Insecurity, Housing Instability, and Transportation

Participants must use one or a combination of validated screening tools to collect HRSN data. This section describes the screening questions related to food insecurity, transportation, and housing instability that are included on the three HRSN screening tools described in **Table 2**. The exhaustive lists in the following sections demonstrates the similarities and differences in questions asked across the preferred surveys. Participants are encouraged to use one or more screening tools to meet the domains listed. If a participant chooses to use different screening tools across domains, they only need to include questions from their chosen screening tool for that specific domain. For example, one participant may choose to use the PRAPARE Tool screening question for food insecurity and the AHC Tool screening questions for housing instability; in this situation, the participant would only include questions listed under the specific tool per respective domain.

2.1 Food Insecurity

AHC Screening Tool

Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

1. Within the past 12 months, you worried that your food would run out before you got money to buy more.
   - Often true
   - Sometimes true
   - Never true
2. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.
   - Often true
   - Sometimes true
   - Never true

Note: "Often true" or "Sometimes true" for EITHER question would be classified as food insecure.

PRAPARE Tool

1. 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)
   - One option choice is "Food: Yes / No"

NCCN Distress Thermometer and Problem List

1. Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)
   - One option choice is "Practical Concerns: Having enough food."

2.2 Housing Instability

AHC Screening Tool

1. What is your living situation today?
    - I have a steady place to live
    - I have a place to live today, but I am worried about losing it in the future
    - 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)

2. Think about the place you live. Do you have problems with any of the following? Choose all that apply.
    - Pests such as bugs, ants, or mice
    - Mold
    - Lead paint or pipes
    - Lack of heat
    - Oven or stove not working
    - Smoke detectors missing or not working
    - Water leaks
    - None of the above

Note: Responses to the second OR third option in question 1, OR any selection indicating a problem in question 2 would be classified as housing unstable.

PRAPARE Tool

- What is your housing situation today?
- I have housing
- 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)
- I choose not to answer this question

1. Are you worried about losing your housing?
    - Yes
    - No
    - I choose not to answer this question

Note: Responses for the second OR third option in question 1, OR responses for the first option in question 1 AND first or third option in question 2 would be classified as housing unstable.

NCCN Distress Thermometer and Problem List

1. Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)
    - One option choice is “Practical Concerns: Housing.”

2.3 Transportation

AHC Screening Tool

1. 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?
    - Yes
    - No

PRAPARE Tool

1. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.
    - Yes, it has kept me from medical appointments or
    - Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
    - No
    - I choose not to answer this question

NCCN Distress Thermometer

1. Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)
    - One option choice is "Practical Concerns: Transportation."

Please see **Appendices C, D, and E** for more detail on the tools and questions.

Section 3: HRSN Best Practices and Considerations

CMS aims to support EOM participants by sharing promising practices and key insights for universal HRSN screening. This section includes best practices for EOM participants to consider. The HRSN screening tools described in this guide provide participants with logistical considerations for administration, including examples of screening questions, locations, and staff training procedures. EOM participants are encouraged to read the documentation for each screening tool for best practices and considerations to promote effective universal screening for HRSNs.[34]

EOM participants are encouraged to take several best practices into consideration to optimize the beneficiary's screening experience. Participants are encouraged to clearly explain the purpose of screening to the beneficiary, including how the HRSN data will be used and stored.[35]

Additional examples of implementing best practices for screening include ensuring the process is minimally disruptive in any setting; that it does not impact the beneficiary's time with the provider; takes place in a private area; and is conducted in a culturally and linguistically appropriate

[34] See Footnote 6.

[35] EH De Marchis, E Brown, B Aceves, V Loomba, M Molina, Y Cartier, et al. (2022). State of the Science on Social Screening in Healthcare Settings. Siren.

manner. **Table 3** in this section provides example resources participants can use to incorporate culturally responsive outreach for patient-provider interactions. Remote screening and in-person screening are both valid processes, as the mode of screening does not appear to impact beneficiaries' willingness to accept assistance and navigation related to their HRSNs.[36]

Participants are encouraged to take multiple best practices into consideration as they implement their screening tools. For example, staff performing the screening should use customized scripts that use appropriate language to foster trust and build confidence with beneficiaries (see example on p. 18 of the AHC Screening Tool Guide). Participants should consider cultivating buy-in at the leadership and staff levels and making space to address staff concerns related to screening. Participants may identify an on-site leader who can serve as a role model and source of information on screening and referral. It is important for participants to ensure a protocol is in place for making timely referrals upon positive screenings for HRSNs.

Participants can provide training for screening staff or volunteers covering:

- the importance of screening and referral protocols;
- how to respond to common questions about screening from beneficiaries;
- how to manage privacy and address safety concerns; and
- how to take the next steps to ensure an appropriate referral is made if one or more HRSN(s) are identified through screening.

Table 3. **Applying Cultural Responsiveness Resources**

Resources	Description
Think Cultural Health	This website features information, continuing education opportunities, resources, and more for health and health care professionals to learn about culturally and linguistically appropriate services, or CLAS.
CLAS Behavioral Health Implementation Guide	This Behavioral Health Implementation Guide underscores the ways in which the National CLAS Standards can improve access to behavioral health care, promote quality behavioral health programs and practice, and ultimately reduce persistent disparities in mental health and substance use treatment for underserved minority communities.
2016 National Ambulatory Medical Care Survey Supplement on Culturally and Linguistically Appropriate Services for Office-based Physicians	This material provides documentation for users of the public use micro-data file for the 2016 National Ambulatory Medical Care Survey Supplement on Culturally and Linguistically Appropriate Services for Office-based Physicians (National CLAS Physician Survey).

[36] AL Steeves-Reece, MM Davis, J Hiebert Larson, Z Major-McDowall, AE King, C Nicolaidis. Patients' Willingness to Accept Social Needs Navigation After In-Person v Remote Screening: A Cross-Sectional Study. J of the American Board of Family Medicine. Abstract published ahead of print (Nov. 11, 2022). 10.3122/jabfm.2022.220259R1

Section 4: Addressing HRSNs: Community Referrals and Patient Navigation

CMS has published case studies and lessons learned on the benefits of addressing HRSNs through community referrals, including the benefits of addressing HRSNs within the healthcare system, expanding and scaling efforts to identify HRSNs, building strong community partnerships to address HRSNs, and promising strategies for sustaining partnerships that address social needs.[37]

If an EOM participant identifies an EOM beneficiary with an HRSN, the next step would be facilitating linkages to follow-up services and community resources, as available and appropriate.[38] For example, this could take the form of referrals to community-based organizations (CBOs) or other third parties that provide elder care, transportation, or financial support, as well as referrals to cancer survivor support groups. These are just a few examples of the core functions of patient navigation, which are further described in Appendix B of the PA).

When developing a plan of care with the beneficiary, several needs should be considered. This includes unmet housing, food, and transportation needs, since these issues will impact the implementation, outcomes, and success of their cancer treatment. In the case of positive screening for unmet HRSNs, EOM participants should provide patient navigation to connect beneficiaries with referral services.

Examples of best practices in patient navigation include helping connect the beneficiary to services and conducting regular outreach to beneficiaries to identify and resolve barriers to referral services. Navigation may be conducted by a clinician or other care team members and should include beneficiary input to ensure mutual understanding of the beneficiary's priorities and opportunities available to resolve unmet needs. Though the accessibility of resources to address a particular need across communities may vary, EOM participants are encouraged to be transparent with beneficiaries about availability of resources and services at community, state, and federal levels.

Should a beneficiary already be connected to referral services, providers should identify and document the patients' HRSN history and any previous resources used. Patient navigation services can help implement, coordinate, and communicate a beneficiary's care plan. Navigation services can also help coordinate and/or obtain care among specialists, required imaging and laboratory testing, appointments with their primary care provider, financial and social support, etc. As most referral services are income-restricted and/or time-limited, the care team should identify additional services to connect patients with resources that accommodate food, housing, and transportation needs.

[37] CMS. (2024). Accountable Health Communities Model. https://innovation.cms.gov/innovation-models/ahcm

[38] Facilitating linkages to follow-up services and community resources is a core function of patient navigation, one of the required PRAs, described in the PA Appendix B.

We encourage EOM participants to follow key guidelines to ensure successful implementation of community referrals and expanded navigation, including:

- Ensuring referrals are relevant to the beneficiary by using language that is easy to understand and culturally appropriate;
- Ensuring that a beneficiary is not excluded from eligibility for a resource due to age, gender, socioeconomic status, or other sociodemographic factors;
- Creating or enabling access to community referral inventories and regularly reviewing and updating, including primary points of contact at each community service, to confirm that all resources and contact information are up to date;
- Communicating to the entire oncology care team any beneficiary's positive screens and active referrals if a beneficiary has an identified unmet social need; and
- Document and where possible, close the loop on active referrals with beneficiaries to ensure services are rendered and identify any potential barriers to getting help from referral services.

EOM participants are asked to consider maintaining a community resource referral platform to support HRSN screening and referrals or to join an existing platform. For example, Findhelp, formerly known as Aunt Bertha, is a free national resource and community referral platform. Findhelp functions as a resource directory, referral management platform, a tool to track and analyze social determinants of health data, and it can also provide needs screening. Findhelp allows individuals to search for resources on their own, or it can be used by health care organizations, community-based organizations, or other partners. In the case of HRSN positive screens, CMS does not require EOM participants to document the specific referral actions taken but encourages EOM participants to close referral loops, when possible. CMS asks EOM participants to develop a care plan for the unmet needs of their EOM beneficiaries as part of their Institute of Medicine (IOM) care plan (e.g., "A plan for addressing a patient's psychosocial health needs…") and consider potential interventions within their HEPs. Participants may also document in their HEP if community resources are not available to address unmet needs in their patient population.

Section 5: HRSN Resources

Table 4 and 5 in this section provide additional HRSN-related literature, case studies, and other informational resources and examples of programs, directories, and applications to address HRSNs.

Table 4. HRSN-related Literature, Case Studies, and Other Informational Resources

Resources	Description
General Resources	
A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool	A guide produced by Mathematica that outlines promising practices and key insights for the Accountable Health Communities HRSN Screening Tool. Example promising practices described in this guide include anticipating population-specific needs, instituting continuous quality improvement, and considering the timing, location, and process for screening to maximize patient's participation.
Accountable Health Communities Model	This source outlines how the Accountable Health Communities Model identifies and addresses health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services.
U.S. Playbook to Address Social Determinants of Health	The Playbook contains background information on the links between SDOH and health outcomes. It also lists actions federal agencies are taking to break down institutional silos and support organizations that address individual HRSNs to equitably build health and well-being within communities. The Playbook is not intended to be final or comprehensive but is rather an initial set of strategies that organizations in both the public and private sector can build upon as they implement programs to address HRSNs.
HHS Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation	This resource complements the companion U.S. Playbook to Address Social Determinants of Health. It catalyses community-level partnerships and calls upon health care, social services, public health, and health information technology to work together to address HRSNs and create a stronger, more integrated health and social care system through shared decision making.
Equitably Addressing Social Determinants of Health and Chronic Diseases	The National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) outlines how equitably addressing differences in social determinants of health helps make progress toward health equity. This source also includes related health equity resources, including how to advance health equity through partnerships, collaboration, and community engagement.
Food Safety For Older Adults and People With Cancer, Diabetes, HIV/AIDS, Organ Transplants, and Auto-Immune Diseases	This FDA guide is intended to help older adults and people with cancer, diabetes, HIV/AIDS, organ transplants, or autoimmune diseases avoid foodborne infections.
Identifying and Responding to Health-Related Social Needs in Primary Care: Understanding the Impact and Planning for the Future	A PowerPoint presentation created by Boston Children's Hospital that outlines the activities, evaluation methods and lessons learned from social risk screening in two different primary care studies.
Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health	The Centers for Disease Control and Prevention developed this resource to help communities identify and address social determinants of health through a series of case reports, public health programs, and policy initiatives.

Resources	Description
Food Insecurity	
Feed1st Food Pantry Toolkit	Feed1st at the University of Chicago Medical Center is a proven and enduring system of 24 hours a day, 7 days a week, and 365 days a year self-serve, no-barriers food pantries operating in inpatient, emergency, and outpatient areas of a major urban academic medical center. This toolkit to provide hospitals and other healthcare organizations across the country with a proven model to address food insecurity among their patients.
Food Insecurity Among People With Cancer: Nutritional Needs as an Essential Component of Care	A commentary that explores the issue of food insecurity in the context of cancer care, explores current mitigation efforts, and offers a call to action to create a path for food insecurity mitigation in the context of cancer.
Improving Cancer Care by Addressing Food Insecurity	Research article that indicated that food insecure patients tended to complete fewer months of treatment than their food secure counterparts. Food insecure patients who refused assistance had the lowest number of months of completed treatment; most food insecure patients who received assistance completed more of their treatment.
Increasing Food Security Efforts Across the Cancer Continuum: A Toolkit for Comprehensive Cancer Control Coalitions	This toolkit contains resources and recommendations aligned with the White House National Strategy for improving food access and affordability and integrating nutrition into disease management.
Nutrition Education Materials | SNAP-Ed (usda.gov)	The U.S. Department of Agriculture provides nutrition education materials that focus on healthy eating, safe food, staying active, stretching their food dollars/SNAP benefits and more. Additional sources found on SNAP-Ed include: Eat Right When Money's Tight | SNAP-Ed (usda.gov), Recipes and Menus SNAP-Ed (usda.gov), Recipe Video Collections | SNAP-Ed (usda.gov) State SNAP-Ed Programs | SNAP-Ed (usda.gov) Stores Accepting SNAP Online | Food and Nutrition Service (usda.gov) Where Can I Use SNAP EBT? | Food and Nutrition Service (usda.gov)
SNAP-Ed Toolkit (snapedtoolkit.org)	This toolkit contains resources to help readers find evidence-based nutrition education interventions, trainings, webinars, and other resources.
USDA Actions on Nutrition Security	USDA Food and Nutrition Security Relevant Links: Nutrition Security | USDA Meaningful Support | USDA Healthy Food | USDA Collaborative Action | USDA Equitable Systems | USDA Leveraging the White House Conference to Promote and Elevate Nutrition Security: The Role of the USDA Food and Nutrition Service | Food and Nutrition Service
VHA Food Security Office - Nutrition and Food Services	The VHA National Food Security Office (FSO) supports Veterans whole health by ensuring food security. The VA can connect Veterans with resources to help them access nutritious, affordable, and culturally appropriate food.

Resources	Description
Housing Instability	
HUD Housing and Homeless Assistance Resources	Resources from the U.S. Department of Housing and Urban Development (HUD), including affordable housing/rental options, tenant rights, fair housing, and homeless housing services.
Housing Insecurity | Consumer Financial Protection Bureau (CFPB)	This site provides information on options for mortgage and rental relief for homeowners, renters, and landlords including programs providing rental assistance, help with utility bills, rental housing counseling, subsidized housing and housing choice vouchers, and legal information.
Housing Insecurity Among Patients With Cancer	This dissemination commentary summarizes the formal presentations and panel discussions from the webinar devoted to housing insecurity. It provides an overview of housing insecurity and health care across the cancer control continuum, describes health system interventions to minimize the impact of housing insecurity on patients with cancer, and identifies challenges and opportunities for addressing housing insecurity and improving health equity.
Transportation	
Addressing Transportation Insecurity Among Patients With Cancer	This commentary summarizes the formal presentations and discussions related to transportation insecurity and will 1) discuss the heterogeneous nature of transportation insecurity among patients with cancer; 2) characterize its prevalence along the cancer continuum; 3) examine its multilevel consequences; 4) discuss measurement and screening tools; 5) highlight ongoing efforts to address transportation insecurity; 6) suggest policy levers; and 7) outline a research agenda to address critical knowledge gaps.
Social Determinants of Health Series: Transportation and the Role of Hospitals | AHA	The AHA's 'Transportation and the Role of Hospitals' guide, one among a series of guides on various social determinants of health, explains the link between transportation and health and discusses the role of hospitals and health systems in addressing transportation issues, improving access and helping design and support better transportation options.
Resources for Reducing Disparities	
Health Equity Challenges and CMS Resources to Help Address Them	This infographic outlines various barriers to health equity and related challenges that populations often face. For each barrier, CMS resources are provided to help close the gap in health equity.
Guide to Reducing Disparities in Readmissions	The Guide to Reducing Disparities in Readmissions provides an overview of key issues related to readmissions for racially and ethnically diverse Medicare Beneficiaries, as well as useful resources for hospitals to take action for addressing readmissions.
Resources for Building Capacity of Health Care Organizations and the Workforce	
Medicare Learning Network	CMS developed and disseminated innovative and promising approaches to support the health care workforce in addressing health disparities and improving the patient experience through provider-focused, accredited trainings supported by the Medicare Learning Network and other platforms. Nearly a dozen provider- focused guides have been produced to help practices take strategic, step-by-step approaches to improving care for vulnerable communities.

Resources	Description
Building an Organizational Response to Health Disparities – Five Pioneers from the Field	In the report, five organizations address how they have made a business case for addressing disparities in health care quality and access. Organizations such as hospitals, health plans, health systems, and others may see their own motivations and challenges reflected in these examples. These case studies increase the evidence base for health organizations in support of building a business case to reduce health disparities.
Improving Health and Well Being through Community Care Hubs	A Health Affairs blog highlighting the value of improving health and well-being through establishing community care hubs –community-focused entities supporting a network of community-based organizations providing services that address individuals' health-related social needs. This blog was co-authored by leaders across the U.S. Department of Health and Human Services.
Partnership to Align Social Care – Community Care Hub Resources	The Partnership to Align Social Care is a national learning and action network that brings together leaders across health plans, health systems, community-based organizations, national associations, philanthropy, and federal agencies to co- design a multi-faceted strategy to enable successful partnerships among health care organizations and community care hubs. A community care hub centralizes administrative functions and operational infrastructure, including contracting with health care organizations, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.
Community Care Hub Contracting Spotlights	These spotlighted examples highlight three community care hubs that have successfully contracted with health plans to offer various services that address health-related social needs. Each spotlight features information on the hub structure, interventions offered, health plan partner(s), and the financial model for the contracted services.

Table 5. Examples of Programs, Directories, and Applications to Address HRSNs

Programs	Description
Food Insecurity	
The Center for Food Equity in Medicine (Chicago, IL)	The Center for Food Equity in Medicine is a nonprofit organization that serves patients with cancer at the University of Chicago Comprehensive Cancer Center and broader Chicago community.
Feed1st Food Pantry Program (Chicago, IL)	Feed1st at the University of Chicago Medical Center is a proven and enduring system of 24 hours a day, 7 days a week, and 365 days a year self-serve, no-barriers food pantries operating in inpatient, emergency, and outpatient areas of a major urban academic medical center. This toolkit to provide hospitals and other healthcare organizations across the country with a proven model to address food insecurity among their patient population.
FindHelp – Search and Connect to Social Care	This is a free housing and transportation resource where viewers can enter their zip code and existing community resources are flagged.
Food to Overcome Outcome Disparities (FOOD) Program (New York, NY)	Food to Overcome Outcome Disparities (FOOD) is a network of medically tailored food pantries, coupled with cancer nutrition education and food navigators, that are embedded in 15 safety net and comprehensive cancer center clinics throughout the Greater New York metropolitan area.
Mobile Pantry, Mobile Food Bank | Feeding America	This program sponsored by Feeding America allows viewers to search by zip code to find their nearest food bank. Food banks help to run mobile pantries across the country.
Shop Simple with MyPlate app	The U.S. Department of Agriculture (USDA) provides details on the MyPlate app, a way for viewers to find savings in their area and discover new ways to prepare budget-friendly foods.
State SNAP-Ed Programs | SNAP-Ed	Patients can contact and visit websites of SNAP-Ed agencies to learn more about free nutrition and physical education opportunities in their communities by state.
USDA Local Food Directories	USDA provides viewers with a search portal to locate farms, farmers markets, and food hubs in close proximity to one's location.
211 | United Way	The 211 network in the United States responds to requests for people looking for help meeting basic needs like housing, food, transportation, and health care.
Housing Instability	
Emergency Rental Assistance Program (ERA)	Treasury's Emergency Rental Assistance (ERA) program has provided communities over $46 billion to support housing stability throughout the COVID-19 pandemic. ERA funds are provided directly to states, U.S. territories, local governments, and, in the case of ERA1, Indian Tribes or their Tribally Designated Housing Entities.
FindHelp – Search and Connect to Social Care	This is a free housing and transportation resource where viewers can enter their zip code and existing community resources are flagged.
Hope Lodge	American Cancer Society Hope Lodge® communities offer a home away from home for people facing cancer and their caregivers when cancer treatment is far away.
Hospital-owned lodging	Certain hospitals offer programs to provide free or reduced-cost lodging to patients during treatment.

Programs	Description
Hosts for Humanity (Baltimore, MD)	Hosts for Humanity connects families and friends of patients traveling to receive medical care with volunteer hosts offering accommodations in their homes.
211 | United Way	The 211 network in the United States responds to requests for people looking for help meeting basic needs like housing, food, transportation, and health care.
Transportation	
FindHelp – Search and Connect to Social Care	This is a free housing and transportation resource where viewers can enter their zip code and existing community resources are flagged.
Non-emergency medical transportation (NEMT) platforms	Non-Emergency Medical Transportation (NEMT) is a state administered program that provides Medicaid beneficiaries with transportation to medical appointments. There are several private corporations focused on NEMT coordination platforms that partner with health-care organizations, health plans, and transportation providers to schedule on-demand patient transportation. Examples include, but are not limited to: Kaizen Health, ModivCare (formerly LogistiCare), MTM, Ride Health, Roundtrip, SafeRide Health, and Southeastrans.
PROgram for Non-emergency TranspOrtation (PRONTO) program (Chicago, IL)	PRONTO is a partnership between the University of Illinois Health and Kaizen Health (a local health-access start-up) that provides free rides to patients being transitioned home from inpatient and ambulatory clinics.
Repetitive Scheduled Non-Emergency Ambulance Transport Medicare Benefit: Operational Guide	This small and specialized Medicare benefit program involves ambulance transportation for those needing at least one round trip per week for at least 3 weeks.
Road to Recovery Program	American Cancer Society's Road to Recovery Program uses volunteer drivers who donate their time and personal automobiles to assist patients with cancer who need a ride to or from a clinical encounter. This program operates in all 50 states.
Veterans Transportation Program (VTP)	VA's Veterans Transportation Program (VTP) offers Veterans many travel solutions to and from their VA health care facilities. This program offers these services at little or no costs to eligible Veterans through the following services: Beneficiary Travel (BT), Veterans Transportation Service (VTS), Highly Rural Transportation Grants (HRTG)
211 | United Way	The 211 network in the United States responds to requests for people looking for help meeting basic needs like housing, food, transportation, and health care.

Note: Although the resources in this table are not endorsed by CMS, they serve as examples that EOM participants can use or adapt to connect their beneficiaries to needed services. There are many more resources available online than are listed here, some of which may be more accessible based on local or state resources. In addition to the sources above, CMS encourages EOM participants to develop community partnerships to help identify and address HRSNs. Practices are encouraged to share any resources not included in the above table with CMS so that they may be included in future updates.

Section 6: Additional EOM Resources

CMS EOM Website

- https://innovation.cms.gov/innovation-models/enhancing-oncology-model

EOM Connect:

- https://app.innovation.cms.gov/CMMIConnect/IDMLogin

EOM Support:

- EOMSupport@cms.hhs.gov
- 1-888-734-6433 option 3

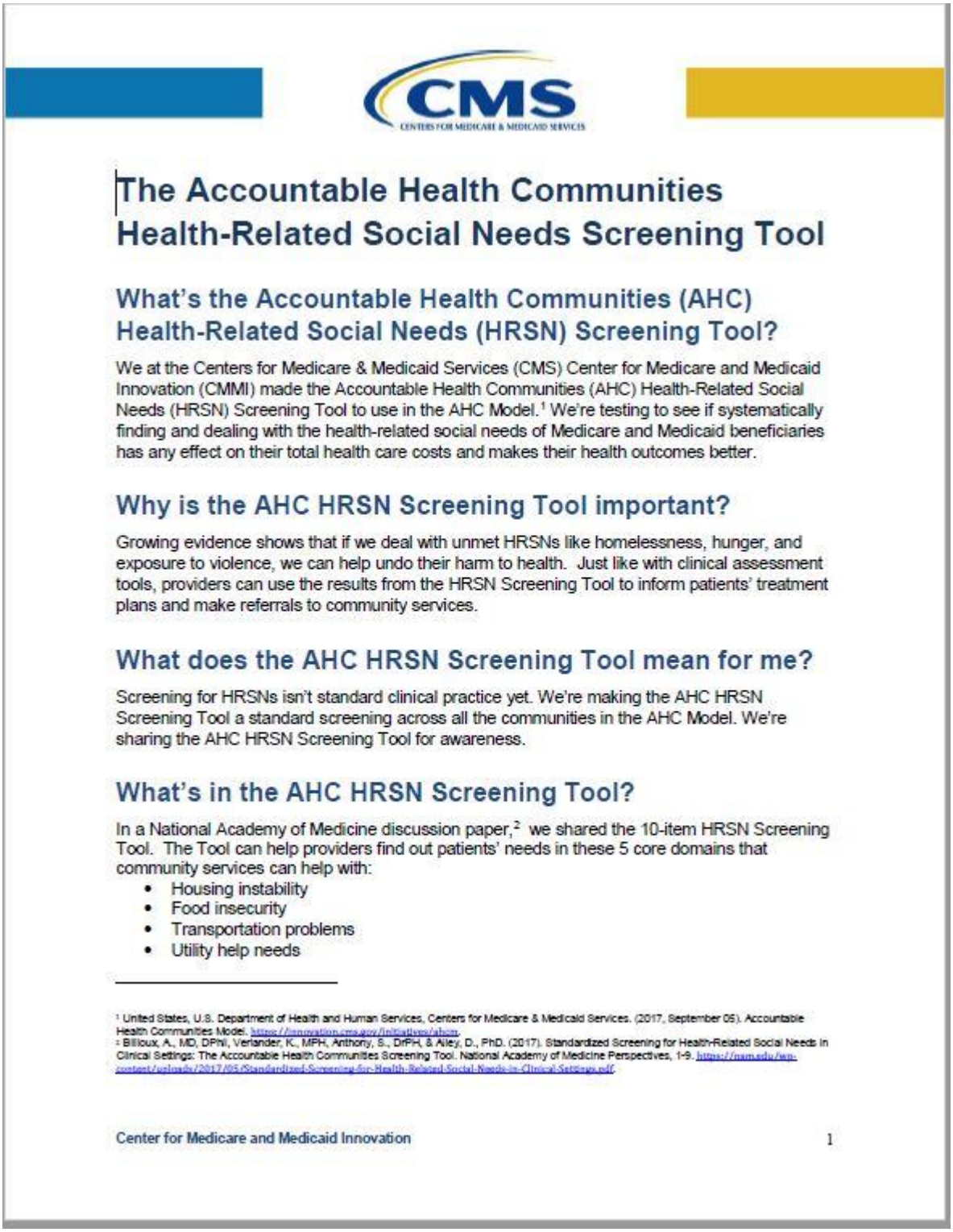
Appendix A: Acronyms and Abbreviations

Acronym	Literal Translation
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
Drivers of Health	DOH
HER	Electronic Health Record
EOM	Enhancing Oncology Model
FFS	Fee-For-Service
FHIR	Fast Healthcare Interoperability Resources
HCPCS	Healthcare Common Procedure Coding System
HDR	Health Data Reporting
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
LOINC	Logical Observation Identifiers Names and Codes
ePROs	Electronic Patient-Reported Outcomes
E&M	Evaluation and Management
HEP	Health Equity Plan
HRSN	Health-Related Social Needs
NCCN	National Comprehensive Cancer Network
OCM	Oncology Care Model
PA	Participation Agreement
PGP	Physician Group Practice
PRA	Participant Redesign Activity
PRO	Patient Reported Outcome
SDOH	Social Determinants of Health
SNOWMED	Systemized Nomenclature of Medicine

Appendix B: Example HRSN Screening Instruments by HRSN Domain

Assessment Instruments by Domain
Housing Stability (including homelessness and housing adequacy) • Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool • American Academy of Family Physicians (AAFP) Social Needs Screening Tool • Health Leads Screening Panel® • The North Carolina Department of Health and Human Services (NC-DHHS) Social Determinants of Health (SDoH) Screening Questions • Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]® • We Care Survey • WellRx Questionnaire
Food Security • Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool • American Academy of Family Physicians (AAFP) Social Needs Screening Tool • Health Leads Screening Panel® • The North Carolina Department of Health and Human Services (NC-DHHS) Social Determinants of Health (SDoH) Screening Questions • Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]® • We Care Survey • WellRx Questionnaire • Hunger Vital Sign™ (HVS) • U.S. Household Food Security (SNPs can select questions from the 18-, 10-, or six-item surveys)
Access to Transportation • Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool • American Academy of Family Physicians (AAFP) Social Needs Screening Tool • Health Leads Screening Panel® • The North Carolina Department of Health and Human Services (NC-DHHS) Social Determinants of Health (SDoH) Screening Questions • Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences [PRAPARE]® • WellRx Questionnaire • Comprehensive Universal Behavior Screen (CUBS)

Appendix C: Accountable Health Communities (AHC) Screening Tool



The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

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[1] United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm

[2] Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

Center for Medicare and Medicaid Innovation 1

- Interpersonal safety

In the final version below, we made small revisions to the original 10 questions based on cognitive testing we did since we shared the first version. In the final version we also included questions in 8 supplemental domains that we haven't shared before:

- Financial strain
- Employment
- Family and community support
- Education
- Physical activity
- Substance use
- Mental health
- Disabilities

Who should use the AHC HRSN Screening Tool?

The questions in the AHC HRSN Screening Tool are meant to be used for individual respondents who answer the questions themselves. A parent or caregiver can answer for an individual, too, if that makes more sense. Clinicians and their staff can easily use this short tool as part of their busy clinical workflows with people of all different ages, backgrounds, and settings.

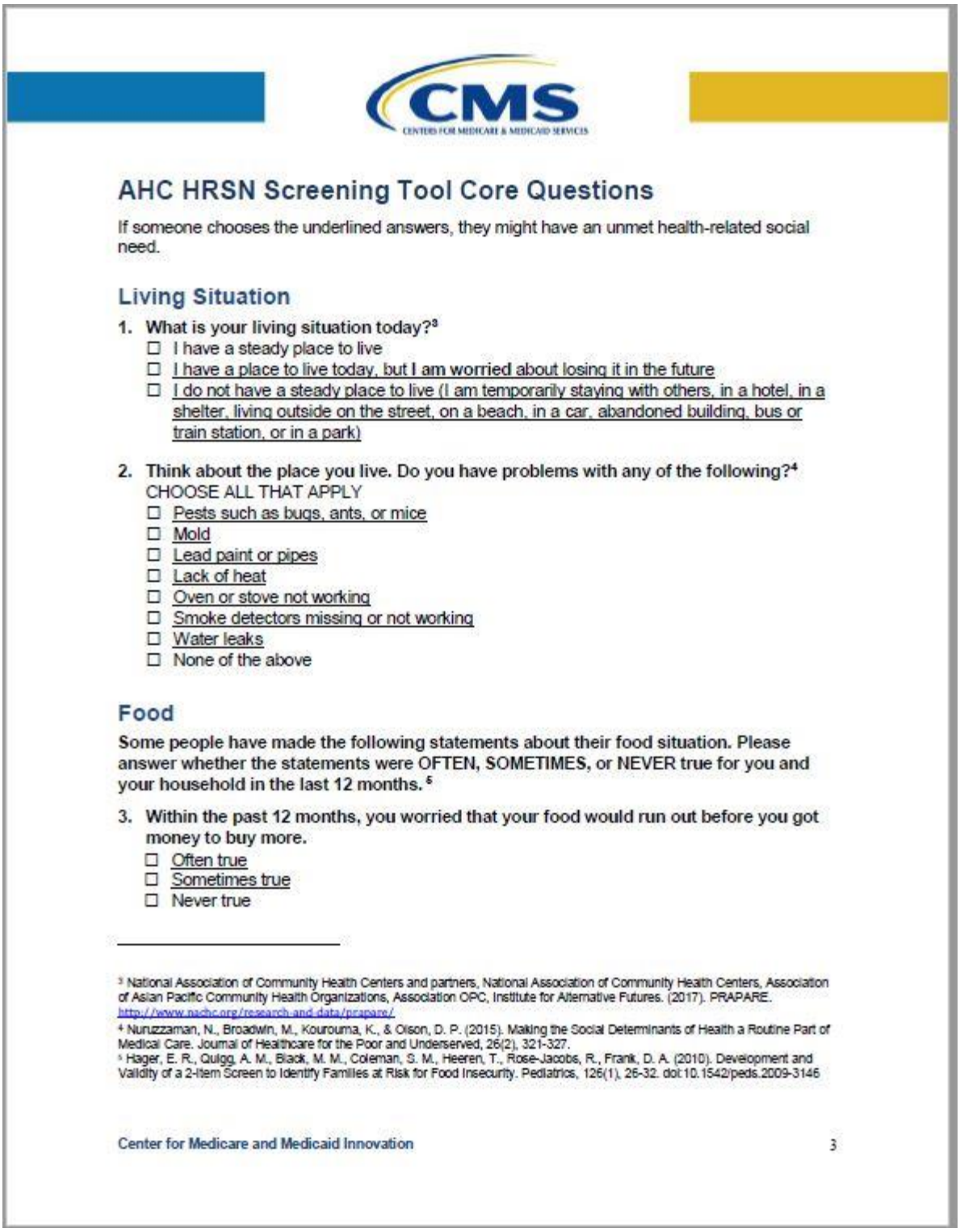
In the next 5 years, hundreds of participating clinical delivery sites across the 32 AHCs will screen over 7 million Medicare and Medicaid beneficiaries using the 10 core domain questions. The AHCs can also choose to add any of the supplemental domain questions into their standard screening processes.

Who made the AHC HRSN Screening Tool?

We made this tool with a panel of experts from around the country including:

- Tool developers
- Public health and clinical researchers
- Clinicians
- Population health and health systems executives
- Community-based organization leaders
- Federal partners

We got permission from the original authors of the questions to use, copy, modify, publish, and distribute the questions for the AHC Model and our use only. Based on feedback from the original question authors, CMS has created this table to specify the citation and notification process for each screening question in the AHC HRSN Screening Tool if the questions are used outside of CMS and the AHC Model.



AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ 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)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

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[3] National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

[4] Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D. P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

[5] Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Frank, D. A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146

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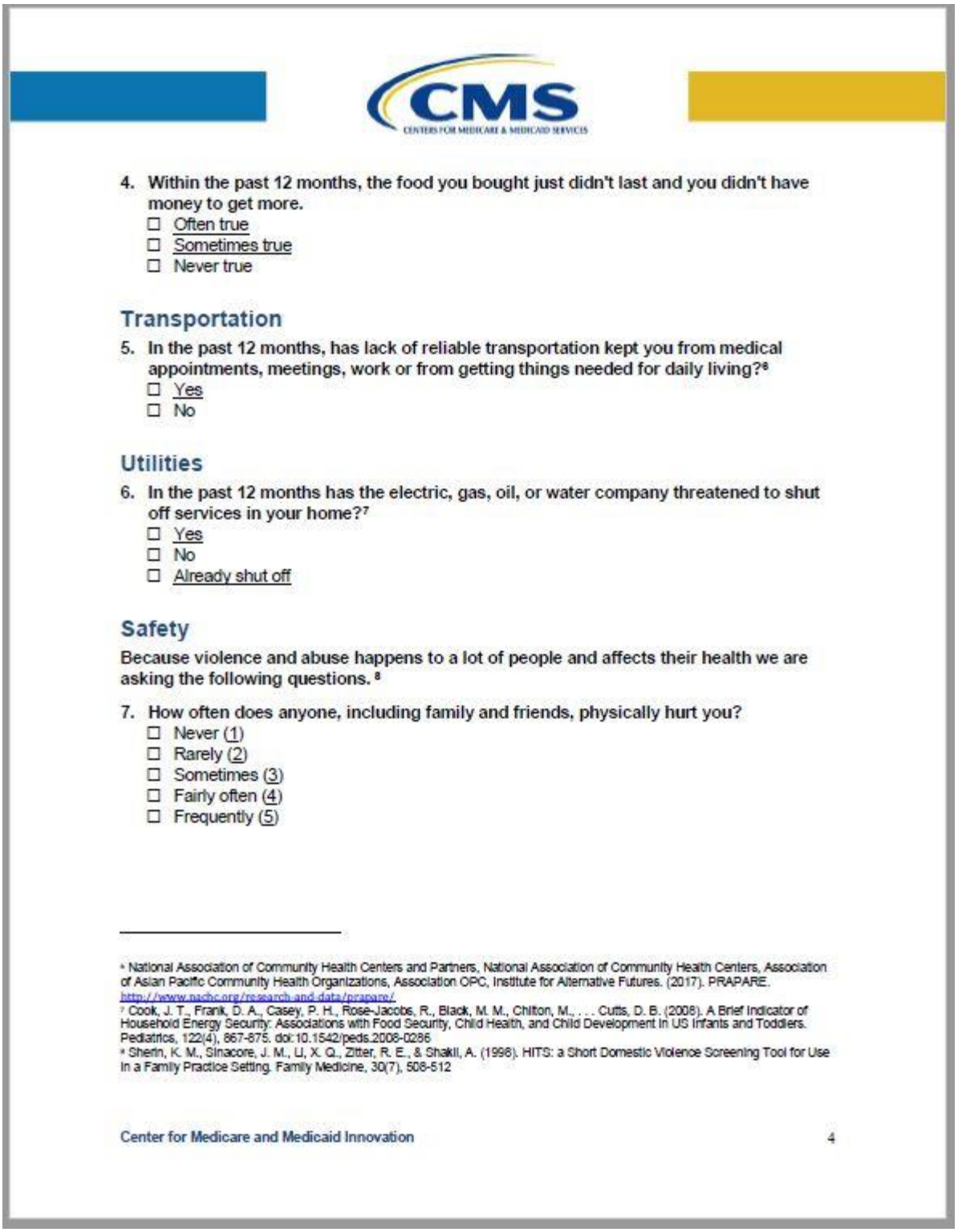

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Transportation

5. **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?[6]**
   - ☐ Yes
   - ☐ No

Utilities

6. **In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[7]**
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions. [8]

7. **How often does anyone, including family and friends, physically hurt you?**
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

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[6] National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

[7] Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., . . . Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286

[8] Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512

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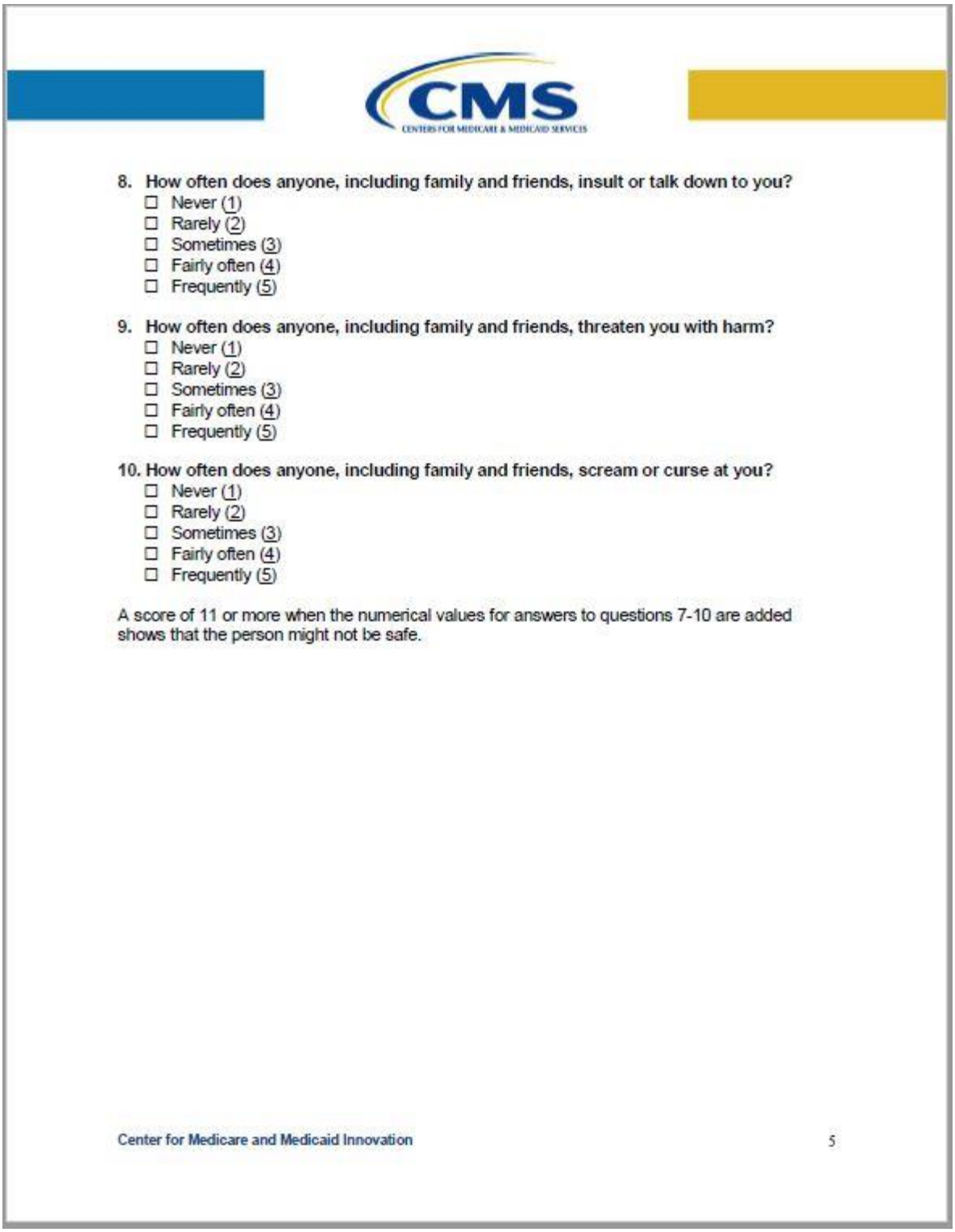

8. How often does anyone, including family and friends, insult or talk down to you?
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

9. How often does anyone, including family and friends, threaten you with harm?
   - ☐ Never (1)
   - ☐ Rarely (2)
   - ☐ Sometimes (3)
   - ☐ Fairly often (4)
   - ☐ Frequently (5)

10. How often does anyone, including family and friends, scream or curse at you?
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

A score of 11 or more when the numerical values for answers to questions 7-10 are added shows that the person might not be safe.

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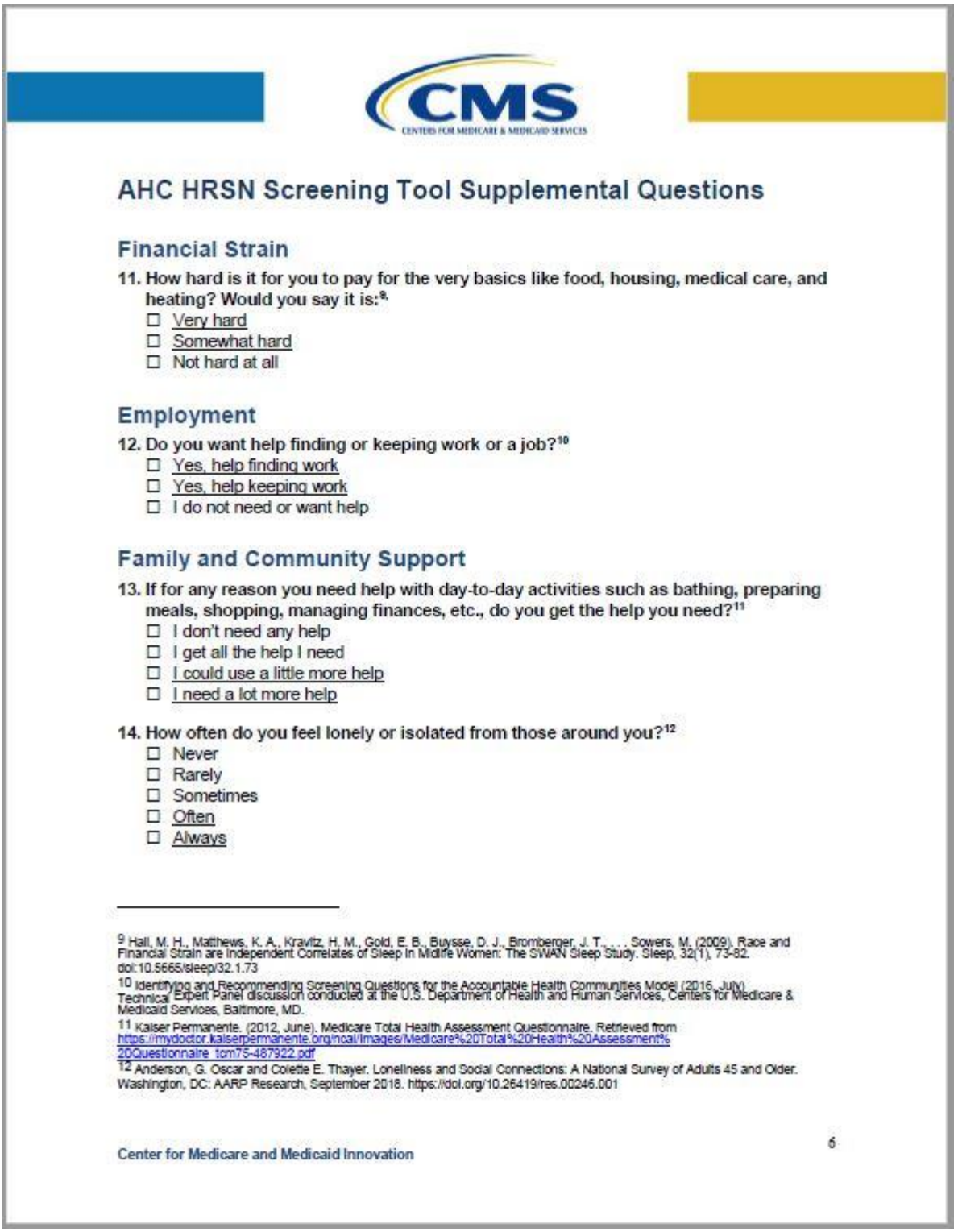

AHC HRSN Screening Tool Supplemental Questions

Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:[9]

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

Employment

12. Do you want help finding or keeping work or a job?[10]

- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ I do not need or want help

Family and Community Support

13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?[11]

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

14. How often do you feel lonely or isolated from those around you?[12]

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

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[9] Hall, M. H., Matthews, K. A., Kravitz, H. M., Gold, E. B., Buysse, D. J., Bromberger, J. T., . . . Sowers, M. (2009). Race and Financial Strain are Independent Correlates of Sleep in Midlife Women: The SWAN Sleep Study. Sleep, 32(1), 73-82. doi:10.5665/sleep/32.1.73

[10] Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July). Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

[11] Kaiser Permanente. (2012, June). Medicare Total Health Assessment Questionnaire. Retrieved from https://mydoctor.kaiserpermanente.org/ncal/Images/Medicare%20Total%20Health%20Assessment%20Questionnaire_tcm75-487922.pdf

[12] Anderson, G. Oscar and Colette E. Thayer. Loneliness and Social Connections: A National Survey of Adults 45 and Older. Washington, DC: AARP Research, September 2018. https://doi.org/10.26419/res.00246.001

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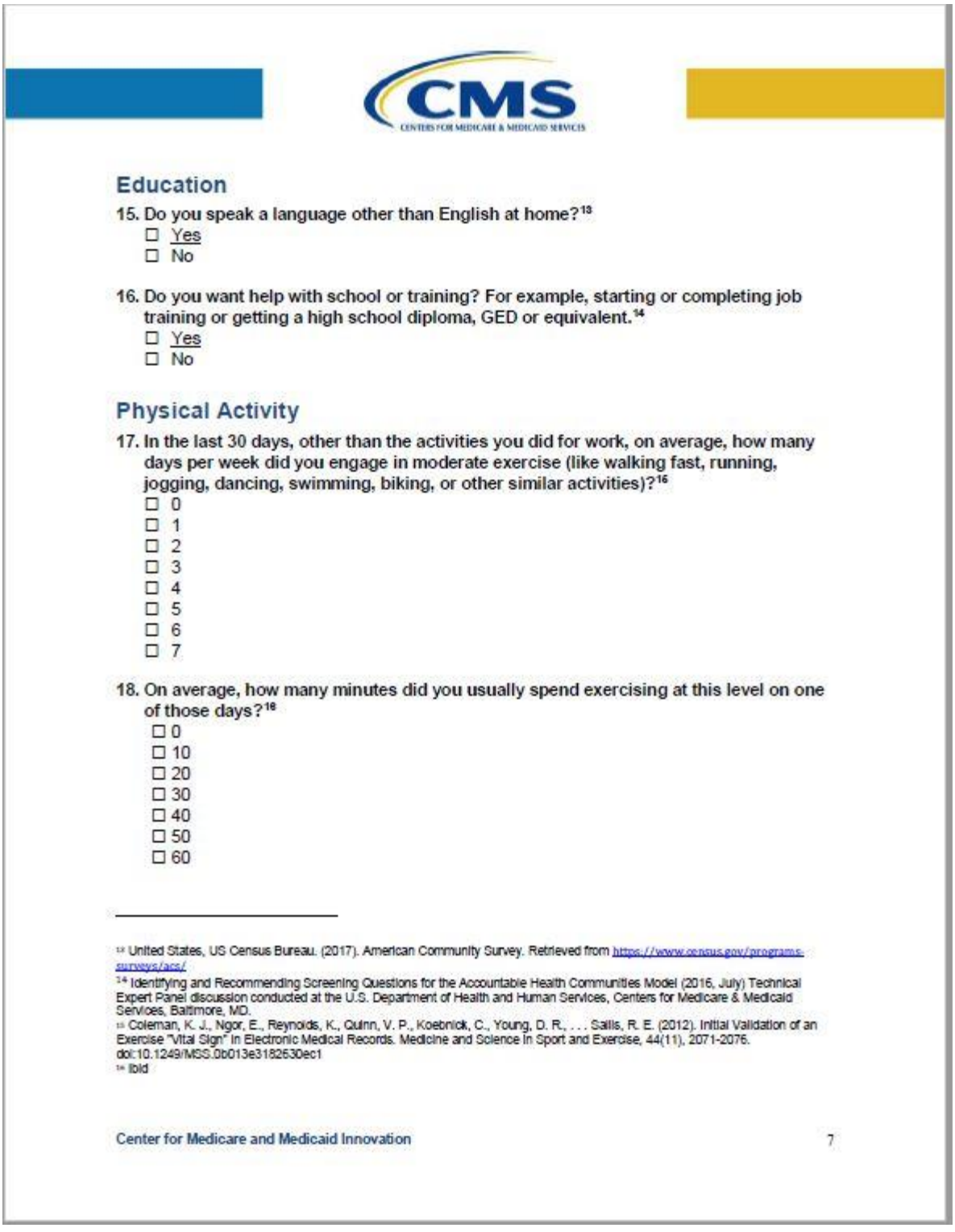

Education

15. Do you speak a language other than English at home?[13]
    - ☐ Yes
    - ☐ No

16. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.[14]
    - ☐ Yes
    - ☐ No

Physical Activity

17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?[16]
    - ☐ 0
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4
    - ☐ 5
    - ☐ 6
    - ☐ 7

18. On average, how many minutes did you usually spend exercising at this level on one of those days?[16]
    - ☐ 0
    - ☐ 10
    - ☐ 20
    - ☐ 30
    - ☐ 40
    - ☐ 50
    - ☐ 60

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[13] United States, US Census Bureau. (2017). American Community Survey. Retrieved from https://www.census.gov/programs-surveys/acs/

[14] Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

[15] Coleman, K. J., Ngor, E., Reynolds, K., Quinn, V. P., Koebnick, C., Young, D. R., . . . Sallis, R. E. (2012). Initial Validation of an Exercise "Vital Sign" in Electronic Medical Records. Medicine and Science in Sport and Exercise, 44(11), 2071-2076. doi:10.1249/MSS.0b013e3182630ec1

[16] Ibid

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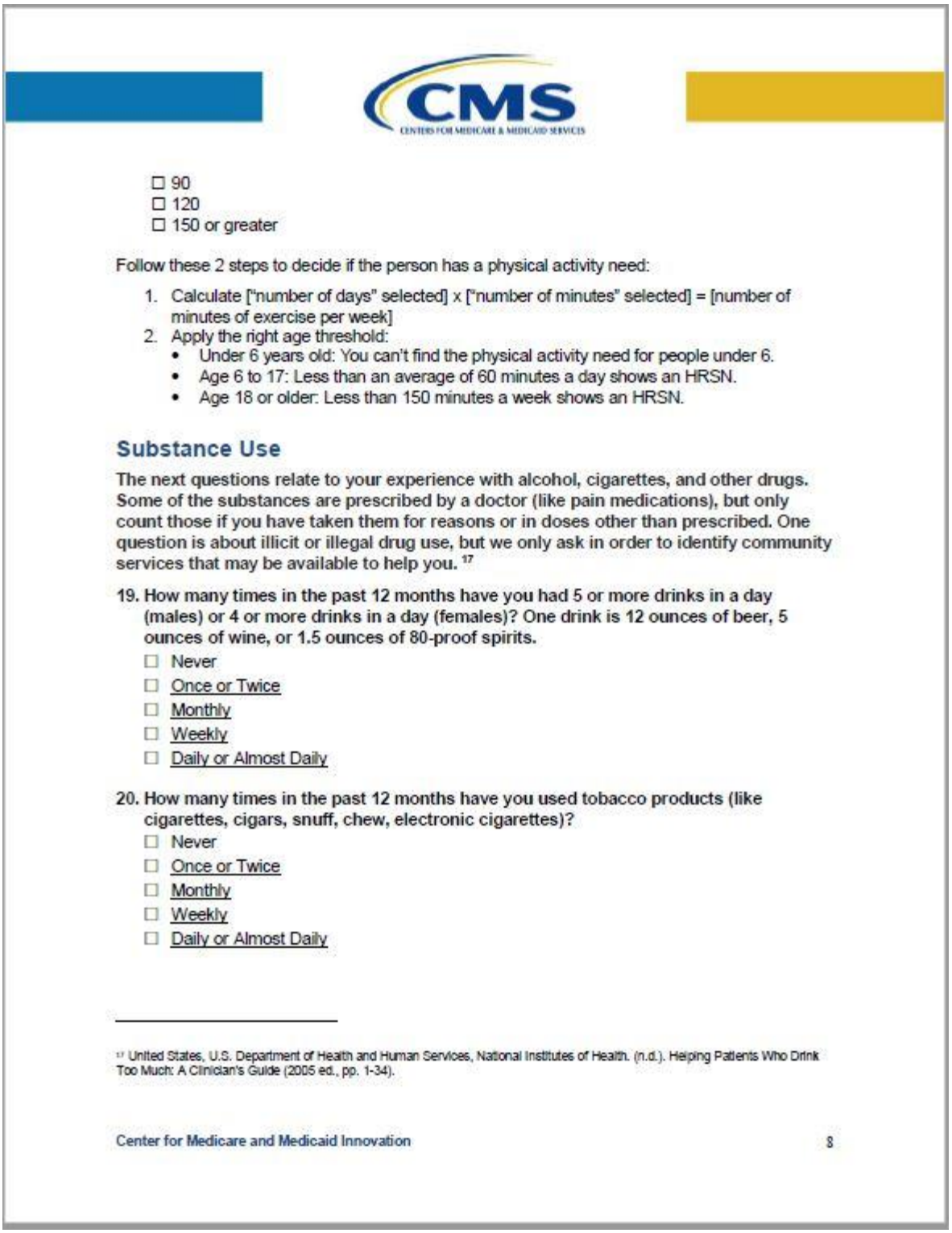

☐ 90
☐ 120
☐ 150 or greater

Follow these 2 steps to decide if the person has a physical activity need:

1. Calculate ["number of days" selected] x ["number of minutes" selected] = [number of minutes of exercise per week]
2. Apply the right age threshold:
   - Under 6 years old: You can't find the physical activity need for people under 6.
   - Age 6 to 17: Less than an average of 60 minutes a day shows an HRSN.
   - Age 18 or older: Less than 150 minutes a week shows an HRSN.

Substance Use

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you. [17]

19. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

20. How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

☐ Never
☐ Once or Twice
☐ Monthly
☐ Weekly
☐ Daily or Almost Daily

[17] United States, U.S. Department of Health and Human Services, National Institutes of Health. (n.d.). Helping Patients Who Drink Too Much: A Clinician's Guide (2005 ed., pp. 1-34).

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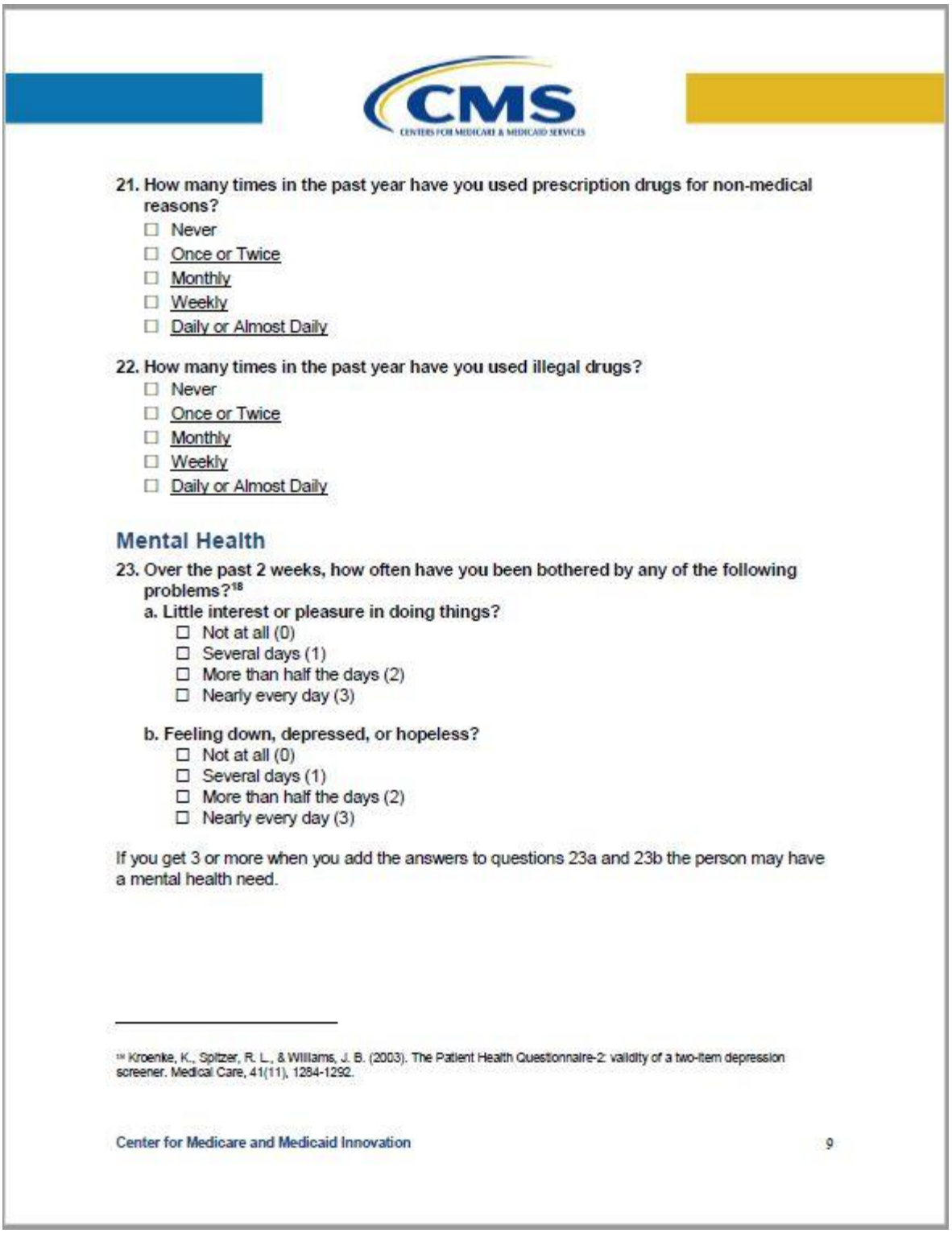

21. How many times in the past year have you used prescription drugs for non-medical reasons?
- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

22. How many times in the past year have you used illegal drugs?
- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Mental Health

23. Over the past 2 weeks, how often have you been bothered by any of the following problems?[18]

a. Little interest or pleasure in doing things?
- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

b. Feeling down, depressed, or hopeless?
- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

If you get 3 or more when you add the answers to questions 23a and 23b the person may have a mental health need.

[18] Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care, 41(11), 1284-1292.

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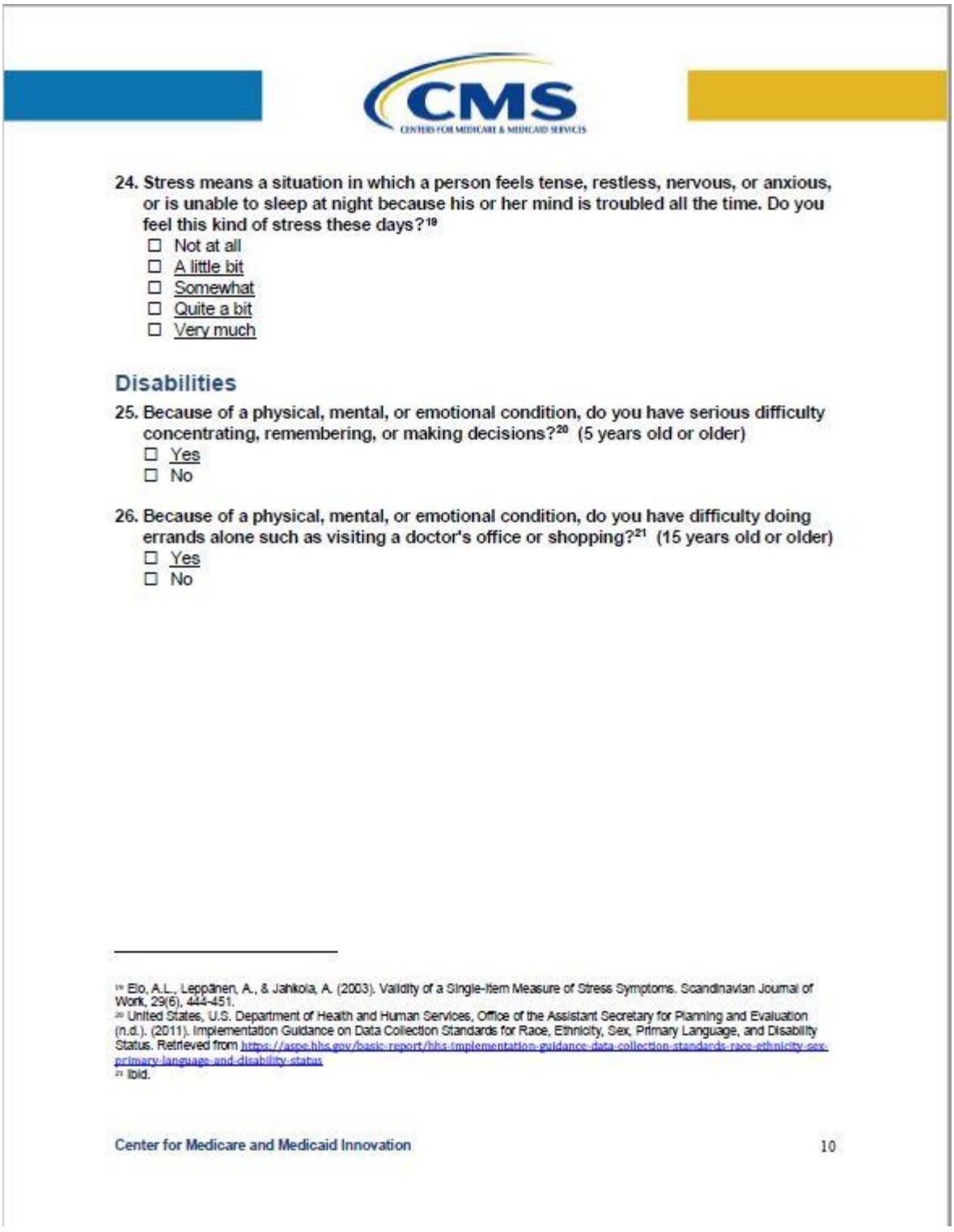

24. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?[19]
    - ☐ Not at all
    - ☐ A little bit
    - ☐ Somewhat
    - ☐ Quite a bit
    - ☐ Very much

Disabilities

25. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?[20] (5 years old or older)
    - ☐ Yes
    - ☐ No

26. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?[21] (15 years old or older)
    - ☐ Yes
    - ☐ No

[19] Elo, A.L., Leppänen, A., & Jahkola, A. (2003). Validity of a Single-Item Measure of Stress Symptoms. Scandinavian Journal of Work, 29(6), 444-451.
[20] United States, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (n.d.). (2011). Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. Retrieved from https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status
[21] Ibid.

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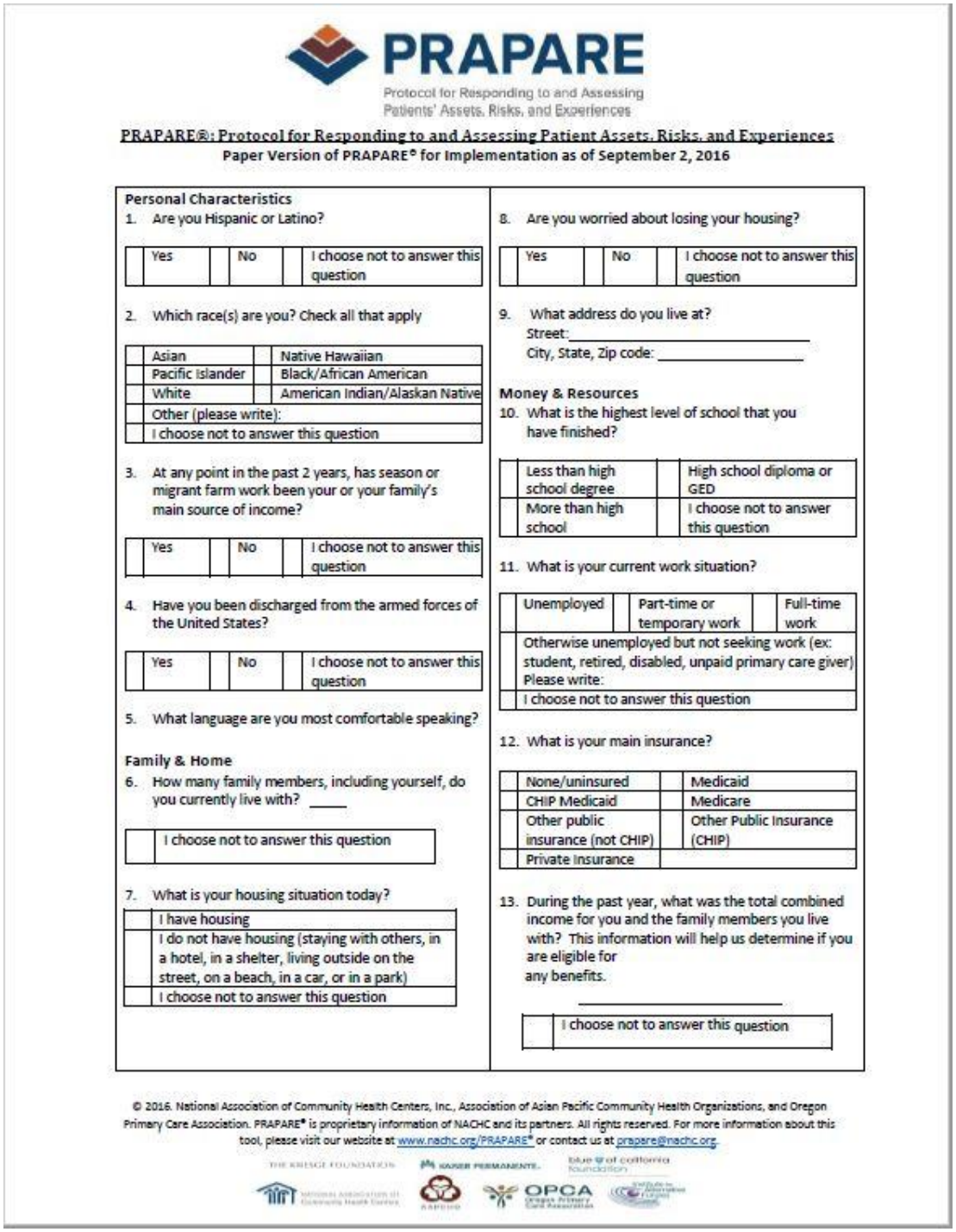
Appendix D: Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)



PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? ____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	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)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street: _____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

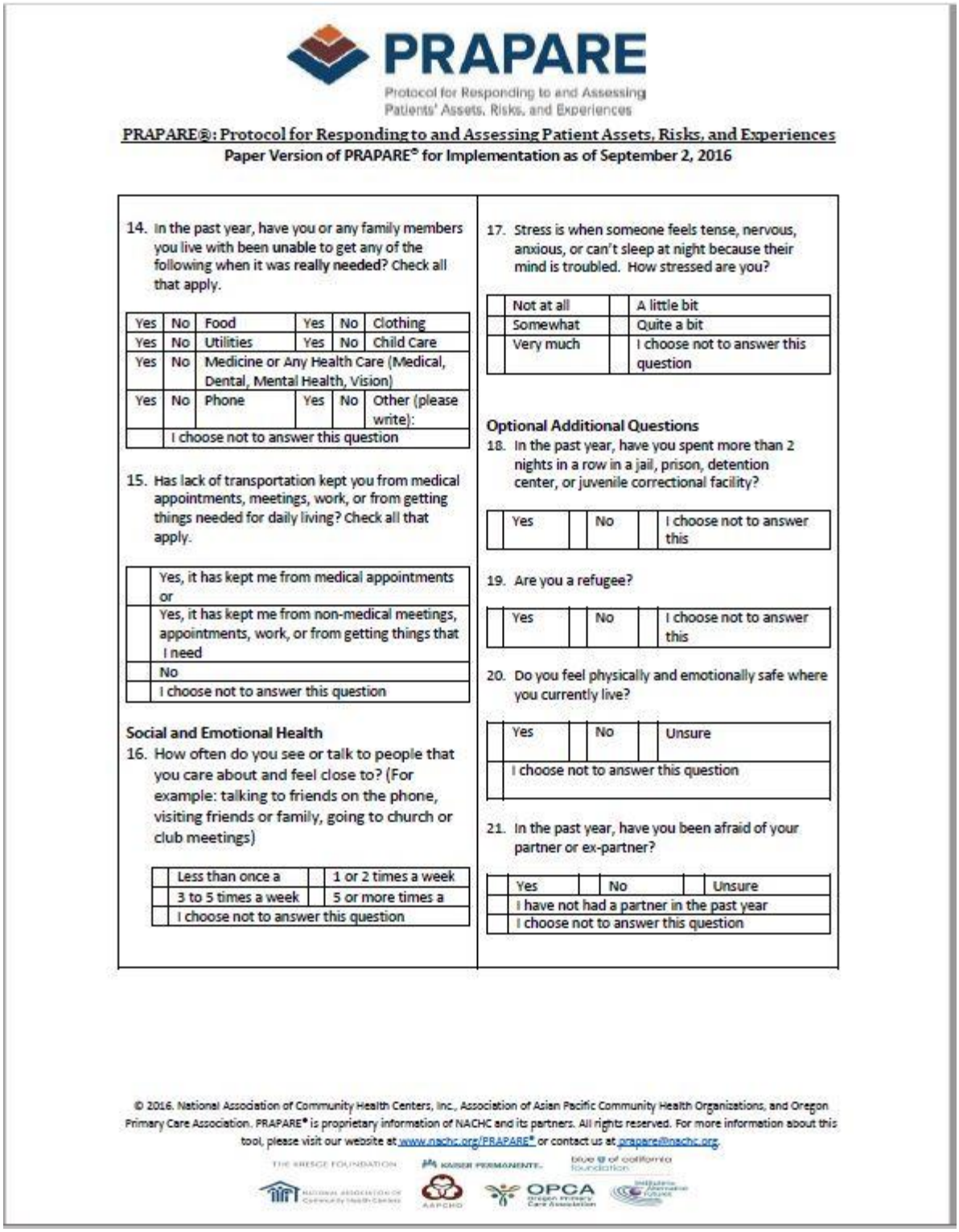
12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

	I choose not to answer this question



PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE© for Implementation as of September 2, 2016

14. 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.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
		I choose not to answer this question			

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a		1 or 2 times a week
	3 to 5 times a week		5 or more times a
	I choose not to answer this question		

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this

19. Are you a refugee?

	Yes		No		I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

Appendix E: The NCCN Distress Thermometer and Problem List

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2023
Distress Management

NCCN Guidelines Index
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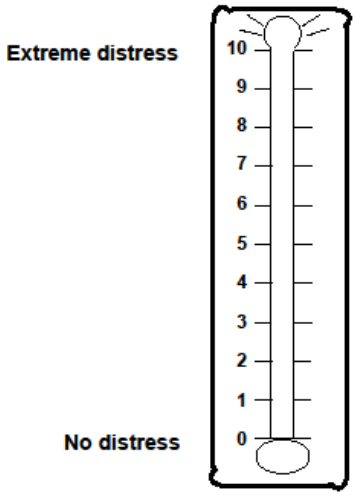
Discussion

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.



PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns
- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns
- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns
- ❑ Relationship with spouse or partner
- ❑ Relationship with children
- ❑ Relationship with family members
- ❑ Relationship with friends or coworkers
- ❑ Communication with health care team
- ❑ Ability to have children

Practical Concerns
- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Work
- ❑ School
- ❑ Housing
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns
- ❑ Sense of meaning or purpose
- ❑ Changes in faith or beliefs
- ❑ Death, dying, or afterlife
- ❑ Conflict between beliefs and cancer treatments
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns:

_____

_____

_____

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

DIS-A

Appendix F: Core Elements of Patient Navigation in EOM

Note: This language is also included in Appendix B of the EOM PA.

As part of the PRAs, Provide patient navigation, as appropriate, to Eligible Beneficiaries.

1. The EOM Participant must provide access to the core functions of patient navigation, as appropriate, to all Eligible Beneficiaries, including:

   i. Coordinating appointments with health care providers to ensure timely delivery of diagnostic and treatment services;

   ii. Maintaining communication with Eligible Beneficiaries, families, and health care providers to monitor Eligible Beneficiary satisfaction with the cancer care experience and provide health education;

   iii. Ensuring that appropriate medical records are available at scheduled appointments;

   iv. Providing language translation or interpretation services in accordance with applicable laws or regulations;

   v. Facilitating linkages to follow-up services and community resources (e.g., referring Eligible Beneficiaries to cancer survivor support groups and community organizations or other third parties that provide child/elder care, transportation, or financial support); and

   vi. Providing access, as possible, to clinical trials as medically appropriate.

2. The EOM Participant may include additional patient navigation functions in an effort to improve the quality of care. The functions of patient navigation may be split among the staff (i.e., there does not need to be a specific staff member designated as a patient navigator).

3. The EOM Participant must certify at least annually to which patient navigation services it provides to Eligible Beneficiaries and which staff is providing the services.

4. The EOM Participant must provide evidence (e.g., documentation within the EHR) to CMS of patient-level interventions of each of the relevant core functions provided by the EOM Participant during site visits and medical record review