



VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER



INFRASTRUCTURE



CARE DELIVERY



PEOPLE

SOCIAL DRIVERS OF HEALTH

WHY consider the Social Drivers of Health?

Health centers, by virtue of their mission and model, play a pivotal role in addressing Social Drivers of Health (SDOH) among medically underserved patients nationwide. Signed into law in 1964 as part of President Lyndon B. Johnson's 'war on poverty', health centers serve patients and communities at greater risk of preventable chronic and other diseases¹⁻³.

Social drivers of health are the conditions in which people are born, grow, work, live, and age. SDOH are non-medical conditions that include social, economic, physical, or other factors present in people's lives. These factors have been found to directly influence health, functioning, and quality of life outcomes and risks⁴⁻¹².

Research shows that social drivers, also called social risks, may have a greater influence on health and health equity than lifestyle choices or health care, with some studies suggesting that SDOH may account for 30-55% of health outcomes¹³.

The movement of health systems toward value-based care provides significant opportunities to address SDOH while improving value and quality of care¹⁴. Value-based care is a potentially important financing mechanism for SDOH services with opportunities for long-term sustainability and population health improvements¹⁴.

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The Value Transformation Framework addresses how health centers can use a systematic process to address the social, economic, and environmental circumstances that influence patients' health and the care they receive. This Action Guide offers a set of action steps health centers can take to integrate social risk assessment and interventions as part of organizational transformation.

WHAT can health centers do to address social risk?

SDOH include such factors as income, education, employment, food, housing, and social inclusion and non-discrimination. Healthy People 2030 groups SDOH into 5 domains⁴:

- Economic stability
- Education access and quality
- Health care access and quality
- Neighborhood and built environment
- Social and community context



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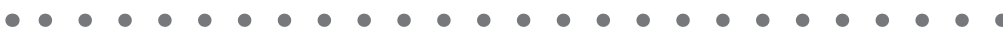
The community health center model and mission, including a patient majority board, strongly positions health centers to address SDOH in medically underserved communities, and:

- Identify the social drivers impacting the local community and target populations
- Screen individuals for social risk factors
- Design interventions to address identified social risks factors
- Design models of care and services that support health equity
- Form partnerships that enhance the community's ability to address social risk factors
- Demonstrate value to payors by incorporating SDOH into care and reimbursement models

A number of SDOH measures appear within health center reporting requirements of the [Uniform Data System](#). This data is a starting point for health center efforts to collect SDOH data and develop interventions to address identified patient needs.

Sample of UDS Reporting for Social Risks	
<p>Table 3B: Demographic Characteristics</p> <p>Address Race Ethnicity Patients best served in a language other than English Sexual Orientation Gender Identity</p>	<p>APPENDIX D: Health Center HIT Capabilities</p> <p><i>Sample social risk questions on the HIT Form required as part of UDS submission:</i></p> <p>Does your health center collect data on individual patients' social risk factors, outside of the data countable in the UDS?</p> <p>How many health center patients were screened for social risk factors using a standardized screener during the calendar year?</p> <p>Which standardized screener(s) for social risk factors, if any, did you use during the calendar year?</p> <p>Of the total patients screened for social risk factors, please provide the total number of patients that screened positive for any of the following at any point during the calendar year:</p> <ul style="list-style-type: none"> • Food Insecurity • Housing Insecurity • Financial Strain • Lack of Transportation/Access to Public Transportation <p>If you DO NOT use a standardized screener to collect this information, please indicate why.</p>
<p>Table 4: Selected Patient Characteristics</p> <p>Income Level Insurance Special Populations (Agricultural Workers, Homeless, Veterans, Accessible Public Housing)</p>	
<p>Table 6A: Selected Diagnosis and Services Rendered</p> <p>Human Trafficking T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42</p> <p>Intimate Partner Violence T74.11, T74.21, T74.31, Z69.11</p>	

[Uniform Data System 2022 Manual Health Center Data Reporting Requirements](#)





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HOW

health centers can collect and respond to SDOH?

This Action Guides outlines a series of steps health centers can take to collect and respond to social risk data.

- STEP 1** **Engage leadership and Board members in prioritizing SDOH efforts:** In setting SDOH as a priority, leadership identifies a staff lead for SDOH screening and intervention processes, supported by an interdisciplinary implementation team.
- STEP 2** **Understand social risk factors in your community:** Review health center needs assessment and population level data sources to understand prevalent social risk factors in your community.
- STEP 3** **Identify community resources to address social risks:** Develop a resource list that identifies internal and external community resources available to address social risk factors.
- STEP 4** **Design a workflow for SDOH screening:** Workflow elements include: selection of a tool and target population(s), how, when, and where in the visit process to collect information, and documentation.
- STEP 5** **Design a workflow for interventions in response to identified SDOH needs:** Workflow elements include the role of staff related to interventions, follow-up of interventions, and documentation.
- STEP 6** **Train health center staff:** Provide training to staff on SDOH workflows and techniques to screen and provide interventions related to sensitive subjects.
- STEP 7** **Optimize billing opportunities:** Explore opportunities to bill for SDOH screening and interventions.
- STEP 8** **Collect and monitor SDOH data over time; use data to inform practice transformation:** Collect and track SDOH data over time and incorporate into risk stratification processes to inform care models and service delivery.
- STEP 9** **Leverage SDOH data to drive value-based payment and reimbursement:** Share SDOH findings with payors, key partners, and policymakers to drive value-based contracting and payment models.

STEP 1 **Engage leadership and Board members in prioritizing SDOH efforts.** Engage health center leadership, Board members, and other stakeholders in SDOH efforts, highlighting the ways this work aligns with existing organizational priorities and adds value to patients, the health center, and the community. Attention to SDOH supports the Quintuple Aim: improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity.

Leadership is responsible for identifying a staff lead responsible for the design and delivery of SDOH screening and intervention processes. A staff leader can integrate SDOH screening and interventions into health center workflows and develop an interdisciplinary team representing varying roles and expertise (e.g., provider, front office, community health worker, quality improvement, and IT) to achieve related goals.



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See NACHC's [Leadership Action Guide](#) for additional engagement strategies. Page 12 of the [PRAPARE® Implementation and Action Toolkit](#) offers examples of how to communicate with staff and patients about targeted SDOH efforts.



Action Step: Engage leadership and Board members in prioritizing SDOH processes.

SDOH is stated as an organizational priority with allocated staff and resources. An identified staff lead oversees screening and intervention processes with support from an interdisciplinary implementation team.

STEP 2

Understand social risk factors in your community. An effective SDOH strategy is based on an understanding of the prevalent social risk factors in the local community served by your health center. Community level social risk data informs strategies for social risk screening and interventions. This data can come from a variety of sources.

Begin your SDOH strategy by reviewing data collected for the needs assessment required as part of HRSA health center program requirements. This needs assessment is completed at least once every three years to inform and improve the delivery of health center services (HRSA). Needs assessments address:

- Factors associated with access to care and health care utilization (for example, geography, transportation, occupation, transience, unemployment, income level, educational attainment)
- The most significant causes of morbidity and mortality (for example, diabetes, cardiovascular disease, cancer, low birth weight, behavioral health) as well as any associated health disparities
- Any other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care (for example, social factors, the physical environment, cultural/ethnic factors, language needs, housing status)

For more information on this health center program requirement, see [Chapter 3: Needs Assessment](#) of the HRSA Health Center Program Compliance Manual.

As part of, or in addition to, the HRSA-required needs assessment, health centers can access a robust array of public data on your community's social risk^{5, 15-21}. These include:

- [County Health Rankings](#) – provides annual data on vital health factors such as high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births.
- [Multidimensional Deprivation Index \(MDI\)](#) – measures poverty and deprivation along six dimensions: standards of living, education, health, economic security, housing quality, and neighborhood quality.
- [National Environmental Public Health Tracking Network](#) – gathers and tracks health and environmental data from the national, state, and county levels. This Centers for Disease Control and Prevention (CDC) tool allows users to search and download data in maps, charts, and tables. Dashboards such as the Environmental Justice Dashboard are also accessible.
- [Neighborhood Atlas®](#) - uses the Area Deprivation Index (ADI) to rank neighborhoods by socioeconomic disadvantage. Factors included are income, education, employment, and housing quality.



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- [PLACES: Local Data for Better Health](#) – provides health data for all counties, incorporated and census designated places, census tracts, and zip code tabulation areas. Offers an interactive map of 29 chronic disease related measures. This data is aggregated through a collaboration between the CDC, the Robert Wood Johnson Foundation, and the CDC Foundation.
- [Social Vulnerability Index \(SVI\)](#) – measures social vulnerability by census tracts. CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) use U.S. Census data to determine social vulnerability on 16 factors mapped into four themes: socioeconomic status, household characteristics, racial and minority status, and housing type/ transportation.
- [AHRQ Social Determinants of Health Database](#) – offers a SDOH database created under a Patient Centered Outcomes Research (PCOR) Trust fund project. Data, available for download and analysis, corresponds to five SDOH domains: social, economic, and healthcare context, education, and physical infrastructure and can be linked to county, zip code, and census tract data.
- [HDPulse](#) - provides interactive graphics and maps to visualize health disparities within a state or county, managed by the National Institute on Minority Health and Health Disparities. A section on practice-based interventions and research is being developed.



Action Step: Understand social risk factors in your community. Review health center needs assessment and population level data to understand prevalent social risk factors for your service area. Use social risk data from multiple sources to drive your targeted SDOH strategy.

STEP 3

Identify community resources to address social risks. Informed by data on the social risk factors affecting your health center's service area, compile a list of resources and service providers to support a response. Some needs may be addressed within the health center, while other needs may require outside organizations and partners. Develop a resource list divided by service-type and identify internal and external resources that staff can refer to when addressing a patient's social needs. This resource list can include:

- local housing organizations
- transportation resources
- job-training programs
- mental health programs
- childcare or eldercare providers
- addiction recovery programs
- food banks
- other similar providers

Include contact information for each resource (address, phone number, email and contact name, if available).



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Consider organizations that can help you create a social risk resource list. These organizations maintain up-to-date information on a variety of resources, by community or zip code²²⁻²³. Examples include:

- [211](#) – offers web, phone, and text search options to connect individuals to local resources and services. Operated through a network of more than 200 organizations across the country.
- [The EveryONE Project Neighborhood Navigator](#) – suggests resources for food, housing, transportation, employment, and other services, by zip code. Uses same search engine as Findhelp.org and AuntBertha.com.

In instances where community resources may not exist for identified social risk factors, health centers should continue to assess need and collect data. This data can help inform new resources and services developed by the health center or community organizations in the future.



Action Step: Identify community resources to address social risks. Develop a resource list, or share information about existing databases, to inform patients about services provided at the health center or within the community that could address their SDOH needs.

STEP 4

Design a workflow for SDOH screening. SDOH screening, and the targeted interventions that follow, requires a team-based approach. Begin by creating a step-by-step workflow for how SDOH screening will be integrated into health center processes.

When designing your screening workflow, be sure to address the following elements:

- **Select the SDOH screening tool.** NACHC in collaboration with the Association of the Asian Pacific Community Health Organizations (AAPCHO) and the Oregon Primary Care Association (OPCA) developed a standardized patient risk assessment tool called the [Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences \(PRAPARE®\)](#) to offer a uniform process to collected data on SDOH. PRAPARE® includes 21 questions with 16 core measures designed to engage patients and assess their social drivers of health. For this Action Guide, the [PRAPARE® Assessment Tool & Toolkit](#) are used to illustrate examples, although health centers may utilize any SDOH screening tool.
- **Define target population.** If implementing SDOH screening is new to your health center, it is recommended that you test a draft workflow with a sample target population to allow for process improvement before expanding this workflow to your entire patient population. For example, you may choose to focus first on the patient panel(s) of one or two providers who are highly engaged and supportive of this new initiative, choose patients who are engaged in care management services, or who have a specific chronic condition.





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OUTLINE SCREENING WORKFLOW

- **WHEN.** Screening could be initiated prior to the patient appointment, when the patient checks in at the front desk, during the rooming process, or after the clinical exam, for example.
- **HOW.** The patient completes the screening tool through an electronic form (iPad/tablet, text messaging), the patient completes the tool via paper form, or a staff member verbally asks the patient each question (in-person or via telehealth or phone call), for example. Because of the personal nature of these screening questions, a private or one-on-one setting is recommended to ensure the patient is comfortable and information is protected.
- **HOW OFTEN.** SDOH screening could occur annually, at every visit, and/or at a 'trigger event' (for example: a certain visit type, care management enrollment, etc.). While it is essential to have a standardized workflow, due to the personal nature of the screening questions and potential sensitivity of patient responses, flexibility may be needed to deliver the screening at a time when patients are most receptive to sharing.
- **WHO SCREENS.** If screening is delivered verbally, you may find that patients are more comfortable sharing information with a Community Health Worker (CHW), Care Manager, or other care extender that has an established care relationship or who can relate to the patient (lived experience). For details on training staff to screen for SDOH with empathic inquiry, see [Step 7](#).
- **HOW/WHERE to DOCUMENT.** It is critical that SDOH screening be documented in the EHR. Depending on which SDOH screening tool is used, you may be able to work with your EHR representative to implement the tool directly into your EHR. Utilizing structured fields within your EHR to document screening results provides a consistent location for staff to capture this information and allows for reports to be pulled from the EHR.

For details on EHR PRAPARE® implementation, see page 32 of the [PRAPARE® Implementation and Action Toolkit](#). You may need to work with your EHR representative for specific implementation questions. In addition to utilizing structured fields, Z codes may be used to capture a patient's social risk factors through coding.

The International Classification of Disease (ICD) is used by providers worldwide to document medical diagnoses. The most recent version, ICD-10 includes SDOH-related Z codes ranging from Z55-Z65 that include encounter reason codes to document SDOH²⁴. Z codes allow for easy reporting when documented in the EHR and provide a 'common language' when sharing risk factor data with payors and other stakeholders

SDOH-Related Z Codes	
Z Code Category	Definition
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

<https://www.cms.gov/files/document/zcodes-infographic.pdf>



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For more information on SDOH Z codes see [CMS Using Z Codes Infographic](#). If using PRAPARE®, see also the [PRAPARE® Data Documentation Quick Sheet](#) and the [PRAPARE® Data Documentation and Codification File](#).

Once you have a screening workflow outlined, ensure your health center has a staffing plan to support screening and follow-up interventions. UDS Table 5 captures Enabling Services data.

Excerpt from UDS Table 5: Staffing and Utilization					
Line	Personnel by Major Service Category	FTEs (a)	Clinical Visits (b)	Virtual Visits (b2)	Patients (c)
24	Case Managers				
25	Patients and Community Education Specialists				
26	Outreach Workers				
27	Transportation Personnel				
27a	Eligibility Assistance Workers				
27b	Interpretation Personnel				
27c	Community Health Workers				
28	Other Enabling Services (specify)				
29	Total Enabling Services (Lines 24-28)				

[Uniform Data System 2022 Manual Health Center Reporting Requirements](#)



Action Step: Design a workflow for SDOH screening. Select the SDOH screening tool your health center will use. Test your proposed workflow, outlining how, when, and where patients will be screened and findings documented. Expand workflow to additional populations, as appropriate. Collect data on staff used to support workflow.

STEP 5 **Design a workflow for *interventions* to address identified SDOH needs.** Outline who and how follow-up will be done for identified needs, and how interventions provided will be documented and tracked with the patient.

DESIGN *INTERVENTION* WORKFLOW

- **WHO FOLLOWS UP.** Identify the staff role(s) responsible for connecting patients to resources and services for identified needs (using the resource list developed in Step 3).
- **HOW FOLLOW UP OCCURS.** Develop a strategy to effectively manage referrals to both internal supports and community resources. For example, use warm handoffs for internal supports including behavioral health, financial counselors, etc. and integrate external community resource referral processes into existing health center referral policies and procedures. Provide coordination and support to patients referred to external services.
- **HOW/WHERE DOCUMENTED.** Similar to screening results, utilize structured fields within the EHR to document social risk interventions. This allows staff to easily locate this information and for reports to be pulled from the EHR. Codes can also be utilized to track social risk interventions.



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While there is not currently a standard set of procedure codes to track SDOH interventions, the Gravity Project is convening national stakeholders to develop new procedure codes to capture SDOH intervention services. The [Gravity Project](#) is a national public collaborative that develops consensus-based data standards for SDOH that allow for interoperability among multiple stakeholders²⁵. **Codes are not yet available for use.**

Gravity Project: Sample of Potential Codes				
1002223009	Assessment of progress toward goals to achieve food security (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1148813002	Assessment of barriers in inadequate housing care plan (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1148814008	Assessment of goals to achieve housing security (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1148815009	Assessment of goals to achieve adequate housing (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1148817001	Assessment of barriers in housing insecurity care (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1148818006	Coordination of services to assist with maintaining housing security (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1148823006	Assessment of progress toward goals to achieve adequate housing (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
171002009	Vocational Counseling (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1759002	Assessment of nutritional status (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
183524004	Referral to psychiatry service (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
183583007	Refer to mental health worker (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96

Visit <https://thegravityproject.net/overview/> or the [Gravity Confluence Portal](#) for more details.

AAPCHO created a set of ‘dummy codes’ that can be used to track interventions/enabling services²⁶:

Sample AAPCHO Enabling Services Codes		
Code	Name	Definition
SS001	Social Services Assessment	Non-medical assessment that includes the use of an acceptable instrument measuring socioeconomic status, wellness, or other non-medical health status.
CM001	Case Management	An encounter with a patient or their household or family member in which a comprehensive patient centered care plan is developed or monitored. The care plan focuses on supporting patients in meeting medical and social service needs of the patients.
RF001	Referral – Health	Facilitation of a visit with a patient to a healthcare provider. Includes re-referrals if necessary
RF002	Referral - Social Services	Facilitation of a visit with a patient to a social service provider. Includes re-referrals if necessary.
FC001	Eligibility Assistance/ Financial Counseling	Counseling of a patient with financial limitations and assessing the patient's eligibility to a sliding fee scale, health insurance program, pharmaceutical benefits program, or assistance in the development of a payment.

AAPCHO [Enabling Services Implementation Guide](#); for a full list of codes and definitions, see pages 27-29.



Action Step: Design a workflow for *interventions* to address identified SDOH needs. Outline who and how follow-up will be done for identified needs, and how interventions will be documented and tracked.



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STEP 6 Optimize available billing opportunities. Billing opportunities for SDOH screening and social risk interventions will vary by payor and state. Leverage billing opportunities for care management (e.g., Medicare Chronic Care Management, Principal Care Management, Complex Chronic Care Management, etc.) and integrated behavioral health visits for qualified services. For more information on these reimbursement opportunities, view NACHC's suite of [FQHC Reimbursement Tips for Medicare Care Management Services](#).



Action Step: Explore opportunities to bill for SDOH screening and interventions.

View NACHC's set of Payment Reimbursement Tips for Federally Quality Health Centers (FQHCs) for Medicare care management services.

STEP 7 Train health center staff in SDOH screening and intervention. Establish staff training programs that create an organizational culture open to social risk assessment and patient engagement. Many social risk questions can be sensitive in nature. They may feel intrusive or reveal information that could be perceived as less desirable, judged, or unlawful²⁷. Sensitive questions can be uncomfortable for the person asking the questions as well as for the person responding to the questions. People sometimes respond by editing their answers to hide things or provide what they believe to be more socially acceptable answers. This is known as a "social desirability bias"²⁷⁻²⁹. To avoid this tendency and gather more accurate data, it is important to build a culture of sensitivity and respect.

Use *empathic inquiry* to authentically connect with patients to understand their needs and priorities and build trust³⁰⁻³². This will ensure patients are treated with respect and consideration so they can speak honestly in a welcoming and open environment, especially when they are asked to speak about vulnerable topics²⁷. Trust between patients and providers is critical to development of appropriate care and treatment plans.

Additional information on empathic inquiry and sample staff SDOH training curriculums can be found on page 50 of the [PRAPARE® Implementation and Action Toolkit](#).

Additionally, train staff on the SDOH workflows. Consider the unique role of each staff member in the process. Training could address, for example: How can providers champion the process and help reinforce the 'why' with patients? What is the role of front office staff who may first identify literacy or language barriers and may be helpful in implementing the screening tool? How can quality improvement staff and/or data analytics staff support workflow development/improvement and data reporting efforts?



Action Step: Train health center staff in SDOH workflows and in techniques to screen and provide interventions related to sensitive subjects, using skills like empathic inquiry.



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STEP 8 **Collect and monitor SDOH data over time; use data to inform practice transformation.**

SDOH data is an essential component to population health management. The staff lead (Step 1) is charged with implementing/enhancing SDOH screening and intervention workflows (Steps 4 & 5). This includes regularly assessing the scope of SDOH screenings, as well as the types and impact of interventions provided. They can also assess staff and patient feedback on the workflow.

Workflow adjustments should be made, as needed, based on findings. If workflows were tested in a smaller target population first, consider expanding to additional population(s).

As SDOH data is collected, integrate it within your health center's risk stratification process and identify areas to reduce redundancy (in questions asked and data collected in the EHR). See NACHC's [Risk Stratification Action Guide](#) and the [PRAPARE® Risk Tally Score Quick Sheet](#) for more information.



Action Step: Collect and monitor SDOH data in target groups and over time in broader populations. Incorporate SDOH data collected into your health center's risk stratification processes to inform care models and service delivery. Use data to drive efficiencies and practice transformation.

STEP 9 **Leverage SDOH data for value-based payment and reimbursement.** Health centers can use SDOH information to drive program decisions and inform value-based payment efforts.

When SDOH data is added to key reports for executive leadership and the board, it can inform organizational priorities and value-based care strategies that support the Quintuple Aim: improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity.

Findings can also be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs and advance health equity.

At the payor level, CMS continues to test Accountable Care Organization (ACO) models, including the recently announced Medicare [Shared Savings Program](#) with Advanced Investment Payments (AIP) to encourage health care providers in rural and underserved areas, such as federally qualified health centers, to participate in ACOs. Additionally, CMS has given payers with Medicare Advantage plans greater discretion in determining supplemental benefits that address SDOH and Medicaid Managed Care Organizations (MCOs) have begun addressing a range of social risk factors in their payment models, as well as home-based community service programs and coordination of care.



Action Step: Share SDOH findings with payors, key partners, and policy-makers to drive value-based contracting and payment models.

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