NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Elevate *Learning Forum*

Social Drivers of Health

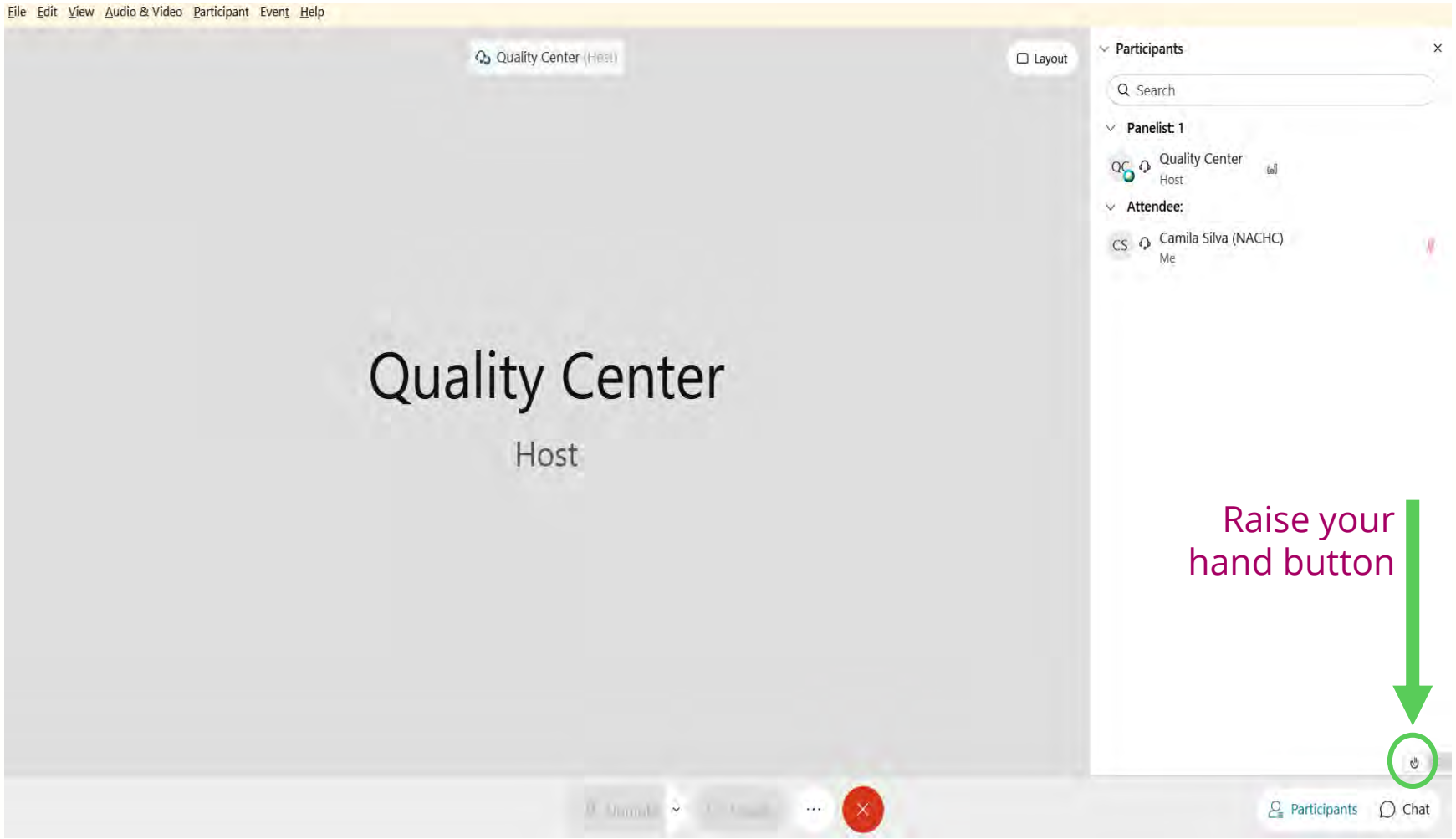
November 8, 2022

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®



Raise your hand button

Chat: When using the chat, please send the message to “Everyone”

During today’s session:

- **Questions:** Send to the chat as you have them; there will be a Q&A and discussion at the end.
- **Resources:** If there is a topic where you have a tool/resource to share, let us know in the chat!

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center

Cassie Lindholm

Deputy Director,
Quality Center

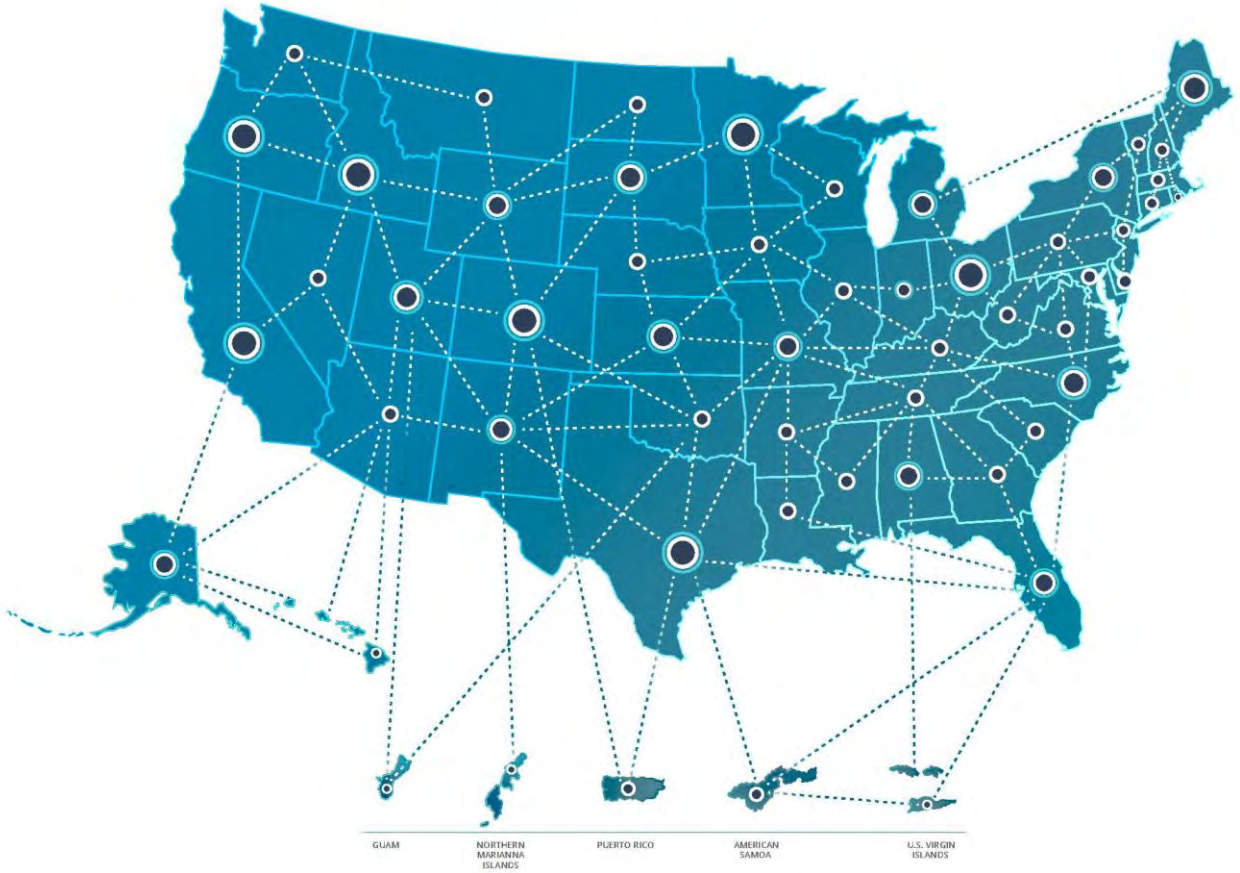
Addison Gwinner

Specialist,
Quality Center

Avani Patel

Manager,
Quality Center

Our Community: ELEVATE 2022



All
States & Territories

600+
Health Centers

70+
PCAs/HCCNs/NTTAPs

35+
CDC Grantees

6,000+
Peers

15 mil
Patients

2022 Featured Health Centers

Su Clínica

ESPERANZA health centers

Charles B. Wang Community Health Center
王嘉廉社區醫療中心

evara HEALTH

PARK DUVALLE COMMUNITY HEALTH CENTER

Mountain People's Health Councils Inc.

NEW HEALTH
North End • Charlestown

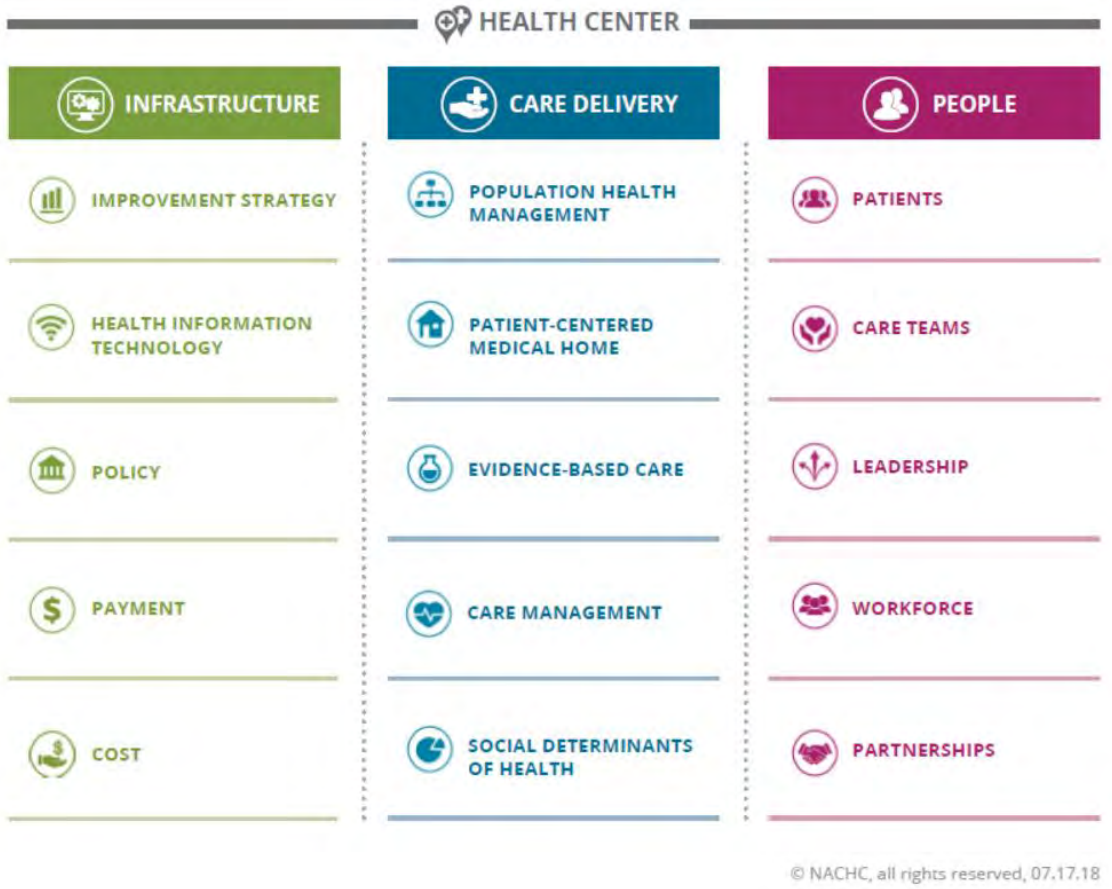
Fish River Rural Health

Keystone Rural Health Consortia, Inc.
One Team Working Together For Better Community Health Care

ZUFALL HEALTH | COMMUNITY HEALTH CENTERS

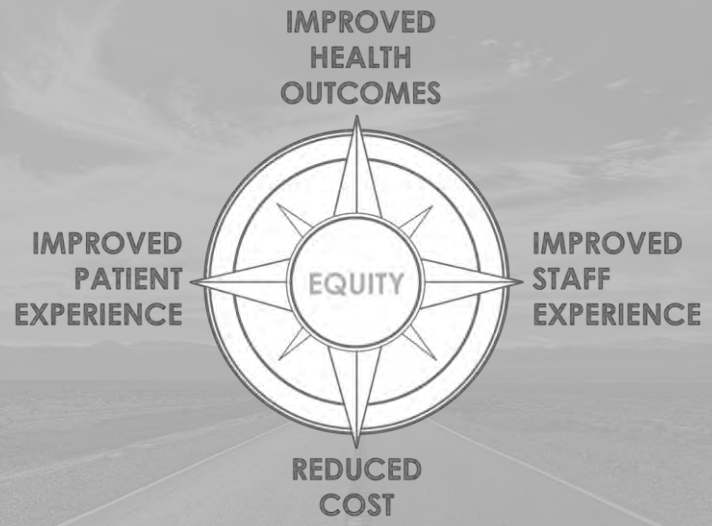
In the top 20 health centers nationally when looking at composite performance across measures for prevention and/or control of six high-cost, high burden conditions (2019 UDS): colorectal cancer, cervical cancer, HTN, diabetes, depression, & obesity

Value Transformation Framework



https://www.nachc.org/clinical-matters/value-transformation-framework/

ELEVATE 2022 JOURNEY



- Leadership
- Empanelment
- Population Health: Risk Stratification
- Payment
- Care Teams
- Care Management
- Evidence-Based Care
- Improvement Strategy
- **Social Drivers of Health (SDOH)**
- Workforce
- Health Information Technology
- Patients
- Partnerships
- Policy
- Cost
- Patient-Centered Medical Home

Social Drivers of Health

15 MINUTES | NOVEMBER 8TH, 2022

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NATIONAL ASSOCIATION OF Community Health Centers

PRAPARE

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

This microlearning acknowledges the work of the National PRAPARE® Team, a collaboration between NACHC and AAPCHO.

For more information on PRAPARE®, visit prapare.org or email prapare@nachc.org

NATIONAL ASSOCIATION OF Community Health Centers

Microlearning Modules

MODULES	ACTION STEPS	RESOURCES
WHAT?	1 ***PRIORITIZE*** SDOH and engage leadership	VTF Resources
	2 ***UNDERSTAND*** risk factors in your community	2022 HRSA UDS Manual
WHY?	3 ***IDENTIFY*** community resources	PRAPARE® Implementation and Action Toolkit
	4 ***DESIGN*** a workflow	PRAPARE® Implementation and Action Toolkit (Spanish)
	5 ***TRAIN*** health center staff	AAPCHO Enabling Services Implementation Guide
HOW?	6 ***IMPLEMENT*** workflow, monitor results, improve process	CDC SDOH Tools
	7 ***COLLECT*** data; use data to drive change	
	8 ***LEVERAGE*** data to drive Value Based Care	

Social Drivers of Health

WHAT?

WHY?

HOW?

WHAT can health centers do to address social risks?

- ✓ Design processes to collect data on social risk factors and respond to the identified needs, within care delivery model.

- ✓ Use a standardized collection tool such as *Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences* (PRAPARE®).

  For this microlearning, we will refer to the PRAPARE® tool and related PRAPARE® Toolkit resources, although health centers may follow the outlined Action Steps for the implementation of a different SDOH screening tool, if desired.

2022 UDS Reporting for Social Risks

Table 3B: Demographic Characteristics

- **Race**
- **Ethnicity**
- **Sexual Orientation**
- **Gender Identity**

Table 4: Selected Patient Characteristics

- **Income Level**

Table 6A: Selected Diagnosis and Services Rendered

- **Human Trafficking**
  - T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42
- **Intimate Partner Violence**
  - T74.11, T74.21, T74.31, Z69.11

APPENDIX D: Health Center HIT Capabilities

- Does your health center collect data on individual patients' social risk factors, outside of the data countable in the UDS?
- How many health center patients were screened for social risk factors using a standardized screener during the calendar year?
- Which standardized screener(s) for social risk factors, if any, did you use during the calendar year?
- 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:
  - **Food Insecurity**
  - **Housing Insecurity**
  - **Financial Strain**
  - **Lack of Transportation/Access to Public Transportation**
- If you DO NOT use a standardized screener to collect this information, please indicate why.

Helpful Resource: 2022 HRSA UDS Manual

Social Drivers of Health

WHAT?

WHY?

HOW?

WHY consider the Social Drivers of Health?

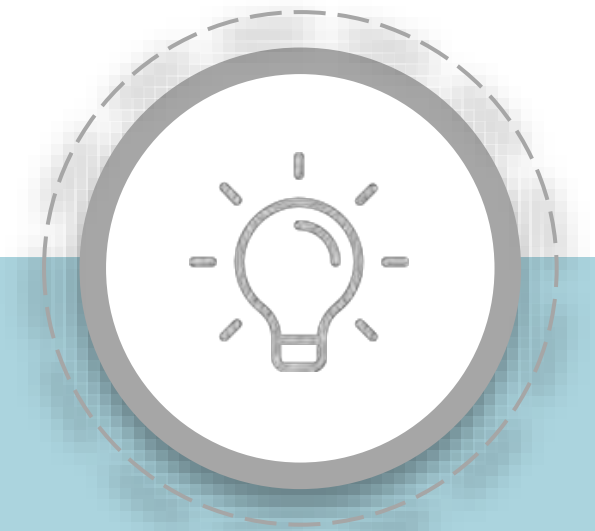
- Medical care alone impacts only about 10% of an individual's health while 60% of health outcomes are tied to social risk factors.[1]
- Health disparities are striking in communities with unstable housing, low income, unsafe neighborhoods or substandard education.[2]
- In the US, approximately 245,000 deaths in 2000 were attributable to low education, 176,000 to racial segregation, 162,000 to low social support, 133,000 to individual-level poverty, 119,000 to income inequality, and 39,000 to area-level poverty.[3]
- Interventions that address social determinants of health have the greatest potential public health benefit.[4]

1. Beyond Health Care: The Role of Social Determinants of Health in Promoting Health and Health Equity. Samantha Artiga and Elizabeth Hinton. Kaiser Family Foundation, May 10, 2018, accessed August 2021.
2. Health Impact Assessment: A Tool to Help Policy Makers Understand Health Beyond Health Care. Brian L. Cole and Jonathan E. Fielding. Annual Review of Public Health, 2007 28:1, 393-412, accessed August 2021.
3. Estimated Deaths Attributable to Social Factors in the United States.
4. A Framework for Public Health Action: The Health Impact Pyramid. Thomas R. Frieden, MD, MPH. American Journal of Public Health, 2010 April; 100(4): 590-595, accessed August 2021.

WHY consider the Social Drivers of Health?

- ✓ To define and document the complex social risks impacting health center patients.
- ✓ To target clinical care, services, and community partnerships that can drive care transformation.
- ✓ To demonstrate the value that health centers bring to patients, communities, and payers.
- ✓ To document strategies that will achieve better health outcomes and better reimbursement.
- ✓ To identify opportunities for change at the community and national levels.

Social Drivers of Health



WHAT?

WHY?

HOW?

STEP 1

PRIORITIZE SDOH AND ENGAGE KEY LEADERSHIP AND BOARD MEMBERS

Engage leaders, health center Boards, and other project stakeholders by highlighting the ways SDOH aligns with existing organizational priorities and how SDOH data will add value to organizational initiatives.

Involve people who will be impacted by the initiative:

- Engaging staff can lead to the development of more effective workflows to collect and act on the socioeconomic data.
- Engaging patients can lead to more targeted interventions or community partnerships.

Helpful Resources:

- NACHC Leadership Action Guide
- Examples of Messaging Resources: PRAPARE® Toolkit (page 12)

STEP 2

UNDERSTAND SOCIAL RISK FACTORS IN YOUR COMMUNITY

Community risk data can help improve understanding of SDOH issues affecting the population in your service area.

Health Center Needs Assessment Findings:

Factors associated with access to care and health care utilization

- Geography, transportation, occupation, transience, unemployment, income level, educational attainment

The most significant causes of morbidity and mortality

- Diabetes, cardiovascular disease, cancer, low birth weight, behavioral health, any associated health disparities

Other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care

- Social factors, the physical environment, cultural/ethnic factors, language needs, housing status

Annual County Health Rankings:

Vital health factors included in this resource are high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births.

Helpful Resources:

- Health Center Compliance Manual: Chapter 3: Needs Assessment
- County Health Rankings

STEP 3

IDENTIFY COMMUNITY RESOURCES THAT ARE AVAILABLE TO ADDRESS THESE SOCIAL RISKS

Develop a resource list of local organizations that staff can use to address social risks.

The resource list can include:

- Local housing organizations
- Transportation resources
- Job-training programs
- Mental health programs
- Local food banks

Be sure to include contact information for each resource (address, phone number, email and contact name, if available).

Helpful Resources:
These organizations maintain up-to-date information on a variety of resources by community or zip code**:** findhelp.org and 211.org

STEP 4

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

Create a step-by-step workflow that outlines the process for integrating social risk assessment, intervention, and data capture & coding processes into the patient visit.

Address the following elements:

A. Select an SDOH screening tool to be used.
B. Determine who will be included in your initial target population.
C. Determine how often data will be collected.
D. Determine which point in the visit the screening will be provided to the patient.
E. Decide how the screening will be delivered to patients.
F. Select staff member(s) who will deliver the screening/screening instructions to patients.
G. Document screening results within the EHR.
H. Map SDOH assessment data to Z codes; capture relevant Z codes for each screening.
I. Select staff member(s) who will follow up on screening results to connect to internal and/or external supports and community resources.
J. Determine how interventions/follow-up will be documented in the EHR.
K. Develop a strategy for effectively managing referrals to internal supports or community resources.
L. Optimize available billing opportunities.

The next few slides describe each of these workflow elements in more detail

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

A **Select an SDOH screening tool to be used (e.g., PRAPARE® or other).**

B **Determine who will be included in your initial target population.**
When implementing a new workflow, test the workflow on a sample target population to allow for process improvement before expanding the workflow to your entire target population:

- Patient panels of one or two providers who are highly engaged and supportive of this new initiative
- Patients engaged in Care Management
- Condition specific

C **Determine how often data will be collected.**
For example, annually, at every visit, and/or at a 'trigger event' (e.g., a certain visit type, care management enrollment, etc.).

- You may find that flexibility is needed to deliver the screening at a time when patients are most receptive to sharing their social risk information.

Helpful Resources:

- Information on workflow implementation PRAPARE® Toolkit (Chapter 5)
- Condition specific SDOH tools CDC SDOH Tools

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

D **Determine which point in the visit the screening will be provided to the patient.**
For example, prior to the patient appointment, when the patient checks in at the front desk, during the rooming process, after the clinical exam, etc.

E **Decide how the screening will be delivered to patients.**
For example, the patient completes through electronic form (iPad/tablet, text messaging), patient completes via paper form, or staff member verbally asks the patient each question (in-person or via telehealth or phone call).

- Due to the personal nature of the screening questions a private setting is recommended to ensure the patient is comfortable and their information is protected.

F **Select staff member(s) who will deliver the screening/screening instructions to patients.**
You may find that patients are more comfortable sharing their personal social risk information with a Community Health Worker, Care Manager, or other care extender, with whom they have an established care relationship.

- For details on training staff to screen for SDOH and using e*mpathic inquiry, see* ***Step 5.***

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

G **Document screening results within the EHR. (Screening results are referred to as ASSESSMENT DATA)**

H **Map SDOH assessment data to Z codes; capture relevant Z codes for each screening.**

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

Helpful Resources:
- Details on EHR PRAPARE® implementation on page 32 of the PRAPARE® Toolkit
- PRAPARE® Data Documentation Quick Sheet
- PRAPARE® Data Documentation and Codification File

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

I **Select staff member(s) who will follow up on screening results to connect to internal and/or external supports and community resources.** **(These connections to supports are captured through INTERVENTION DATA)**
This identified role will use the resource list developed in ***Step 3*** to connect patients to needed resources and social supports.

J **Determine how interventions/follow-up will be documented in the EHR.**
Using a set of codes is recommended so that health centers can track data and pull reports on the volumes and types of interventions and follow up services provided.

There is ***not currently a standard set of procedure codes to track SDOH interventions!*** However…

Helpful Resource: PRAPARE® Toolkit (Chapter 10)

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

AAPCHO has created a set of 'dummy codes' that can be utilized to track interventions/enabling services:

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.

Sample of enabling services codes. For full list of codes and definitions see page 27 of the AAPCHO Enabling Services Implementation Guide.

Helpful Resource: AAPCHO Enabling Services Implementation Guide

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

The *Gravity Project* is a convening of national stakeholders to develop new procedure codes to capture SDOH intervention services. Codes are not yet available for use.

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 plan (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
1148823005	Assessment of progress toward goals to achieve adequate housing (procedure)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
171062009	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

gravity PROJECT®

Consensus-driven standards on social determinants of health

Helpful Resource: Gravity Project Confluence Page

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

In addition to implementing coding workflows to track SDOH interventions, ensure your health center can pull reports of Enabling Services (visits and patients) for UDS Table 5:

TABLE 5: STAFFING AND UTILIZATION (CONTINUED)

Calendar Year: January 1, 2022, through December 31, 2022

Line	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Virtual Visits (b2)	Patients (c)
24	Case Managers				
25	Patient 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)				

Helpful Resource: 2022 HRSA UDS Manual

STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

K

Develop a strategy for effectively managing referrals to internal supports or community resources.

Use warm-handoffs for internal supports including behavioral health, care managers, financial counselors, etc.

Integrate external community resource referral processes into existing health center **referral tracking and follow** up policies and procedures.

L

Optimize available billing opportunities.

Billing opportunities for SDOH assessments and interventions will vary by payor and state.

When qualifying, leverage billing opportunities for care management (e.g., Medicare CCM) and integrated behavioral health visits.

Helpful Resources:

- ECRI Referral Tracking
- NACHC CCM Reimbursement Tip Sheet
- NACHC Behavioral Health Integration Reimbursement Tip Sheet

STEP 5

TRAIN HEALTH CENTER STAFF IN SDOH WORKFLOWS AND IN TECHNIQUES TO SCREEN AND PROVIDE INTERVENTIONS RELATED TO SENSITIVE SUBJECTS

Provide training to staff on the workflow developed in *Step 4*.

- Consider each health center staff members' unique role in SDOH screening and interventions, for example:
  - How can providers champion the process and help to reinforce the 'why' with patients?
  - What is the role of front office staff members, who may often be the first to identify literacy or language barriers?
  - How will the health center quality staff and/or data analytics staff support workflow development/improvement and data reporting efforts?

Empathetic inquiry is used to authentically connect with patients to understand their needs and priorities by building trust between the patient and care team.

- It also builds trust between patients and providers and leads to the provision of more appropriate care and treatment plans.

Helpful Resources:
For more information on ***Empathic Inquiry*** and sample staff training curriculums, see page 50 of the PRAPARE® Toolkit.

STEP 6

IMPLEMENT WORKFLOW, MONITOR AND ASSESS RESULTS, INITIATE PROCESS IMPROVEMENT

- Engage an interdisciplinary SDOH implementation team comprised of health center staff with varying roles
    - Providers, front line staff, quality improvement staff, data analytics staff, leadership
- As an implementation team, regularly assess the volume of SDOH **screening and intervention data** collected throughout the implementation period and discuss staff and patient feedback on the workflow.
- Adjust the workflow as needed.
- When ready, expand the workflow beyond the initial target population.

Helpful Resource: NACHC Improvement Strategy Microlearning

STEP 7

COLLECT AND TRACK SOCIAL RISK DATA OVER TIME; USE SOCIAL RISK DATA TO DRIVE CHANGE

Integrate SDOH as a component of your health center's risk stratification process.

- At the individual level, a patient's risk category is the first step towards planning, developing, and implementing a personalized care plan.
- At the population level, risk stratification allows care models to be personalized to the needs of patients within each subgroup.

By incorporating SDOH into risk stratification processes, your health center can better assess and deliver services to the needs of the 'whole-person'.

Helpful Resources:

- NACHC Risk Stratification Action Guide
- PRAPARE® Risk Tally Score Quick Sheet

STEP 8

LEVERAGE SDOH ASSESSMENT AND INTERVENTION DATA TO DRIVE VALUE-BASED CARE AND SUPPORT CONTRACTING

Health centers can analyze social risk data and use this information to drive program decisions and inform transformation/payment reform efforts.

- ✓ Add data to key reports for executive leadership and Boards of Directors to inform value-based care opportunities and to document strategies that will achieve better health outcomes and better reimbursement.

- ✓ Share findings with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs and advance health equity.

    - Quantifying and analyzing SDOH assessment/intervention **code data** can help payors to better understand or process the information you share with them.

STEP 8
Continued

LEVERAGE SDOH ASSESSMENT AND INTERVENTION DATA TO DRIVE VALUE-BASED CARE AND SUPPORT CONTRACTING

Payors are motivated to support your work on SDOH, as it may lead to lowered total cost of care!

- CMS continues to test the Accountable Health Communities Model, which brings clinical and community-based organizations together to address patients' health-related social needs in an effort to improve outcomes and reduce costs.
- CMS has given payers with Medicare Advantage plans greater discretion in determining supplemental benefits that address SDOH.
- 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.

Optimizing SDOH Coding

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Physician Informatacist, Clinical Affairs Division
National Association of Community Health Centers

NATIONAL ASSOCIATION OF Community Health Centers

USING CODES TO OPTMIZE SDOH PROCESSES

Why use codes? Interoperability!

Unless SDOH data are captured in a consistent, structured way using standardized terminology, they cannot be easily transmitted.

Standardization is essential to ensuring that information collected from an individual in one setting is meaningful when shared with another entity and in another setting.

- Payors, community agencies, hospitals, other health care providers, etc.

What codes do I use? When do I use them?

CODE CATEGORIES TO KNOW

ICD-10 CM	LOINC	SNOMED CT	HCPCS	'Dummy' Codes
• Standardized method for capturing diseases, illnesses, injuries and health conditions • Also referred to as 'diagnosis codes' • For SDOH, fall within code categories Z55-Z65 (sometimes referred to as 'Z codes')	• LOINC is a common language (a set of identifiers, names, and codes) for identifying health measurements, observations, and documents	• Standardized way to represent clinical phrases captured by the clinician	• Standardized coding system describing services, drugs, items and supplies provided or rendered to a patient • HCPCS is divided into two subsystems, one of which is CPT codes (also referred to as 'procedure codes')	• Codes that are created on an individual basis for the purpose of aiding in tracking and monitoring. • Can be useful on an individual level but not useful for interoperability.

MAPPING CODES TO SDOH DATA

PRAPARE® Question	PRAPARE® Response Categories *Yellow highlight = alignment with UDS	ICD-10 CM Z Codes v.10-1-21	LOINC v.2.71	SNOMED CT v.US 3-1-2022
TRANSPORTATION				
Rationale:	Transportation plays a vital role in an individual's life and a critical role in one's ability to sustain a healthy livelihood by determining one's ability to get to and from work, accessing healthy food options, and visiting healthcare providers (Transportation Research Board & IOM, 2005).			
Alignment:	Developed by stakeholders and experts; related to enabling servicesCrosswalk for UDS Appendix D: Health Center Health Information Technology: Lack of Transportation/Access to Public Transportation = "Yes" responses on Transportation Question			
Minimum Update Frequency:	At every visit			
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.			**Question ID:** 93030-5	
	Yes, it has kept me from medical app	Z75.3 Unavailability and inaccessibility of health-care facilities	LA30133-5	713458007 Lack of access to transportation (finding) 160695008 Transport too expensive 160696009 Transport distance too great 266934004 Transport problems (finding)
	Yes, it has kept me from non-medica	Z75.4 Unavailability and inaccessibility of other helping agencies	LA30134-3	419024006 Transport unavailable 307109002 No car 424629004 Transportation barrier impedes ability to use community resources
	No		LA32-8	
			0; LA6132-0 (Able to independently drive a regular or adapted car, OR uses a regular or handicap-accessible public bus) 1; LA6141-1 (Able to ride in car only when driven by another person OR able to use bus/handicap van only when assisted/accompanied by another person)	
	I choose not to answer this question		LA30122-8	
	Question not administered			
	Skipped question			

Helpful Resource: PRAPARE® Data Documentation and Codification File

WHAT IS THE GRAVITY PROJECT?

The Gravity Project seeks to identify data elements and associated value sets to represent SDOH information documented in electronic health records (EHRs) across four clinical activities:

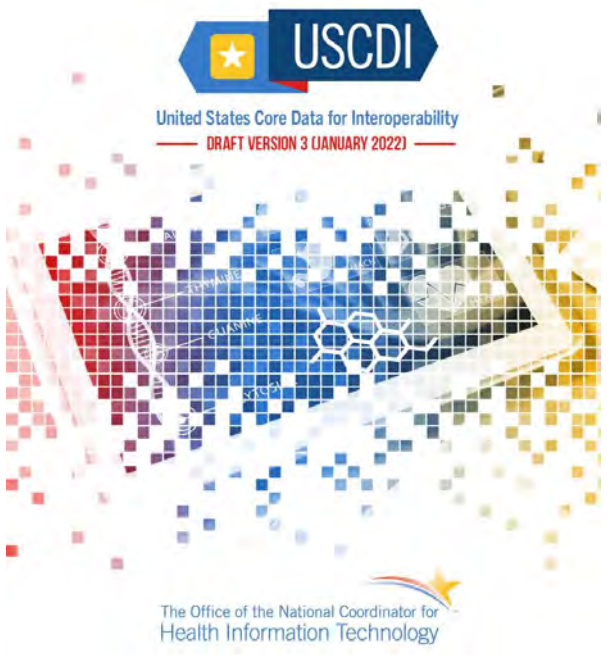
- ✓ Screening
- ✓ Diagnosis
- ✓ Goal setting
- ✓ Intervention activities

The Gravity Project will develop a consensus-based set of recommendations on how best to capture and group these data elements for interoperable electronic exchange and aggregation and collaborate with coding and terminology organizations to address coding gaps identified and apply for new codes (e.g., CPT codes for interventions).

gravity PROJECT®

Consensus-driven standards on social determinants of health

WHAT IS THE GRAVITY PROJECT?



Draft USCDI v3 Summary of Data Classes and Data Elements

Allergies and Intolerances
- Substance (Medication)
- Substance (Drug Class)
- Reaction

Assessment and Plan of Treatment
- Assessment and Plan of Treatment
- SDOH Assessment

Care Team Member(s)
- Care Team Member Name
- Care Team Member Identifier
- Care Team Member Role
- Care Team Member Location
- Care Team Member Telecom

Clinical Notes
- Consultation Note
- Discharge Summary Note
- History & Physical
- Procedure Note
- Progress Note

Clinical Tests
- Clinical Test
- Clinical Test Result/Report

Diagnostic Imaging
- Diagnostic Imaging Test
- Diagnostic Imaging Report

Encounter Information
- Encounter Type
- Encounter Diagnosis
- Encounter Time
- Encounter Location
- Encounter Disposition

Goals
- Patient Goals
- SDOH Goals

Health Insurance Information ★
- Coverage Status ★
- Coverage Type ★
- Relationship to Subscriber ★
- Member Identifier ★
- Subscriber Identifier ★
- Group Number ★
- Payer Identifier ★

Health Status ★
- Health Concerns ➡
- Functional Status ★
- Disability Status ★
- Mental Function ★
- Pregnancy Status ★
- Smoking Status ➡

Immunizations
- Immunizations

Laboratory
- Tests
- Values/Results
- Specimen Type ★
- Result Status ★

Medications
- Medications

Patient Demographics
- First Name
- Last Name
- Middle Name (Including middle initial)
- Suffix
- Previous Name
- Date of Birth
- Date of Death ★
- Race
- Ethnicity
- Tribal Affiliation ★
- Sex (Assigned at Birth)
- Sexual Orientation
- Gender Identity
- Preferred Language
- Current Address
- Previous Address
- Phone Number
- Phone Number Type
- Email Address
- Related Person's Name ★
- Related Person's Relationship ★
- Occupation ★
- Occupation Industry ★

Problems
- Problems
- SDOH Problems/Health Concerns
- Date of Diagnosis
- Date of Resolution

Procedures
- Procedures
- SDOH Interventions
- Reason for Referral ★

Provenance
- Author Organization
- Author Time Stamp

Unique Device Identifier(s) for a Patient's Implantable Device(s)
- Unique Device Identifier(s) for a patient's implantable device(s)

Vital Signs
- Systolic blood pressure
- Diastolic blood pressure
- Heart Rate
- Respiratory rate
- Body temperature
- Body height
- Body weight
- Pulse oximetry
- Inhaled oxygen concentration
- BMI Percentile (2 - 20 years)
- Weight-for-length Percentile (Birth - 36 Months)
- Head Occipital-frontal Circumference Percentile (Birth-36 Months)

Key: ★ New Data Class or Element ➡ Data Element Reclassified

US Core Data for Interoperability (USCDI) version 2 and onwards

- Supported by the 21st Century Cures Act which also requires specialty content to be certified
- USCDI creates a framework for annual updates to expand the data classes

USCDI establishes a minimum set of data classes that are required to be interoperable nationwide

WHAT IS THE GRAVITY PROJECT?

SAMPLE

Value Set Members

Expanded Code List

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Code	Descriptor	Code System	Version	Code System OID
156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)	CPT	2021	2.16.840.1.113883.6.12
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes	CPT	2021	2.16.840.1.113883.6.12
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	CPT	2021	2.16.840.1.113883.6.12
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	CPT	2021	2.16.840.1.113883.6.12
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	CPT	2021	2.16.840.1.113883.6.12
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	CPT	2021	2.16.840.1.113883.6.12
S5170	Home delivered meals, including preparation; per meal	HCPCS Level II	2022	2.16.840.1.113883.6.285
S9470	Nutritional counseling, dietitian visit	HCPCS Level II	2022	2.16.840.1.113883.6.285
32911000	Homeless (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
Z59.00	Homelessness unspecified	ICD10CM	2022	2.16.840.1.113883.6.90
1156191002	Housing instability (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1156195006	Housing instability due to being behind on payments for place of residence (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1156193004	Housing instability due to frequent change in place of residence (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1156192009	Housing instability due to imminent risk of homelessness (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1156196007	Housing instability due to threat of eviction (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
1156194005	Housing instability following recent homelessness (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96
Z59.819	Housing instability, housed unspecified	ICD10CM	2022	2.16.840.1.113883.6.90
Z59.812	Housing instability, housed, homelessness in past 12 months	ICD10CM	2022	2.16.840.1.113883.6.90
Z59.811	Housing instability, housed, with risk of homelessness	ICD10CM	2022	2.16.840.1.113883.6.90
105531004	Housing unsatisfactory (finding)	SNOMEDCT	2021-09	2.16.840.1.113883.6.96

WHAT DOES THE GRAVITY PROJECT MEAN FOR MY HEALTH CENTER?

The Gravity Project team expects for a standardized code set (including CPT codes for SDOH interventions) to be shared with health centers nationally toward the end of 2023.

- The team is also working with EHR vendors to aid in the implementation of the code set.

In the meantime, health centers can incorporate SDOH ICD-10 codes, LOINC Codes, and SNOMED Codes into workflows and prepare SDOH intervention documentation for new CPT codes to be available.

gravity PROJECT®

Consensus-driven standards on social determinants of health

Helpful Resource: Stay up to date on The Gravity Project through the Gravity Project Confluence Page

Yuriko de la Cruz, MPH, CPHQ
Program Manager, Social Drivers of Health
National Association of Community Health Centers

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

NATIONAL ASSOCIATION OF Community Health Centers

Discussion

Elevate 2022 Participants:

QI Professional Development Opportunity

Institute *for* Healthcare Improvement

Free access to the IHI's full catalog of online courses including:

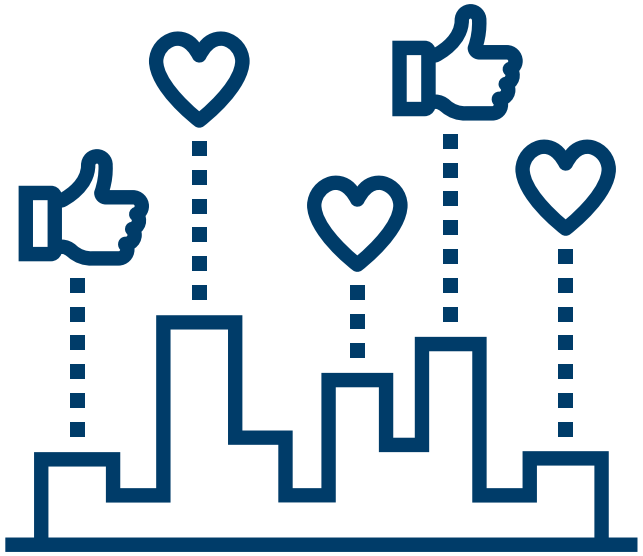
- More than 35 continuing education credits for nurses, physicians, and pharmacists
- Basic Certificate in Quality and Safety

VTF

Open to registered participants who complete the VTF assessment

Submit interest here: https://bit.ly/Elevate_IHI to be eligible for a scholarship

PCAs and HCCNs: did you know you can gift a scholarship to someone in a member health center? Follow this link for more info: bit.ly/Elevate_Gift



Provide Us Feedback

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SHARE YOUR FEEDBACK

Don't forget! Let us know what you thought about today's session.

Next Monthly Forum Call:

December 13, 2022
1-2 pm ET

NATIONAL ASSOCIATION OF
Community Health Centers