



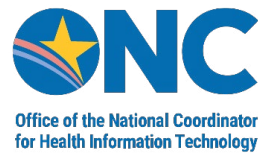
CALL TO ACTION

Addressing Health-Related Social Needs in Communities Across the Nation

U.S. Department of Health and Human Services (HHS)

November 2023

HHS AGENCIES



HHS Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation

HHS is issuing this Call to Action to catalyze efforts at the community level to encourage partnerships across sectors.

HHS is calling upon individuals working in health care, social services, public and environmental health, government, and health information technology to partner and work together across silos to address health-related social needs¹ (HRSNs) through community partnerships to improve the health and well-being of every American.

Vision and Context

In recognition of research findings that social determinants of health (SDOH) account for about half of the variation in health outcomes in the nation,² the U.S. Department of Health and Human Services (HHS) is moving with urgency to advance a series of new policies, as well as funding and training opportunities, to address SDOH and unmet health-related social needs³ (HRSNs) that have the potential to worsen health and well-being. We envision a future in which everyone, regardless of their social circumstances, has access to aligned health and social care systems that achieve equitable outcomes through high-quality, affordable, person-centered care. The health care system is shifting toward identifying and addressing individuals' social risk factors (such as financial strain; housing instability; food insecurity; neighborhood air, water, and soil pollution; limited English proficiency;⁴ and lack of transportation) that can contribute to poor health outcomes, including behavioral health outcomes. To support this shift, organizations from different sectors operating within the same community must come together to meet these needs with a shared vision and collaborate to improve care coordination. Crises, such as climate change events, further exacerbate structural inequities, magnify negative impacts on health, and need coordination across sectors to prevent and mitigate impacts. This cross-organizational and cross-sector collaboration should include significant representation of people with lived experience regarding HRSNs and related social care services. Everyone will need to work together to create a stronger, more integrated health and social care system that meets individuals where they are and improves equitable opportunities for the highest level of health and well-being.

1 Health-related social needs are social and economic needs that individuals experience that affect their ability to maintain their health and well-being. These include needs such as employment, affordable and stable housing, healthy food, personal safety, transportation, and affordable utilities.

2 Hood CM, Genus KP, Swain GR, Catlin BB. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. Am J Prev Med. 2016 Feb;50(2):129-35. doi: 10.1016/j.amepre.2015.08.024. Epub 2015 Oct 31. PMID: 26526164.

3 Social determinants of health refer to community-level factors, while HRSN refer to individual-level factors, both of which impact an individual's health and well-being.

4 Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type or service, benefit, or encounter.

Multiple agencies across HHS are implementing policies and programs to help facilitate community-led transformation. The Centers for Medicare & Medicaid Services (CMS) has provided multiple opportunities to address certain unmet HRSNs. In Medicaid, this is done through Medicaid section 1115 demonstrations and Medicaid managed care in-lieu-of services and supports. In Medicare, HRSNs can be addressed through supplemental benefits in Medicare Advantage and through the Merit-Based Incentive Payment System and the Medicare Shared Savings Program in the traditional Medicare program. These policies drive health care professionals toward routine screening for unmet HRSNs and, in some instances, allow Medicare and Medicaid to cover the cost of certain services to address housing instability, food insecurity, and lack of transportation. To help facilitate access to such services, the Administration for Community Living (ACL) and the Centers for Disease Control and Prevention (CDC) have awarded grants and provided training and technical assistance to communities that are building the infrastructure to connect the health and social care sectors. To help develop and advance SDOH data standardization essential for person-centered health and effective cross-sector referrals, the Office of the National Coordinator for Health Information Technology (ONC) advances technical and policy approaches including the use of the United States Core Data for Interoperability (USCDI), which includes SDOH data elements and classes. Additionally, the CDC has provided states with an SDOH module for the Behavioral Risk Factor Surveillance System to help assess SDOH at a population level.

This Call to Action complements the companion U.S. Playbook to Address Social Determinants of Health, which highlights the critical need to develop well-coordinated systems of health and social care to better address HRSNs and describes actions the federal government is taking to promote this transformation. Support from other levels of government — state, territorial, tribal, and local — is also critical to ensuring these types of aligned systems expand across the nation. In addition to government, cross-sector partnerships among social care service providers, public health departments, health (including behavioral health) care providers, faith-based organizations, community members, persons with lived experience, refugee and newcomer-serving agencies, and others are necessary to transform how we address HRSNs and reduce inequities in related health outcomes.

HHS is calling upon all our partners to collaborate — no single sector can drive this type of change alone — so that together we can achieve a future in which everyone, regardless of social circumstances, has access to aligned, high-quality, person-centered health and social care systems that can improve health and well-being.

Transformation Through Backbone Organizations

[Backbone organizations](#) play an important role in managing community-based partnerships formed across sectors such as health (including behavioral health) care, housing, social care services, public and environmental health, employment training, and economic development to focus on a shared vision and responsibility for the health and well-being of communities. They can help develop and sustain community-based infrastructure and partnerships to improve coordination between health care

and community-based organizations (CBOs) to address an individual's HRSNs and are important partners for health care in meeting these needs.

One promising type of backbone organization focused on aligning health and social care is the community care hub ("hub" for short). Hubs leverage community capacity and expertise to allow for an efficient, scalable approach to health care/CBO partnerships that can facilitate care coordination and service delivery to address HRSNs. Hubs can leverage trusted relationships to develop, manage, support, and maintain accountability for a network of CBOs, while enabling their network of CBOs to have a more active seat at the table with health care entities in communities where under-resourced CBOs may not otherwise be included in decision-making. See the appendix for a conceptual model of community care hubs and the role of partners.

Hubs coordinate administrative functions and funding for a network of CBOs. They allow health care organizations to efficiently contract with multiple CBOs in a streamlined way through a single point of contact and ensure the quality of services delivered across the network. They are skilled at braiding and blending various funding sources (i.e., federal, state, philanthropic, and private funds) to address the full scope of an individual's social needs. Hubs also provide smaller CBOs with the support and infrastructure necessary to deliver services in partnership with the health care sector as a part of a larger CBO network. For additional details on backbone organizations and community care hubs, please refer to the U.S. Playbook on Addressing SDOH as well as this [article](#).

This Call to Action asks partners across health care, social care, public and environmental health, government, and health information technology organizations to take shared and individual actions, described below, to promote system transformation, support shared decision making and collaboration, and leverage community resources. The collective goal is to enable individuals, health care organizations and professionals, and communities to effectively address HRSNs and achieve equitable health outcomes by supporting promising models such as hubs. Shared and individual actions across partner types are listed below.

Recommended Partner Roles and Actions

Below are key actions that partners in different sectors can take to help build a stronger, more integrated health and social care system. These actions seek to help communities address key factors affecting hub implementation and success, including planning and governance, sustainable funding and partnerships, shared metrics of success, and data infrastructure. In addition to reviewing actions relevant to your own sector, we encourage you to review actions listed for other sectors to help you consider how you might align your actions to help facilitate those of your partners. We also list a set of shared actions at the end of the document that are broadly applicable to all sectors and that would particularly benefit from close collaboration across partners, as well as a list of additional resources applicable to each set of actions.

Individual Partner Actions

Community-Based Organizations

Action: Develop/expand capacity to serve as a hub.

- Local CBOs, such as area agencies on aging, aging and disability resource centers, centers for independent living, community mental health centers, community action agencies, and other private sector nonprofits, are often trusted organizations within communities that can convene key partners across sectors to develop a shared vision that includes expanded reach and responsibility for the health and well-being of the community. Their workforce is often drawn from the communities they serve, such as community health workers who help those in need of services navigate the system.
- CBOs with expert knowledge of social care services and experience working with health care organizations are ideally suited to serve as hubs. In this role, they support a network of their peers by centralizing the administrative functions and operational infrastructure necessary to address HRSNs in partnership with health care.
- Entities interested in becoming hubs should conduct landscape analyses of existing resources in their local communities, reaching out to and working alongside other cross-sector community partners such as health care entities, public health departments, human services agencies, and 211 networks to identify resources that can be leveraged and gaps in capacity that need to be addressed to create coordinated systems of care. It is often resource-intensive to develop and sustain a hub, and such partnerships can help ensure those interested in serving as hubs can leverage existing resources and capacity. Building such partnerships early in the process can also create awareness within the health care community about the hub and how it can help facilitate shared objectives.
- Existing or emerging hubs can expand their capacity to serve populations in need through braiding public funding from social services, public health, housing, transportation, and health care to finance services and supports that address HRSNs.
- Community-led hubs addressing climate resilience should partner with and integrate health care delivery systems, including community health and behavioral health centers, into their service delivery networks.

Action: Participate as a partner organization in a CBO network led by a hub.

- CBOs are critical partners in hub networks. These networks should include a diverse set of organizations that facilitate broad service offerings, populations engaged, and geographic reach.

- By participating in a hub network, CBOs can access new sources of revenue and maximize their operational efficiency and effectiveness, as well as economies of scale, inherent in an organized network delivery model (versus entering contracts individually).
- A CBO network led by a hub can ‘level the playing field’ by creating a shared infrastructure that permits smaller CBOs that lack the organizational capacity and resources to work directly with health care organizations to participate in contracting opportunities.
- Such networks should seek out opportunities to engage in collaboratives and other learning opportunities to identify and share best practices and informational resources.

Health Systems and Clinicians

Action: Engage community partners, including existing and emerging hubs, on local health and social needs assessments and in shared decision making on strategies to address these needs.

- Health care clinicians, including primary care clinicians, specialists, and behavioral health clinicians, should consider screening for HRSNs and partner with hubs, CBOs, and public and environmental health entities to perform a more comprehensive assessment and help meet the needs that are identified. [Many hospitals report](#) that they currently collect data on patients’ HRSNs. [Beginning in 2024](#), hospitals participating in the [Inpatient Quality Reporting Program](#) must report Screening for Social Drivers of Health and Hospital Commitment to Health Equity quality measures. Dialysis centers and inpatient psychiatric hospitals will also have to report SDOH quality measures, and post-acute care providers will collect SDOH information through assessment instruments. Under the calendar year 2024 [Physician Fee Schedule](#) final rule, Medicare will separately pay for SDOH risk assessments, which identify unmet social needs that may affect the diagnosis and treatment of medical problems, starting January 1, 2024. Hospitals should also consider working in partnership with hubs and CBOs to establish new care transition workflows, including referral pathways, contracting mechanisms, data sharing strategies, and implementation training that can track both health and social needs outcomes to ensure unmet HRSNs are being successfully addressed through closed-loop referrals and follow-up.
- Collaboration with community partners, including in planning and advisory councils, can break down traditional silos, expand perspectives, and generate new insights by bringing together individuals with unique expertise, including lived experience, across multiple sectors to identify the needs and resources of a community, develop shared goals, and create and implement innovative, community-based solutions.

- Providers should consider working with hubs and CBOs that employ community health workers and other appropriate auxiliary staff to furnish community health integration and principal illness navigation services for patients with Medicare as required under the 2024 Physician Fee Schedule.

Action: Enlist the expertise of backbone organizations, such as hubs, to provide services and support.

- Hubs and their CBO partners provide a broad array of service offerings that health systems can leverage to support the needs of their patients, including during discharge planning. Rather than duplicating services already available within their communities, health systems should focus on aligning their work with local partners and expanding their services and reach to help individuals and families easily find the services and supports they need. This may include asset mapping, understanding local resources, and partnering with hubs and other local CBOs.

Action: Consistently identify patients with HRSNs by indicating a corresponding diagnosis code in medical claims, sometimes referred to as a Z-code. Health systems and clinicians can connect patients with the community resources that they have identified through the steps outlined above; such points of connection could occur as needs are being assessed, including during discharge planning.

- The 2024 Medicare Inpatient Prospective Payment System rule recognizes homelessness as an indicator of increased resource utilization in the acute inpatient hospital setting, which may result in higher payment for certain hospital stays and encourage Z-code reporting.
- Proposed coding and separate payment for community health integration, principal illness navigation, and SDOH risk assessments in the 2024 Medicare Physician Fee Schedule will encourage providers to report [Z-codes](#).

Action: Identify and implement new and existing financing mechanisms, such as [Medicare Shared Savings Program Advance Investment Payments](#) and nonprofit hospital community benefit resources, to pay for social care services.

- New, smaller accountable care organizations (ACOs) in the Medicare Shared Savings Program may be eligible for advance investment payments, which can be utilized by ACOs to partner with CBOs and to arrange for social services for unmet HRSNs.
- Work with local CBOs on community health needs assessments and implementation strategies to determine how community benefit and community-building dollars can be used to address HRSNs and SDOH. Working with local CBOs to identify where there are unmet HRSNs or opportunities to address underlying SDOH can help nonprofit hospital organizations better target their investments needed to qualify for tax-exempt status to help build stronger communities.

Payers

Action: Consider covering and paying for allowable services. CMS is doing so by providing regulations and guidance for Medicare Advantage plans, traditional Medicare, and Medicaid flexibilities (including state plan amendments, section 1115 demonstration authority, 1915(c) home and community-based services waivers, and managed care contracting — including In-Lieu of Services and Settings [ILOS]).

- Medicare Advantage organizations, including Special Needs Plans, may utilize authority to provide special supplemental benefits for the chronically ill to partner with CBOs and address unmet HRSNs for certain chronically ill beneficiaries.
- States may contract with managed care plans to provide ILOS if applicable requirements are met to enable the Medicaid managed care plans to reduce health disparities and address unmet HRSNs by offering, for example, medically appropriate, cost-effective, tailored meals for people with severe, chronic health conditions made worse by poor diet, living in “food deserts,” or not having access to nutritious food choices.
- State Medicaid agencies may rely on several different federal authorities and flexibilities to design an array of services to address SDOH that can be tailored, within applicable federal rules, to address state-specific policy goals and priorities, including the movement from fee-for-service to value-based care, where payment is linked to improved outcomes.

Action: Incentivize health care providers to screen and refer patients for HRSNs, utilizing backbone organizations, such as hubs, as a resource.

- Under the [2024 Physician Fee Schedule](#), traditional Medicare may pay providers for furnishing community health integration, principal illness navigation, and SDOH risk assessment services.

Action: Establish partnerships with backbone organizations, such as hubs, as well as federal, state, tribal, territorial, and local government entities, to address HRSN navigation and coordination of community-based services to address identified needs.

- Payers should consider working in partnership with hubs and CBOs to provide navigation and service coordination facilitated by their community-based workforce, with hubs supporting transition workflows, including contracting mechanisms, referral pathways, and data sharing strategies that can track both health and social needs outcomes to ensure unmet HRSNs are being successfully addressed through closed-loop referrals and follow-up.
- In addition to supporting accountability and quality improvement, data sharing can help facilitate reporting of quality measures related to HRSNs to CMS and other health care accrediting organizations.

- Payers should consider reimbursing the community-based workforce to help with patient navigation and education, facilitate access to services, and improve the quality and cultural competency of the services delivered.
- Partner with hubs working on community resilience, including climate resilience, to incorporate health services into the array of social services provided.
- Partner with federal, state, tribal, territorial, and local government related to policies and community planning to address HRSNs. Partnerships across government entities and health payers could focus on addressing gaps in services based on the identified needs of local communities and how government entities and health plans can use their assets, resources, and other partnerships to build a stronger, more responsive health and service delivery system.

Public Health Departments

Action: In line with the vision of Public Health 3.0, governmental public health agencies have long supported SDOH activities in their jurisdiction, including conducting community health assessments, bringing together multi-sector partnerships, and connecting to health care. With the emergence of community hub models, new opportunities to utilize these existing leadership capacities exist.

- Public health departments have a history of convening multi-sector coalitions that are critical for addressing SDOH and resulting HRSNs. These existing coalitions can be connected to the hub to help address elements of healthy communities. In some cases, the public health department might serve as the hub for the community.

Action: Public health can forge relationships with backbone organizations, such as hubs, to ensure public health capacity and vision as well as programs (i.e., community health workers, screening programs, vaccine and STI programs) are incorporated into the social care delivery infrastructure and determine where intersections exist. They can act as a hub themselves.

- Public health departments are also service providers. They often offer evidence-based programs, such as the National Diabetes Prevention Program, as well as other prevention programs addressing HIV, falls, physical activity, and chronic disease self-management. These are important resources to fulfill HRSNs. Thus, there is an opportunity to engage as network members of hub organizations. Public health departments may also provide training of program facilitators to CBOs, extending the reach of state and local health departments.
- Community health worker programs, training, and certification, as well as other related initiatives supported by public health departments, are important workforce assets for the delivery of social care services through a hub.

Action: Public health departments possess ample knowledge on data, surveillance, evaluation, and community needs assessment that are needed to support community resources, policies, and practices to improve community health. They can complement and amplify the health care arena's work on SDOH and HRSNs by focusing on their core mission of improving the overall health of communities.

- Public health departments can support ongoing evaluation and evidence-building for hub models. Data collected by public health departments, as well as the epidemiologic skills they bring to the table, are critical to supporting community organizations. These data range from reportable communicable and chronic diseases to environmental health concerns including exposure to toxic substances and climate change-related hazards such as extreme heat and how health-vulnerable populations are affected. Public health departments are key organizations that can address health-related policy, leading to population-based health improvement (e.g., tobacco-free laws, safety, and regulatory statutes).
- Community health needs assessments and resulting community health improvement plans can help with the targeting and prioritization of populations and services to align resources more efficiently with existing and emerging social care needs.

Health Information Technology Community

Action: Partner with entities such as hubs, CBOs, and health care organizations in planning and implementing interoperable, community- and person-centric approaches to electronic social care referrals and care coordination. Interoperable approaches facilitate seamless referrals and care coordination across hubs, CBOs, and health care organizations.

- All involved organizations including hubs and referral technology platforms, should work to advance effective, electronically enabled, and equitable referral practices and to understand how electronic social care referrals work — whether they exist and why or why not — in the geographic area or population of focus. This may include supporting the capacity of the community to participate.
- All involved organizations should work together, including trusted community partners and individuals and families, to develop an understanding of shared rights and responsibilities, and support integrated systems, including but not limited to case management. This should be done through a process of co-design, evaluation, and decision-making in partnership with local communities and organizations.

Action: Adopt and advance the use of open data standards included in the ONC Interoperability Standards Advisory and as part of the United States Core Data for Interoperability (USCDI) data set.

- Federal funding opportunities and resources drive organizations to make investments in expanding capacity for interoperable infrastructure.

- Organizations should apply the Foundational Elements of the Social Determinants of Health Information Exchange Toolkit to facilitate interoperability in communities. SDOH information exchange in communities involves more than the underlying technology and must include community buy-in and active participation and partnership across social services and supports, health care organizations, and local CBOs.

Shared Actions Across All Partners

- Aligned with the [HHS Strategic Approach to Addressing Social Determinants of Health](#), engage in shared priority setting and decision making across your community to advance a common strategy to address HRSNs across payers and health systems within a community, in collaboration with trusted community partners and people with lived experience with unmet HRSNs.
- Engage state, local, and tribal grassroots consumer advocacy groups and individuals with lived experiences in all phases and domains of community partnership building.
- Identify, leverage, and support existing community infrastructure and shared assets, such as CBO staff and relationships, to coordinate care for HRSNs instead of duplicating resources within communities.
- Work across local public and private partners, including CBOs, existing community coalitions, public health departments, community mental health centers, local government, businesses, faith-based organizations, and health care organizations, to plan future community investments to fill gaps in meeting HRSNs where needed services and infrastructure don't already exist.
- Establish shared financing among partners to pay for community infrastructure, capacity, and needed services, leveraging, as appropriate, available public and private funds, including Medicaid section 1115 demonstration authority, advanced investment payments in the Medicare Shared Savings Program, and social service and low-income benefit programs.
- Develop an approach, including relevant training, to facilitate seamless, culturally competent referrals for information sharing and reduced burden when accessing multiple systems (e.g., interoperability between referral systems).
- Collaborate across hubs/CBOs and health care organizations to implement referral approaches that “close the loop” between referring health care professionals and CBOs, and as feasible monitor outcomes and service utilization patterns to ensure HRSNs have been met.
- As part of capacity expansion and infrastructure approaches, CBOs, health care organizations, and public health entities using and exchanging data across settings should utilize health IT tools and open data standards consistent with ONC Interoperability Standards Advisory and the Social Determinants of Health Information Exchange Toolkit.

Additional Resources

Community-Based Organizations

- [Advancing Partnerships to Align Health Care and Human Services](#)
- [Braiding Resources to Collaboratively Develop and Strengthen Housing & Services Partnerships](#)
- [Person-Centered Practices Self-Assessment](#)
- [Aging and Disability Business Institute — Connecting Communities and Health Care](#)
- [Partnership to Align Social Care — A National Learning and Action Network](#)
- [Medicare Shared Savings Program Advance Investment Payments — Roles for Community-Based Organizations](#)
- [To Find a Community Care Hub — Searchable Map of Community Care Hub National Learning Community Participants](#) or email communitycarehubs@acl.hhs.gov

Health Systems/Clinicians

- [Aligning Quality Measures Across CMS — the Universal Foundation](#)
- [A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising Practices and Key Insights](#)
- [Physician Fee Schedule Final Rule Fact Sheet](#)
- [Substance Abuse and Mental Health Services Administration — Behavioral Health Equity](#)

Payers

- [State Health Official Letter: Opportunities in Medicaid and CHIP to Address Social Determinants of Health \(SDOH\) \(January 2021\)](#)
- [State Medicaid Director Letter: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care \(January 2023\)](#)

Public Health Departments

- [Public Health 3.0: A Call to Action for Public Health to Meet the Challenges of the 21st Century](#)
- [Partnering to Catalyze Comprehensive Community Wellness — An Actional Framework for Health Care and Public Health Collaboration](#)
- [Community Health Assessment & Health Improvement Planning](#)
- [Community Health Worker \(CHW\) Resources](#)
- [CDC — PLACES: Local Data for Better Health](#)
- [Chronic Disease Self-Management Program](#)
- [Administration for Children and Families Office of Community Services Programs](#)
- [CDC/Agency for Toxic Substances and Disease Registry \(ATSDR\): Environmental Justice Index](#)

Health Information Technology Community

- [ONC Social Determinants of Health Website](#)
- [United States Core Data for Interoperability \(USCDI\)](#)
- [Social Determinants of Health Information Exchange Toolkit](#)

Community Care Hub Conceptual Model*

Funding Sources

Including federal, state, local, philanthropic, and private funds

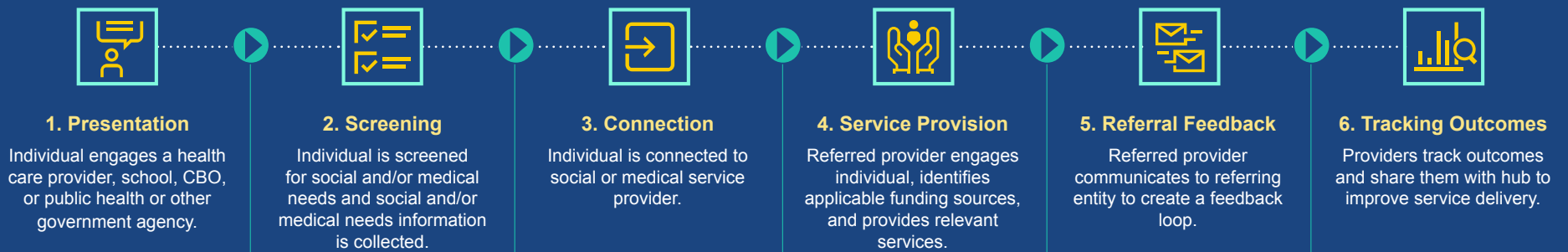
Community health workers may serve an important role in making connections between the various steps in this diagram.



Health IT is an enabling tool for the functions outlined in this visual model that should be used in a coordinated and equitable manner.

Community Care Hub

Community Care Hub coordinates administration functions, funding, and operational infrastructure, including enabling health care contracting on behalf of a wider network of community-based organizations (CBOs) to align care and track outcomes to inform quality improvement and contractual requirements.



*Conceptual model is evolving and may differ between communities. In practice, individuals may not move through this model in a linear fashion.