CHI Intervention Categories and Service Descriptions	
Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit.	
	Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed).
	establishing an action plan.
	Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.
Practitioner, Home-, and Community-Based Care Coordination	
	Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).
	Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.
	Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
	Facilitating access to community-based social services (*e.g.,* housing, utilities, transportation, food assistance) to address the SDOH need(s).
Health Education	

	Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision-making.
Building patient self-advocacy skills	
	Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.
Health care access/health system navigation	
	Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.
Facilitating behavioral change	
	Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.
Faciliating and providing social and emotional support	
	Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.
Levaraging lived experience	
	Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.