American Cancer Society®

Screening for Social Determinants of Health

Health System Organizational Self-Assessment and Toolkit

Acknowledgments

This toolkit was developed by the American Cancer Society's Hospital Systems Capacity Building Initiative for participating Communities of Practice (COP) sites. Health systems can use this toolkit to identify opportunities to improve the systematic screening for social determinants of health within their organization.

We appreciate our colleagues and partners for their contributions to this toolkit.

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Contents

Introduction

Social determinants of health (SDOHs) are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."[1] These social and environmental factors greatly influence population health; addressing the social determinants of health is vital for improving health and reducing health disparities.[2] Despite being ranked as one of the 10 richest countries in the world per capita, the U.S. experiences high rates of health disparities that are rooted in economic, social, and environmental factors. One meta-analysis found that over a third of total deaths in the U.S. in one year were attributable to social factors such as poverty, social supports, racial segregation, and education.[3] On average, there is a 15-year difference in life expectancy between the richest and poorest U.S. residents.[4] Relatedly, location of birth is strongly associated with life expectancy.[5,6]

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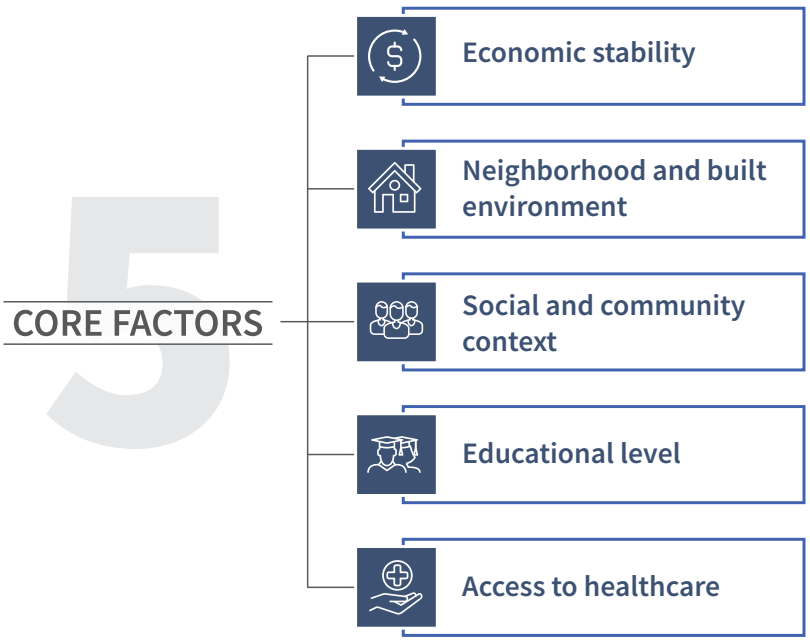
SDOHs are an important factor in cancer prevention, screening, and treatment. Recent evidence shows disparities in cancer screening by age, educational status, insurance status, race/ethnicity, income and geography.[7,8] Similarly, there are disparities in cancer treatment outcomes by SDOH.[9,10] In 2019, the American Cancer Society developed a blueprint for practice, research and policy to understand and address the social determinants of health to improve cancer health equity in the U.S.[11]

In recent years, health systems and clinics have identified the importance of addressing these social determinants of health as a way to improve overall health.

The core five SDOH factors include a patient's:



Other important factors that affect a patient's health include access to transportation, food security, and personal safety. Many health systems are moving toward conducting SDOH screening to link individuals to supports in the community, such as transportation passes, food banks, or housing and employment agencies, with the goal of improving overall health and wellbeing.

This toolkit provides health systems with important resources to develop programs to screen for SDOH.

How to Use This Guide

This toolkit has four main sections:

1

ACS Health System SDOH Self-Assessment

The organizational health assessment on pages 6 to 10 will help your team identify your health system's strengths and opportunities when addressing SDOH. There are 10 questions for your team to review. Consider sharing the assessment with members of your team prior to completing it, so everyone has time to gather the information needed to answer the questions. Agree on a process to collect everyone's feedback. For example, you may want to meet to discuss and reach consensus on the answers or you may want to collect answers and enter an average answer.

2

Matrix for Identifying Next Steps

The matrix on pages 11 to 13 will help you identify potential next steps to improve your health system's SDOH approach. Your answers from the SDOH assessment will assist you in choosing your next steps. The matrix is divided into three tiers – fundamental concepts, implementation resources, and system integration – to assist you with your planning efforts.

3

Action Planning

The action planning template on page 16 will help you prioritize your steps. These steps can be integrated into your team's overall collaborative action plan.

4

Tools

There are tools on pages 17 to 29 to assist you with selected steps in each tier of the matrix. There are also additional SDOH resources for your team to consider.

1 – ACS Health System SDOH Self-Assessment

Health System Organizational Self Assessment for Implementing Social Determinants of Health

This assessment is a tool to identify and reflect on the areas of strength and opportunities for improvement in your health systems' work addressing social determinants of health (SDOH). The purpose of the self-assessment is to illuminate the current processes and capacity related to SDOH screening in order to identify areas for next steps (see: Expanding Capacity for Screening for Social Determinants of Health).

Instructions: Read the statement under each domain and fill in the the answer that best reflects your organization's current status.

Leadership

1. The commitment of leadership in this health care agency to addressing SDOH …

1	2	3	4	Answer
… is not visible or communicated.	…is rarely visible; the communication around the importance of addressing SDOH is rare and inconsistent.	… is sometimes visible and sometimes discussed in meetings; or is visible in some areas and invisible in others.	…fully committed to the work of screening and linking patients to SDOH.	A1

System Prioritization

2. Screening and addressing SDOH…

1	2	3	4	Answer
… is not a priority at this time.	… is a low priority compared to the other work done in the clinical setting.	… is important, but there are other initiatives that are more important.	… is a central focus of the health system.	A2

1 – ACS Health System SDOH Self-Assessment

Champions

3. Responsibilities for supporting and implementing SDOH screening…				
1	**2**	**3**	**4**	**Answer**
…have not been assigned to designated leaders (champions).	…have been assigned to leaders (champions), but no resources have been committed.	…have been assigned to leaders with dedicated resources, but more support is needed.	…have been assigned. Dedicated resources support protected time to support implementation.	A3

Staffing

4. Staffing to support SDOH screening and referral, such as case managers or patient navigators…				
1	**2**	**3**	**4**	**Answer**
… does not exist.	…exist at the health center, but are already overburdened with other work.	…exist at the health center, and have limited time to support SDOH screening and referrals.	…exist at the health center and are able to support SDOH screening and referrals.	A4

1 – ACS Health System SDOH Self-Assessment

Reimbursing Staff Time

5. The ability to reimburse staff time for screening for SDOH and supporting linkages to services…

1	2	3	4	Answer
… is not possible.	…has not been explored.	…has been explored, but challenges remain.	…is currently being done.	A5

SDOH Screening – Topics and Tools

6. The health system…

1	2	3	4	Answer
… has not selected or identified what SDOH to screen for or what screening tool to use.	…has begun discussions of what SDOH to screen for or what screening tool to use.	… has identified what SDOH to screen for, but has not fully integrated a screening tool.	…has integrated a screening tool into their SDOH workflow.	A6

1 – ACS Health System SDOH Self-Assessment

Goal Setting and Measuring

7. Goals for SDOH screening and linkage to services…

1	2	3	4	Answer
… have not been discussed.	… have been discussed, but no specific goals have been made.	… have been discussed, and goals have been identified but not finalized or are not yet SMART or meet other goal measures.	… is documented with SMART (specific, measurable, attainable, realistic, time-based) measures or meet other goal measures.	A7

Workflows

8. Clinic workflows for screening patients for SDOH…

1	2	3	4	Answer
…do not exist.	…exist, but are not followed.	… exist, but are inconsistently followed.	…exist, and are fully implemented.	A8

1 – ACS Health System SDOH Self-Assessment

EHR Integration

9. SDOH screening tools…				
1	**2**	**3**	**4**	**Answer**
…do not exist.	…are all on paper and not integrated into the EHR.	… are inconsistently entered into the EHR.	… are systematically entered into the EHR.	A9

Tracking and Monitoring Patients Screened for SDOH

10. The use of a system to track and monitor patients screened for SDOH…				
1	**2**	**3**	**4**	**Answer**
…has not been explored or is not possible with existing data systems.	…is technically possible, but systems to get useful reports are not in place.	…is possible and systems are in place to produce basic reports on a regular basis.	…is possible, systems are in place, and reports are produced that allow for tracking screening and linkage.	A10

You have completed the assessment and will now move on to suggested next steps based on your answers.

2 – Matrix for Identifying Next Steps

Matrix for Identifying Next Steps in Developing an SDOH Screening Process

The matrix below will help you expand your capacity for screening social determinants of health. Based on your answers from the ACS Health System Organizational Self-Assessment, below are 'next steps' within each domain. Any domains where you reported a '4' are deemed to be strong and do not require next steps. Review how you answered on the ACS self-assessment and identify the appropriate next steps by completing the following matrix. You can find your answers on previous pages 6–10.

Recommendations: Tier 1 – Fundamental Components

Leadership

1. The commitment of leadership in this health care agency to addressing SDOH …

If you answered… 1	If you answered… 2	If you answered… 3	Answer
• Meet with health system and clinical leadership to explore their interest and willingness to support SDOH.			A1 Pg 6

System Prioritization

2. Screening and addressing SDOH…

If you answered… 1	If you answered… 2	If you answered… 3	Answer
• Determine whether leaders, clinicians, and clinical staff think SDOH screening and linkage to services is important for clinical care.	• Determine whether leaders, clinicians, and clinical staff believe SDOH should be prioritized by the organization.	• Determine whether the current level of prioritization of SDOH is sufficient to effectively screen and link patients to services.	A2 Pg 6

2 – Matrix for Identifying Next Steps

Champions

3. Responsibilities for supporting and implementing SDOH screening…

If you answered… 1	If you answered… 2	If you answered… 3	Answer
• Identify a potential clinical champion for the SDOH screening and linkage program. • Use the **Clinical Champion Checklist** on page 19 for considerations in selecting a champion.	• Work with leadership to identify resources to provide champion protected time, EHR staffing support, or other project management support for the program.		A3 Pg 7

Recommendations: Tier 2 – Implementation Resources

Staffing

4. Staffing… Staffing to support SDOH screening and referral, such as case managers or patient navigators…

If you answered… 1	If you answered… 2	If you answered… 3	Answer
• Explore the ability to reimburse for services through Medicaid. • See the **Reimbursing Staff Time for SDOH Screening and Linkage** on page 20.			A4 Pg 7

2 – Matrix for Identifying Next Steps

Reimbursing Staff Time

5. Reimbursing Staff Time… The ability to reimburse staff time for screening for SDOH and supporting linkages to services…

If you answered... 1	If you answered... 2	If you answered... 3	Answer
• Explore the ability to reimburse for services through Medicaid. • See the **Reimbursing Staff Time for SDOH Screening and Linkage** on page 20.			A5 Pg 8

SDOH Screening – Topics and Tools

6. The health system…

If you answered... 1	If you answered... 2	If you answered... 3	Answer
• Use the **Guide to Developing SMART Goals** on page 24 to identify goals and metrics to track progress. • Use the **Screening and Linkages Checklist** on page 21 to explore what SDOH components to screen for and what services exist for linkages. • Identify what services need to be expanded. • Conduct ongoing outreach to community agencies to expand services.			A6 Pg 8

2 – Matrix for Identifying Next Steps

Goal Setting and Measuring

7. Goals for SDOH screening and linkage to services...

If you answered... 1	If you answered... 2	If you answered... 3	Answer
• Use the **Guide to Developing SMART Goals** on page 24 to identify goals and metrics to track progress.			A7 Pg 9

Recommendations: Tier 3 – Systems Integration

Workflows

8. Clinic workflows for screening patients for SDOH…

If you answered... 1	If you answered... 2	If you answered... 3	Answer
• Use the **Workflow Process Map** on page 26 to develop a workflow for screening and linking patients to SDOH services.	• Use the **Workflow Process Map** on page 26 to map the existing workflow for screening and linking patients to SDOH services, identify challenges, and explore potential solutions.		A8 Pg 9

2 – Matrix for Identifying Next Steps

EHR Integration

9. SDOH screening tools…

If you answered... 1	2	3	Answer
• Meet with IT/EHR staff to explore whether the current EHR allows for screening for SDOH. • For more information, review **Integrating SDOH Screening into the EHR** on page 28.	• Meet with IT/EHR staff to explore whether the current EHR allows for screening for SDOH. • For more information, review **Integrating SDOH Screening into the EHR** on page 28. • Meet with leadership to identify resources to expand IT support for building systems.	• Use the **Workflow Process Map** on page 26 to map how the screening tool is entered into the EHR, identify challenges, and explore potential solutions.	A9 Pg 10

Tracking and Monitoring Patients Screened for SDOH

10. The use of a system to track and monitor patients screened for SDOH…

If you answered... 1	2	3	Answer
• Meet with IT/EHR staff to explore whether the current EHR allows tracking or monitoring screening. • For more information, review **Integrating SDOH Screening into the EHR** on page 28.	• Meet with IT/EHR staff to explore whether the current EHR allows tracking or monitoring screening. • Meet with leadership to identify resources to expand IT support for building systems.		A10 Pg 10

3 – Action Planning

In the previous table, the domains are placed in tiers that range from 1 to 3.

TIER 1 Likely the most essential for implementation

TIER 2 Needed, but are likely dependent on the completion of Tier 1 domains

TIER 3 Important or good to have, but perhaps not required or essential for early program implementation

Use the action plan below to list your top 3-5 priorities, prioritizing domains by Tier (starting with Tier 1). List the next steps from the table above, and updates on progress to date (see the example). It is recommended that you build capacity related to Tier 1 (until you reach a answer of 3 or 4 on the self-assessment) before moving on to Tier 2 activities.

Example:

Priority	Next Step	Progress Update
Workflows	Use the Workflow Process Map to develop a workflow for screening and linking patients to SDOH services.	Meeting with clinical team next Tuesday to work through workflow process map.

Priority	Next Step	Progress Update

4 – Tools

On the following pages are tools to assist you with tiers 1, 2, and 3. These tools include:

TIER 1

- Clinical Champions

TIER 2

- Staffing and Reimbursing Staff
- Screening and Linkages
- Goals and Measurement

TIER 3

- Workflow Process Mapping
- EHR Integration

4 – Tools

TIER 1

Clinical Champions

"Champions" are individuals who are committed to supporting the implementation of a new intervention/process. The champion will lead or support the work of gathering and evaluating data on existing processes or on potential changes; engaging leadership, thought leaders, or others to explore the topic; seeking best practices; and implementing and guiding changes.

Champions are often most successful when they work in collaboration with a team, including people in leadership, representatives from IT or other relevant parties, and support staff with time to support implementation. Alternatively, other models have found success with a few champions (2-3) that work closely together to tackle an issue.

Research on the importance of champions is emerging, but several characteristics of champions have been identified. In determining a champion for your program, consider the following characteristics:

- Who has enough influence or power within the organization to make things happen? This can include both authority through positions of leadership, or influence through respect and reputation.
- Who has the available time to commit to implementation?
- Who is intrinsically motivated and enthusiastic about the practice they are promoting (SDOH screening)?
- Who is a strong communicator, with the ability to persuade and motivate to make the required changes?

In addition to these characteristics, there are other characteristics that are especially helpful, but not required in a champion.

- Who has content expertise/knowledge that is relevant for SDOH screening/implementation (e.g., behavioral health specialist/social worker, other relevant past education/experience)?

4 – Tools

TIER 1

Brainstorm Potential Champions

Clinical Champion Checklist						
Name	**Reach/ Influence?**	**Available time?**	**Enthusiastic about SDOH?**	**Strong communicator?**	**Content expertise?**	**Other comments**

Reach out to these potential champions to gauge their interest in leading this important effort.

For more information:

- Damschroder, L. J., Banaszak-Holl, J., Kowalski, C. P., Forman, J., Saint, S., & Krein, S. L. (2009). The role of the "champion" in infection prevention: results from a multisite qualitative study. BMJ Quality & Safety, 18(6), 434-440. **https://qualitysafety.bmj.com/content/18/6/434.short**
- Kaplan, H. C., Brady, P. W., Dritz, M. C., Hooper, D. K., Linam, W. M., Froehle, C. M., & Margolis, P. (2010). The influence of context on quality improvement success in health care: a systematic review of the literature. The Milbank quarterly, 88(4), 500-559. **https://pubmed.ncbi.nlm.nih.gov/21166868/**

4 – Tools

TIER 2

Staffing and Reimbursing Staff

It may be possible for your health system to be reimbursed for your work screening and addressing SDOH through Medicaid or other sources.

Below are some resources that may help you explore your options:

- Kaiser Family Foundation, **State Health Facts**
- National Academy for State Health Policy (**NASHP**)
  - » **States are advancing healthy food policies in 2020**
  - » **NASHP's Housing and Health Resources for States**
- Medicaid and CHIP Payment and Access Commission (**MACPAC**)
- National Association of Medicaid Directors (**NAMD**)
- Department of Health and Human Services issued updated guidance in January 2021 to support addressing SDOH [**pdf**]
- Health Affairs Blog has an **entry** focused on reimbursement for SDOH

Beyond the links above, consider:

- Contacting other health systems in your area to investigate if and how they reimburse for SDOH screening and linkage to services.
- Medicaid managed care plans may also support addressing SDOH. For example, **UnitedHealthcare** supports affordable housing in underserved communities. Contact managed care plans/insurers/payers to investigate whether they have policies related to SDOH screening and linkage to services.

4 – Tools

TIER 2

Screening and Linkages

Use the checklist below to identify what components of SDOH you currently screen for, and identify the existing programs and services in the community that you work with to support patients with those needs. For each component, respond whether you do screen or have an interest in expanding screening. If you respond that you do or may want to screen for each component, please detail what services or programs in the community you have relationships with to refer patients (e.g., food banks, employment or housing services).

Consider completing this checklist in collaboration with your partners, including local state and local health departments.

Social Determinants of Health Screening and Linkages Checklist			
Topic	Yes – we screen for this.	Is there a plan to expand screening in this area in the next year?	What services/programs in the community do you work with to support needs in this area?
Economic Stability			
Employment			
Utilities			
Child care			
Finances			
Food			
Other: _____			
Education Access and Quality			
English language comprehension			
Education status			
Other: _____			

4 – Tools

TIER 2

Social Determinants of Health Screening and Linkages Checklist			
Topic	**Yes – we screen for this.**	**Is there a plan to expand screening in this area in the next year?**	**What services/programs in the community do you work with to support needs in this area?**
Social and Community Context			
Incarceration status			
Immigration status			
Personal Safety			
Intimate Partner Violence			
Social integration/social support			
Other: _____			
Healthcare Access and Quality			
Insurance type/status			
Health literacy			
Other: _____			
Neighborhood and Built Environment			
Housing			
Neighborhood			
Transportation			
Other: _____			

4 – Tools

Other National Resources to Explore

Community Resources for Addressing Social Determinants of Health	
General Resources	
211 – Essential Community Services Line	**http://www.211.org**
Aunt Bertha – National social care network to connect people to resources	**http://www.auntbertha.com**
Cap4Kids – Linkage to community resources to improve the lives of children and families	**http://cap4kids.org**
Food Insecurity	
Feeding America – Network of food banks and food pantries	**http://www.feedingamerica.org**
Supplemental Nutrition Assistance Program (SNAP) – Federal program that provides nutrition assistance	**http://www.fns.usda.gov/snap**
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Federal program that provides nutrition assistance	**http://www.fns.usda.gov/wic**
Housing	
Public Housing and Voucher Program – Federal program to provide low-income families, the elderly, and the disabled with housing in the private market	**http://www.hud.gov/topics/ rental_assistance**
Legal Topics	
Medical-Legal Partnerships – provides legal services as a way to respond to social needs.	**http://medical-legalpartnership.org**

4 – Tools

TIER 2

Goal Setting and Measurement

Programs can fail because there is not a sufficient focus on goal setting and tracking. It is important to create systems to develop and track goals, to ensure the program is having the desired impact.

A useful pneumonic for developing goals is SMART – specific, measurable, attainable, relevant, time-based.

S

Specific:

Create a goal with specific numbers and real deadlines.

For example: "We want to screen 75% of patients in primary care for SDOH by the end of the year."

M

Measurable:

Make sure your goal is actual countable and trackable.

For example: If the goal is 75%, ensure you can calculate both the numerator (the number of patients screened) and the denominator (the number of patients; the number of active patients; the number of patients who have visited the clinic during the time period).

A

Attainable:

Select a goal that is challenging but possible.

For example: A goal of 25% screening for SDOH is likely very easy; 50% is more challenging; but 75% would require relatively consistent effort across clinics and clinical staff.

R

Realistic:

Be honest with yourself and your team's capabilities. Do not make a goal too challenging.

For example: A goal of 95-100% may be an ideal, but may be unattainable at the beginning. Consider setting a more realistic goal, if even for the short-term.

T

Time-based:

Give yourself a deadline. Goals that have amorphous deadlines are hard to measure and track.

For example: A goal 6-12 months out provides time for ramp up, implementation, and tracking.

4 – Tools

TIER 2

Other Considerations and Suggestions

- Consider creating short-term goals for 'easy wins' to gain momentum.
- Make sure to celebrate successes.

Guide to Developing SMART Goals					
	Is the Goal...				
List Goal(s)	Specific?	Measurable?	Attainable?	Realistic?	Time-based?

4 – Tools

TIER 3

Workflow Process Mapping

A process map is a useful tool for depicting the actual or intended process to ensure activities are completed in a timely and efficient manner. When thinking about screening patients for SDOH, consider the following questions to outline steps involved:

How are patients identified for screening?

- Are they screened during every visit? Just particular visits (e.g., physicals)?
- Who is alerted that a patient should be screened (e.g., the medical assistant who rooms the patient, or the front desk staff who checks the patient in)? How does the alert happen (is it programmed into the EHR)?

How does the patient complete the screening tool (on paper, on a tablet, on their phone)?

- If the screening tool is on paper, how does the screening tool get entered into the EHR?
- Are there separate fields for results in each category in the EHR?

Who reviews/responds to the screening tool?

- How does your system prompt providers/clinicians that a screening tool is ready for review? (EHR prompts, physical reminders in charts)
- Does the provider/clinician review and refer to services? Or do eligible patients get automatic referrals to a case manager/navigator for support?
- How much time elapses between the patient completing the screen and being referred to services, if eligible?

How are the results of the referrals tracked?

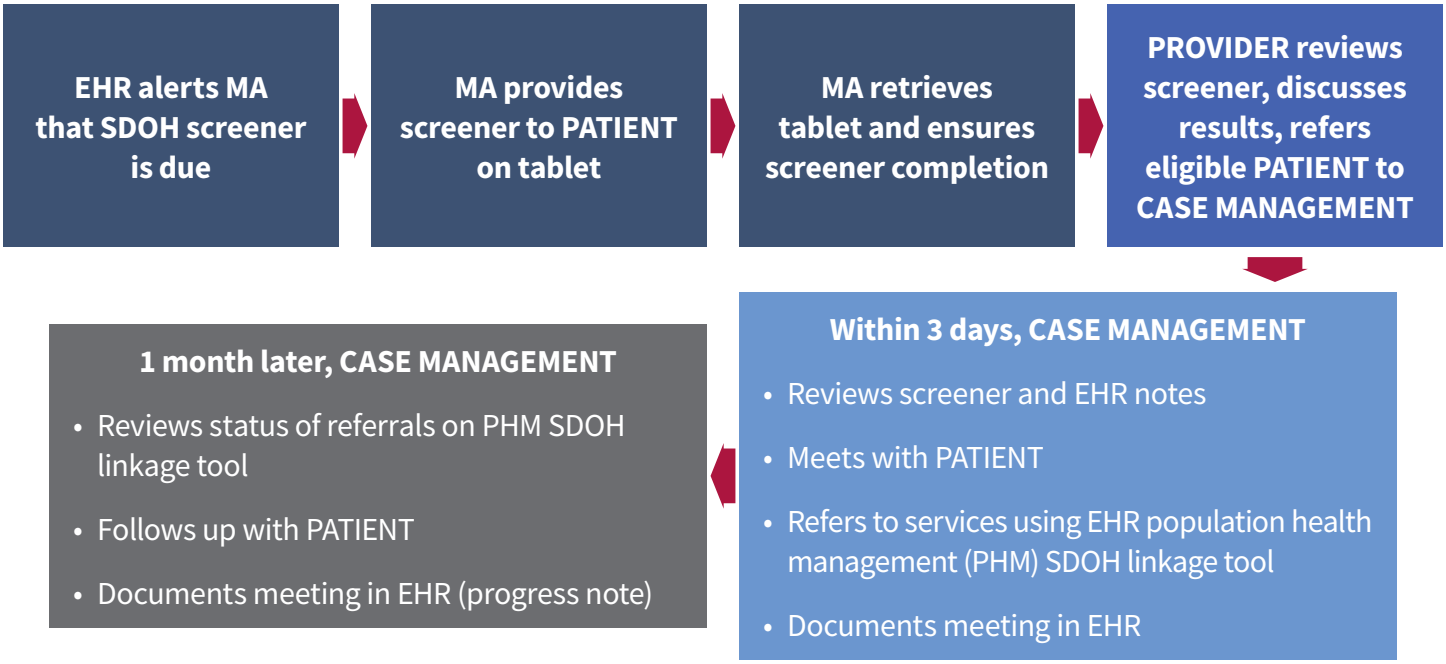
- Do partner organizations receive notification of referrals provided to patients?
- Do we have a mechanism to track referral progress or outcomes? If so, how is this documented (e.g., notes fields, attachments, fields in the EHR)? Who is responsible for follow-up with patients and/or partner organizations?

Next, begin to visually map out the process of screening. Consider using different colors or shapes to depict roles or decision points. In the example below, blue squares are the responsibility of the medical assistant (MA), green squares are the responsibility of the provider, and orange squares are the responsibility of case management.

4 – Tools

TIER 3

Example SDOH Screening and Linkage Process



Meet with the clinical team (e.g., medical assistants, providers, and case management) to verify or revise this workflow, assessing any challenges and potential solutions. You can find different types of process maps to use **here**.

Consider **posting this process map** with some information about the screening process to re-affirm commitment to SDOH screening and linkage to services.

4 – Tools

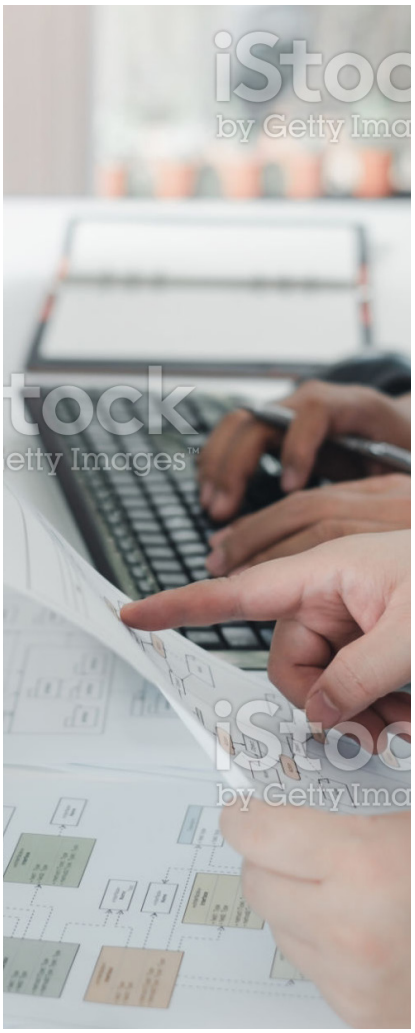
TIER 3

EHR Integration

Because of the importance of the social determinants of health in overall population health, many health systems are integrating SDOH screening and services within their population health management systems. To support this work, more and more electronic health records (EHR) are integrating SDOH screening and linkage tools into their systems.

Developing EHR Functionality

Work with your IT/EHR staff to identify the existing or available tools within the EHR to screen, link, or track patients to services. Here are some screening questions to explore in these conversations.



Screen

- How can the SDOH screening tool or result entered in to the EHR? Can the patient complete the screening tool electronically for it to save in the EHR? Can a staff member report the screening tool answer into a field in the EHR?
- Where can the results from previous screening tools be seen or reviewed? Can a panel or field be included?

Link

- Can referrals to services be made through the EHR? For example, **Aunt Bertha** can be integrated into existing care management systems.
- Can a dashboard or EHR panel be used to display the SDOH needs and services linked to aid referrals?
- How can case managers/patient navigators/community health workers document the work they are doing to support SDOH? Can progress notes for this role be added?

Track

- Once a patient screens for SDOH needs, how can the care team track linkages.
- Can the tracking system be monitored from a population health level, to capture metrics related to number of patients screened, number of patients referred, and number of patients who received services?

4 – Tools

ICS-10 Codes

Some health systems have integrated SDOH Screening into their EHR using ICD-10 Codes. Below we link to a variety of resources to support your health system exploring how to integrate ICD-10 answers into your EHR.

- The **American Hospital Association** has an extensive overview for ICD-10-CM Coding for Social Determinants of Health [**pdf**]
  - » The AHA also supports the **AHA Coding Advisor** service to improve ICD-10-CM coding.
- The J**ournal of American Health Information Management Association** (AHIMA) has an **article** to improve ICD-10-CM Coding for SDOH
- **Centers for Medicare & Medicaid Services** developed a **Data Highlight** to describe Z Codes Utilization among Medicare Fee-For-Services Beneficiaries in 2017.

Other Resources

- The **National Committee for Quality Assurance** has developed this Population Health Management **Resource Guide**, which includes a section on Social Determinants of Health (see page 24).

Testing Functionality

Once you have identified and developed new EHR tools and functionality to support SDOH screening, linkages, and tracking, review and test the tools thoroughly.

- Work with end users (providers, case managers) to work through the functionality, recognizing any challenges and possible solutions
- Consider developing a tipsheet to aid the use of the SDOH tools and functionality

The following are helpful resources that provide guidance on how to collect information, what information to collect, how to connect patients with resources, and so on. They can be useful tools in addition to the tools developed as part of this self-assessment and toolkit.

- The **Agency for Healthcare Research and Quality** has developed "**Identifying and Addressing Social Needs in Primary Care Settings**"
- The **Center for Health Care Strategies** has developed "**Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations**"
- The **Centers for Disease Control and Prevention** has developed S**DOH data, research, tools for action, programs, and policy resources**.
- **Healthy People 2030** has identified **goals and objectives for five SDOH domains**.
- The **National Association of Community Health Centers** has developed a suite of tools related to their **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences** (PRAPARE), including an **implementation and action toolkit**, **trainings**, an **infographic**, and **frequently asked questions**.

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