COLLECTING STANDARDIZED DATA ON SOCIAL DETERMINANTS OF HEALTH TO ADDRESS STRUCTURAL RACISM, DRIVE HEALTH EQUITY, AND RESPOND TO COVID-19

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NATIONAL ASSOCIATION OF Community Health Centers®

AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

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Executive Summary

Identifying and documenting the socioeconomic and structural drivers of poor outcomes, health disparities, and higher costs is recognized as a necessary step for providers caring for complex patients and accountable for population health goals. Current events underscore the critical importance of addressing these social determinants of health (SDOH), with populations served by Health Center Program grantees and look-alikes being disproportionately impacted by COVID-19 and health centers committed to addressing structural racism and health equity. By collecting standardized data on the SDOH, Health Center Program grantees and look-alikes can use that information to provide more appropriate, comprehensive, and integrated patient-centered care—either in-house through interdisciplinary teams or through community partnerships.

In response to a growing demand for training and technical assistance (T/TA) to support the implementation and use of standardized social risk assessment tools at health centers and look-alikes, the National Association of Community Health Centers (NACHC), in partnership with the Association of Asian Pacific Community Health Organizations (AAPCHO), have convened various stakeholders representing the Health Resources and Services Administration (HRSA), Bureau of Primary Health Care (BPHC) Health Center Program. This includes the various HRSA-funded T/TA providers representing the 21 National Training and Technical Assistance Partners (NTTAPs), 52 state and regional Primary Care Associations (PCAs), and 49 Health Center Controlled Networks (HCCNs). Given the increasing number of health centers collecting standardized SDOH data, there is a desire for further collaboration on SDOH-related programmatic goals to spread SDOH screening strategies and best practices among health centers. NTTAPs serving special and vulnerable populations, for example, are expected to increase the number of health centers that have received T/TA on screening and documenting social determinants.

The publication is divided into different sections, including eight (8) "Power Packs", where the reader can select which population of focus they would like to learn more about. While each Power Pack is interconnected and builds off of one another, each Power Pack can be a standalone resource for T/TA providers serving a special and vulnerable population type (e.g. individuals or families experiencing homelessness; LGBTQ+ people; migratory and seasonal agricultural workers; older adults; people experiencing intimate partner violence; residents of public housing; and school-aged children).

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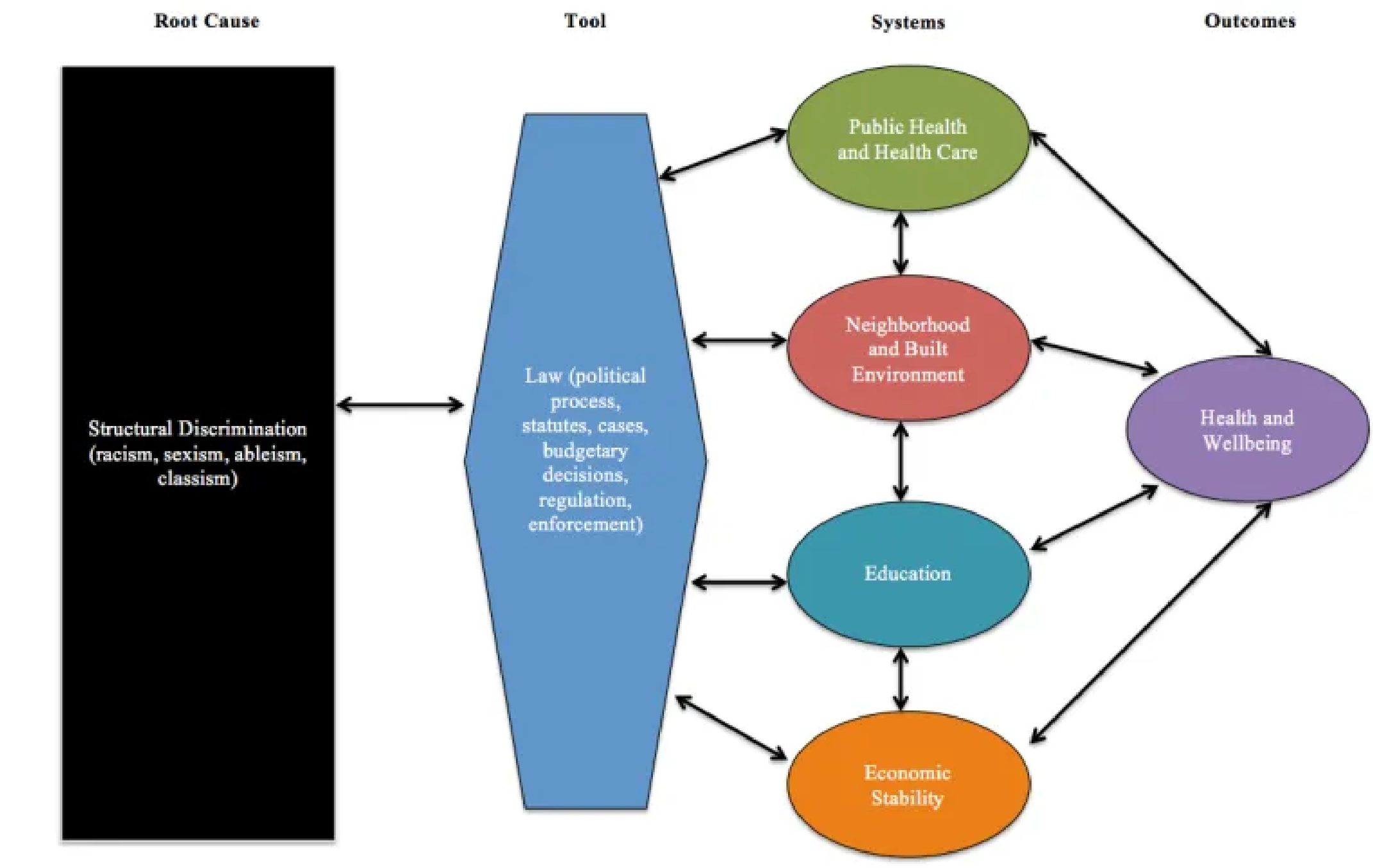
Introduction

Social Determinants of Health (SDOH) data collection has the power to address structural racism, drive health equity, and respond to public health emergencies, such as the COVID-19 pandemic. In order to collect SDOH data, we must first understand the principles and root causes of SDOH.

Social determinants of health (SDOH) 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)

Structural racism plays an active role in designing systems to produce racial inequalities in the continental U.S., Hawai'i, U.S. Territories, and the Compacts of Free Association.

To drive health equity and address health disparities, it is important to acknowledge structural discrimination as the root cause of SDOH. (2)



Revised SDOH Framework created by Ruqaiijah Yearby (2020)

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1) Social Determinants of Health. Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health
2) Yearby, R. (2020). Structural Racism: The Root Cause of the Social Determinants of Health. https://blog.petrieflom.law.harvard.edu/2020/09/22/structural-racism-social-determinant-of-health/

Publication Overview

The COVID-19 pandemic underscores the critical importance of addressing SDOH with populations served by Health Center Program grantees and look-alikes. It is well documented that populations served by the Health Center Program are disproportionately impacted by COVID-19. Throughout the pandemic, health centers have demonstrated their continued commitment to address structural racism and drive health equity for the underserved.

This publication will present key findings from a national assessment of training and technical assistance (T/TA) strategies for supporting community health centers in systematically implementing patient-level SDOH screening and data standards, documenting findings in clinical records, and developing strategies to address SDOH risk factors and needs at the patient and population levels. Additionally, the publication will highlight key findings from interviews between T/TA providers and health centers regarding recommended SDOH screening strategies.

HRSA-funded T/TA providers -- including National Training and Technical Assistance Partners (NTTAPs), state and regional Primary Care Associations (PCAs), Health Center Controlled Networks (HCCNs) -- can utilize this publication to strengthen existing T/TA strategies to increase or improve health centers' SDOH screening, documentation, and intervention efforts.

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Overview of Training and Technical Assistance Providers

HRSA funds 21 National Training and Technical Assistance Partners (NTTAPs), 52 state and regional Primary Care Associations (PCAs), and 49 Health Center Controlled Networks (HCCNs) as T/TA providers for health centers. (3) NTTAPs, PCAs, and HCCNs with a HRSA cooperative agreement are required to work in concert with each other to serve the health center program (see Figure 1 below). In order to distinguish the scope of work and activities of the NTTAPs, PCAs, and HCCNs, below is a program overview of the different T/TA provider types (as defined by HRSA): (4)

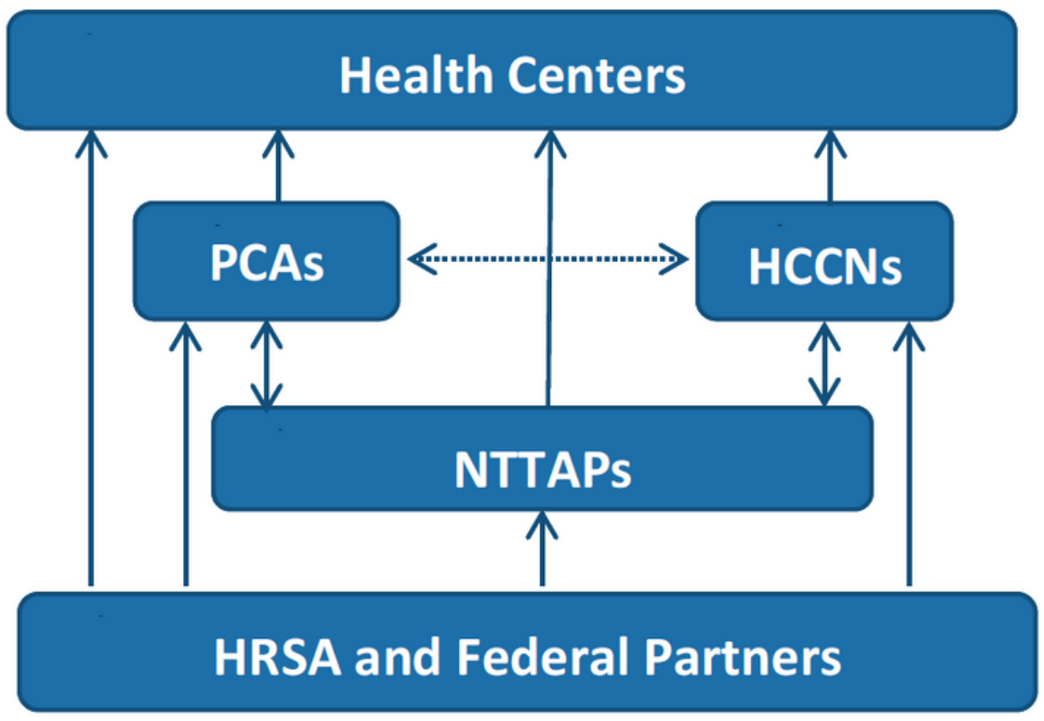

Figure 1. HRSA-supported T/TA Partners

National Training and Technical Assistance Partner (NTTAP): provide national-level T/TA to support health centers to innovate and otherwise advance their operations and care delivery models to adapt to current and anticipated changes in the health care environment and in their local communities. (5)

Primary Care Association (PCA): develop state and region-specific T/TA to support increased access to comprehensive primary care services, accelerated value-based care delivery, a health center workforce that addresses current and emerging needs, enhanced emergency preparedness and response, and advanced health center clinical quality and performance. (6)

Health Center Controlled Network (HCCN): develop tools and resources to increase participation in value-based care through enhancing the patient and provider experience, advancing interoperability, and using data to enhance value. (7)

In addition, NTTAPs, PCAs, and HCCNs possess the collective knowledge, skills, and abilities in serving communities that are made vulnerable due to systems that, by law and regulation, have been structured in a racially discriminatory way. 1,400+ HRSA-funded health centers and health center look-alikes either bear witness to and/or have researched, different forms of structural discrimination -- racism, sexism, homophobia, ableism, xenophobia, ageism, and classism.

3) Health Center Resource Clearinghouse - Our Partners. https://www.healthcenterinfo.org/our-partners/
4) HRSA Health Center Program. Strategic Partnerships. https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/index.html
5) HRSA. National Training and Technical Assistance Partners. https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/national-training
6) HRSA. Primary Care Associations. https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html
7) HRSA. Health Center Controlled Networks. https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/hccn.html

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Overview of Training and Technical Assistance Providers

As Training & Technical Assistance (T/TA) providers, we have the power, privilege, and responsibility to guide the health centers that we serve, to be able to assess for social risk factors that patients and vulnerable community members experience, especially during the COVID-19 pandemic; and with this social risk assessment data, would we be able to utilize at the individual level (to improve patient care), organizational level (to design care teams), system/community level (to change local policies), payer level (to executive payment models that sustain value-based care), and policy level (to ensure capacity for serving complex patients). While all levels are important, it is at the policy level, where we can truly begin to work towards improving the health and wellbeing of racial and ethnic minorities; thus achieving racial health equity.

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SDOH Screening T/TA Needs Assessment Findings

Overview

The Association of Asian Pacific Community Health Organizations (AAPCHO) and the National Association of Community Health Centers (NACHC) developed a Needs Assessment to assess how T/TA providers can be supported to assist health centers in implementing patient-level SDOH screening and data standards, documenting findings in clinical records, and developing strategies to address SDOH risk factors at the patient and population levels. The Needs Assessment was reviewed by eight NTTAPs and four PCAs/HCCNs.

The Needs Assessment was launched nationally between February 28, 2021 and April 5, 2021, with the target population being NTTAPs, PCAs, and HCCNs. T/TA providers that served the following special and vulnerable populations were prioritized (in alphabetical order): Individuals or Families Experiencing Homelessness, LGBTQ+ People, Migratory & Seasonal Agricultural Workers, Older Adults, People Experiencing Intimate Partner Violence, Residents of Public Housing, and School-Aged Children.

Results

The Needs Assessment collected responses from 41 PCAs, 37 HCCNs, and 14 NTTAPs. Of the PCA responses, 24 were also HCCNs. Of the HCCN responses, 25 were also PCAs. After cleaning the data, a total of 65 responses were analyzed.

Key Findings

- T/TA Needs for SDOH Screening Implementation for Health Centers
  - Implementing Customized Workflows
  - Getting Staff Buy-In
  - Collecting and Sharing Impact Stories
  - Identifying and Promoting Best Practices
- T/TA Needs for Upstream Initiatives
  - Demonstrating the Value of SDOH Data Collection
  - Leveraging SDOH Data to Raise Awareness of Patient Needs
  - Identifying Opportunities for Risk Stratification
- Strategies for SDOH Screening T/TA
  - Peer Sharing and Learning

Collecting data on the social determinants of health using an SDOH screening tool can be accomplished in a variety of ways. There is no absolute “right way” — only what works best in your setting. Use your organizational workflow to identify opportunities for staff to engage with patients (i.e. waiting room) for meaningful discussions to assess social determinants without lengthening the visit. Think of your organizational workflow to identify opportunities when patients are waiting to be seen or are not engaged in meaningful connection with staff and use that time instead for dialogue and assessment around social determinants so as not to lengthen the visit.

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SDOH Screening Workflows

Also, consider how SDOH screening workflows can align with existing staff roles and responsibilities as there are many different types of staff who can help implement SDOH screening. From there, you can determine where in the organization and who amongst your staff would have the available time and skills to administer SDOH screening with the patient and address their needs. (8)

Use PRAPARE's Five Rights Framework to determine the best SDOH data collection and response workflow for your own setting. The framework below walks through the key questions to consider when determining your PRAPARE workflow.

THE RIGHT INFORMATION	IN THE RIGHT FORMAT	WITH THE RIGHT PEOPLE	VIA THE RIGHT CHANNELS	AT THE RIGHT TIMES
WHAT sociodemographic information is already being collected that PRAPARE can align with rather than duplicate? How will intervention or resource information be organized so that it is readily available and standardized for all when needs are identified by PRAPARE?	**HOW** will the PRAPARE tool be administered to patients to ensure it accurately and respectfully captures the patients' social determinants of health?	**WHO** will collect the PRAPARE data and who will address the social determinant needs identified?	**WHERE** will PRAPARE data be collected and how will it be shared with the appropriate care team members to inform care appropriately and address needs identified?	**WHEN** in the patient visit does it make sense to administer the PRAPARE tool and when is the best time to address the identified needs?

8) Adapted from the PRAPARE Implementation and Action Toolkit by AAPCHO, NACHC, Oregon Primary Care Association.

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SDOH Screening Workflows

5 Rights	Workflow Considerations
Right Information--WHAT	What information in PRAPARE do you already routinely collect? • Part of registration • Part of other health assessments or initiatives
Right Format--HOW	How are we collecting this information and in what manner are we collecting it? • Self-Assessment • In-person with staff
Right Person--WHO	Who will collect the data? Who has access to the EHR to input the data? Who needs to see the information to inform care? Who will respond to needs identified? • Providers and other clinical staff • Non-Clinical Staff
Right Time--WHEN	When is the right time to collect this information so as to minimize disruption to clinic workflow? • Before visit with provider? (before arriving at clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?
Right Place--WHERE	Where are we collecting this information? Where do we need to share and display this information? • In the waiting room? In a private office? • Share during team huddles? Provide care team dashboards?

© 2021. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

Photo Courtesy of AAPCHO

SDOH Screening Strategies During / After COVID-19 Pandemic

Through a series of stakeholder meetings and CHC listening sessions via Zoom, NTTAPs, PCAs, and HCCNs identified key SDOH screening strategies and recommendations from 22 health centers across the continental U.S. SDOH screening strategies for specific special and vulnerable population groups were identified, including but not limited to the following HRSA defined groups of persons who face economic, cultural or linguistic barriers to health care:

- **Individuals or Families Experiencing Homelessness:** the term "homeless individual" means "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing." (9)
- **Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQIA+) People:** a diverse community that share a common need for culturally competent health care that recognizes and responds to specific medical risks. The LGBTQ+ community faces greater health challenges than their heterosexual peers. This is due to a combination of the following: differences in sexual behavior; social and structural inequities (e.g. stigma and discrimination) (10)
- **Migratory and Seasonal Agricultural Workers:** the term "migratory agricultural worker" means "an individual whose principal employment is in agriculture, who has been employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode." Per section 330(g)(3)(B), "seasonal agricultural worker" means "an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker." (11)
- **Older Adults:** the age 65 years and older population that require innovative and culturally competent models of care, which may include inter-professional training, educational resources, and technical assistance to health care professionals in community health centers who provide care to older adults (12)
- **People Experiencing Intimate Partner Violence:** defined as individuals experiencing or surviving intimate partner violence and human trafficking, which may require health centers to be trained in trauma-informed services, partnerships and policy development, and the integration of processes designed to increase the identification and referral to treatment for this population.
- **Residents of Public Housing:** the population served includes residents of public housing and individuals living in areas immediately accessible to public housing. Public housing includes public housing agency-developed, owned or assisted low-income housing, including mixed finance projects, but excludes housing units with no public housing agency support other than Section 8 housing vouchers. (13)
- **School-Aged Children:** defined as children, youth, and adolescents, which may require that health centers increase capacity to address the unique health needs of this population and improve the health outcomes of underserved youth, particularly in school-based health centers (14)

9) HRSA. Health Center Program Terms and Definitions. https://www.hrsa.gov/sites/default/files/grants/apply/assistance/Buckets/definitions.pdf
10) HRSA. Health Equity for Diverse Populations. https://www.hrsa.gov/about/organization/bureaus/ohe/populations/diverse-populations.html#lgbt
11) HRSA. Health Center Program Terms and Definitions. https://www.hrsa.gov/sites/default/files/grants/apply/assistance/Buckets/definitions.pdf
12) HRSA. National Training and Technical Assistance Partners. https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/national-training

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SDOH Screening Strategies During / After COVID-19 Pandemic

Additional SDOH screening strategies are offered by health centers that collaborate closely with their PCAs and HCCNs. The population specific “Power Packs” and associated quotes below are general reflections by health center administrators, clinical providers, and non-clinical providers. The quotes are modified and phrased to actively portray key insights for T/TA providers and health centers.

Photo Courtesy of AAPCHO

13) HRSA. Glossary. https://bphc.hrsa.gov/programrequirements/compliancemanual/glossary.html
14) HRSA. National Training and Technical Assistance Partners. https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/national-training

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Individuals or Families Experiencing Homelessness

Did you know? **Corporation for Supportive Housing (CSH)** is a key provider of technical assistance where housing and health intersect, offering health centers instruction in the development of clinical and operational processes that are culturally sensitive and appropriate for the unique needs of patients experiencing homelessness or residing in public housing. **Request TA from CSH**.

National Health Care for the Homeless Council (NHCHC) provides health centers with tailored technical assistance designed to address the needs of unstably housed individuals and includes trauma-informed care, chronic and acute medical management of unstably housed individuals, and outreach and enabling services. **Request TA from NHCHC**.

SDOH Screening Considerations:

- Minimizing Duplication: How to ask questions only once across the system and providing the why.

Photo Courtesy of NHCHC

  - ***"It is recommended to review the SDOH screening questions, and identify if any of them are asked in your behavioral health and/or case management assessments. Try to develop workflows that result in providers not having to reassess and/or repeat SDOH screening questions."***
  - ***"It is important to remember that patients are not thinking about the different data systems we're trying to navigate. It is recommended to develop a tool that is flexible to meet patients where they are at. It is also recommended that screeners are well-versed in why we are collecting SDOH data, and what happens with that data."***

- Data Collection and Reporting: How to collect SDOH data and pull reports efficiently to evaluate social needs

  - ***"Explore opportunities to automatically populate and streamline SDOH data from multiple assessments. It is recommended to implement a data management tool that serves as a one-stop shop, where you can pull reports, evaluate data, and conduct a deep dive on specific social needs. One of many tools that exist out there is Azara."***

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LGBTQIA+ People

Did you know? The **National LGBTQIA+ Health Education Center** provides educational programs, resources, and consultation to health centers with the goal of optimizing culturally affirming, patient centered, high-quality and cost-effective health care for lesbian, gay, bisexual, transgender, queer, asexual, and all sexual and gender minority people.
Request TA from the National LGBTQIA+ Health Education Center.

SDOH Screening Considerations:

- Intersectionality: Acknowledging the patients' full background
    - ***"It is important to facilitate training sessions that focus on the intersectionality of people. We need to consider how much we factor intersectionality of identities for people, and how to make referrals where they feel comfortable following-up on."***

Photo Courtesy of National LGBTQIA+ Health Education Center

- Technology: Leveraging technology to initiate referrals prior to connecting with providers
    - ***"It is recommended to pilot workflows that direct patients to a website resource and/or referral directly through their mobile phone, so that the patient can begin the process of responding to a social need until a Case Manager is available. This allows the opportunity for patients to be referred immediately after SDOH screening and using technology to increase capacity for staff."***
- Closing the Loop: How to follow-up with patients and measure impact of referrals
    - ***"It is important to acknowledge that SDOH screening implementation allows you to connect the dots between patient needs and resources available at your clinic and/or in your community. It is recommended to keep track of services that patients are referred to. It is easy to make a referral, and we should be mindful of the amount of time it takes for staff to follow-up if the referral still offers the service and who is eligible for those services."***

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Migratory and Seasonal Agricultural Workers

Did you know? **Farmworker Justice (FJ)** provides T/TA designed to improve health center processes and health care delivery that address the health and occupational safety needs of migrant and seasonal farmworkers. **Request TA from FJ.**

Health Outreach Partners (HOP) provides T/TA on outreach and enabling services such as transportation, program planning and development, needs assessments and evaluation, and community collaboration to improve migrant and seasonal agricultural worker health care access and outcomes. **Request TA from HOP.**

MHP Salud provides T/TA to health centers to develop, implement, and sustain Promotoras de Salud (Community Health Workers) programs through culturally-appropriate health education and community outreach development. **Request TA from MHP Salud.**

Migrant Clinicians Network (MCN) provides T/TA on all aspects of clinical care and issues impacting migratory and seasonal agricultural worker patients, providers and clinic systems through consultation, patient tracking, bridge case management, and clinical education. **Request TA from MCN.**

National Center for Farmworker Health (NCFH) specializes in T/TA related to health center governance, administration, and patient education designed to enhance health centers' delivery of services for the migrant and seasonal agricultural workers and their families. **Request TA from NCFH.**

SDOH Screening Considerations:

- Workflow: When and where providers screen for SDOH related questions
    - ***"It is recommended to know when and where providers will ask SDOH screening questions. One recommendation is to have a conversation with patients about social needs during their intake and when vitals are taken. Workers can get to know patients well during this time and build trust. Once you build trust in a language they understand, you can ask the SDOH screening questions more easily."***

Photo Courtesy of Migrant Clinicians Network

- Cultural Safety: Building trust, cultural and linguistic concordance and understanding migration patterns
    - ***"It is important to acknowledge that personal characteristics, such as gender, play a powerful role. If the patient sees a provider of the same gender, they are more likely to be comfortable in responding to SDOH screening questions."***
    - ***"SDOH training events need to be tailored to help providers better understand the communities they serve. For example, for migrant workers, it is important to acknowledge the high level of mistrust in the community. It is also important to understand that the demographics of migrant workers have changed over time -- it is no longer families. There are new workers who are single men and participating in the H-2A program."***
    - ***"Having a dedicated provider for migrant workers can help to build trust."***

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Older Adults

Did you know? National Center for Equitable Care for Elders (NCECE) provides innovative and culturally competent models of care, inter-professional training, educational resources, and technical assistance to health care professionals in community health centers who provide care to older adults. **Request TA from NCECE.**

SDOH Screening Considerations:

- Practicing Cultural Humility: Not assuming patients have the autonomy to make decisions
    - ***"It is important to be mindful of cultural norms. For older adults, we find it very common when all decisions are deferred to their children. This is not a language issue -- it is a cultural norm for patients to say, 'You can ask my daughter', and they hand off the phone. This also happens for in-person visits as well -- patients allow their kids to answer questions."***

Photo Courtesy of National Center for Equitable Care for Elders

    - ***"It is important to remember that it is a cultural norm for some patients to complete forms on their own, and for some patients to expect the provider to complete the forms."***
- Workflow: Being mindful of who is the right person to conduct SDOH screening
    - ***"Determining your workflow is really important for SDOH screening to be successful. It is important to ask yourself, 'When is it the right time to ask SDOH screening questions? Who is the right person to conduct the screening?' Giving one more thing for a clinical provider to do is one more minute of their limited time to care for patients. Consider non-clinical providers such as Medical Assistants and Community Health Workers. Medical Assistants and Community Health Workers can conduct SDOH screenings first, and then facilitate a warm hand-off to clinicians during the visit."***
- Policy Effects: Acknowledging policies that impact access to care for patients
    - ***"Policies such as the Public Charge still looms for a lot of patients. It is important to remember that negative aspects of federal and statewide policies are often maintained with people. For older adults, many are concerned about loss of benefits. As a result, some older adults may not disclose their needs or have hesitancy to accept resources. It is important to be mindful of larger systems that influence patient behaviors."***

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People Experiencing Intimate Partner Violence

Did you know? **Futures Without Violence** offers health centers training on trauma-informed services, partnerships and policy development, and the integration of processes designed to increase the identification and referral to treatment, for individuals experiencing or surviving intimate partner violence and human trafficking. **Request TA from Futures Without Violence.**

Photo Courtesy of Futures Without Violence

SDOH Screening Considerations:

- The Why: Learning about root causes of SDOH
    - ***"It is rare when deep roots of SDOH are discussed. It is highly recommended to provide training on racial trauma, implicit bias, redlining, and the impacts of slavery. Staff and providers will better understand why SDOH screening questions are important after they know more about deeper causes."***
- Practicing Cultural Humility: Not assuming patients' situations
    - ***"It is important to not assume patients' situations. Do not ask close-ended questions like, 'You're not getting hit by your partner, right? You don't drink alcohol, right? You're not depressed, right?' It is recommended to provide training for clinical and non-clinical providers on why and how SDOH screening questions are being asked for patients."***
- Breaking the Workforce Silos: How to scale SDOH screening across the organization
    - ***"It is important to acknowledge that SDOH screening should not take place within one department or be held responsible by a specific workforce type. We should also remember that providers who are being trained to ask questions should also be trained with knowledge of available resources. Do not provide training that is focused on the need for data -- provide training on how you can manage health and social care for patients holistically."***

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Residents of Public Housing

Did you know? **National Nurse-Led Care Consortium (NNCC)** delivers technical assistance to public housing primary care health centers to enhance clinical practice and improve the skills and capacity of health centers to meet the health care needs of residents of public housing. **Request TA from NNCC.**

National Center for Health in Public Housing (NCHPH) enhances the capacity of public housing primary care health centers to deliver high-quality primary care services to residents of public housing. **Request TA from NCHPH.**

Photo Courtesy of National Center for Health in Public Housing

SDOH Screening Considerations:

- Closing the Loop: How to follow-up with patients and measure impact of referrals
    - ***"For those who have SDOH screening built into implementation workflows, the next step is to determine how to connect patients with resources that respond to identified needs. It is important to measure how effective SDOH screenings and referrals are -- ask yourself: 'What is our impact?' It is important to revamp screening and referral protocols as we continue to perform telehealth and hybrid (telehealth and in-person care) services."***
- Workflow: How to screen and refer for SDOH for hybrid services (in-person and telehealth)
    - ***"When the COVID-19 pandemic hit, the first thing we dropped was SDOH screening to focus on telehealth implementation and health literacy. It is important to acknowledge how to develop new workflows during challenging times like these. For example, if you are collecting information on social needs and interventions/responses in multiple places, identify opportunities to streamline data collection without doubling the amount of work for staff. Establish clear workflows."***
    - ***"Some of our patients with Medicaid have smartphones, and many do not know how to use them. Enabling Services providers like Case Managers can help patients use technology to access video visits and patient portals. Community Health Workers can also help bridge the digital divide. The more proactive we are in engaging people with accessing and using technology, we can work upstream to help people get the resources they need more easily."***

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School-Aged Children

Photo Courtesy of School-Based Health Alliance

Did you know? School-Based Health Alliance (SBHA) strengthens the capacity of health centers to address the unique health needs of school-aged children and improve the health outcomes of underserved youth, particularly in school-based health centers. **Request TA from SBHA.**

SDOH Screening Considerations:

- The Why: Asking the 'why' behind the ask and then responding appropriately
    - ***"It is recommended for screeners to incorporate the 'why' before conducting an SDOH screening for patients. It is important for staff and providers to be trained on how to ask sensitive questions, and provided with tips on how to react to both positive and negative responses from the patient. Staff and providers should be trained on how to conduct a warm hand-off to another person in the clinic or to a resource outside of the clinic."***
    - ***"When you're screening a child, you are really screening the whole family."***
- Trauma-Informed Approach: Being sensitive to children's emotional responses to SDOH screenings
    - ***"It is important to remember that kids do not want to be embarrassed or traumatized through an SDOH screening process."***
- SDOH Response: Identifying in-house and community resources, connections, and partnerships
    - ***"It is recommended to work with your colleagues to crowdsource resources that respond to specific social risk factors identified in a SDOH screening process. Share your social needs data with community partners to initiate conversations on prioritizing effective response strategies."***
    - ***"Use dashboards to analyze social needs at the local and community level. Heatmaps are helpful to see how specific social risk factors are spread across a community, such as food insecurity, safety concerns, and rates of homelessness."***

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Perspectives of Health Centers Collaborating with PCAs and HCCNs

Did you know? Primary Care Associations (PCA) are state or regional nonprofit organizations that use HRSA funds to provide T/TA to health centers and look-alikes. For more information, visit **https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/ncapca/associations.html.**

Health Center Controlled Networks (HCCN) are groups of health centers and look-alikes working together to improve clinical practices by making health information technology easier for patients and providers to use, increasing the security of patient information, and using data to improve patient care. The networks help health centers to improve value-based care. For more information, visit **https://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/hccn.html.**

SDOH Screening Considerations:

- Workflows for Workforce: How to support staff to implement SDOH screening, referrals, and partnerships

    - ***"It is important to know for T/TA providers that there is help needed with what the SDOH screening assessment looks like, what kind of workflows are effective, and loop closure. Loop closure is often not discussed when we talk about SDOH screening. It is recommended that providers are trained on referral processes and connected with resources through the help of Enabling Services providers such as Community Health Workers."***

Photo Courtesy of HRSA

- Policy Impacts Outreach & Enrollment: How Medicaid Expansion impacts health coverage for the uninsured

    - ***"Over 40% of our patients are uninsured. For patients who are considered high risk, they are even more at high risk and getting support for them can be very challenging. Many patients fall into this gap because of policies such as the absence of Medicaid Expansion. It is important to recognize how policy shapes access to care for underserved patients."***

- Staff buy-in: How to motivate providers to learn about SDOH and SDOH screening

    - ***"It is important to consider the roles of staff when delivering training on SDOH training. Trainers should be mindful of the audience's question: 'What does this SDOH screening question have to do with me?' It is recommended for training events to be tailored for different stakeholders (e.g., Medical Assistants, Customer Service Representatives, Clinical Providers, Administrators, etc.)."***

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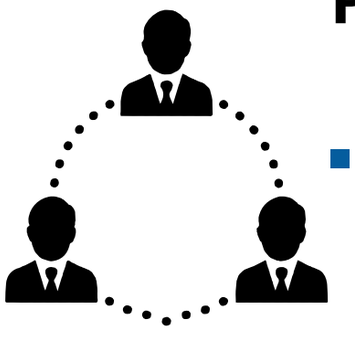
SDOH Screening T/TA Recommendations

Based on the Needs Assessment findings and health center interviews, here are some recommendations for training modalities that T/TA providers should consider.



Peer-to-peer collaborative learning

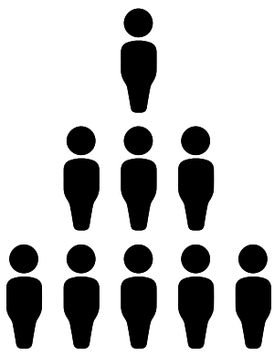
- ***"I find it more helpful when there's working conversation groups (video calls that start with discussions, breaking out into smaller groups for peer-to-peer collaborative learning). We know what SDOH is, how it's done, but we need to learn from each other about successful implementation strategies and workflows."***
- ***"So we can hear about future possibilities from peers."***

Offering tools for interdisciplinary teams to use after training events

- ***"Logistically, it's a matter of having the materials (new tools that are gained from the webinar), so our team has a direct training resource/toolkit to utilize. It is helpful to learn how health centers have addressed SDOH -- what's worked, what hasn't, how have things played out, on-the-ground examples -- so that we can talk through these things with our internal teams based on our own experiences with SDOH screening."***

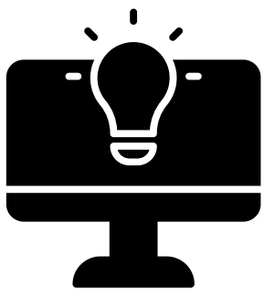
Hands-on and in-person training

- ***"Hands-on, in-person training events are best. It is preferable to hear people share their experiences in a live presentation. Ongoing technical assistance is preferred. For example, someone can come in for a half day and then revisit in a month. It is exhausting to have an information dump at one time."***
- ***"I like to see examples of SDOH screening in action, and I enjoy learning about pilot programs and case studies. Case studies allow me to apply what we've learned and what we would do in various scenarios of SDOH screening."***



Focused training: Identify key issues most prevalent to the patient population

- ***"Make it a focused SDOH screening training. Trainers should ask themselves, 'What are the issues that are most prevalent to the community?'. Is it human trafficking, food insecurity, or transportation? Every health center has a patient population with different social risk factors."***



Self-paced online training

- ***"Virtual and online trainings would be ideal: Pre-recorded and self-paced modules that are short (20-30 minutes each)."***

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