Social Determinants of Health Lessons Learned, Challenges, and Barriers: A Resource for Health Centers, Vol. 2

TABLE OF CONTENTS

ACKNOWLEDGEMENTS 2

Authors 2
Contributors 2
Funding & Support 2

INTRODUCTION & OVERVIEW OF LEARNING COLLABORATIVE 3

The Importance of SDOH Screening and Data Collection 3

PARTICIPANT ENGAGEMENT 4

Execution of the Learning Collaborative & Participant Engagement 4

EXPRESSED BARRIERS & PROPOSED SOLUTIONS 6

Cultural Appropriateness 6
Staff Buy-In 7
Operationalizing Screening 7
Data Utilization 7
Quality Improvement 8
Partnership/Resources 8

RESULTS 9

Session Feedback 9

PREFACE TO YEAR 3 12

APPENDIX A 14

ACKNOWLEDGEMENTS

National Training and Technical Assistance Partner (NTTAP) faculty from the Association of Asian Pacific Community Health Organizations (AAPCHO), Health Outreach Partners (HOP), MHP Salud, and the National Health Care for the Homeless Council (NHCHC) would like to thank the participants of the Learning Collaborative for facilitating the sharing of knowledge between health center peers. Feedback and lessons gleaned from this Learning Collaborative will be used to inform activities in the upcoming years.

Authors

- AAPCHO – Sakura Miyazaki, *Program Manager, Training and Technical Assistance*
- HOP – Beleny Reese, *Project Manager*
- MHP Salud – Hansel Ibarra, *Program Director*
- NHCHC – Brett Poe, *Research Associate*

Contributors

- AAPCHO – Albert Ayson, Jr., *Associate Director, Training and Technical Assistance*; Kristine Alarcon, *Associate Manager, Communications and Engagement*
- NHCHC – Lauryn Berner, *Research Manager*

Funding & Support

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards as follow: Association of Asian Pacific Community Health Organizations (AAPCHO) National Training & Technical Assistance Cooperative Agreement totaling $625,000.00 with 0 percent financed with non-governmental sources, Health Outreach Partners (HOP) National Training & Technical Assistance National Cooperative Agreement totaling $932,014.00 with 0 percent financed with non-governmental sources, MHP Salud National Training & Technical Assistance Cooperative Agreement totaling $753,959.00 with 0 percent financed with non-governmental sources, and National Health Care for the Homeless Council Training and Technical Assistance National Cooperative Agreement totaling $1,967,147.00 with 0 percent financed with non-governmental sources. This information or content and conclusions are those of the presenter and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government. For more information, please visit HRSA.gov.

INTRODUCTION & OVERVIEW OF LEARNING COLLABORATIVE

Special and vulnerable populations (SVPs)[1,2] often face additional barriers to care, many of which are compounded by social determinants. Screening for Social Determinants of Health (SDOH) allows health centers to identify the factors influencing disparities in patient health outcomes. Screening for SDOH is the first step towards addressing these disparities and understanding how to collect and utilize screening data is a crucial second step.

From August to September 2021, AAPCHO, HOP, MHP Salud, and NHCHC hosted the "Screening Methods and Strategies for Using Data on Outreach and Enabling Services to Address Social Determinants of Health" Learning Collaborative for health centers serving special and vulnerable populations to explore effective strategies to screen for SDOH and build effective practices to utilize SDOH screening data to address SDOH through the provision of outreach and enabling services (e.g., non-clinical services that facilitate access to care such as eligibility assistance, case management, and transportation).

The content of this publication will include information from lessons learned, challenges, barriers, and impact stories shared from the four (4) sessions of the Learning Collaborative, interwoven with information gleaned from research.

The Importance of SDOH Screening and Data Collection

Health centers across the United States provide care to over 30 million patients across approximately 14,500 service delivery sites, most of whom are uninsured or publicly insured.[3,4] Acknowledging the role of the conditions in the places where people live, learn, work, and play, or the Social Determinants of Health,[5] is vital to strengthening the capacity to improve health outcomes for underserved and marginalized communities, and thus, advance health equity.[6] Addressing the impacts of SDOH on SVPs begins with screening and data collection to identify key barriers to care and create opportunities to facilitate better service delivery.

The application of data from SDOH screenings is not limited to quantifying health outcomes and disparities. Data about enabling service utilization allows health centers to appropriately staff sites in order to meet patients' needs; monitoring Medicaid reimbursement policy can help health centers plan for necessary funding in order to continue providing high quality care; tracking patient and provider satisfaction can help improve the quality of care and service provision to increase value-based payment; standardizing data collection methods and creating avenues for cross-sectoral data sharing helps facilitate community-based resources and solutions to reduce the impact of social determinants on health outcomes for SVPs. Throughout this Learning Collaborative, NTTAP faculty sought to provide guidance on some of the ways health centers can use the data collected when screening for

---

[1] https://www.nachc.org/health-center-issues/special-populations/
[2] https://health.gov/healthypeople/objectives-and-data/browse-objectives
[3] https://www.nachc.org/about/about-our-health-centers/
[4] https://www.nachc.org/wp-content/uploads/2020/10/2021-Snapshot.pdf
[5] https://www.cdc.gov/socialdeterminants/
[6] https://www.cdc.gov/publichealthgateway/publichealthservices/pdf/ten_essential_services_and_sdoh.pdf

SDOH to facilitate change, not just in health outcomes, but in the conditions influencing those outcomes.

PARTICIPANT ENGAGEMENT

Execution of the Learning Collaborative & Participant Engagement

NTTAP faculty worked together in the method of a Learning Collaborative to increase the number of health centers that receive training and technical assistance on screening and documenting SDOH. In the second year, session content emphasized the role of data collection, analysis, and utilization to address SDOH. Similar to the previous year, an in-depth Learning Collaborative followed an introductory webinar. To learn more about our first-year learnings and key takeaways, access the report at: https://bit.ly/SDOH-Lessons-Learned-Vol1.

Timeline

Applications to participate in the Learning Collaborative were accepted throughout the month of July 2021. Priority acceptance was given to Year 1 participants, who received a special invitation to apply. Learning Collaborative sessions took place on a biweekly schedule as follows:

- Session 1: Wednesday, August 4, 2021
- Session 2: Wednesday, August 18, 2021
- Session 3: Wednesday, September 1, 2021
- Session 4: Wednesday, September 8, 2021

Evaluation data were collected following each session, and an overall evaluation survey was shared following Session 4. A follow-up evaluation survey was conducted in January 2022.

Participants & Engagement

A total of 51 unique organizations applied to participate in the Learning Collaborative. **Table 1** shows the participants who attended at least one Learning Collaborative session, along with their provided funding streams.

Table 1. Participating Organizations by Group. ***Funding defined below*.**

Group, Staff Lead	Organization Name	Funding Stream*
Group 1: Sakura Miyazaki, AAPCHO	Belmont County Health Department	Not 330 funded
	Family Health Centers of San Diego	330(e), (h), (i)
	East Liberty Family Health	330(e), (i)
	Neighborhood Resilience Project	Not 330 funded
	Charter Oak Health Center	330(e), (h), (i)
	Community Health Centers of South Florida, Inc.	330(e), (g), (h)

Group 2: Beleny Reese, HOP	HealthSource of Ohio	330(e)
	Hill Pharmaceuticals	Not 330 funded
	Hunter Health Clinic, Inc.	330(e), (h)
	Keystone Health	330(e)
	Kodiak Health Center	Not 330 funded
	Lone Star Circle of Care	330(e)
	Marias Healthcare Services, Inc.	330(e)
Group 3: Hansel Ibarra, MHP Salud	Charles Drew Health Center, Inc.	330(e), (h), (i)
	Norwalk Community Health Center	330(e)
	Partnership Health Center	330(e)
	Ryan Health	330(e)
Group 4: Brett Poe NHCHC	Ohio Department of Health	Not 330 funded
	One Health	330(e)
	Pillars Community Health	330(e), (h)
	Pittsburgh Mercy	Not 330 funded
	Primary Care Health Services, Inc.	330(e), (h), (i)
	Star Community Health	Not 330 funded
	Unity Care NW	330(e), (h)

**Funding streams from HRSA are defined as follows: Community Health Center Programs, funded under Section 330 of the Public Health Service Act (42 U.S.C. §254b)[7] Health Care for the Homeless (HCH) Programs, funded under section 330(h); Migrant Health Center (MHC) Programs, funded under section 330(g); and Public Housing Primary Care (PHPC) Programs, funded under section 330(i). Participants self-identified funding in the application process. Funding streams were self-reported upon application to the Learning Collaborative. Additional participants were admitted based on populations served as space and interest allowed regardless of source funding.*

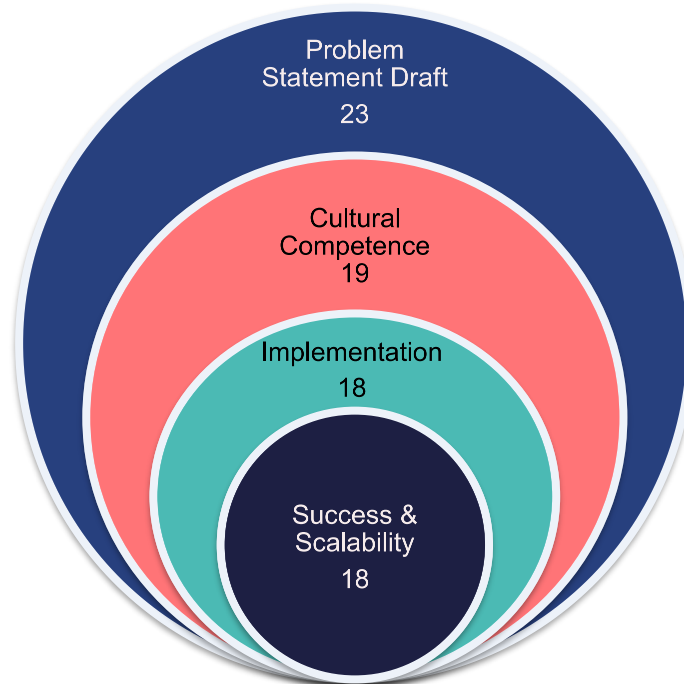
Change Map Completion

As with the previous year, the Change Map Model guided session content and participant engagement between sessions. Before each session, summaries of participant responses to the guiding questions for each section were entered into the corresponding segment of the Change Map and shared on screen during subsequent sessions for discussion, elaboration, and feedback. Completed Change Maps can be found in **Appendix A**. The variation across the Change Map

[7] https://bphc.hrsa.gov/programrequirements

process and its completion is again reflective of the stages of implementation that health centers and organizations were in at each stage of the Learning Collaborative (**Figure 1**).

Figure 1. The number of participants who completed each stage of the Change Map



EXPRESSED BARRIERS & PROPOSED SOLUTIONS

Throughout the four sessions, NTTAP faculty and participants identified challenges to successful SDOH screenings. Each session captured specific promising practices and/or barriers for participants, and group discussions allowed participants to engage in peer learning to create and/or improve strategies. Below are some of the barriers and proposed solutions for participants identified through the learning collaborative.

Cultural Appropriateness

Participants identified the cultural appropriateness of their SDOH screening workflows and resources as a barrier. Participants discussed different stages of their workflow with respect to cultural appropriateness, such as SDOH questions, workflow feedback, and workforce education. A significant concern for health centers was the cultural sensitivity of SDOH questionnaires and the staff who asked the questions. Although most health centers patients come from underserved communities, some health centers expressed that the processes in place were not appropriately aligned with community needs.

During the learning collaborative sessions, the NTTAP faculty and participants discussed topics related to cultural appropriateness such as the five rights framework for SDOH screening, cultural humility, and trauma-informed care. Expanding on cultural appropriateness, participants in group discussions expressed the need to build trust with patients and community members to identify useful next steps and resources. Some participants shared their promising practices to address cultural

appropriateness. For example, one health center shared that they continuously involve the board (which includes patients) and another health center shared training programs implemented to address topics such as implicit bias and trauma-informed care. Through these session presentations and discussions, participants included different solutions in the change map to address cultural appropriateness. Common solutions for participants included utilizing the staff from shared backgrounds with the patient community as drivers for screening and leveraging connections with patients (e.g., the board, advisory committees) for feedback.

Staff Buy-In

Buy-in at the leadership level and from frontline staff for the development of SDOH screening was generally high among participants. Hesitation was conveyed by a few individuals who reminded us all about the short-staffed situations many health centers face, while others underlined the scarcity of funds. These concerns were addressed throughout the four-part learning collaborative.

Participants were introduced to the benefits of screening for SDOH data. It was discovered that many of the questions that fall under SDOH screening were questions already being asked by the staff. Collecting SDOH data adds value to the “other” work already being done by the team that isn't usually captured. The SDOH data can be used to support annual health center UDS reporting as well as reimbursement.

The community health worker (CHW) was offered as a culturally appropriate method to reach special and vulnerable populations. CHWs are often from the same communities they serve, giving them a unique understanding of these communities. With the proper training and supervision, CHWs can assist with screening for SDOH data. A combination of clinical and non-clinical staff can alleviate the burden of gathering the data.

Operationalizing Screening

Participants showed varying levels of readiness when it came to operationalizing an SDOH screening process. Some organizations found themselves already implementing a social needs screening tool but wanted to sharpen their skills and learn how other organizations might be doing things differently. The rest were either starting the journey or on their way to incorporating the screening and collecting of data. Common hiccups that arose were the possibility of duplicate or unnecessary questions, when to approach the patient to gather the information, and who will be collecting the information and evaluating it.

Health centers voiced their successes, struggles, and worries, which allowed others to take note and offer support. A potential solution described included creating an advisory team that would allow for input from all staff levels. The organization would identify a project champion at each level who would report back to the team. The project champions would meet with their level staff and look for potential implementation challenges and devise ways to overcome those challenges. This would facilitate the questions' effectiveness, ensuring there are not duplicate or unnecessary questions. The team would also be in charge of establishing, standardizing, and reviewing the structure for standardized screening.

Data Utilization

A common reason for the incertitude around screening for SDOH factors was the lack of awareness/context for comparing data at the local, regional, and national levels and how to leverage the results. Throughout group discussions and the NTTAP teachings, health centers learned how to utilize the SDOH factors to better understand a patient's needs. Return-on-investment (ROI) was offered to the participants as a reliable tool for demonstrating value in gathering SDOH factors. ROI empowers users to leverage data to improve health equity at the individual, community, and systems

levels. ROI results provide a great “snapshot” of information to share with both stakeholders and the community to demonstrate social and fiscal responsibility.

This data along with the success stories shared by health centers, can aid in bringing awareness and federal funding to the community. With the results at hand, health centers can better advocate for the people they serve. Once gathered, SDOH data can be used to look at the macro perspective of the community, making the process of finding commonalities among community members much easier.

Quality Improvement

Another barrier for successful SDOH screening for participants was the difficulties of utilizing the data and measuring the success of its outcomes. Several health centers expressed concern if the collected data was leading patients to referrals that addressed the impacted SDOH factors, especially when the SDOH data is not tied to referral tracking systems. Furthermore, participants overwhelmingly agreed that the resources themselves are limited and unavailable for patients. Especially since the start of the COVID-19 pandemic.

Through group discussions: participants shared promising practices, resources, and their contact information to connect after the completion of the four sessions. Overall, participants expressed a need to develop evaluation measures for quality improvement in SDOH screening and referrals. A common evaluation method suggested for the technical aspect was utilizing a Plan-Do-Study-Act (PDSA) cycle to develop feedback loops for referrals and SDOH data integration for referrals. Participants were interested in establishing regular meetings for brainstorming sessions and to eventually standardize quarterly evaluation of SDOH data. For those facing challenges with limited resources, participants proposed surveys for patients to review the usefulness of the resources and establish an advisory team to improve the referral process. Through these types of evaluation measures, participants hope to identify specific referrals or referral types that are limited or underutilized for patients.

Partnership/Resources

Following up on the previously listed challenge of quality improvement and referrals, the NTTAP faculty and participants did a deeper dive into the challenges of limited referrals. Even if participants improve SDOH screenings, internal referral processes and identifying the types of referrals that are limited, may leave health center and service provider staff feeling frustrated that they could not help patients get the actual services. Health centers further expressed the need for culturally appropriate resources to help patients navigate referrals.

As participants shared resources and contact information during the learning collaborative, they all explored identifying partnership opportunities at an organizational-level to expand the breadth of available referrals. Participants reflected on the importance of establishing and strengthening relationships with internal and external partners. Through these partnerships, participants have a larger view into the patients and the resources by interviewing the partners to identify their barriers that exist outside of the purview of the participants. One participant discussed how partners themselves could support the health centers by providing referrals, translations, and follow-ups for patients. Another participant reflected on the importance of strengthening relationships with internal partners, such as the IT department, to facilitate SDOH screening and data collection. Overall, there was a general consensus that although partnerships are difficult to establish when there are other competing priorities, they increase efficiently and effectiveness in the long-term by providing meaningful and culturally tailored services.

RESULTS

Session Feedback

Feedback from individual sessions demonstrated consistent participant satisfaction and confidence in the ability to apply session information to their daily work. We believe that due to the nature of sharing existing practices within the limitations of individual environments, the assessment of gains in knowledge per session were evaluated slightly lower, however a full series evaluation administered after the completion of the Learning Collaborative overall showed an increase in impact across all evaluation domains compared to session-by-session averages. Details of session and overall scoring are seen in **Table 2.**

Table 2. Session and Series Evaluation Scores

Sessions	Satisfaction	Confidence	Knowledge Gained
Session 1	4.12	3.70	3.12
Session 2	4.21	3.63	3.32
Session 3	3.75	3.20	3.10
Session 4	4.00	3.93	3.33
TOTAL SESSION AVERAGES	**4.02**	**3.62**	**3.22**
OVERALL EVALUATION	**4.5**	**4.1**	**3.9**

IMPACT OF LEARNING COLLABORATIVE

In the overall evaluation, participants stated where they felt their organizations were in their practices of SDOH screening and in the provision of enabling services. After participating in the Learning Collaborative, 75 percent of respondents said their organizations were “halfway down the road” or “close to the finish line” in both practices (**Figures 2, 3**).

Figure 2. Organizations’ current standings with screening for SDOH

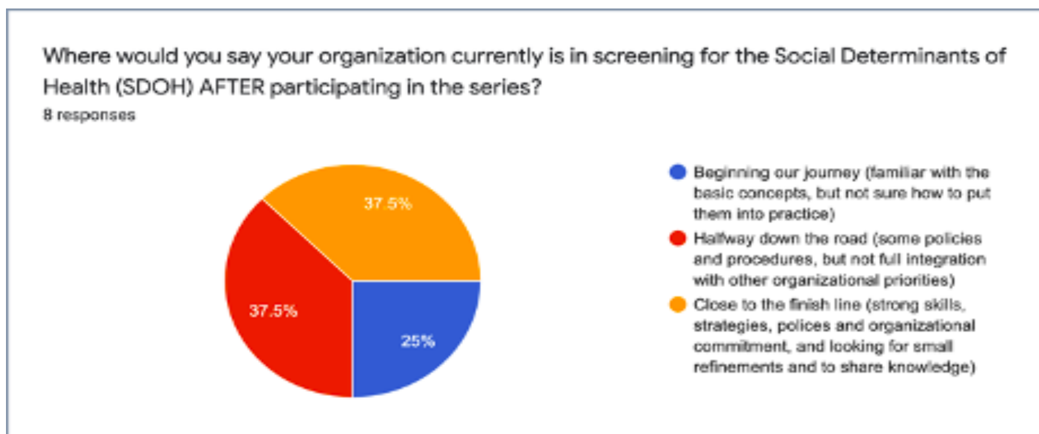
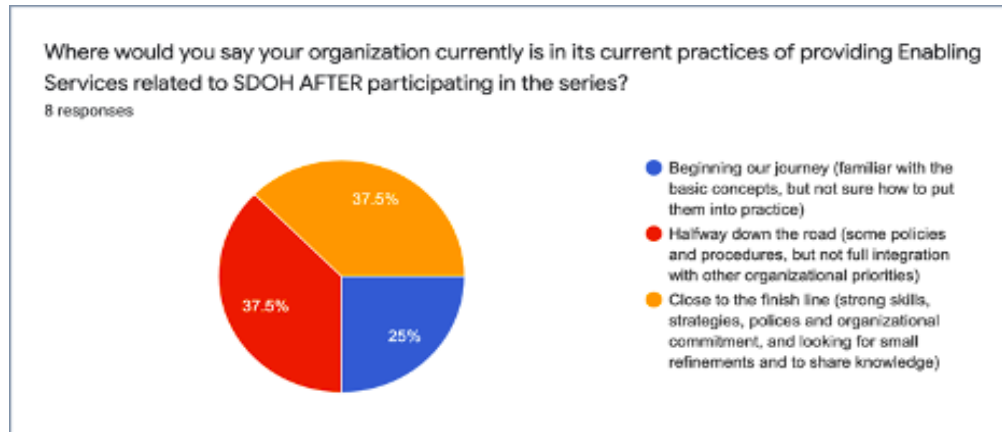


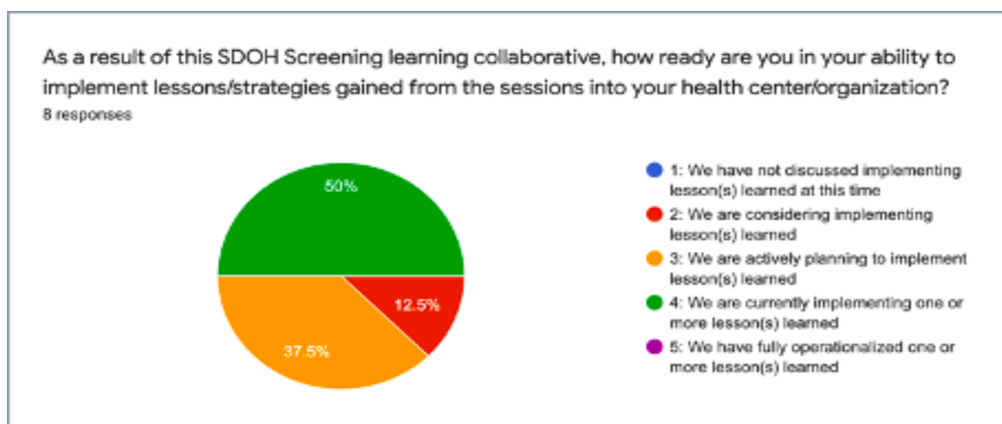
Figure 3. Organizations' current practices with screening for ES



Seventy-five percent of respondents also stated that participating in the Learning Collaborative had a moderate to major impact on the implementation of screening for SDOH and data collection at their organizations (**Figure 4**). As a result of participating in the Learning Collaborative, about 88 percent of respondents reported that their organizations were either actively planning or have already implemented one or more lessons learned (**Figure 5**).

Figure 4. Impact from Learning Collaborative on screening & data collection

Figure 5. Readiness of implementation after SDOH Screening Learning Collaborative



The average self-evaluated score of knowledge of standardized SDOH screening practices after participating in the Learning Collaborative was 7.9 out of 10, and the average score of knowledge of standardized Enabling Services data collection was 7.5, with 75 percent self-evaluating with a score of 8 or higher. Prior to participating in the Learning Collaborative, the average self-evaluation of both knowledge areas was 5.5 and 4.6, respectively.

PARTICIPANT PROGRESS: THREE-MONTH FOLLOW-UP

In a three-month follow-up with six total participants, about 83 percent of respondents said their organizations were “halfway down the road” or “close to the finish line” in both the practice of SDOH screening and in the provision of enabling services **(Figures 6, 7**).

Figure 6. Three-month follow-up for SDOH screenings

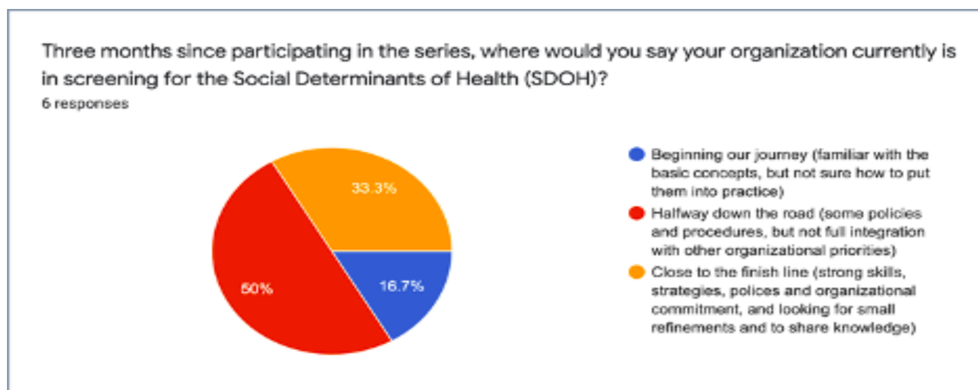
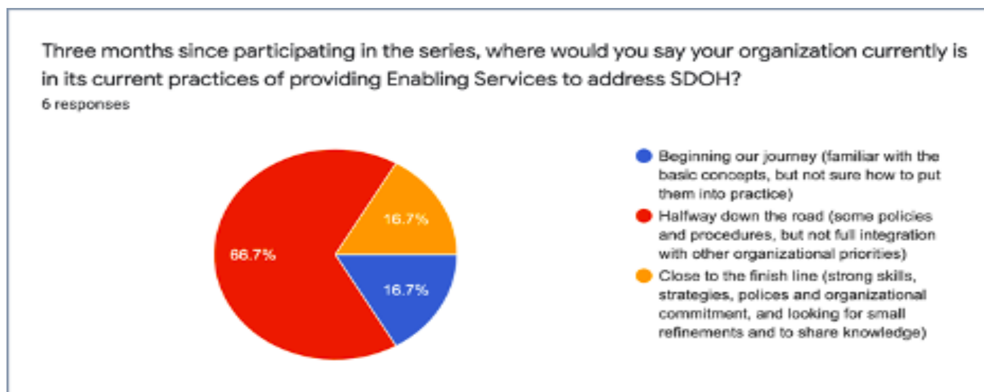


Figure 7. Three-month follow-up for ES practices



About one-third of respondents said they were considering implementing lessons learned from the Learning Collaborative, and another one-third were either actively planning or have already implemented one or more lessons learned. The final third of respondents reported that they had not yet discussed implementation of lessons learned at the time of response (**Figure 8**). It should be noted that the overall evaluation received a total of eight participant responses, while the three-month follow-up evaluation received six.

Figure 8. Readiness in implementation of lessons from SDOH screening Learning Collaborative

QUALITATIVE RESPONSES AND LESSONS LEARNED

In open responses, participants reported that it was helpful to hear from others that sites were not alone in their struggles to effectively integrate SDOH screening into daily practice. It was also noted that it was beneficial to hear from experts as well as others' experiences with visual examples of processes to help talk and think through challenges and offer potential solutions. Feedback to inform the planning of year 3 of this Learning Collaborative include aiming to engage more team members in real time, and to increase the length and depth of breakout discussions when possible.

In response to the development and progress of programs implemented during the Learning Collaborative, one site indicated that they had now implemented a new SDOH screening tool but were still working as a team to gather enough data to determine how to address emerging concerns. (See **Figure J**, **Appendix A** for description of proposed implementation for Keystone Health). Similarly, another organizational participant has since incorporated PRAPARE screening into registration, and patients are referred to Community Health Workers as needs are identified. Another participant noted that while multiple rounds of pilots have been launched (**Figure L, Appendix A** - Primary Care Health Services), the process has since halted to work on some components that need extra attention.

Additional feedback across sites highlighted the importance to consider staff buy-in and retention to continue to make progress and should be planned for and addressed periodically. Specifically noting that "gaining and sustaining sufficient staff buy-in is an ongoing process," therefore considering breaking processes down into incremental steps can help prevent potentially overwhelming both staff members and patients. More detailed steps and action plans of all 18 completed Change Maps of participating sites can be found in **Appendix A**.

PREFACE TO YEAR 3

Implementation of the "Screening Methods and Strategies for Using Data on Outreach and Enabling Services to Address SDOH" Learning Collaborative highlighted many valuable takeaways for both participants and NTTAP faculty. In order to continue to improve the access to and quality of care for special and vulnerable populations and move closer to health equity, health centers must work to identify the barriers to care in order to intervene and remove them. Enabling Services provision and screening for SDOH are two crucial elements to this intervention. Data collected from providing these services gives health centers a powerful tool to address their patients' needs in a sustainable way. However, standardizing data collection processes can present a significant challenge. Given each

health center’s unique position in the community, patient population, access to resources (e.g., human, financial, technological), workflow, etc., there are any number of variables that can challenge the process of standardization across the health center and even at the individual patient level.

As a result, a lesson learned after guiding participants through the Change Map Model process and listening to each health center’s carefully planned strategy is that there is no One-Size-Fits-All approach to developing and implementing a standardized SDOH screening process. Social risk data, no matter how it is collected, is useful at various levels of health center operation and implementation. What is most important is that the health center understands the utility of the data and can work to create a standard process to collect data that will ultimately allow them to better advocate for and serve their patients’ or clients’ needs.

APPENDIX A

Contributor(s): Lucinda Balsome

Figure A. Final Change Map from ACT

Belmont County Health Dept.

Contributor(s): Kellie Haney, Linda Mehl

Problem Statement

Providers overwhelmed and unable to spend the amount of time needed with patients. Awareness of available resources, utilities assistance, housing, food, transportation, mental health, child care etc.

Target Population

The women health program will target women 180-44 the team will focus on reaching out to underserved population for participation in program

Contributing Factors

Lack of transportation, fear of stigma of pre-extisting or chronic health conditions and lack of insurance coverage

Intervention

Better referral process

Culturally Appropriate

Our health dept created a Preconception and inter-conception health survey to gather data from the community. The survey targeted women 18044. The survey was used to find out what women need in the community to identify barriers

Resources

Our health dept staff and community partners helped to get surveys out the public. We required materials like clip boards, pens, and survey boxes. We had to make sure we had staff available to hand out surveys that were able to explain what the survey was for and what we do with the data collected

Partnerships

Local hospitals, mental health agencies, exercise facilities, reproductive health and wellness programs and pregnancy centers

Staff Buy-in

We created an advisory team to help come up with ideas on how to implement a women's health program in our community. The team members hare their experience and show support for the program

Activities & Phases

Survey community members, social service agencies and clinicians to find out what barriers they have. Develop an action to plan to show how changes will be made to reduce barriers

Timeline

3 year grant

1. Create advisory team with social service agencies and clinicians (Oct 2020 – Dec 2021)
2. Develop health assessment survey and outreach plan (Dec 202- March 2021
3. Conduct health assessment survey (March 2021 = July 2021)
4. Collect Data (July 2021)
5. Interpret data (July 2021 – August 2021)
6. Action and evaluation plan (August 2021)
7. Implement program (Oct 2021 – Sept 2021)

Tracking Progress

Results of survey revealed that one barrier is that the community is unaware of services that are available to them. Our health department will partner with another agency to improve referral process by hiring additional staff and using computer system that will track referrals and follow-ups. The staff member will work directly with clients in need and refer to programs available in our county. The partner agency will help eliminate gaps in referral process

Data

We will track referrals and follow ups to determine program success.

Define Success

When we receive a positive response from clients that program has helped them

Sustain & Scale

By improving referral process and working closer with clients we will be able to help more people in the community get the help they need

Goal

Implement a preconception and inter-conception women's health program

Figure B. Final Change Map from Belmont County Health Dept.

Issue & Need — Charles Drew Health Center — Overall Goal

Contributor(s): Samantha Wall

Problem Statement

Implementing a SDOH screening and referral to care as needed as part of routine patient care.

Target Population

Pregnant OB patient population

Contributing Factors

Homelessness, lack of insurance, food insecurity, many other SDOH. Non-English speaking; Clinic time; staffing, complex referrals, buy-in

Intervention

1. Annual screening
2. Text-based screening surveys.
3. Consent for referrals
4. EHR integration
5. Referral management

Culturally Appropriate

1) Communication with staff to get input on how to best incorporate screening into their daily routines

Resources

Time
Staff
Staff buy-in
Trainings
Printed materials

Partnerships

UNITE-NE

Other CBOS would be helpful

Staff Buy-in

Buy-in from leadership, providers, RNs & MAs is needed

Activities & Phases

1. Screening tool development
2. Workflow development
3. Referral process development
4. Data tracking process creation
5. Staff trainings
6. Screening & referral process implementation
7. Process evaluation & review
8. Expand to all patients

Timeline

1. August 13st
2. August 31st
3. August 31st
4. August 3st
5. September30th
6. October 4th

Tracking Progress

EHR reports, Care Message reports, UNITE-NE report. Staff feedback via conference calls and emails.

Data

1. Determine what SDOH data is already collected at registration to prevent duplication of questions
2. Collect number of patients screened
3. Needs identified
4. Actions taken on SDOH indicators
5. Patterns of SDOH indicators by patient populations

Define Success

Patient centered integrated workflow, consistent data tracking, > 80% referral rate for SDOH indicators, routine staff feedback to address needs and measure success.

Sustain & Scale

Ensure design of workflows allows for universal SDOH screening of all patients annually and have a process for efficient referrals to COBs to address the need

Goal

Effective workflow to screen for SDOH, refer to resources and track patterns of indicators

Figure C. Final Change Map from Charles Drew Health Center

Issue & Need

Community Health of South Florida Inc.

Overall Goal

Contributor(s): Eunice Hines

Problem Statement

Patients unable to get their medications on time

Target Population

Leaders in my organization

Contributing Factors

Population has expressed that because of transportation issues, they can't get around to their medical appointments nor get their medication on time.

Intervention

1. Having a mobile pharmacy van
2. Medication Delivery

Culturally Appropriate

CHI has collected data using PREPARE and it has identified that not having transportation is a SDOH for the population that I serve.

Resources

We will need materials of information in all English, Spanish and Creole. Electronic access to get in touch with the pharmacy with the use of a phone or tablet, a mobile unit or a delivery of medication program

Partnerships

Pharmacy and delivery program.

Staff Buy-in

Yes, our main focus is for our patients to have access to care and follow-up, which includes medication and appointments to see their doctors

Activities & Phases

Collecting data, which we are collecting using PRAPARE

Timeline

A project charter will help us visualize these deadlines. 3 months of data. 5 months of researching the best online platforms for pharmacy where patients ca get access to their medication and pharmacies. 4 delivery company

Tracking Progress

Develop project timeline plan with a DMAIC process steps (Define, Measure, Analyze, Improve and Control.)

Data

We have the PRAPARE data to address the SDOH

Define Success

When we get to analyzing the implementation process

Sustain & Scale

Our long term goals are to have control over what decide whether it's a mobile pharmacy unit, a delivery program, access to pharmacies or all three

Goal

Patients will get their medications at a time and location they choose

Figure D. Final Change Map from Community Health of South Florida, Inc.

Issue & Need

East Liberty Family Health Care Center

Overall Goal

Contributor(s): Sidney Harper, Stephanie Esdaile, Kristen Hillebrand

Problem Statement

Underserved and lack of resources, assistance with housing, utilities, behavioral health, social supports.

Target Population

Patient Population

Contributing Factors

Factors contributing are lack of access or. Knowledge to available resources

Intervention

More "hands-on" from health care providers

Culturally Appropriate

Yes. We have changed dour SDOH protocol to be more accessible to our target population we did (and still do) have in place 3 target languages (English, Spanish & Portuguese) for questionnaire, considering our culturally diverse population. We have translators and use of a Certified Languages line where any language can be translated while on the phone with a patient

Resources

Kiosks in waiting rooms for sign in that prompt SDOH questionnaire. Decreased categories to most common needs to make user friendly, writing grans for transportation funding

Partnerships

Housing Authorities; enormous need and almost no suppl. Spanish speaking agencies

Staff Buy-in

CEO/CFO, leadership very supportive. Staff are more challenging. Providers want our departments toc call patients directly, while were trying to enable patients reach out to us.

Activities & Phases

*increase # of pts reaching out for assistance. *Fewer provider referrals to SDOH Counselor – Patients need to reach out for assistance * Provide a 'pamphlet' of resources for assistance (English, Spanish, Portuguese) in waiting area

Timeline

*Deadline for use of SDOH questionnaire on waiting room kiosk was 8/2021. This deadline has been met but needs additional 'Provider input' to be successful. *Ideally there will be steady increase of patients completing questionnaire between 9/2021 – 12/2021. *Pamphlet of resources cold be made available by 12.21021

Tracking Progress

Once patients complete questionnaire on waiting room kiosk, data is collected and tracked in our charting system *ECW*

Data

We are already collecting SDOH data: data is broke down by location, SDIG barrier selected, Wants help, Help with employment, BH visits, SUD visits

Define Success

1. Increase in # of questionnaires completed
2. fewer referrals from providers
3. Increase in # of patients reaching our for assistance

Sustain & Scale

Increased # of patients advocating for themselves

Goal

To provide resources of enabling services for patients to advocate for themselves

Figure E. Final Change Map from East Liberty Family Health Care Center

Family Health Centers of San Diego

Issue & Need

Overall Goal

Contributor(s): Sandra D'Alonzo, Freddy Sanchez

Problem Statement

Inconsistent screening methods and lack of awareness of existing agency screenings

Target Population

Pts enrolled/receiving services through department program

Contributing Factors

Lack of resources, difficulty navigating healthcare system.

Intervention

More connection with community resources/enabling services that exist internally/externally.

Culturally Appropriate

Community resources and enabling services will be vetted for cultural appropriateness

Resources

IT systems development management commitment/time, staff training across departments, system rollout

Partnerships

Internal referrals (e.g. homeless, case mgm.), external, referrals for SS are informal – difficult to aggregate data, track/monitor, stronger collaboration with community partners (e.g. 211)

Staff Buy-in

Partial. Leadership is supportive of SDOH development. Will need buy-in for adoption of a new process

Activities & Phases

Meet with primary care and IT leadership. Decide on universal screening tool, develop decision aids for data collected, integrate UDS reimbursement

Timeline

Meet with leadership in the next 30 days, decide screening tool in the next. 60-90 days, develop decision aids in the next 90 -120 days, integrate UDS reimbursement in the next 90-120 days.

Tracking Progress

Completing activities outline

Data

Data from existing SDOH screenings

Define Success

Integrated SDOH screenings and data tracking to support UDS reimbursement

Sustain & Scale

UDS reimbursement improvement in health outcomes for patients.

Goal

Integrate SDOH screening into current SS Dept assessments/protocols. Implement across department

Figure F. Final Change Map from Family Health Centers of San Diego

Issue & Need

Health Source of Ohio

Overall Goal

Contributor(s): Jean Patrick, Logan Graham, Ellen Reilag

Problem Statement

Mining and presenting the data from SDOH screenings to advocate for change and create impactful programming

Target Population

Strategic partnerships w community. Clermont County Safety Net Alliance or developing Brown County Aliance

Activities & Phases

- Monthly connections and CAN review & adjustments
- Turning data into consumable product (1-2pager)
- Applying to specific projects and audiences to develop programs and partnerships to address SDOH
- Tracking and recording progress adjusting as needed.

Timeline

Connections and data review, current and on-going. 1-2 pager in progress. Pilot project and presentation in-progress. Tracking and adjustment ongoing.

Goal

Use aggregate data to demonstrate population health and influence CNAs, partnerships and legislators

Contributing Factors

Sensitive question when there is not a remedy in place. Need to increase structured collab with resources partner

Intervention

Monthly/quarterly review of screening results

Culturally Appropriate

Questions are relevant and sensitive to the target population's culture and beliefs. We serve rural communities, with some resource limitations (Transportation, food deserts etc.)

Resources

Current Clermont County SNA 21 1/online resources.

Community Resource Guide, Local Chambers, Community Needs Assessment

Partnerships

Clermont County Safety Net Alliance, Aunt Bertha type resource, Community Connections/Partners

Staff Buy-in

Leadership, case management and front line workers – time constraints need reliable resources across the board

Tracking Progress

Monthly/quarterly progress from internal stakeholders. Annual Data reviews and 3 –year synthesis to federal, and 5 year strategic review.

Data

Currently collect county, state, national. Utilizing internal, UDS data, Census,, local CHNA and SDOH dat. Need t collect payer specific data.

Define Success

CNAs that highlight target populations or areas for improvement and then created connections to address those specific needs

Sustain & Scale

Maintaining data points and producing relevant content for evolving needs of community. Scaling to address specific needs, target audience and systemic policy change

Figure G. Final Change Map from Health Source of Ohio

Issue & Need — Hills Pharmaceuticals, LLC — Overall Goal

Contributor(s): Marilyn Belt, Annette Watson

Problem Statement

To develop a plan to collaborate our services to providers (i.e Opioid users)

Target Population

Local providers at 2 specific clinics. Meet with them to show data of the amount Opioids prescribed in the las 306 months

Contributing Factors

Discuss with the providers the perfect adherence to Opioids but not to maintenance medication

Intervention

Continually assess prescription and review for patterns of misuse. Develop case plan and follow up monthly to deter overuse

Culturally Appropriate

yes

Resources

1 CCHW and 1 Pharmacist, material funding

Partnerships

With prescribers

Staff Buy-in

Yes

Activities & Phases

Send letters to prescribers with a referral form

Timeline

November 1st 2021: Follow up in 1 week if no referrals received. List those from software that have greater than 50 MME

Tracking Progress

Develop case plan monthly phone calls to patient and discussion with MD titrate opioids over 6 months. Discuss titrations with patient and expected outcome

Data

Define Success

Sustain & Scale

Assess case plans in 3-mmonth intervals for progress and next steps to be off opioids. Follow up with MDs on outcomes of case plans. Celebrate with patients the benefits of being off opioids. Continue to monitor monthly fills and Kaspers tov recovery

Goal

To have providers refer persons that are dependent on Opioids to our Pharmacy for case planning and follow up until Opioid free

Figure H. Final Change Map from Hill Pharmaceuticals, LLC

Issue & Need

Hunter Health

Overall Goal

Contributor(s): Tara Nolen

Problem Statement

We do not track patient utilization & satisfaction with community resources

Target Population

Homeless patients who visit our Friday Shelter clinics

Activities & Phases

Consult and collaborate with care teams, Initiate consultation with referral system, develop network, develop workflows, test referral loop; implement and evaluate, quarterly evaluate SDOH status

Timeline

One year

Goal

Track utilization of resources, impact on SDOH, and patient satisfaction with community resources/partners

Intervention

Closed loop referral system that racks referrals, utilization & satisfaction. Expand transportation assistance program. 100% competition of SDOH questionnaires annually

Contributing Factors

Transportation, severe mental health issues, substance abuse, transient nature, other higher priorities (food, water, housing

Staff Buy-in

Leadership –yes, staff – some (time is always a constrain- especially short staffed working with homeless at shelters.)

Partnerships

VA medication, orthodontics, specialists, special imaging, housing, transportation, foodbanks

Tracking Progress

Timeline Gannt chart, team meetings celebrate milestones

Sustain & Scale

Decrease impact of SDOH on our patients'' overall health

Culturally Appropriate

Yes

Resources

Referral program integrated with EHR, more homeless clinic hours, staff time , staff buy-in, funding, training/expertise

Data

Current PREEPARE rate, current referral patterns/resources

Define Success

Consistent utilization of referral system, marked change in patients' top 3 SDOH

Figure I. Final Change Map from Hunter Health

Issue & Need

Keystone Health

Overall Goal

Contributor(s): Erin Harris

Problem Statement

Addressing SDOH in our patient community

Target Population

Each patient at arrival and annually; patients that identify as homeless or in abusive relationships

Activities & Phases

1. Finalize new SDOH tool with administration
2. Submit tool for translation to Spanish and Haitian Creole.
3. Present tool to each office ensue all old tools have been removed from use.
4. Collect data on the amount of tools being completed versus how many patients come into the office (taking into account the tools that were already completed within the last year)
5. Develop an algorithm for offering resources to patients show progress and benefit of SDOH screening

Timeline

1-2 years

Goal

To gather data on SDOH, offer resources to high-risk patients, connect them to these resources and create better health outcomes

Intervention

Connection with local resources;
Developing a way to review SDOH prior to patient appointments

Contributing Factors

Lack of housing in the area, Covid-19 causing tension among relationships, and lack of knowledge of resources.
Lack of awareness of SDOH

Staff Buy-in

There is some buy-in although there is no additional funding and little expertise on the best way to hand out the screening tool as well as what is the most appropriate screening tool

Partnerships

WN, SCCAP, Wellspan health

Tracking Progress

Weekly check in with supervisor to ensure deadlines are being met. Once tool has been provided to offices collect weekly data on implementation and percentage being completed. Touch base with the offices on a monthly basis with the offices to show progress

Sustain & Scale

Implementing the tool and reaching as many patients as possible. All positive screens will receive information in the mail or a phone call. Works and additional social workers to reach more patients. Promote health and health educations and increase compliance

Culturally Appropriate

We have not had patient/consumer input on our screening tool. However, our interventions are inclusive for all populations. The resources provided serve the target populations.

Resources

Screening tools in other language (we have a Spanish and English, need Haitian Creole and Italian at least), resources in other language (we have only English), staff/time to provide tools to patients in the most appropriate, Community Health Workers to extend the hang of the SWW who cannot be in the homes.

Data

All the data will need collected, the new tool should be implemented this week or next week

Define Success

When 80% of patients have received tool within the last year

Figure J. Final Change Map from Keystone Health

Issue & Need

Neighborhood Resilience Project

Overall Goal

Contributor(s): Bisrat Tesfagiorgis

Problem Statement
Trauma. There is a lot of trauma in our community

Target Population
Community members in our current space or in new block where we are doing an intervention

Contributing Factors
Poverty & Safety. We have a safe space but need more people to know about it and come to utilize it. Difficult to use tool and may receive pushback.

Intervention
Cleaner facilities,, more open trauma informed staff to welcome persons and assist with needs

Culturally Appropriate
Those who would use the intervention are part of the target population, so they would be considered as part of the culture to a certain extent. There may be some push back regards to the length of the questionnaire. I am not certain how culturally appropriate or inappropriate it is.

Resources
We have the expertise. Staff training, more materials and time for training and using it

Partnerships
SDOH partnership who understand the screening method. Although there is a partnership between university and professionals in apps.

Staff Buy-in
Yes, from the leadership. There may need to be more work done to make sure all staff is on board

Activities & Phases
1. Have community support staff on the same page (I,e same page of continuously seeking the health/betterment of our client/neighbor population). A – we need to constantly have short meetings or to constantly be told this is the right way? B – have a way in which community folks have support. That is apparent in the worship that occurs during noon-day and other times, as our ceo/priest shows support/care/loveto community folks
2. Retreat for community support staff. A – make the call for the orthodox Christian monastery retreat location. B- plan the rides. C- go there.
3. Get participants into neighborhood resilience project for groups a – have a drive b. can we drive the van? C. Staff person to drive D- make flyer for our groups and activities to pass our – use Canva –E. pass out flyers when handing food/items to community members
4. 4 Having groups: A -brainstorm groups b. – Possibility sessions it C. who can do it? Staff or volunteers – call and ask

Timeline
1. 2 years, a. 3 months b. 2 months
2. 3 weeks a. 2 days b. 8 days c. 3 weeks
3. Continuous a 1 week. B. 4 weeks. C. Weeks. D. 3 weeks
4. 2. months a. 1 month b. 1month c. 1 month 1 week

Tracking Progress
Monthly meetings in which all data of # of participants and groups is shared with leadership. In order to grow it. And using our SDOH screening tool on all persons walking in to measure health and resilience. We need to first a, discuss with coworkers/leadership plan for using it. Possible to find out how its work on the ground where its being used. B. Begin using on few individuals then get to using more. C. Use feedback to understand/grow it

Data
We already have the # of groups and the number of participants in group. We document the people who sign-in to our organization and receive services (social/enabling services) as well. We document the items that go out (food/clothing) and that come in

Define Success
Community space with 25-50% capacity of persons whether they want to participate in a group, church service or for other services (count of the capacity +percentage

Sustain & Scale
Long term goals are to continually have persons that are healed when coming to our space or interacting with our programs and they themselves become healers. We always have the correct staff, with a positive view and attitude and continuous work on the steps to get to the goal

Goal
To screen each individual to asses where they are in their health and address patient trauma

Figure K. Final Change Map from Neighborhood Resilience Project

Issue & Need

Primary Care Health Services

Overall Goal

Problem Statement

Patients have communicated problems with accessing SDoH –related resources. After initial contact, there are issues with follow through and access to services.

Target Population

To all patients receiving referrals

Contributing Factors

Patient challenges with compliance to provided resources; Pandemic atmosphere; Making patients aware of available resources with more information on specifics/ details; More guidance on the appropriate use of each resource provided may be necessary.

Intervention

Cultural Humility Training for staff; providing referrals; Ensuring that written materials cater to all health literacy levels; Building referral assistance into our workflow

Culturally Appropriate

Yes. Many of our participating staff members are well-versed in community - specific needs around resource usage issues& health literacy & due to their years of experience with and close ties to patient panel members.

Resources

Cultural Humility Training

Time to modify printed materials & workflow

Partnerships

Intra organizational partnerships/ collaborations should suffice (specifically between our medical staff and social service staff). If this is not sufficient, we will look into potential interorganizational partnerships with local entities. .

Staff Buy-in

Yes

Activities & Phases

1. Discuss effective strategies 2. Narrow down solution/ decide on a combination of solutions 3. Implement the quick fixes (changing our self-assessment to ask about how well previous referrals (if received, have worked/ helped with need). 4. Develop a procedure for the larger/ more comprehensive solution (integrating a follow up call into our work flow. This call will include questions about the use of resources/ if any issues or barriers arose in the process of utilizing them)

Timeline

1. In progress/ continuous
2. By 9/14
3. if received, have worked/ helped with need, by 9/15.
4. By 9/30

Tracking Progress

1. By reviewing patient feed back in case management reports (in our EMR) 2. By developing a form/ survey in our EMR to gauge how patients have been able to utilize each service (more in depth than case management note)

Data

1. Based on anecdotal data, we know that patients have had difficulties with accessing resources. 2. We need data on exactly which resources have caused problems, and at which particular step.

Define Success

Once we've been able to develop and utilize a guide, based on patient feedback, including all of the common issues that patients have while accessing resources.

Sustain & Scale

Establishing a referral process that renders maximum value to patients

Goal

To ensure that we are primed to collect the necessary SDOH data and formulate an adequate response, and post referral roadblocks

Figure L. Final Change Map from Primary Care Health Services

Partnership Health Center Missoula

Issue & Need

Overall Goal

Contributor(s): Jennifer Means, Zachary Clare – Salzler, Laurie Francis, Rebecca Goe

Problem Statement

Identify appropriate staff to administer and implementing follow up for needs

Target Population

Patients experience behavioral or mental health issues

Activities & Phases

Implementing prepare- Currently asking 20 other questions in the initial/annual patient registration intake and general medical intake. Plans to roll out other 7 remaining questions

Organizational awareness: Approaches to care, overall projects and objectives, SDOH evidence

Staff training MA process, social work students process Clinical Informatics: Data Analysis

Timeline

April: addition of housing & food insecurity to general medical intake. July: Transportation added to general medical intake. August: Education, incarceration, refugee status, social interaction added to initial/annual patient registration intake. September: Referral to social work for any food housing and transportation positive screens. Social work warm handoff to students & will ask remaining 7 questions. October: define technology or in person roles that will screen pts annually on reaming 7 questions long term. Reinforce use of documenting SDOH screenings with PRAPARE smart form in HER. Enhance referrals to our Social work department and community resources

Goal

To identify patients need s and provide resources & aide; based on data advocate within the broader community

Contributing Factors

Highly stressful environments and knowledge of systems

Intervention

Identification of patients sooner in the cycle and coordinator of resources or referrals

Staff Buy-in

Leadership buy-n is high, staff buy-in would need more information and structural change to implement full PRAPARE

Partnerships

Partnership with housing agencies, childcare organization, other mental health organization, legal counsel, job corps, job service

Tracking Progress

Azara Drvs – Measures for reporting SDOH assessment completion

Sustain & Scale

Screening PRAPARE on annual basis for all patients, address SDOH screening at all sites, strengthening relationships with community resources, decrease in risk scoring among patients .

Culturally Appropriate

Request consent and introduce topics then offered a patient the opportunity to decline and ask for additional feedback

Resources

Staffing and time primarily, expertise in staffing

Data

Complete PRAPARE data has been collected on some patients, goal is to collect PRAPARE data on all patients

Define Success

Drvs data – pulled on monthly basis and reported to leadership and PPHC BOD

Figure M. Final Change Map from OHC Missoula

Issue & Need

Pillars Community Health

Overall Goal

Contributor(s): Linda Stevens, Claudia Valenzuela, Ryan Alderman

Problem Statement

We do not consistently collect information on SDOH that impact our patient's ability to reach optimal by using wrap around services

Target Population

Homelessness, chronic conditions, low-income households, substance use, DV/SA, mental health

Contributing Factors

Standardized tools, staff workflow, staff use of tablets/tech patients and staff education on tools reports form eCW

Intervention

ADAPT PRAPARE as a tool in eCW, new form at dept meeting. Demo by eCW of dashboard workflow redesigning, utilizing staff for transitions to tool.

Culturally Appropriate

Need PRAPARE in >2 languages (E/S). Staff appropriately trained to have sensitive conversations and health or tech literacy level explain the importance of data collection; appropriate privacy; all patients for input or feedback as we go

Resources

Tools, tablets and formatting, charge cases, smart form (PRAPARE), E/S paper tools, staff for use of tablets and assistance, tool dashboards for reports, cost eCW $1000, CQI budget

Partnerships

Work with IT CC CHW nursing and provider staff. Externally partner orgs that offer wrap around services

Staff Buy-in

Yes- CMO CFO DON AND VP operations and mental services in various settings. Front and back offices have reacted positive to tool.

Activities & Phases

Acquire and create workflow for tablets; translate forms in top 5 languages. Create forms for those who prefer over tablets, use eCW PRAPARE to review data, report to CQI, establish referral process, PCH card resource reference, identify gaps.

Timeline

We have developed and tried Gannt charts. We find it creates anxiety and frustration as the timetables can be off due to circumstances beyond individual or system control

Tracking Progress

We will have weekly or biweekly meetings to track progress and revise timeline

Data

We do not have any data per say. We will collect data based on the items on SDOH form

Define Success

Getting project off the ground. Baseline data will lead to additional goals in: transportation, food pantry, housing assistance, utility assistance or others as learned from collecting information

Sustain & Scale

We are going to see this activity as sustainable so long as we can consistently collect SDOH information and connect patients to resources

Goal

To collect useable and meaningful SDOH data to assist patients with connections to wrap around services

Figure N. Final Change Map from Pillars Community Health

Issue & Need

Pittsburgh Mercy

Overall Goal

Contributor(s): Sarah Kidwell, Michael Turk

Problem Statement

Unser/unaware of the level of use our practice has adopted of SDOH screening. A review of our HER shows no evidence of adoption of this practice

Target Population

High risk population

Contributing Factors

Mental illness and substance use disorders/lack of follow up

Intervention

Better staffing in care coordination

Culturally Appropriate

I believe they are culturally appropriate. We've found that patients are more apt to answer questions truthfully when asked on paper ad have planned to move the food insecurity question to paper included with other paper they bring with them when roomed

Resources

When food insecurity questions are answered in a way that indicates a need they will be given resources. We have an onsite food bank for immediate needs and a handout to give for future needs. We are currently short on care managers and are seeking to hire 2 more . Those positions will assist with other social determinants of health needs

Partnerships

Better staffing. We are currently within a large social services agency so there is no shortage of partnerships in that regard. Staff is a concern agency wide

Staff Buy-in

Absolutely

Activities & Phases

Gather data on frequency of SDOH questions being asked and answered recorded. Moving towards asking 100% of patients SDOH questions. Use new staff to address needs such as food insecurity

Timeline

By the end of this month, extract data on SDOH questions being asked. Nxt month – plan to increase assessment to all patients. New staff starts this week to address needs

Tracking Progress

Monitor HER. Engage with new staff on needs addressed and resources needed

Data

HER recently changed to add date SDOH questions asked

Define Success

When data consistently shows SDOH questions are being asked to every visit and staff are addressing needs and using resources.

Sustain & Scale

Connect patients to resources to improve SDOH

Goal

To integrate SDOH screening into the practice and using the data to determine additional services

Figure O. Final Change Map from Pittsburgh Mercy

Issue & Need

Ryan Health

Overall Goal

Contributor(s): Amie Marie Irvine, Ethan Bernhardt

Problem Statement

How do we develop a workflow to ensure that PRAPARE screening is done routinely for patients

Target Population

High risk primary care patients.

Contributing Factors

Network has nothing in place for patients to receive concrete services, providers left without resources to adequately service patients

Intervention

Standardization SDOH screening and referral workflow, better relationships with nearby CBOS .

Culturally Appropriate

No. While we can make learn from research and past experiences, there has not been a significant patient input into the developing a workflow Out workflow would benefit from presenting SDOH workflow to a patient advisory committe for feedback

Resources

Staff funding are the most important resources

Partnerships

Community resources. Particularly housing resources because this is such a big need in NYC. It is also important that we build strong relationships with CBOs in the surrounding neighborhoods

Staff Buy-in

We have the support from the medical director and administrators, but are still working on buy in from staff who are often the first point of contact for the patients

Activities & Phases

- Create multidisciplinary workgroups at each site within the network
- Develop small scale workflows thar can be expanded to meet the project goal
- Train necessary staff members and implement workflows
- Design reports and monitor workflow progress/outcomes
- Review data and adjust workflows as necessary
- Meet with each site to share lessons learned and best practices

Timeline

Small scale workflows at all sites in the network by the end of the year. Goal is to have universal 18+ primary care SDOH screening by 2023

Tracking Progress

Biweekly monitoring reports and monthly team check ins

Data

# of PRAPARE screenings completed per pilot sites, referrals made, referrals closed. # of clients connected to services. # patients needed an updated PRAPARE (ongoing). #of PRAPRE completed prior to check in ((kiosk)

Define Success

Consistently screening at our target percentage

Sustain & Scale

Universal screening for primary care patients 18+

Better integration of social services as part of routine part of primary care

Permanent staff dedicated to SDOH screenings and social services

Goal

Universal annual SDOH screenings for all primary care patients 18+

Figure P. Final Change Map from Ryan Health

Issue & Need

Unity Care NW

Overall Goal

Contributor(s): Katie Stephens, Breanna Beach Duffy

Problem Statement

16% UCNW exp homelessness; 63% on Medicaid 3 CHWs and 7 Case Managers Need to properly refer pts with SDOH needs to enabling services programs

Target Population

UCNW's medical patient population (1799h, 930h NH) or UCNW's VH population (495 h, 1917 NH)

Contributing Factors

Lack of affordable housing; affordability of other basic needs stretch thin multiple complex systems that are challenging to navigate, underreported homelessness or SDOH needs

Intervention

Establish system to screen, identify and refer to CM or CHW programs as needed

Culturally Appropriate

To make culturally appropriate, no wrong door approach, no limit to number of times assistance is offered, visual and auditory options for screening interpreter language options for screening from all staff, consistently asked but responses optional. Clarity on who sees responses and role in care team information incorporated into health histories from other discplines

Resources

A visual screening tool (with pictures)

An option for screening through conversation (empathic inquiry) = staff time staff training

Integration with the EMR and social histories

Partnerships

Depended on workflow

Check in- front desk, new patient or annual – support services, OE/CM or Mas. Rooming process – MAs, SBH visits – counselors clinicians, medical health history – providers.

Staff Buy-in

Not yet

Activities & Phases

Identify willing partners for this work when and where in the workflow to do the screening. Identify SDOH screening tool, build screening tool workflows, test & analyze data

Timeline

3-6 months

Tracking Progress

Meetings on the colander – decision made:

- Partners to work with
- Integration point with clinic workflows chose
- Screening tool chose
- Workflow created

Data

We will eventually want to create a way for the SDOH data to be shared with clinical team in a patient history/family history format so its relevant for clinical psychosocial assessments. Clinical assessment tools collect the same information we are asking in the SDOH screener but they are not yet consolidated . This will be another project – clean up our assessment tools

Define Success

A new workflow for screening patients for SDOH and referring to CM will be established

Sustain & Scale

To be able to assess the the SDOH needs of the UCNW population

Goal

To screen and appropriately refer UCNW patients to case management & CHW programs

Figure Q. Final Change Map from Union Community Care

Issue & Need

Union Community Care

Overall Goal

Contributor(s): Sarah Schwartz

Problem Statement

Demonstrating the value of addressing SDOH needs within a medical setting

Target Population

Heavy ED utilizers with underlying SDOH needs

Contributing Factors

No associated fee for ER use for most patients. Primary care providers not something they are used to using

Intervention

Get the community health resource coordinators involved in low acuity ED follow up calls to engage patient in care and educate them on benefits of having a PCP

Culturally Appropriate

Yes, we have placed health equity as our top driving goal. We consider the unique experiences of the patient population that we are serving when we make organizational decision and implement any change processes. We developed a community impact team playbook that includes training around impact bias , and continued education opportunities around culturally appropriate care. We are in the process of creating patient advisor committees for each of the regions that we serve 3 total. While our BOD is compromised of over 50% patients – the type of patient is likely to participate on a non profit board is not necessarily representative of our overall patient base

Resources

More staff/ More time. We are expecting our community health resources coordinators to accomplish a lot. ED follow up, using an EMR (filling every role in the data documentation processes scheduling/ check in. documenting billing codes /check out /make referrals /respond to referrals) receiving warm hand offs, participating in community events, stay up to date on training requirements, assist with SSI and insurance application, document in an information and referrals system … it is a lot [

Partnerships

Having a direct interface with our local hospitals system would be very helpful. It is challenging to get data form these systems shared in a uniform way. We have a grant that is focusing on reducing inappropriate ED utilization for behavioral health concerns, so building closer relationships with our local behavioral health resources is an ongoing process

Staff Buy-in

We have had some push back form staff who would like the ED outreach to be narrowed to subjectively inappropriate use only. Leadership maintain a stance that we should outreach to every patient

Activities & Phases

We are in the assessment phase. We have implemented a system that provides outreach to all patients and have staff in place to provide follow up We need to determine how we will ensure success and align those measurements with other initiatives (HRSA/NCQA/hospital community needs assessments/ insurance providers

Timeline

Initial reporting in September. 3-4 months out bring data to local hospitals partners to review

Tracking Progress

Reduced ED utilization

Data

We need a better way to understand the ED utilization of our full patient base

Define Success

When our patient population has a lower ED utilization rate compared to the surrounding area PCP practices

Sustain & Scale

Improve patient health, reduce cost burden, better relationships with local hospitals systems and insurance providers

Goal

Get buy in from all levels of staff so that implementation goes smoothly

Figure R. Final Change Map from Unity Community Care