Social Determinants of Health Lessons Learned, Challenges, and Barriers: A Resource for Health Centers, Vol. 3

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ACKNOWLEDGMENTS

SUMMARY

Special and marginalized populations may face additional barriers to care, often compounded by Social Determinants of Health (SDOH). When screening for SDOH, health centers serving special and marginalized populations need to consider the unique needs and circumstances of the populations they serve. While screening for SDOH is a necessary first step in identifying these disparities, responding to the data is the goal of addressing SDOH.

Health centers, community-based organizations, and other organizations seeking to respond to SDOH are likely to face challenges in any step of their SDOH response mission. AAPCHO, HOP, MHP Salud, and NHCHC, all serving as National Training and Technical Assistance Partners (NTTAPs), recognized these challenges and, with their collaboration, developed a three-year curriculum of activities and resources to support organizations and their SDOH response missions. Each of the three years focused on a particular theme of SDOH and data. In Year 1, the NTTAP faculty offered an introduction to SDOH data as well as enabling services. Year 2 activities and resources highlighted promising practices for gathering data. In Year 3, the webinar and Learning Collaborative focused on the importance of responding to data.

Following the completion of the Learning Collaborative, AAPCHO, HOP, MHP Salud, and NHCHC analyzed the results of the closing evaluation survey, reflected on the overall execution of the activity, and discussed participants' engagement. This publication is a summary and analysis of these findings. The content of this publication will include lessons learned, challenges, barriers, and impact stories shared from the four (4) sessions of the Learning Collaborative interwoven with information gleaned from research.

To learn more about our first and second-year findings and key takeaways, access Volumes 1 and 2 here:
- Volume 1: https://bit.ly/SDOH-Lessons-Learned-Vol1
- Volume 2: https://bit.ly/SDOH-Lessons-Learned-Vol2

Importance of SDOH Screening, Data Collection, and Acting on The Data
Federally funded health centers provide care to more than 30 million patients across the continental United States, Hawai'i, U.S.-Affiliated Pacific Islands (USAPI), and the Compacts of Free Association (COFA) nations. With such diverse locations where patients receive care, it is essential to acknowledge the conditions where people live, learn, work, and play. Data on these SDOH factors are vital to strengthening capacity to improve health outcomes for underserved and marginalized communities. Addressing the impacts of SDOH on Special and Vulnerable

Populations (SVPs) begins with screening and data collection to identify critical barriers to care and create opportunities to facilitate better service delivery.

The impact of data on enabling services utilization is wider than quantifying health outcomes and disparities. Enabling services data informs health centers on their capability to: Hire and maintain personnel to meet patients' needs; monitor Medicaid reimbursement policy to budget for the necessary funding to continue providing high-quality care; track patient and provider satisfaction, which can improve the quality of care and service provision to increase value-based payment; standardize data collection methods and create avenues for cross-sectoral data sharing helps facilitate community-based resources and solutions to reduce the impact of SDOH outcomes for SVPs.

Throughout this Learning Collaborative, NTTAP faculty sought to provide guidance on how health centers can act on the data collected when screening for SDOH to facilitate change in health outcomes and the conditions influencing those outcomes.

Overview of the Year 3 Learning Collaborative
Building upon work completed in the previous two years, NTTAP faculty worked together to facilitate this Learning Collaborative to increase the number of health centers that receive training and technical assistance on: screening, documenting, and responding to SDOH. Year 3 emphasized the importance of acting on and responding to SDOH data. On July 28, 2022, NTTAP faculty hosted a National Audience webinar in which the objectives of the Year 3 Learning Collaborative were announced.

Learning Collaborative Objectives:
1. Participants will understand the unique considerations of special and marginalized populations when screening for SDOH.
2. Participants will identify at least one strategy to screen for SDOH for special and marginalized populations effectively.
3. Participants will identify at least three (3) strategies to respond to SDOH screenings and effectively address the SDOH of their patient populations.
4. Participants will gain the tools to demonstrate the value of screening for SDOH, providing enabling services, and responding to patient data.
5. Participants will learn from the cohort's experiences screening for SDOH and addressing social determinants and will identify best practices for health centers.

Timeline

Applications to participate in the Learning Collaborative were accepted from July 12, 2022, to August 1, 2022. Priority acceptance was given to previous Learning Collaborative participants, who received a special invitation to apply. Learning Collaborative sessions took place on a biweekly schedule as follows:

- Session 1: August 10, 2022
- Session 2: August 24, 2022
- Session 3: September 7, 2022
- Session 4: September 21, 2022

Evaluation data were collected following each session, and an overall evaluation survey was fielded following Session 4.

Participants & Engagement

A total of 23 unique organizations applied to participate in the Learning Collaborative. **Table 1** shows the participants who attended at least one Learning Collaborative session and their funding streams.

Table 1. Participating Organizations by Group. *Funding is defined below*.		
Group, Staff Lead	**Organization Name**	**Funding Stream***
Group 1: Albert Ayson, Jr., and Gabrielle Peñaranda (AAPCHO)	Center for Health Affairs	Not 330 Funded
	Chinese American Service League	Not 330 Funded
	Community Clinic NWA	330(e)
	Community Health of South Florida, Inc.	330(e)
Group 2: Andria Batise/Meghan Erkel (HOP)	Community Medical Wellness Centers, USA	330(e)
	Country Doctor	330(e)
	Education and Leadership Foundation (ELF)	Not 330 Funded
	Herald Christian Health Center	330(e)
	HHSA Tulare County Public Health	Not 330 Funded
	Kodiak Area Native Association	330(e)

Group 3: Hansel Ibarra (MHP Salud)	Montana Legal Services Association	Not 330 Funded
	MS HEALTH SAFE NET	Not 330 Funded
	New Mexico Primary Care Association	Not 330 Funded
	Pillars Community Health	330(e), (h)
Group 4: Lauryn Berner (NHCHC)	Iowa Primary Care Association	Not 330 Funded
	Sunshine Community Health Center	330(e)
	The Wahiawa Center for Community Health	Not 330 Funded (Look-Alike)
	Turner House Clinic d/b/a Vibrant Health	330(e)

METHODOLOGY

Introduction

This Learning Collaborative is the culmination of a three-year series of packaged activities to provide training and technical assistance to health centers and look-alikes on screening and addressing Social Determinants of Health (SDOH). The year three Learning Collaborative built on the work and subject area of years one and two and provided a deeper dive into topics covered in the accompanying year three webinar held in July 2022.

The year three Learning Collaborative focused on how health centers could act on SDOH data to address barriers to health better. This is a natural endpoint to the three-year series that began with the following:
- Year One: screening methodology and the role of outreach and enabling services
- Year Two: using SDOH data to address SDOH.
- Year Three: taking the data to the next level and assessing how to act on SDOH.

Consistent with previous years, NTTAP faculty met monthly and shared leadership roles in quarterly planning meetings for all activities, with additional ad hoc meetings scheduled as needed. During these meetings, partners shared language and updates for work plans, so all activity descriptions and objectives were consistent across organizations.

Session Structure

Each session of the Learning Collaborative was centered on peer-learning and guided by participants' identified challenges, goals, and ideas. While each session included content delivered by NTTAP faculty according to expertise (as listed below), there were also two breakout group times – once at the beginning and once at the end of the session. The breakouts provided space where participants met with a smaller, consistent group to share their experiences at their health center and discuss their progress on the homework prompts to generate a plan to meet their goals.

The July 2022 webinar and each of the four (4) Learning Collaborative sessions focused on one aspect of this year's theme: "Acting on SDOH data." NTTAP faculty demonstrated their expertise in various aspects of screening and responding to social risk factors.
- MHP Salud shared the benefits of conducting return on investment (ROI) at participants' organizations.
- HOP presented the structural competency framework to analyze better and address SDOH and health disparities.
- NHCHC discussed strategies for community health centers (CHCs) to build external capacity and community partnerships in their mission to address social risks.
- AAPCHO shared how CHCs can build their capacity to respond to SDOH within their organization.

Application Process
The Learning Collaborative application was shared broadly with health centers through the NTTAP partner e-blasts, the BPHC's Primary Health Care Digest, and directly with webinar participants and past Learning Collaborative cohorts. The application assessed where organizations are regarding screening and addressing SDOH, including what they view as their successes and areas they would like to grow. In total, the Learning Collaborative received applications from 23 unique organizations. Throughout the series, 36 individuals representing 18 organizations participated in the Learning Collaborative.

This Learning Collaborative sought to address challenges participants identified and set goals for acting on SDOH data across the four sessions. Goal setting was aided by guided questions relating to the Change Map model, described below, with questions discussed in breakout groups and completed as homework. Session discussions and activities were divided to represent key sections of the Change Map (Figure 1).

Figure 1. Topics Covered by Learning Collaborative Session.

Session 1	Session 2	Session 3	Session 4
"Show The Value of Enabling Services Staff and How They Can Impact Clinical and Non- Clinical Decision Making at Health Centers"	"Structural Competency: A Framework to Analyze and Address Social Determinants of Health and Health Disparities"	"Acting on Data: Building Partnerships and Demonstrating Progress"	"Building Internal Capacity and Defining Success"
Overview & Introduction to the Learning Collaborative	Cultural Appropriateness & Required Resources	Implementation & Tracking Progress	Defining Success & Scalability
Return on Investment for Enabling Services	Structural Competency	Building External Capacity	Building Internal Capacity

All materials shared during the Learning Collaborative sessions were made available to participants using a shared platform. This allowed participants to access recordings, supplemental resources, and slides, as well as chat with other participants between sessions. A public version of the compiled resources is available here. (For best results, users should access using Google Chrome.)

Change Map Framework

As previously mentioned, this Learning Collaborative followed the Change Map in how sessions were structured. The Change Map was developed in 2018 by Lauryn Berner of the National Health Care for the Homeless Council to support health centers and other organizations in identifying steps to address a need. The tool incorporates program evaluation and planning tools to start initiating a new intervention or adapting an existing program to meet the Learning Collaborative's and individual organizations' objectives. The objectives for each session are listed in Figure 2.

Figure 2. Learning Objectives by Session

Session 1

- Identify unique considerations of special and vulnerable populations when screening for SDOH.
- Understand the purpose and structure of a Change Map .
- Craft a problem and goal statement regarding SDOH screening within their patient population.

Session 2

- Use a lens of cultural sensitivity, discuss appropriate strategies to effectively screen SDOH for special and vulnerable populations.
- Propose a SDOH screening intervention and work through key considerations required for success.

Session 3

- Discuss data collection tools and strategies to support and track progress of new practices.
- Outline activities/phases, propose a timeline, and describe a plan to track progress and collect data for their SDOH screening intervention.

Session 4

- Define what success looks like and articulate long-term goals for SDOH screening and providing Enabling Services.
- Complete your change map to meet identified goals for SDOH screening within special and vulnerable populations.

Change Map Framework
The Change Map model is designed to be adapted to the needs of an individual health center. The model can also be used to evaluate a program or process and its efficacy. The structure encourages health center staff to utilize existing resources, consider where practices can be more effective, or identify ways to fill gaps. The Change Map is not intended to be a static tool but rather one that allows for dynamic updates as ideas are refined. Those completing the tool can revisit previous questions and continue to refine their plan as needed.

For the purposes of this Learning Collaborative, participants were introduced to a section of the Change Map questions in the second breakout group of a session. These questions were provided to each organization between sessions. They were intended to offer an opportunity to reflect on the content covered in the previous session. Below is a breakdown of the questions that shaped the organization of the Learning Collaborative (Table 2).

Table 2. Change Map Questions by Section	
Section Heading	**Questions**
Section 1: Background	- What is the big picture problem? - What is your overall goal? - To whom do you want to provide the initial implementation? - Consider using data to identify any disparities - What is contributing to the issue within your identified population? - Consider talking to providers (both clinical and non-clinical) and consumers to understand the need
Section 2: Action	- What interventions could help address the contributing factors? - Do you have to make any adjustments to ensure the intervention is culturally appropriate for your intended population? - Consider asking for consumer input on this step.
Section 3: Support	- What resources are needed to implement the intervention? (materials, staff time, financial need, etc.) - What partnerships would be helpful? - Do you have buy-in from staff and leadership?
Section 4: Details	- What are the steps and/or phases for implementing this project? - Create a list and drill down as many details as possible - What is the expected timeline for implementing these activities? - Consider developing a Gantt Chart, which is a table that outlines activities in detail along with their designated time frame, to help frame and track activities

Section 5: Monitor	• How will you track your progress? • What data do you have or need? • How will you know when you have reached your goal? • What are the long-term goals for this intervention? - Consider sustainability and scalability.

Participant responses to these questions were entered into the Change Map and were shared in breakout groups for further discussion, elaboration, and feedback with peers and NTTAP faculty. Participants completed their Change Maps in stages throughout the Learning Collaborative. Completed change maps can be found in Appendix A.

BARRIERS TO ACTING ON SDOH DATA

Introduction
Acting on SDOH data involves collecting and using data as evidence to identify and address the social and economic factors that impact health outcomes for individuals and their communities. Attendees expressed concerns about completing this phase; many felt this to be the hardest step. In each of the four (4) sessions, the NTTAP faculty facilitated talks where participants discussed barriers and concerns over acting on the data once collected. Attendees were allowed to meet in smaller groups to brainstorm and share possible solutions. The following are some of the barriers brought up by the attendees.

Addressing Staff Buy-In
Acting on SDOH data requires the involvement and commitment of staff members at all levels of the organization. Gathering SDOH data can be time-consuming, burdening the already heavy staff workload. Therefore, educating and communicating the importance of capturing SDOH data to staff members is crucial. Failure to complete the SDOH questionnaire can be a common occurrence if the significance of this information is not adequately conveyed. However, when everyone is on the same page, the probability of completing the SDOH form increases significantly. To achieve staff buy-in, the following strategies can be implemented:

Education and training: Providing education and training to staff members can help raise awareness about SDOH and their impact on health outcomes. Education and training can help staff members understand the importance of addressing these determinants and how they can contribute to the efforts.

Leadership Support: Ensure that leadership supports efforts to address SDOH. This helps create a culture that prioritizes addressing these determinants and encourages staff members to get involved.

Clear Communication: Ensure that communication about efforts to address SDOH is clear and consistent across all levels of the organization. This consistency helps ensure that staff members understand the goals and objectives of the efforts and how they can contribute.

Staffing
The appropriate staff must be selected to evaluate the SDOH data. Hiring the correct staff is vital because it ensures that individuals with the proper skills and qualifications are in place to address these SDOH. They will assess and condense the gathered data into digestible chunks that help paint the scenario. C-suite staff, frontline workers, and enabling service staff may

assist in breaking down the results and offering insight into the data. Building capacity for social determinants data analysis requires specialized skills and expertise, which may be in short supply. In a time when organizations need more staff and funds, our participants found themselves wrestling with the idea of hiring/moving staff versus partnering with a third party for this task.

Navigating/ Analyzing Determinants of Health
Navigating through the data can be intimidating, but once mastered, the data can shed light on your community's struggles. For example, food insecurity may be a significant SDOH for low-income communities, whereas access to transportation may be more important for rural populations. Understanding which social determinants are most relevant to your population is critical for analyzing data effectively.

Even when available, data may be of poor quality or not standardized, making it difficult to compare across regions or populations. This can also limit the effectiveness of interventions and hinder efforts to build capacity. Use data gathered by trusted third-party sources (local, city, county, state, federal agencies, private or non-profit organizations) to compare to the data collected in-house. The data provided by these agencies have been reviewed and deemed reliable.

Capacity to respond
The capacity to respond to SDOH data involves the ability of organizations to discover and address the root causes of health disparities and implement interventions that improve health outcomes. Building capacity can be costly, requiring investment in staff, technology, and other resources; limited resources may make it difficult for organizations to build the necessary capacity. Addressing SDOH and improving an organization's ability to respond requires a commitment to equity and a willingness to engage in meaningful partnerships and collaborations. The following three steps are essential in addressing SDOH:

Building partnerships and collaborations: Addressing SDOH requires collaboration across sectors and disciplines. The organization should build partnerships with community organizations, healthcare providers, government agencies, and other stakeholders to leverage resources and expertise. By discovering mutual communities served, organizations can prevent duplicating existing services.

Developing and implementing interventions: The organization can develop and implement interventions that address SDOH based on the needs assessment and partnerships. These

interventions may include programs to address food insecurity, affordable housing, transportation access, and other social determinants.

Monitoring and evaluating progress: It is essential to monitor and assess the impact of interventions over time to ensure they are effective and make a difference in health outcomes. Doing this can involve tracking key indicators and outcomes and engaging with stakeholders to gather feedback and input.

EVALUATION OF THE LEARNING COLLABORATIVE

Feedback for the Learning Collaborative sessions shows that participants had relatively consistent levels of satisfaction, confidence in their ability to implement lessons learned and knowledge gained. The overall evaluation showed higher levels of satisfaction, confidence, and knowledge changes than the average of the sessions individually (Table 3).

Table 3. Session and Series Evaluation Scores on a Five (5) Point Scale			
	Satisfaction	**Confidence**	**Knowledge Gained**
Session 1	4.17	3.82	3.53
Session 2	4.29	3.89	3.82
Session 3	4.14	4.07	3.5
Overall Evaluation	4.43	4.43	3.71
Averages	**4.26**	**4.05**	**3.64**

Impact of Learning Collaborative

The overall evaluation showed that participants felt their organization was in the process of screening for SDOH and providing enabling services to address SDOH. After participation in the Learning Collaborative, 100% felt their organization was "Halfway down the road" or "Close to the finish line" regarding screening for SDOH, and 85% felt similarly for providing enabling services (Figures 3 and 4).

Figure 3. Current standing with screening for SDOH

Where would you say your organization currently is in screening for the Social Determinants of Health (SDOH) AFTER participating in the series?

7 respondents
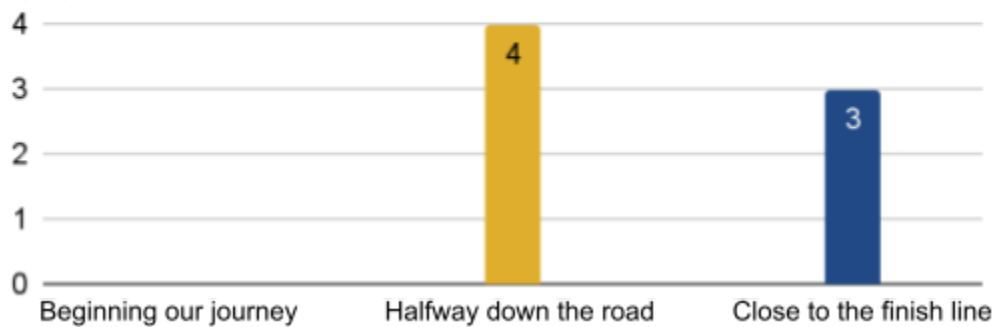
Figure 4. Current standing with providing enabling services related to SDOH

Where would you say your organization currently is in its current practices of providing Enabling Services related to SDOH AFTER participating in the series?
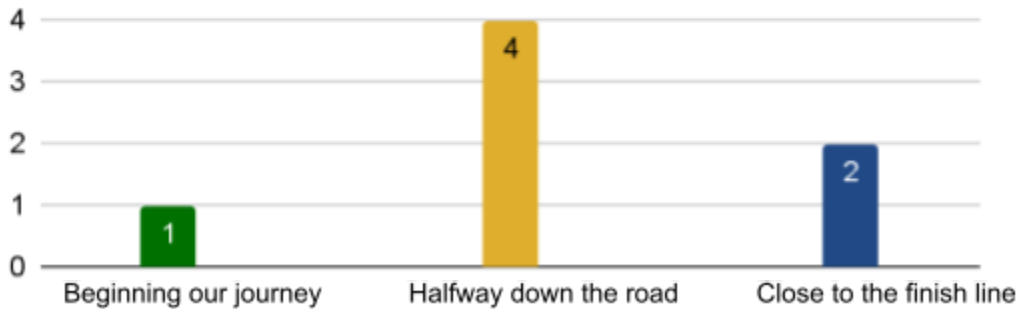
7 respondents

One hundred percent of respondents reported that participating in the Learning Collaborative had a moderate or significant impact on the implementation of screening for SDOH and data collection (Figure 5). Similarly, about 85% stated that they are actively planning to or are already implementing lessons learned from the Learning Collaborative (Figure 6).

Figure 5: Impact from Learning Collaborative

To what degree has the Learning Collaborative impacted the implementation of screening for SDOH and data collection at your organization?

7 respondents
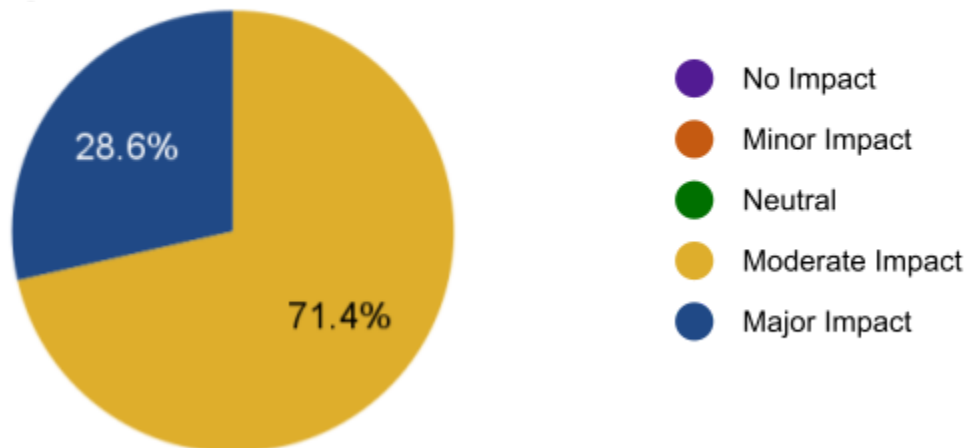
Figure 6. Readiness to implement lessons learned

As a result of this SDOH Screening learning collaborative, how ready are you in your ability to implement lessons/strategies gained from the sessions into your health center/organization?

7 respondents

- ● We have not discussed implementing lesson(learned at this time.
- ● We are considering implementing lesson(s) learned.
- ● We are actively planning to implement lesson(s) learned.
- ● We are currently implementing one or more implementing lesson(s) learned.
- ● We have fully operationalized one or more lesson(s) learned.
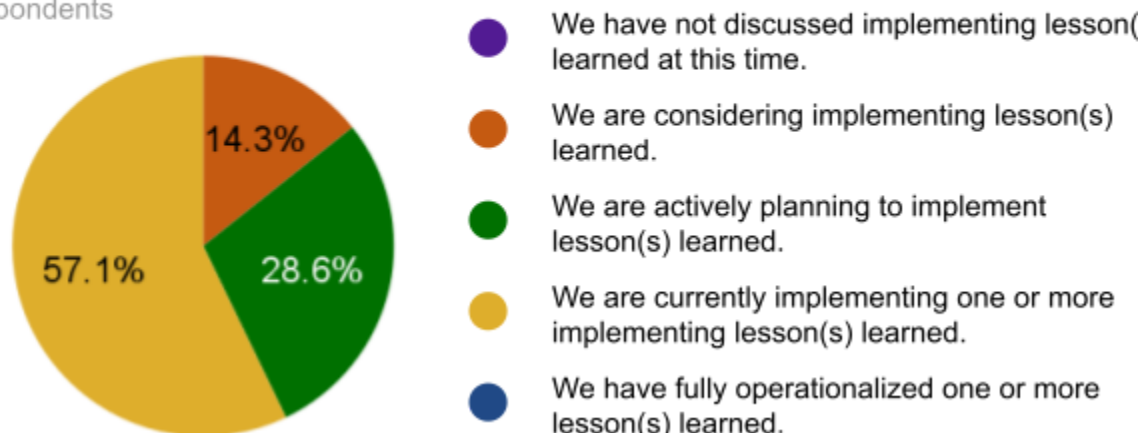
The average self-evaluated score of knowledge of standardized SDOH screening practices after participating in the Learning Collaborative was 7.9 out of 10. The average score of knowledge of standardized Enabling Services data collection was 7.9, with 85 percent self-evaluating with a score of 7 or higher. Prior to participating in the Learning Collaborative, the average self-evaluation of both knowledge areas was 5.5 and 4.5, respectively.

Change Map Completion

All four teams had a 66 % or higher completion rate on the change maps. Participants expressed their satisfaction with the change map tool. They appreciated the adaptability of the change map; some used it to start planning, others to evaluate existing programs.

Some participants expressed they could not complete the change maps due to their current workload, while others voiced their uncertainty about some of the steps. The "details and monitoring" portions of the change map seemed to trouble most participants. Two of our four Learning Collaborative sessions discussed these steps in further detail.

Participant Progress: 3 – 6-month follow-up

In a follow-up four months survey after the last Learning Collaborative session, a total of 6 respondents reported that 67% of their organizations were "halfway down the road" or "close to the finish line" regarding SDOH screening, and 50% were "halfway down the road" or "close to the finish line" regarding providing enabling services (Figures 7 and 8).

Figure 7. 3-6-month follow-up for SDOH screening

Since completing this learning collaborative, where would you say your organization currently is in screening for the SDOH?

6 respondents

2	3	1
Beginning our journey	Halfway down the road	Close to the finish line
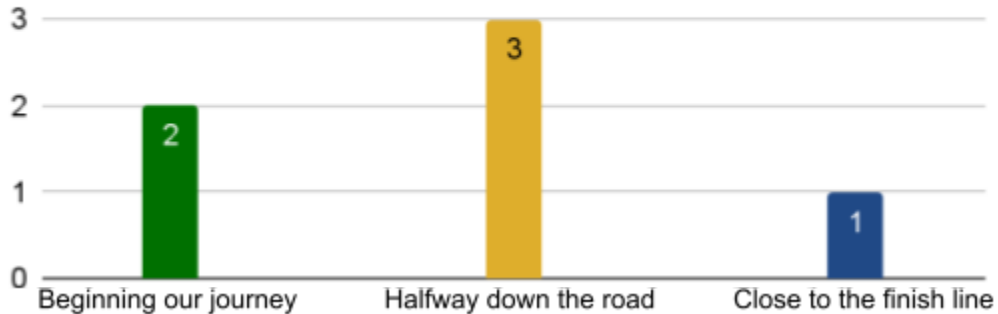
Figure 8. 3-6-month follow-up for providing enabling services

Where would you say your organization currently is in its current practices of providing Enabling Services related to SDOH AFTER participating in the series?

6 respondents

3	2	1
Beginning our journey	Halfway down the road	Close to the finish line
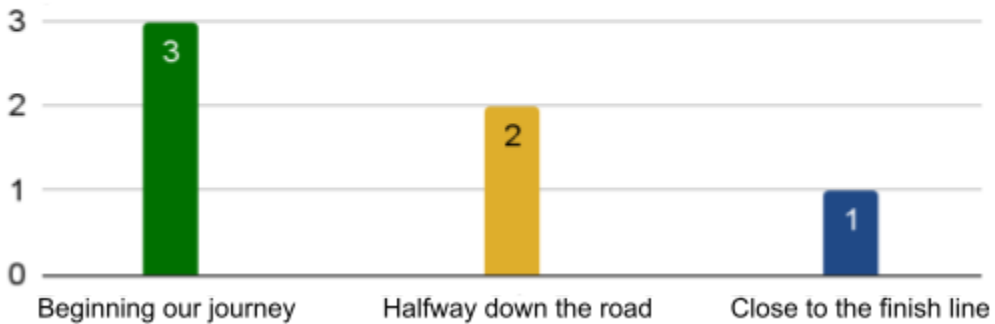
Eighty-three percent of respondents noted that participating in the Learning Collaborative had a "moderate" or "major" impact on their ability to implement SDOH screening and/or provide enabling services related to SDOH (Figure 9). About 33% of respondents said they were considering implementing lessons learned, 33% were actively planning to implement lessons learned, and an additional 33% are currently implementing lessons learned. (Figure 10).

Figure 9. Impact of Learning Collaborative at 3-6 month follow-up

To what degree has the Learning Collaborative impacted the implementation of screening for SDOH and data collection at your organization?

6 respondents

- No Impact
- Minor Impact
- Neutral
- Moderate Impact
- Major Impact

16.7% 16.7%

66.7%
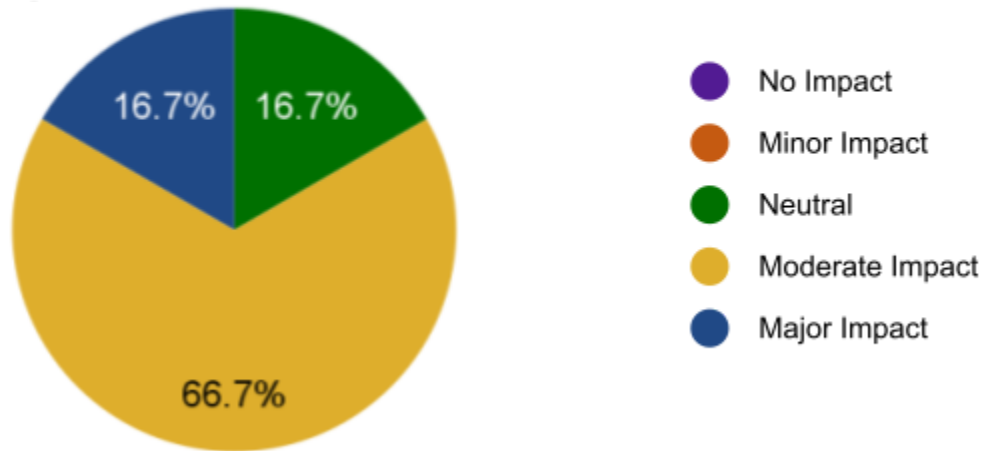
Figure 10. Readiness to implement SDOH screening and data collection at 3-6 month follow-up

As a result of this SDOH Screening learning collaborative, how ready are you in your ability to implement lessons/strategies gained from the sessions into your health center/organization?

6 respondents

- We have not discussed implementing lesson(s) learned at this time.
- We are considering implementing lesson(s) learned.
- We are actively planning to implement lesson(s) learned.
- We are currently implementing one or more implementing lesson(s) learned.
- We have fully operationalized one or more lesson(s) learned.

33.3% 33.3%

33.3%

Qualitative responses

In the open response questions, participants noted that connecting with other participants during breakout sessions was helpful, especially considering the similarity across challenges organizations faced. They also found it helpful to dig into their specific goals for their organization using the Change Map. Some participants expressed challenges related to implementing sections or the framework of the Change Map and coming up with ideas to implement their plans. Several communities completed their Change Maps and gave permission to share their ideas. These are available in Appendix A.

PUTTING IT ALL TOGETHER

This three-year curriculum, developed and presented by AAPCHO, HOP, MHP Salud, and NHCHC, provided participants with a particular theme around social determinants of health (SDOH) data for special populations each year. Year 1 introduced the importance of SDOH data and enabling services, while Year 2 provided tools and resources on promising practices on how to collect it. Year 3, the webinar and Learning Collaborative focused on the importance of responding to data. By synthesizing the feedback over the three years, we found that participants demonstrated a strong understanding of the importance of SDOH and the need to collect data better to inform their health center's programs and practices. However, each year we continued to hear similar challenges and barriers to implementing a strong SDOH screening process at their health centers and organizations. To support health centers in overcoming these challenges, below are three recommendations for implementing a successful and sustainable SDOH data system.

1 - Operationalize processes around data collection, management, and analysis

Participants relayed varying levels of readiness regarding their health center's success in operationalizing a SDOH screening process. As the results in year 3 found, participants overwhelmingly reported that their organization/health center was "halfway down the road" or "close to the finish line" regarding screening for SDOH. However, as noted above, participants relayed that utilizing the data once collected was the most challenging step for various reasons. Some participants reported time and resources as barriers to this final step. Yet, many participants noted they were ultimately stuck at this "halfway" point because the organization did not have a strong process in place that could get them across this finish line.

Getting started with data screening before operationalizing a data process from start to finish can lead organizations and health centers to get stuck at this halfway point. To successfully "cross the finish line," health centers must first internally decide why the data they wish to collect is necessary, the focus for Year 1. Health centers must design a methodology that includes data collection, management, and analysis to best design a plan for their team. Failure to create an analysis plan before collecting the data will eventually lead to what can be termed as "dead data," which is when an organization or health center collects, stores, and fails to use valuable data. Operationalizing sustainable data processes will allow health centers and organizations to carry out data from collection to analysis in an organized, timely manner to truly unlock data's power of identifying challenges and uncovering solutions to reduce patient barriers and improve community health outcomes for special populations.

2- Identify roles and responsibilities among key staff members in all steps of the process

Participants often referred to staff buy-in being a fundamental factor in whether a screening process for SDOH was successfully implemented and followed through. As noted above, participants remarked that questionnaires were often left blank or incomplete. Among special populations, data is limited yet critical. Without the data surrounding the lived experiences of these special populations, we fail to see the whole picture when it comes to implementing wraparound services that target the specific needs these different demographics and communities require.

Identifying roles and responsibilities among key staff members in all steps of the process is essential for two main reasons. Firstly, it allows staff members to recognize their role within the process and keep themselves and other staff accountable. Secondly, it will enable leadership to note if staff members have gaps in responsibilities. For example, many participants indicated that their team often needs staff who have training in data analysis. Mapping out roles and responsibilities throughout the process from start to finish encourages leadership to fill gaps in responsibilities. It also discourages staff from taking on other roles and responsibilities, often leading to staff burnout.

3 - Create positive and negative feedback loops in the data process and invite the whole team to contribute

Data processes are not linear. Even when organizations operationalize a data process from start to finish, milestone checkpoints enable key staff members to take a step back and discuss what is and is not working to implement solutions in real-time. Positive and negative feedback loops must be set in place to monitor the system and make adjustments to create a smoother workflow for all involved.

An essential first step in implementing feedback loops is encouraging an open reporting approach. An open approach allows leadership to focus on the errors in the system and supports staff members to contribute to the ongoing discussions and potential solutions. This also empowers those carrying out the data processes to provide suggestions for improving the system.

Feedback loops can be formal or informal, but both are essential for long-term success. Ensuring feedback from all level employees helps to acknowledge their value in the long-term goal and remind staff of their impact on that goal.

Looking Forward

Health centers provide high quality primary and preventive care to diverse populations in special and other populations in underserved communities. Health centers also offer various enabling services – non-clinical services that aim to increase access to health care and improve population health outcomes. The ability to track and evaluate these services is an essential tool for health centers to demonstrate their value in addressing patients' SDOH factors. The ability to make this data actionable to address patients' barriers to access is of equal importance.

Looking ahead, AAPCHO, HOP, MHP Salud, and NHCHC will build upon evaluation data and lessons learned from the 2020-2023 webinars and Learning Collaborative series and continue to support health centers and look-alikes in screening and utilizing SDOH data. The faculty will continue collaborating and co-designing activities for health centers, Primary Care Associations, Health Center Controlled Networks, and other key stakeholders to explore strategies to screen special populations for SDOH.

APPENDIX
Completed Change Maps

Issues & Need   **Pillars Community Health**   Overall Goal

Completed by Jennifer Swoyer, Abigail Contreras, and Ellen Kunkle

Problem Statement
Determine what type of data to gather and what to do with it

Background

Intended Population
All clients/patients; initial care and annual exam

Activities & Phases
Finalize tool; longer format first visit, smaller more focused on gaps on annual visit

Details

Timeline
By January 1 we will implement comprehensive screenings for all patients consistently

Goal
Our overall goal is to establish a sustainable workflow and process to: Identify SDOH metrics that we can impact by aligning patients with services within our community; Better assess when there are patient/client needs that are not addressed within the current system ; Include a set of streamlined basic questions (PHQ-2 behavioral health, Housing insecurity, Food insecurity) with follow up questions if needed.

Action

Intervention
Staff training, move from paper to electronic tracking

Contributing Factors
Lack of established workflow

Staff Buy-in
Trainings and sharing success stories

Partnerships
warm handoffs, don't recreate the wheel/ duplicate services

Tracking Progress
we will utilize emr to queery % of patients screened and chart audit to identify those aligned with resources

Monitor

Sustain & Scale
# of patients screen and assisted

Culturally Appropriate
Consult with board and local leaders (CHWS)

Support

Resources
track information (paper, online), software, HIPPA

Data
# of billed annual exam, % of completed surveys per visits, % of patients who would benefit from additional

Define Success
screen 80% of patients for SDOH, lower HGBA1C, improve blood pressure by 85%, improve adult vaccination 65% or more, dental intervention of prenatal patients at 90%

Issues & Need

County of Tulare

Overall Goal

Completed by Luis Cortez and Manuel Rodriguez

Problem Statement

Building trust with the community with their LHJ and other community services. In addition modify/ strengthen the intake form to identify the services the community needs and collect essential data for reference.

Background

Intended Population

To the most vulnerable communities that lack resources based off their area/zip code.

Activities & Phases

Create a workplan, recruit, provide trainings, host check-in meetings, outreach, gather data, and create educational material.

Details

Timeline

Refer to Year 2 work plan

Goal

To become more understanding of the importance of the CHW role in the community and why they should be certified in California. Along with gaining knowledge from my fellow peers to better our work at hand that we are currently working through our county.

Action

Intervention

Promoting the available resources out into the rural communities through the CHWs. Providing resource information in different languages. Using the presence of social media more to enhance the reach to the community.

Contributing Factors

Lack of confidence with the community and the resource providers. Lack of knowledge of the available resources in the community. Language barriers, and cultural barriers.

Staff Buy-in

Yes we have support from staff and leadership to conduct our efforts in activities through our funded program.

Partnerships

Partnerships with local community-based organizations and Federally Qualified Health Clinics (FQHC)

Tracking Progress

bi-weekly data analysis provided by consultant; monthly check in meetings with CBOs

Monitor

Sustain & Scale

The long term goal would be for this grant to be self-sufficient. Where the CHWs are able to continue providing education, outreach, linkage to services and to build a rapport with the community.

Culturally Appropriate

Yes, hence our discussion in regards to providing appropriate services to our targeted population, in this case the Latino Community in the Central Valley.

Support

Resources

Time, expertise, adequate trainings to provide for CHWs, health education material, staff, CBOs.

Data

We currently have data regarding the Health Fair tracker, Outreach tracker, and Referral linkage tracker. Although we have data collected there is still room for improvement to reduce discrepancies.

Define Success

When there is minimal discrepancies, CHWs are aligned with the year two workplan and understand their duties, and lastly when the program/grant becomes self sufficient.

Chinese American Service League

Issues & Need — **Overall Goal**

Completed by David Li and Josh Samos

Background

Problem Statement
-Disaggregate data is scarce when it comes to the special and vulnerable populations we serve (immigrant & minority communities-e.g. low-income AANHPIs)
-Unsure on when and how to address unmet needs identified during SDH screening.

Intended Population
2 primary stakeholder groups:
-Staff at AANHPI-serving agencies and institutions with similar goals;
-AANHPI clients/patients at those organizations (ourselves included)

Details

Activities & Phases
-Making the case for social determinants screening to 3 key stakeholders (leadership, clinical/non-clinical staff, clients and/or patients): implementing SDOH screening helps (1) ID most prevalent risks in service population; (2) prioritize/reallocate limited resources; (3) connect individuals with targeted interventions; (4) ID community factors contributing to risks & educate policy makers; (5) reduce cost of care; (6) increase efficiency; (7) improve quality of care through better clinical decision-making; (8) leverage partnerships with other community-based social services organizations; (9) increase client/patient-provider trust & client/patient self-determination; (10) service population is healthier as a result. These are not necessarily in order…

Timeline
~rolling, but for our first few pilots (currently on first one), a span of about a year
-current year (pilot): 3 months for training, 2 months for data collection, 2 months for data analysis, and a month and a half for reporting. These are extremely conservative timeframes, but the feasibility of timeline will be modified moving forward

Goal
Address the needs of AANHPI individuals and communities with identified SDH risks by developing tailored interventions that are relevant, timely, and culturally-appropriate.

Action

Intervention
-Modified workflows for clinical and non-clinical staff
-Additional, consistent, and sustained buy-in at all staff levels
-Training on data management systems and quality assurance (multiple platforms)
-Educational workshops/awareness campaigns on why responding to SDH risks are important
-Unified data collection procedures

Contributing Factors
We have been there/done that before - only to have upper management let go of our outreach team. I always say "don't ask patients questions that you can't answer or address - it's just not fair to our patients"
-Buy-in inconsistency
-Unknown data infrastructure to capture SDH risks
-Lack of comparatively accurate data on a more granular level
-Lack of resources (funds, staff capacity, time)

Staff Buy-in
Leadership, yes. Some staff, but majority no.

Partnerships
Research institutes, hospitals & health clinics, municipal/state/federal leaders, schools, houses of worship/religious centers, other social service organizations

Tracking Progress
-After roles assigned, metrics will (and have) include rates of response, qualitative feedback from administrators, quality of the data collected, and presentation/reporting standards. The metrics we have now are fairly elementary in nature and will require some significant bolstering

Monitor

Sustain & Scale
Long-term goal: eliminate health disparities disproportionately impacting AANHPI communities (but this is very vague, lofty, and admittedly difficult to capture)

Culturally Appropriate
No consumer input at this time, which is something we hope to incorporate moving forward. Proposed interventions/practice not yet installed, still trying to define what they are.

Support

Resources
Expertise-currently 1 subject matter expert, 4 collaborators
Staff-stretched thin, need additional content expertise, more collaborators
Time-not enough
Funding-contingent on insights gathered from SDH data (which relies on having enough staff to administer/document)
Materials-data infrastructure sometimes insufficient, limited communication

Data
Quality of life data, PRAPARE data, demographic data, and program-specific intake data is already collected, but the real catch is whether or not these giving us the insights we need. Our pilot using PRAPARE is but a step in addressing disparities within the AANHPI diaspora, but the primary objective was to highlight the need for social determinants screening among AANHPI communities in general and the benefit of identifying risks at the individual-level. We need to collect additional information that gets more specific into the "why" rather than "what".

Define Success
There's meeting outputs like how many trainings facilitated, how much data collected, and what reports get attention from whom, but the goal is really that clients/patients have greater trust with providers/staff and that as a result, our communities get healthier

Education and Leadership Foundation

Completed by Nora Zaragoza-Yáñez, Vianey Barraza Chávez and Martha Rosales

Issues & Need

Overall Goal

Background

Problem Statement
Existing clients need access and notification of community and other wrap-around services and resources; Clearer communication

Intended Population
Undocumented, Immigrants, Low-Income Individuals

Activities & Phases
1. Meet with other department heads to go over SDoH screening and how to implement it; 2. Finalize SDoH where it is integrated into our organization intake sheet (English and Spanish versions); 3. Implement use of SDoH screening in our organization; 4. Track and collect data on patient demographics, SDoHinformation; 5. Run monthly reports on case management system to evaluate SDoH screening progress; 6. Make changes as needed

Details

Timeline
October 2022: Meet with Department Heads to discuss implementing SDoH questions; November 2022: Implement and update organization intake sheet to include SDoH - December 2022: Soft-run to evaluate client perception, response, and make changes as needed; January 2023 - December 2023 (and onward): Fully implement revised intake sheet that includes screening for SDoH

Goal
Implement an agency-wide SDoH Screening as part of a routine screening process, to connect clients to the services they need.

Action

Intervention
Interdepartmental Collaborations, Multi-faceted/Inclusive Outreach, Implementing an agency-wide SDoH screening

Contributing Factors
Trust, Language Barriers, Immigration Status (Public Charge), COVID-19, Educational Attainment, Transportation, Childcare, Job Insecurity, Confusion in Navigation of Services, Misinformation, Socioeconomic Status

Staff Buy-in
Buy-in from staff and leadership is counted on

Partnerships
Local Health Departments, State Health Departments, Local Social Services Departments, State Social Services Departments

Tracking Progress
Case Management System (Quickbase)

Monitor

Sustain & Scale
The long-term goals of this activity is to see how many individuals in the Central Valley need assistance and how having CBOs provide wrap-around services is a positive impact/showcase the importance of integrating CBOs as key players in the health care system

Culturally Appropriate
The proposed interventions and/or practice changes are culturally appropriate for our target population.

Support

Resources
We need the following resource: Staff, Funding, Materials, Time

Data
Demographics; Other services requested; Income level; Use of Public Benefits/Social Services

Define Success
By running monthly reports and tracking interdepartmental referrals, we'll be able to see if the SDoH intake sheet where clients expressed their needs had the checklist marked off and case was closed due to completion

Wahiawa Health

Issues & Need

Overall Goal

Completed by Dr. Cyndy Endrizal

Background

Problem Statement
large rural area to cover; lack of outreach staff/programs due to inability to bill for services

Intended Population
As of 2022 YTD, only 50% of our patients have been screened for SDOH. Don't know how many actually had their SDOH issues addressed/ resolved. But, before getting MAs onboard, NEED upper management/leadership support

Activities & Phases
1. Ask to be on agenda of Board of Directors: Topic="What's all the noise about SDOH? What is it and how does it relate to our patients'/community's health?"; 2. Obtain funding for Enabling Services positions (CHWs, Patient Advocate, MSW, RDN, Case Mgr/Care Coordinators, Delivery Drivers, Eligibility Workers, Food Hub Coordinator, etc) and training (on SDOH, how to ask the tough questions, Cultural Safety); 3. Create the training engaging the Hawaii Primary Care Association who represents all 15 FQHCs in Hawaii. The training would be specific to Native Hawaiians, Other Pacific Islanders and all other cultures in the Pacific Island Region. (maybe we could sell this product at IHI? AAPCHO? etc); DO THE TRAINING statewide for ALL FQHC employees - this will be mandatory yearly and for all new hires

Details

Timeline
By 12/31/2022: Board Meeting training; By 6/30/2023: Obtain funding to hire support staff and pay for creation of training; By 9/30/2023: Create Training; By 12/31/2023: Do training for all Wahiawa Health staff

Goal
Leadership will know and appreciate the benefits of addressing SDOH via outreach teams and programs

Action

Intervention
1) get leadership buy-in and support; 2) properly train MAs with role-playing; 3) monitor % of patients with PRAPARE answers; 4) open discussion on challenges and change workflows; 5) continue to encourage more PRAPARE tool use; 6) next step would be to monitor actions taken to address SDOH; 7) monitor resolution of SDOH

Contributing Factors
We have been there/done that before - only to have upper management let go of our outreach team. I always say "don't ask patients questions that you can't answer or address - it's just not fair to our patients"

Staff Buy-in
Overall, the staff and leadership are "aware" of SDOH and that it "seems" to be important and related to health somehow. I heard our CMO tell our staff in an all-staff meeting this week "we have to get that SDOH data so that we can report it to the feds". That was his only explanation. He made no other connection to patient's health, provider time taken to address SDOH due to insufficient staff, MCO incentive payments related to SDOH data, need for SDOH data to write grants relevant to the SDOH needs of our patients, etc... so, "no" we don't necessarily have buy-in.

Partnerships
all FQHCs in Hawaii and within the Pacific Island Region need same Cultural Safety training - makes sense for an organization to fund this project and disperse to all (ie HPCA).

Monitor

Tracking Progress
Board Meeting minutes; Hiring of needed employees; Evidence of comprehensive training packet; Training logs of attendance (pre- and post-tests?) - and ultimately, we'll see if this makes a difference in the # of PRAPARE questionnaires completed/referrals made/# of SDOH factors/pt decrease

Sustain & Scale
Enabling Services Department will gain financial stability beyond grant funding by billing for services such as: Chronic Care Management; Transitional Care Management; Medical Nutrition Therapy; Diabetes Self Management Education/Support; z-codes will be built into EMR system to track for (not sure what yet)

Culturally Appropriate
We use our Board of Directors as representatives of our community. They are included in the brainstorming of projects and initiatives targeting our patient populations.

Support

Resources
Materials for Cultural Safety (not competency) training - doesn't really exist for our patient population (85% identify as other than White - mostly Pacific Islanders/Native Hawaiian and Asian) so will need to create the materials. Staff time to attend meetings/collect data/identify barriers and change workflows. Funding is needed since our sole source of income is billable visits (besides some special project grants) - taking MAs away from patient visit related work means less billable visits/hour. Also need funding to create Cultural Safety Training.

Data
baseline data of # of PRAPARE questionnaires currently being completed (~55% of all pt visits) - need to validate this and compare reports with Phreesia (Admissions software) -> Athena (EMR) -> Azara (Population Health software)

Define Success
1. Staff are stoked about addressing SDOH and work very closely with Enabling Services new department; 2. # of PRAPARE questionnaires (data) completed are trending UP while SDOH challenges are trending down with our patients; Board of Director members ask "how's that SDOH project going?"

Issues & Need

Turner House Clinic d/b/a/ Vibrant Health

Overall Goal

Completed by Valorie Coffland and Andrea Perdomo-Morales

Background

Problem Statement

Many, if not most of patients and families we serve, have unmet human and social services needs that impact their health condition and quality of life

Intended Population

Established patients with more than a year in our care

Activities & Phases

-Supervisors of medical assistants, chws, psr team develop workflow/training -Targeted training for all staff: sdoh prevalence and domestic violence -Identified food resources in house -Tool and workflow training for staff -Hire at least 1 chw (now have 2) -Final overview with all staff: workflow; targeted training with medical assistants, psrs -Roll out September 12 -Data review planned at 2 week mark -receipt of donated tablets in October/November will require

Details

Timeline

Assessment rollout September 12; data review/process evaluation 2 weeks & 1 month; addition of tablet option to workflow Oct/Nov

Goal

To identify patients and families and with need and connect them to available and accessible resources.

Action

Intervention

Proactive outreach to patients and families to assist with meeting needs directly and through established community partners. Continuing to build our list of available and accessible resources

Contributing Factors

Unfamiliarity with available resources, shame or fear in asking for help, cultural stigma,

Staff Buy-in

We have established buy-in from leadership, enabling and quality improvement staff with plans this week to provide background and implementation plans with all staff and additional focused training for smaller teams.

Partnerships

Expertise from others in the field, from assessment to documentation and community partnerships with agencies that assist with social and human services needs.

Tracking Progress

Data is entered into structured fields in the practice electronic health record for review; formal check in with ma, psr, chw, provider teams at next all staff meeting (10/13);

Monitor

Sustain & Scale

Assessment of patients for human and social service needs at every visit; improved patient portal use for additional contact with care team; consistent referral to expanded CHW team; formal reimbursement for CHW time and efforts

Culturally Appropriate

The team receiving referrals to provide assistance with SDOH needs have received and will continue to receive ongoing training on cultural responsiveness, which is integrated into our plans for SDOH assessment roll out. At this time, however, we have not formally garnered patient input into assessment plans. Under discussion is how to best solicit feedback once enacted. When patients are engaged with the CHW team and other enabling staff we do plan to assess 'satisfaction' with interactions that may include culturally appropriate responses.

Support

Resources

Staff time to conduct, document and evaluate assessments is essential as is workflows that successfully connect patients with needs to staff and external partners who can provide assistance. Funding for additional staff to perform these activities may be useful as the program grows.

Data

New EHR data will be collected around annual or new patient assessments completed; how many patients screen positive; review of referrals to chws from positive screens; referral outcome

Define Success

Workflow used consistently; screen 100% of patients when eligible; referrals are made to chw team; patients have timely assistance with referrals for assistance