Social Determinants of Health Lessons Learned, Challenges, and Barriers: A Resource for Health Centers, Vol. 1

TABLE OF CONTENTS

ACKNOWLEDGEMENTS 3

Authors 3
Contributors 3
Funding & Support 3

INTRODUCTION & OVERVIEW OF LEARNING COLLABORATIVE 4

The Importance of SDOH Screening 4
The Role of Outreach & Enabling Services 5

LEARNING COLLABORATIVE METHODOLOGY 6

The Change Map Model 9

RESULTS OF THE LEARNING COLLABORATIVE 12

Session Feedback 12
Learning Collaborative Evaluation 14

BEST PRACTICES TAKEAWAYS 18

A No-One-Size-Fits-All Approach 18
Utility of SDOH Screening Data at Various Levels of Implementation 19

Conclusion 21

APPENDIX A 22

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INTRODUCTION & OVERVIEW OF LEARNING COLLABORATIVE

Special and vulnerable populations (SVP)[1,2] often face additional barriers to care, many of which are compounded by social determinants. When screening for Social Determinants of Health (SDOH), health centers serving SVP will need to take into account the unique needs and circumstances of the populations they serve, particularly during times of crisis (e.g., COVID-19 pandemic). Screening for SDOH is the first step towards addressing these disparities.

From October to November 2020, AAPCHO, HOP, MHP Salud, and NHCHC hosted the "Screening Methods and Using Outreach and Enabling Services to Address Social Determinants of Health" Learning Collaborative for health centers serving SVPs to explore effective strategies to screen for SDOH and build effective practices 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

Social Determinants of Health are the conditions in which people are born, grow, live, work, and age.[3] These conditions can have a significant impact on an individual's health. Many of these conditions are shaped by the distribution of money, power, and resources.[4] Studies show that social and economic factors are the primary drivers of health outcomes and can shape individuals' health behaviors.[5] Furthermore, SVP are often most impacted by SDOH. As such, addressing SDOH plays a key role in improving health outcomes for underserved and marginalized communities.

However, to address the impacts of SDOH on SVP, we need to identify these factors. SDOH screening allows us to collect SDOH data or information to identify and understand how these factors may affect one's health.[6] Collecting this [non-medical] information about patients' circumstances can help identify needs and fill gaps with enabling and social services. Furthermore, screening helps health centers identify key barriers to care and create opportunities to facilitate better service delivery.

[1] https://www.nachc.org/health-center-issues/special-populations/
[2] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-health#11
[3] https://www.cdc.gov/socialdeterminants/index.htm
[4] http://www.who.int/social_determinants/sdh_ definition/en/
[5] https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
[6] http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Using Standardized SDOH Screening Tools to Assess Needs of Special and Vulnerable Populations

The use of a standardized tool to collect social risk data is important to be able to collect data on barriers to care across all points of patient contact with the health center and use that data to create coordinated care plans. Which tool to use, however, is determined by patient population demographics, the data to be collected, and who will be collecting the data. The type of tool used will determine both provider workflow and the questions asked of the patient (i.e., which data points are collected). Additionally, compatibility with the health center's electronic health record (EHR) will determine how data is recorded and shared between providers.

Whether health centers are specially funded to serve particular SVP (e.g., persons experiencing homelessness, migrant and seasonal agricultural workers, residents of public housing, racial and ethnic minorities), or they provide care to patients representing many different vulnerable populations, the SDOH screening tool(s) used should accurately reflect all needs of the patients.

SDOH Screening Tools

The Health Resources and Services Administration's (HRSA) Uniform Data System (UDS), is a national system of data to which Federally Qualified Health Centers (FQHCs) or health centers, report on patient outcomes, services delivered, and other important metrics on the nation's most vulnerable populations.[7] In the 2019 UDS report, among 1,385 FQHCs, more than 70% reported collecting data on individual patients' social risk factors outside of the data reportable in the UDS. Among health centers who screen for patient social risk factors (i.e., SDOH), 36% use Protocol for Responding to and Assessing Patients' Assets Risks and Experiences (PRAPARE),[8] the most commonly used SDOH screening tool. Other commonly used tools include:

- Recommended Social and Behavioral Domains for Electronic Health Records[9]
- Well Child Care Evaluation Community Resources Advocacy Referral Education (WE CARE)[10]
- Centers for Medicare & Medicaid (CMS) Accountable Health Communities (AHC) Screening tool[11]

Regardless of what tool(s) health centers use, one of the most important factors when choosing a social needs screening tool is ensuring that the data collected and reported is meaningful and actionable for health center providers and staff. Moreover, the SDOH screening tool should take into account intended population or setting, total number of questions, social health domains covered, and domain-specific measures used.[12]

The Role of Outreach & Enabling Services

Health centers have long recognized the importance of acting on adverse social determinants for individual patients given the Health Center Program's history and roots in the social justice movement of the mid-1960s and the War on Poverty Era. Fast forward to today, health center's core values and mission-driven workforce align with many of the current social, racial-ethnic, economic, and

[7] https://bphc.hrsa.gov/datareporting/reporting/index.html
[8] https://www.nachc.org/research-and-data/prapare/
[9] https://www.nap.edu/initiative/committee-on-the-recommended-social-and-behavioral-domains-and-measures-for-electronic-health-records
[10] https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/poverty/Pages/practice-tips.aspx
[11] https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
[12] https://sirenetwork.ucsf.edu/SocialNeedsScreeningToolComparisonTable

environmental justice movements, which have been heightened during this time with the COVID-19 pandemic.

Under Federal Statute Title 42, and in Section 254b of the US Code, health centers are required to provide primary health services that include both clinical and non-clinical services.[13] As defined by the Health Center Program under Section 330(b)(1)(A)(iv), enabling services (ES) are non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.[14] Many of these ES, if not all, are likely to improve patient experience and health outcomes, which potentially saves on total cost of care for payers and the overall health care system.[15]

In terms of the enabling services workforce, HRSA's UDS reporting requirements have eight (8) Enabling Services Categories including case managers, patient/community education specialists, outreach workers, transportation staff, eligibility assistance workers, interpretation staff, community health workers, and other enabling services (ES) staff.[16] On an annual basis, health centers are required to report full time equivalents (FTEs), types of ES visits (face-to-face or virtual), and number of unduplicated patients served.

Going beyond the UDS and Health Center Program requirements related to ES, it is invaluable to recruit and retain non-clinical staff who can work in tandem with clinical providers to holistically address the health and social needs of patients. For example, outreach workers can provide information about in-house health center services or refer out to community partner's services in order to meet the needs of patients. Some examples of outreach activities include community health fairs; street outreach to homeless patients; formal or informal informational presentations at homes, worksites, or community locations; and contacting a patient automatically assigned to your health center by a managed care organization.[17] By virtue of providing outreach and ES to patients, health centers are in a position to effectively address patients' SDOH barriers and can benefit from a standardized screening tool to systematically document those social needs.

LEARNING COLLABORATIVE METHODOLOGY

For this Learning Collaborative, the NTTAP partners worked together to meet the objective of increasing the number of health centers that receive training and technical assistance on screening and documenting SDOH.

To meet this objective, the partners developed three interrelated activities to deliver comprehensive training from each partner's vulnerable population's unique perspective. These activities included a national webinar to lay the framework for SDOH screening and identifying the appropriate non-clinical workforce and services in place, followed by an in-depth Learning Collaborative that would further

[13] https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section254b&num=0&edition=prelim
[14] https://www.hrsa.gov/sites/default/files/grants/apply/assistance/Buckets/definitions.pdf
[15] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05228
[16] https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/pdf/2020UDSTables.pdf
[17] Enabling Services Data Collection Implementation Packet. Available at: https://aapcho.org/enabling-services-data-collection-implementation-packet/

develop ideas identified in the webinar. The third activity is this publication, which will assess what was learned from participants of the Learning Collaborative as well as its challenges and successes.

NTTAP faculty met monthly and shared leadership roles in planning meetings for all activities quarterly, 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.

The previous webinar was outlined according to the partnering NTTAP staff members' expertise, which was then expanded in correlating sessions of the Learning Collaborative. These roles were developed according to the NTTAP partners' expertise and resources:

- AAPCHO – Enabling Services Data Collection Toolkit
- HOP – Structural Competency
- MHP Salud – ROI Education Tool
- NHCHC – Assessment Tools for Persons Experiencing Homelessness

Application Process

After promoting across all four NTTAP organizations' networks and the HRSA Bureau of Primary Health Care Digest, a weekly newsletter for the health center community published every Tuesday, the Learning Collaborative received applications of interest from 49 unique organizations. A large group introductory session that included 85 individual participants from 41 organizations prompted NTTAP faculty to split participants into smaller cohorts, with each faculty leading a cohort. Cohorts met in breakout groups during the remaining Learning Collaborative sessions. Participating organizations are listed in **Table 1**. Due to participant attrition, breakout groups 3 and 4 were ultimately combined and co-facilitated.

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

Group, Staff Lead	Organization Name	Funding Stream*
Group 1: Beleny Reese, HOP	Alabama Regional Medical Services	330(e), (h), (i)
	Circle the City	330(e), (h)
	Bay Area Community Health Foundation	Not provided
	Family Health Centers of San Diego	330(e),(h), (i)
	Herald Christian Health Center	330(e)
	TCC Family Health	330(e)
	Colorado Health Network	Not provided
Group 2: Albert Ayson, Jr., AAPCHO	Premier Community HealthCare	330(e), (g)
	Mercy Care Atlanta	330(h)
	Kōkua Kalihi Valley	330(e), (i)

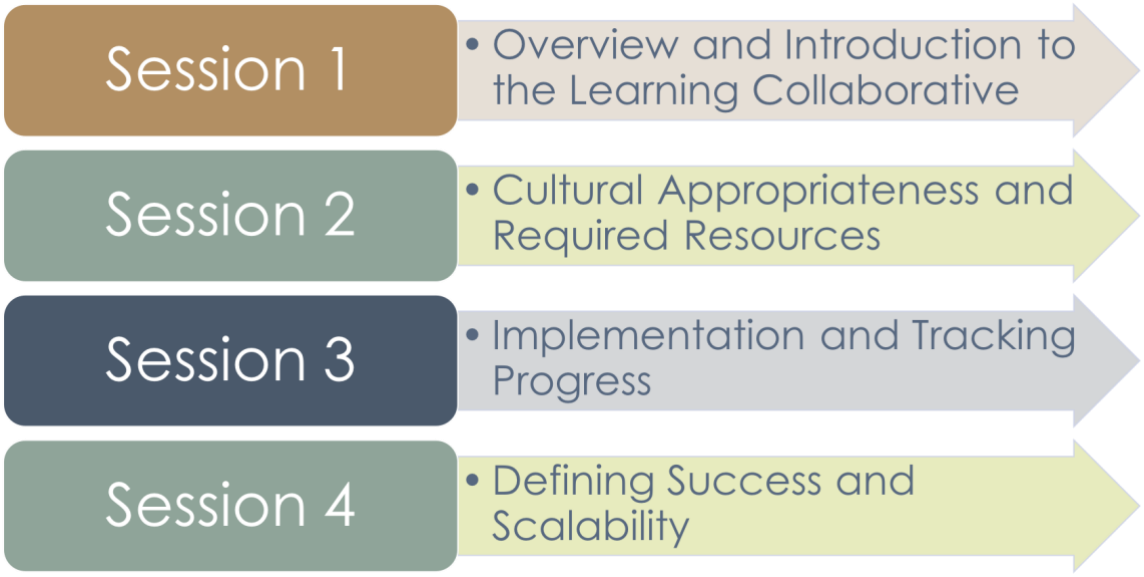
	Wahiawā Health Center	Not provided
	Waikiki Health	330(e), (h)
	Waimanalo Health Center	330(e)
	West Hawaii Community Health Center	330(e)
Group 3: Esly Reyes, MHP Salud	Medina County Health Department	Not provided
	Rocking Horse Community Health Center	330(e)
	HCH Primary Care Health Services, Inc.	330(e), (h), (i)
	Multi-Cultural Health Evaluation Delivery Systems, Inc.	Not provided
	Welsh Mountain Health Center	330(e)
	TTUHSC-Larry Combest Comm. Health and Wellness Ctr	330(e)
	NeighborCare Health	330(e)
	Unity Care Northwest	330(e)
Group 4: Joe Lee, AAPCHO	2-1-1 Maryland	Not provided
	Bronxworks, Inc.	Not provided
	Community Health Care Association of New York State	Not provided
	Cornell Cooperative Extension Onondaga County	Not provided
	Cornell University	Not provided
	Joseph's Home	330(h)
	Kentucky Primary Care Association	Not provided
	Oklahoma Primary Care Association	Not provided
	St. Peter's Health Partners	Not provided
	WVU Center for Excellence in Disabilities	Not provided
Group 5: Brett Poe, NHCHC	Chestnut Family Health Center	330(e)
	Chicago Family Health Center	330(e)
	TCA Health	330(e)
	Boston Healthcare for the Homeless Program	330(h)
	Community Action Health Center	330(e), (g)
	Project HOPE	330(h)

	Mount Vernon Neighborhood Health Center	330(e)
	Ryan Health	330(e)
	HealthSource of Ohio	330(e)

**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)[18] 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.*

This Learning Collaborative addressed problem areas and goal setting for SDOH Screening Practices across four sessions, with guided questions that correlate with the Change Map model, described in the next section. Sessions and related independent activities were organized to address key components of the Change Map process (**Figure 1**).

Figure 1. Topics covered by Learning Collaborative session.



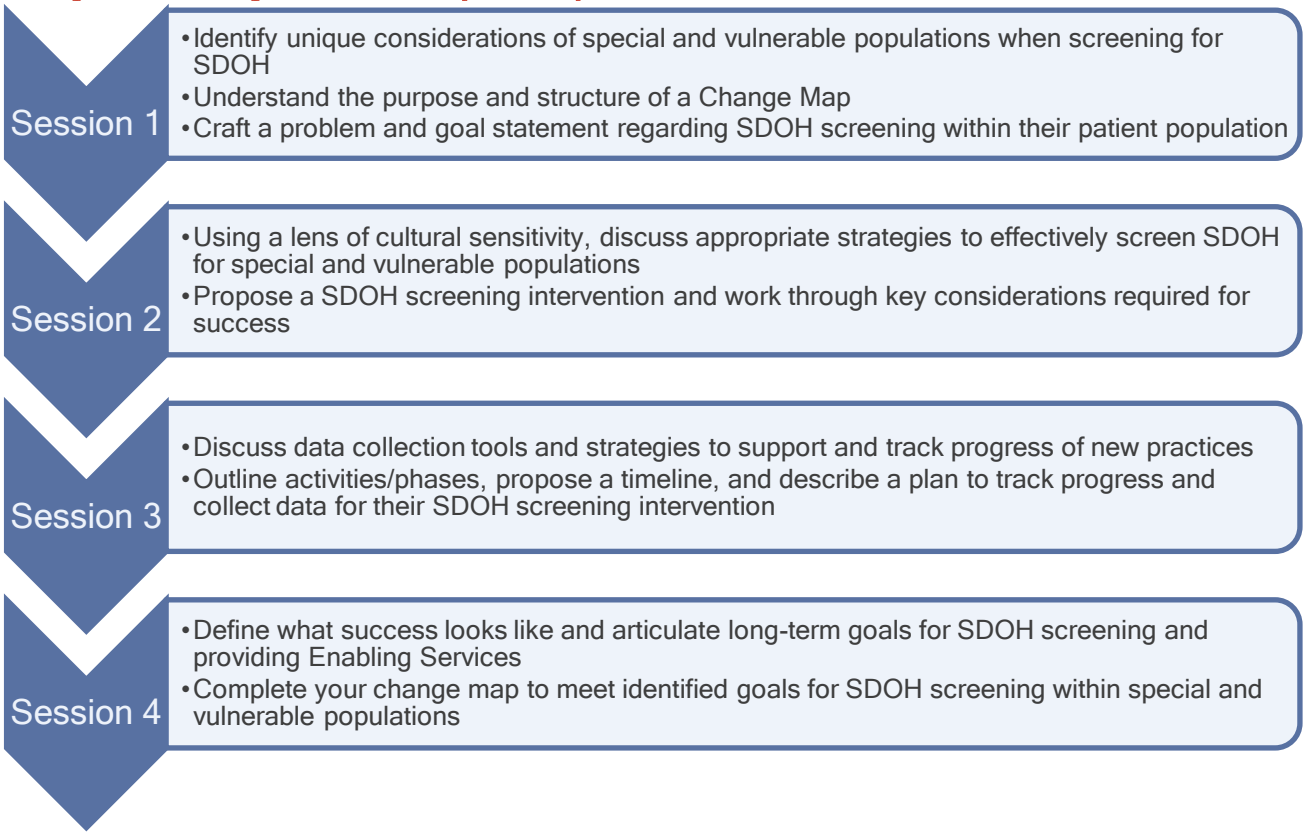
Participants were also provided access to a Group Participant Page to access session materials, recordings, shared resources, and chat options between sessions. A public version of these compiled resources is available here. *(For best results, users should access through Google Chrome.)*

The Change Map Model

This Learning Collaborative followed the structural model of a Change Map, developed in 2018 by Lauryn Berner, Research Manager of the National Health Care for the Homeless Council. This model utilizes program evaluation tools to initiate interventions or opportunities to evaluate and adapt existing programs to meet the objectives set by the Learning Collaborative. Each session's objectives are listed below in **Figure 2**.

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

Figure 2. Learning Collaborative objectives by session.



Health center staff can also use the model as a method to reverse engineer a program or a process and evaluate its effectiveness after the completion of the Learning Collaborative. The Change Map model is designed to encourage health center staff to utilize existing resources and identify where staff and/or leadership can be more fully effective.

Participants were provided questions between sessions to reflect on the content covered in the previous session. Below is a breakdown of the questions that shaped the modeling and organization of the Learning Collaborative. Questions were broken down into the following sections:

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

Action

- What interventions could help address the contributing factors?
- Do you have to make any adjustments to ensure that the intervention is culturally appropriate for your intended population?
    - Consider asking for consumer input on this step.

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?

Details

- What are the steps and/or phases of 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 here to help frame and track activities

Monitor

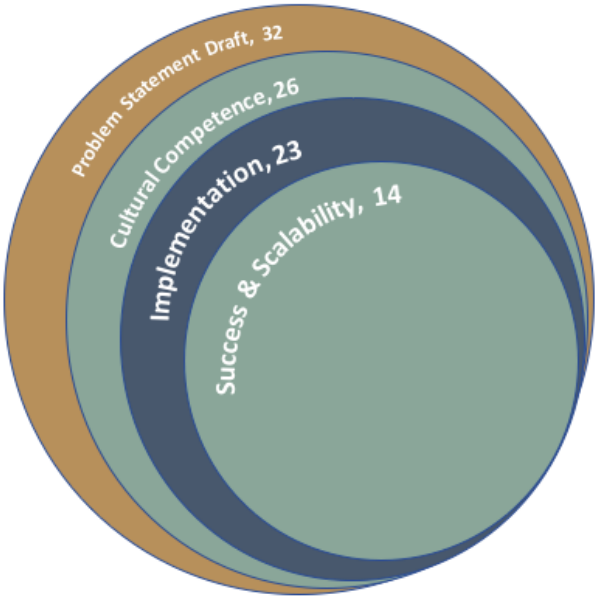
- How will you track your progress?
- What data do you have or need?
- How will you know when you have reached your goal?
- What are the long-term goals for this intervention?
    - Consider sustainability and scalability

Summaries of responses were then entered into the Change Map, as seen in the appendices of this document, and shared on screen during subsequent sessions for discussion, elaboration, and feedback during breakouts with Learning Collaborative faculty. Throughout the Learning Collaborative, organizational participants completed their change maps at various stages. A selection of examples of completed Change Maps can be found in **Appendix A**.

This process allows providers, staff, or administrators to develop a plan that demonstrates consideration of the background and context of a perceived problem area, cultural considerations, and necessary support to receive the buy-in needed from staff who are responsible for the proposed activities, as well as leadership. The Change Map model takes participants through the steps of implementation and data collection. These are determined by the needs and available resources of the participating organization.

Participants were then encouraged to identify the data needed to support their proposed interventions and to utilize it in such a way that highlights the value of work that is often overlooked. Once these foundations are established, the Change Map can be used as a visual for previous work or utilized when approaching potential funders.

Figure 3. The number of participants who completed respective Change Map sections.



The variation across the Change Map process and its completion reflects the stages of implementation that health centers and organizations were in at each stage of the Learning Collaborative (**Figure 3**).

The intent of this model is to identify a pre-determined or developing goal that will effect change and encourage a useful method of re-visiting and addressing new concerns for health centers as they arise. Using this method, health center staff can not only take the necessary steps to achieve the goal, but also have a tool to re-evaluate and make improvements to better achieve the goals of the health center, the community, and their served populations.

RESULTS OF THE LEARNING COLLABORATIVE

Session Feedback

As a means of evaluating the effectiveness of facilitation strategies used and utility of the content shared during each Learning Collaborative session, poll surveys were launched at the end of individual sessions to assess participant satisfaction, confidence in their ability to apply the information to their work, and knowledge gained throughout the session. Participants were asked to rate their satisfaction, confidence in their ability to apply the information to their work, and knowledge gained throughout the session on a scale of 1-5, with 1 being not at all satisfied and 5 being extremely satisfied. The target average rating was 3.5 for each measure across all Learning Collaborative sessions.

As for limitations, the responses to our session polls fluctuated across the Learning Collaborative since attendance and attentiveness is beyond our control. Some potential barriers include scheduling conflicts with our four session dates and times as well as competing priorities in health center/organization workload due to the COVID-19 pandemic. **Table 2** shows the average participant ratings in each category for all four sessions.

Table 2. Average participant satisfaction, confidence, and knowledge gained ratings per Learning Collaborative session.

October 7

Satisfaction Rank	Percent	Count
5 - Extremely Satisfied	29%	10
4 - Very Satisfied	49%	17
3 - Moderately Satisfied	20%	7
2 - Somewhat Satisfied	0%	0
1 - Not at all Satisfied	0%	0

Average: 4.1

Confidence Rank	Percent	Count
5 - Extremely Confident	20%	7
4 - Very Confident	40%	14
3 - Moderately Confident	31%	11
2 - Somewhat Confident	6%	2
1 - Not at all Confident	0%	0

Average: 3.8

Knowledge Gained Rank	Percent	Count
5 - Extremely High Level	9%	3
4 - High Level	29%	10
3 - Moderate Level	49%	17
2 - Minimum Level	11%	4
1 - No gain	0%	0

Average: 3.4

October 21

Satisfaction Rank	Percent	Count
5 - Extremely Satisfied	32%	12
4 - Very Satisfied	42%	16
3 - Moderately Satisfied	26%	10
2 - Somewhat Satisfied	0%	0
1 - Not at all Satisfied	0%	0

Average: 4.1

Confidence Rank	Percent	Count
5 - Extremely Confident	26%	10
4 - Very Confident	39%	15
3 - Moderately Confident	29%	11
2 - Somewhat Confident	5%	2
1 - Not at all Confident	0%	0

Average: 3.9

Knowledge Gained Rank	Percent	Count
5 - Extremely High Level	13%	5
4 - High Level	34%	13
3 - Moderate Level	47%	18
2 - Minimum Level	5%	2
1 - No gain	0%	0

Average: 3.6

November 4

Satisfaction Rank	Percent	Count
5 - Extremely Satisfied	33%	11
4 - Very Satisfied	39%	13
3 - Moderately Satisfied	27%	9
2 - Somewhat Satisfied	0%	0
1 - Not at all Satisfied	0%	0

Average: 4.1

Confidence Rank	Percent	Count
5 - Extremely Confident	21%	7
4 - Very Confident	52%	17
3 - Moderately Confident	24%	8
2 - Somewhat Confident	3%	1
1 - Not at all Confident	0%	0

Average: 3.9

Knowledge Gained Rank	Percent	Count
5 - Extremely High Level	15%	5
4 - High Level	39%	13
3 - Moderate Level	39%	13
2 - Minimum Level	6%	2
1 - No gain	0%	0

Average: 3.6

November 18

Satisfaction Rank	Percent	Count
5 - Extremely Satisfied	27%	9
4 - Very Satisfied	52%	17
3 - Moderately Satisfied	12%	4
2 - Somewhat Satisfied	0%	0
1 - Not at all Satisfied	0%	0

Average: 4.2

Confidence Rank	Percent	Count
5 - Extremely Confident	27%	9
4 - Very Confident	42%	14
3 - Moderately Confident	21%	7
2 - Somewhat Confident	0%	0
1 - Not at all Confident	0%	0

Average: 4.1

Knowledge Gained Rank	Percent	Count
5 - Extremely High Level	15%	5
4 - High Level	36%	12
3 - Moderate Level	36%	12
2 - Minimum Level	3%	1
1 - No gain	0%	0

Average: 3.7

Learning Collaborative Evaluation

As a means of evaluating the overall effectiveness of our Learning Collaborative related to screening and utilizing enabling services to address SDOH a post-learning collaborative evaluation was conducted using Google Forms. The information shared by participants will be used for continuous quality improvement since we will be offering this training for two more rounds during Fall 2021 and Fall 2022.

Knowledge Change & Impact

The first area of interest is participant knowledge change (whether knowledge was affected and to what degree) and the overall impact of the Learning Collaborative, as it relates to participants' work. For example, **Figures 4-5** show that a majority of participants gained significant knowledge in both areas of standardized SDOH screening and standardized ES Data Collection as a result of the Learning Collaborative. **Figures 6-7** show the impact of the Learning Collaborative on stage of implementation for both SDOH screening and ES provision.

Figure 4. Change in knowledge of standardized SDOH screening as a result of the Learning Collaborative.

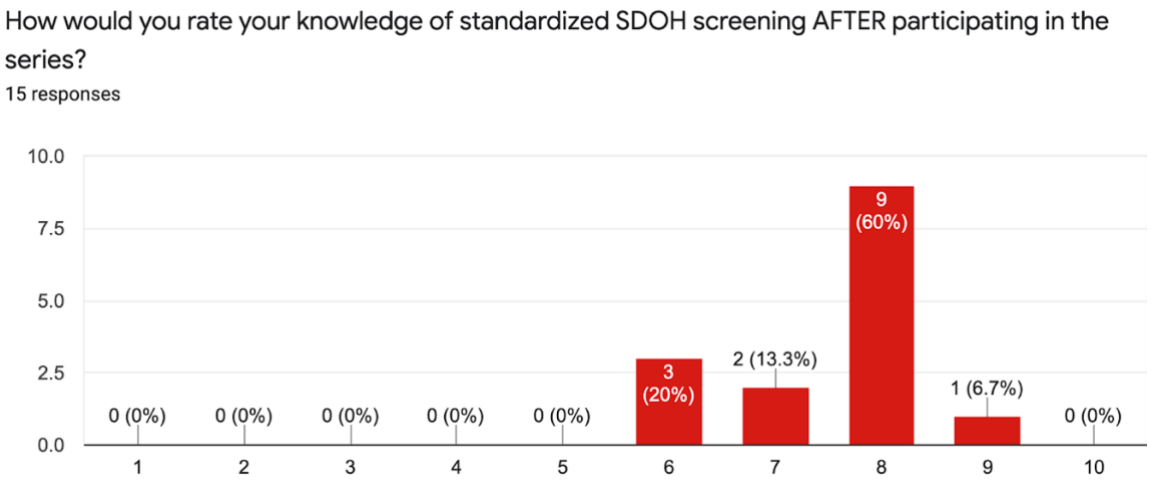


Figure 5. Change in knowledge of standardized ES Data Collection as a result of the Learning Collaborative.

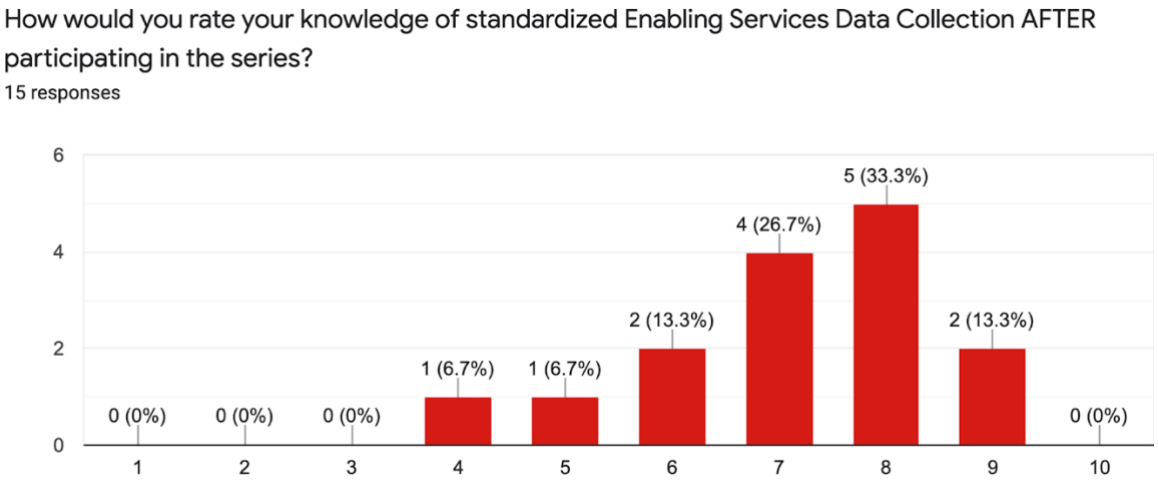


Figure 6. Change in status of SDOH screening programming after the Learning Collaborative.

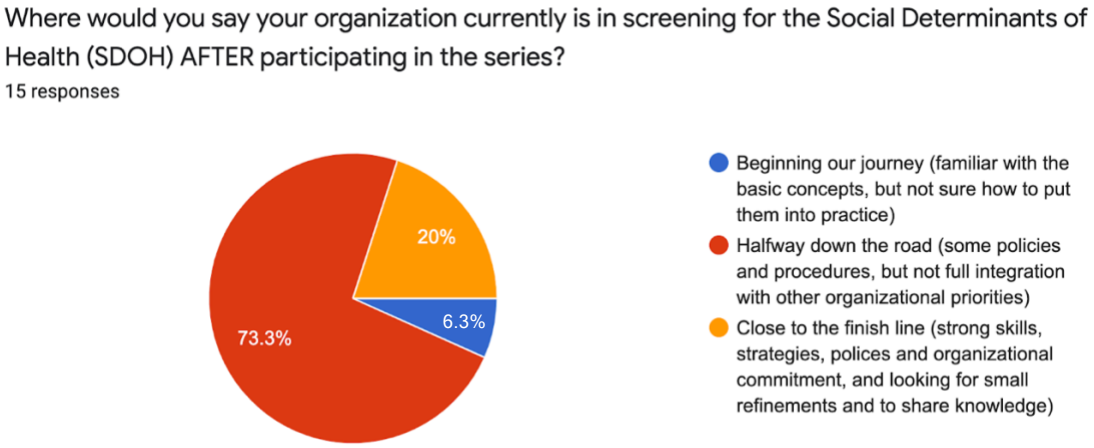


Figure 7. Change in status of Enabling Services provision after the Learning Collaborative.

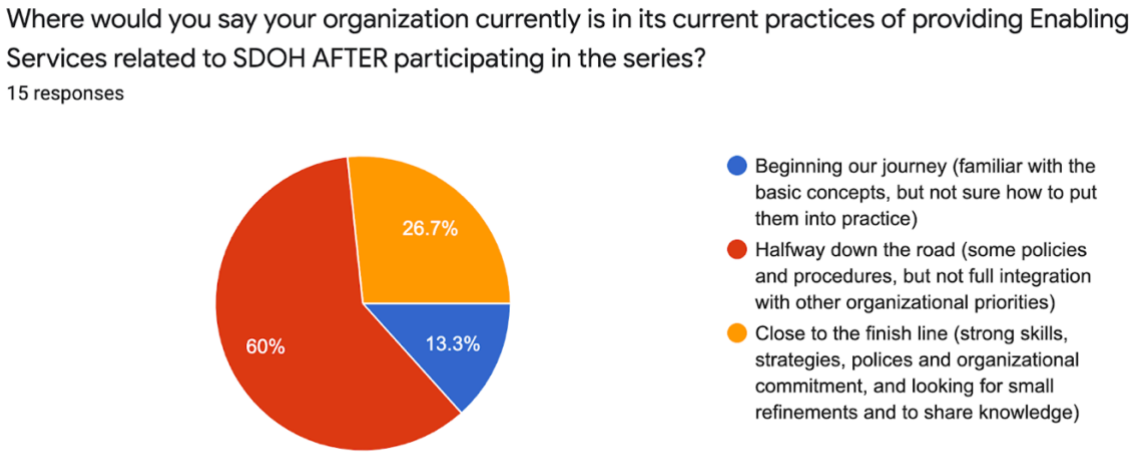


Figure 8 shows organizational readiness to implement strategies for SDOH screening as a result of the Learning Collaborative. **Figure 9** demonstrates the self-reported impact the Learning Collaborative had on the implementation of SDOH screening, and shows that two thirds of participants (66.7%) observed a moderate impact in their SDOH screening implementation as a result of the Learning Collaborative.

Figure 8. Readiness to implement lessons and strategies learned from the Learning Collaborative

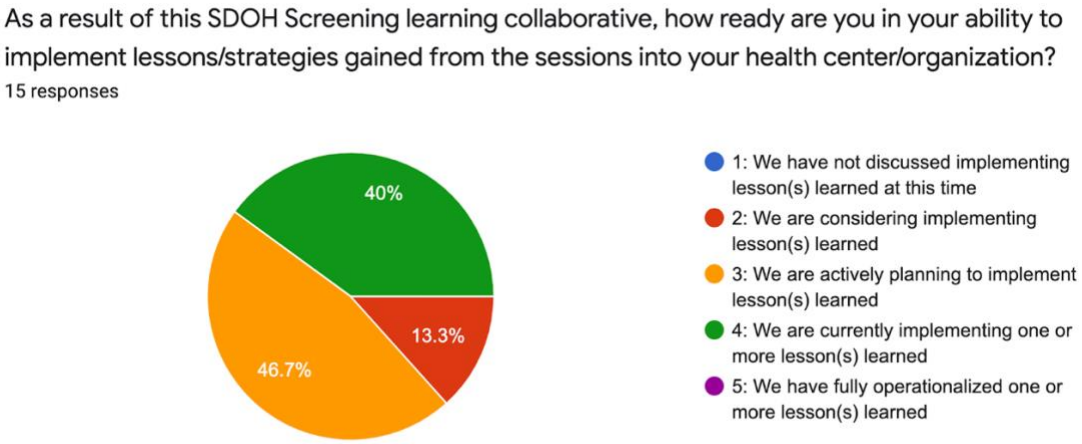
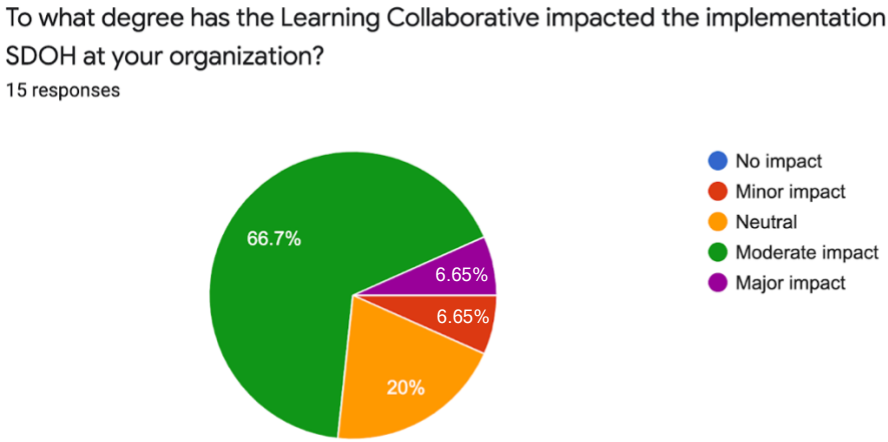


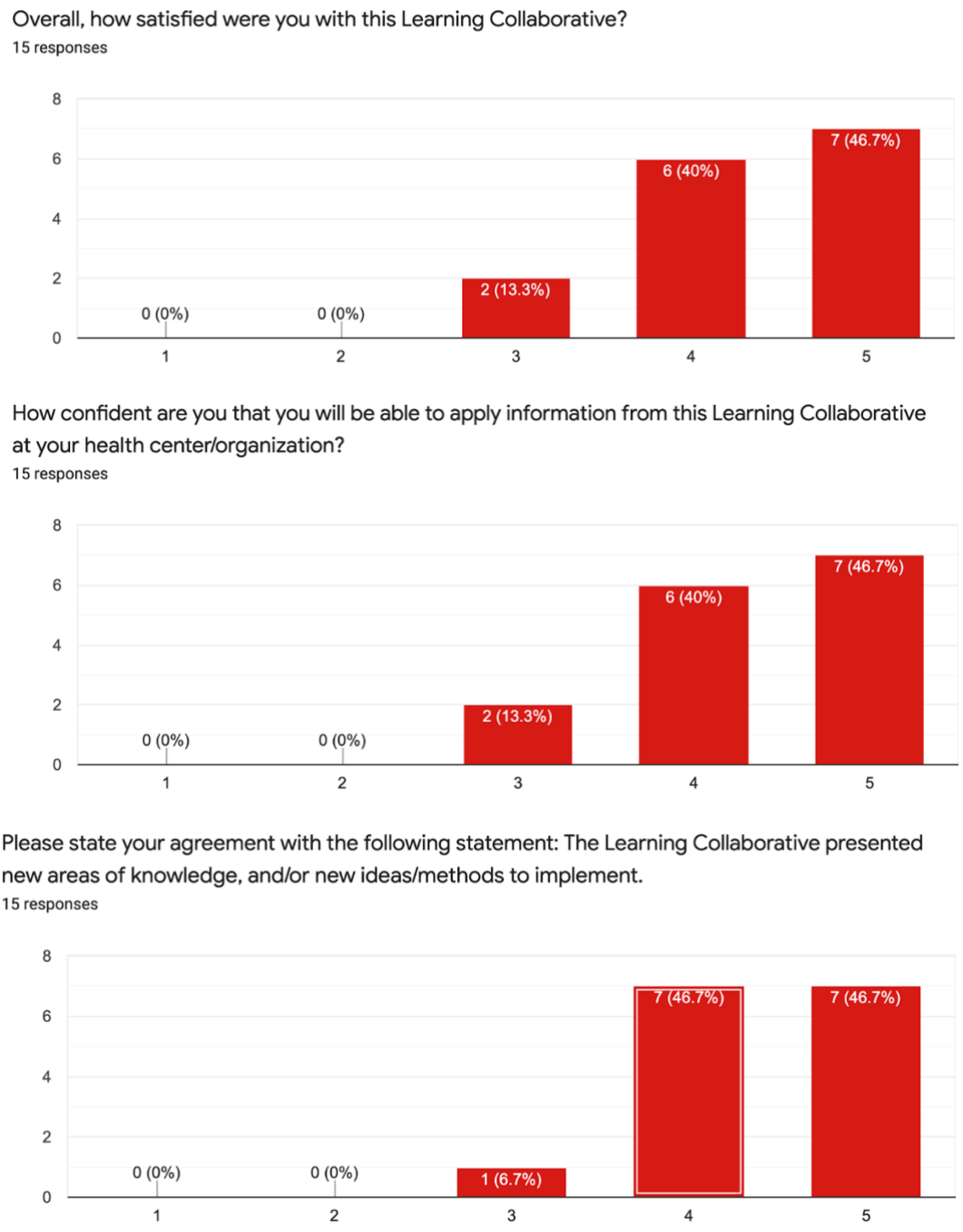
Figure 9. Degree of impact of Learning Collaborative on SDOH screening implementation



Overall Satisfaction, Confidence, and Knowledge Gain

The second area of interest is overall Learning Collaborative evaluation related to satisfaction, confidence, knowledge change ratings, similar to individual Learning Collaborative sessions. **Figure 10** shows the average participant ratings of satisfaction, confidence, and knowledge change following the Learning Collaborative completion.

Figure 10. Participant ratings of satisfaction, confidence, and knowledge change after completion of the Learning Collaborative.



Health Center Perception of NTTAP Implementation

Due to high attendance at the start of the Learning Collaborative, NTTAP faculty took the aforementioned approach of leading smaller cohorts during each session as a means of increasing engagement. Since this was a new practice, NTTAP partners sought to collect feedback from participants about their experience, including their opinions regarding the ideal cohort size. Eighty percent (80%) of participants who responded to the Learning Collaborative evaluation indicated that the ideal cohort include individuals from less than 10 different organizations. Further open-ended feedback indicated that participants found the time to hear from and discuss with peers during the cohort breakouts very valuable.

Follow-up Evaluation in May 2021

For context, from 2017-2020, the National Resource Center Advisory Group (NRC AG) organized a Common Evaluation Framework (CEF) subgroup. The goal of the common evaluation framework is to measure immediate impact and intermediate learning across all NTTAPs collectively; and continuously assess the quality, reach, and perceived usefulness of T/TA activities. The framework guides all NTTAPs to seek regular input from existing health centers and other HRSA-supported T/TA providers; collect consistent quantitative and qualitative data; impact monitoring and measurement; evaluate performance; and disseminate evaluation results efficiently.

The CEF subgroup came to a consensus on a core set of Participant Satisfaction and Behavior Change measures in November 2019-December 2019. As of December 2020, the CEF subgroup proposed a standardized 3-6 month "behavior change" follow-up question to better understand participant level impact as a result of NTTAP learning collaborative activities. The CEF subgroup sought subject matter expertise from program evaluation staff within the NTTAP collaborative and used the Transtheoretical model (Stages of Change) framework to guide the development of the new question.

In May 2021, NTTAP faculty reached out to participants with a six-month follow up evaluation to assess the degree of impact in the months following the Learning Collaborative. Questions focused on change in participant behavior regarding implementation of lessons and strategies gained as a result of Learning Collaborative participation.

BEST PRACTICES TAKEAWAYS

A No-One-Size-Fits-All Approach

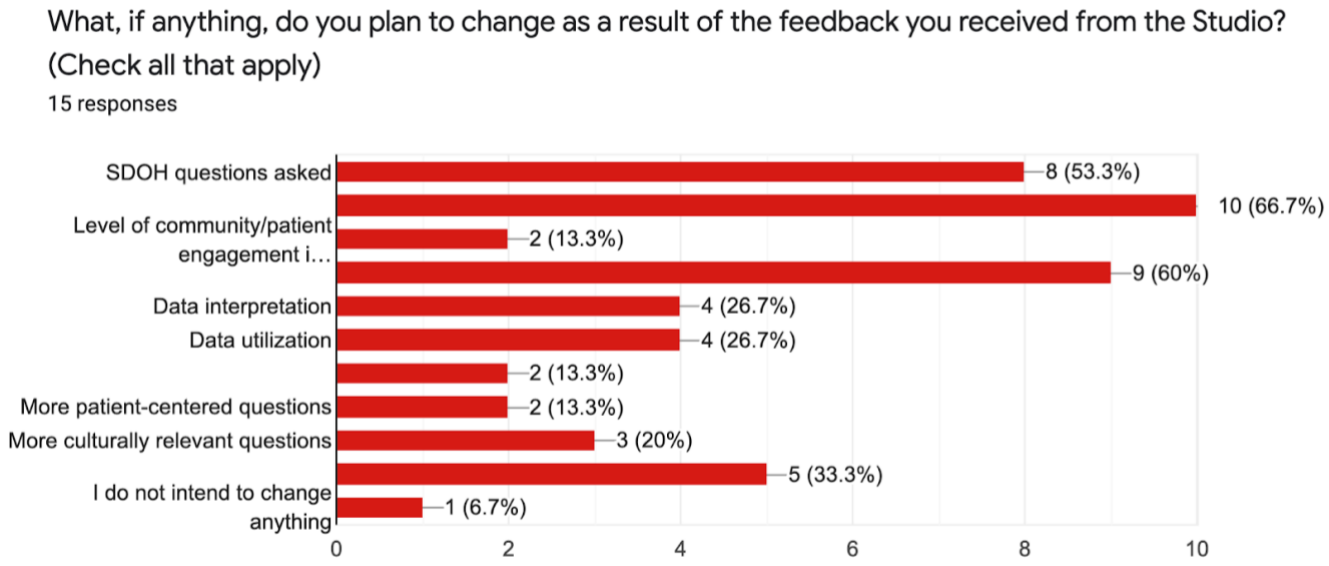
Throughout the Learning Collaborative and Change Mapping process, participants demonstrated that a standardized approach to SDOH screening is, in fact, not standard. Many variables of the screening process, including the use of a screening tool, access to resources, ES staffing models, target patient population, EHR compatibility, level of implementation of SDOH screening in the health center, and more are not standardized, resulting in significant variations in that process at the health center level, or even at the individual patient level. Moreover, since participants differed widely in the extent to which their SDOH screening programs are being implemented, some health center participants emerged as models of innovative strategies for others who were still in the process of developing strategies for their screening practices.

Due to the large number of participating health centers and level of knowledge and experience with SDOH screening, the Learning Collaborative addressed many components and levels of the SDOH screening process and use of ES in order to remain applicable to all participants, regardless of where they were in the implementation process. At the end of the Learning Collaborative, participants identified a wide range of elements addressed across all four sessions to revise within their own SDOH screening strategies. **Figure 11** shows which aspects of their SDOH screening implementation strategy participants wanted to change after participating in the Learning Collaborative and creating their Change Maps.

The Change Maps completed by each participating health center showcase the specific and often singular case for which health center participants have developed their SDOH screening strategies. A

wide variation in needs was represented by participants' problem statements, and review of the various overall goals and definitions of success further highlight the difference in each strategy with regard to access to resources, experience with SDOH screening or ES provision, EHR compatibility, level of implementation, etc. **Appendix A** includes completed participant Change Maps.

Figure 11. Aspects of their SDOH screening implementation strategy participants wished to change after participating in the Learning Collaborative.



Utility of SDOH Screening Data at Various Levels of Implementation

Any SDOH data that is documented through paper or electronic screening tools helps provide health centers, both clinical and non-clinical providers with a data-driven strategy to assess patient risks as well as population level needs. Understanding patients' social risk positions health centers to do the following:

- Define and document the complex and interconnected health and social needs of patients;
- Identify workforce development needs to help providers that can assist patients with in-house resources and/or connect them to community services and partnerships;
- Integrate clinical care and social service interventions that drive care and practice transformation;
- Promote health equity and immediate changes at the community, state, regional, and/or national levels;
- Demonstrate the value of the health center program to payers and policymakers in order to ensure these social services are reimbursable and sustainable.

Identifying Enabling Services (ES) Workforce Providers for SDOH Screening and Documentation

Using ES or non-clinical staff for SDOH screening and documentation is recommended since they are often employed from the community and can easily relate to patients, and understand their needs. For example: case managers, community health workers, outreach staff, and patient/community education specialists are often aware of available community resources, which ensures health center staff who administers SDOH screening is also able to address some or all needs of the patient. In other words,

the ES workforce providers may have immediate warm hand-off to community resources and services. When push comes to shove, any staff from front desk to clinical providers can support SDOH screening efforts since the goal is to paint a fuller picture of each patient that seeks care at health centers.

In order to determine who should conduct SDOH screening and documentation at the health center, it is important to educate key staff on the importance of SDOH and how it aligns with their roles and responsibilities within the organization. The Five Rights Framework adapted by the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) partnership has helped health centers brainstorm the appropriate workforce and customized workflow needs when it comes to SDOH screening.[19] **Figure 12** walks through the Five Rights Framework key questions to consider when determining your SDOH workflow.[20]

Figure 12. Use the Five Rights Framework to Strategize the SDOH Implementation Plan

5 Rights	Workflow Considerations
Right Information—WHAT	What information do you already routinely collect? • Part of registration • Part of other health assessments or initiatives
Right Format—HOW	How are we collecting this information and in what manner are we collecting it? • Self-Assessment • In-person with staff
Right Person—WHO	Who will collect the data? Who has access to the EHR to input the data? Who needs to see the information to inform care? Who will respond to needs identified? • Providers and other clinical staff • Non-Clinical Staff
Right Time—WHEN	When is the right time to collect this information so as to not disrupt clinic workflow? • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?
Right Place—WHERE	Where are we collecting this information? Where do we need to share and display this information? • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?

Analyze SDOH Screening and Enabling Services Data to Highlight Structural Inequities

As community-based, patient-directed organizations that work to overcome geographic, cultural, linguistic, and other barriers to health by providing comprehensive preventive and primary healthcare services,[21] health centers are advocates for some of the nation's most vulnerable populations. For health centers to meet the needs of all patients, it is critical to understand the structures that work to impact health, especially for those patients accessing public services such as healthcare. This means looking beyond SDOH to the larger systems that underlie and influence these determinants, such as policies, economic systems, and social hierarchies. Understanding structural inequity can help health centers support and promote policies and initiatives at the local or even national level that will allow them to better serve their patient populations.

An important tool for assessing the structural impact on health is data collection. By collecting and analyzing data on SDOH screening and ES, health centers can recognize trends in disparities and

[19] http://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Chpt5.pdf
[20] http://www.nachc.org/wp-content/uploads/2019/04/NACHC_PRAPARE_Chpt3.pdf
[21] https://bphc.hrsa.gov/about/what-is-a-health-center/index.html

identify the structures creating them. Understanding what affects health at the population level allows health centers to appropriately plan and procure resources, implement services that are specific and adaptable (e.g., Outreach and Enrollment), and leverage necessary community and cross-sectoral partnerships to extend their reach. Awareness of structural barriers to health through data collection and analysis helps health centers advocate for patients in a way that is proactive rather than reactive.

Assess the Overall Value and Impact of Enabling Services

Aside from the more common outwardly facing benefits to patient health outcomes, service delivery, and overall quality of care, ES provision and data collection also has demonstrable financial impact for health centers. Operationally, ES can help reduce health center costs by providing services like care coordination, health education, and outreach, while also improving patient health outcomes. Thus, the value of ES can be reflected at the individual, community, and health center levels.[22]

In order to understand the impact of ES, health centers must evaluate both the patient benefit and the health center output. Data collection is crucial for this analysis. By tracking services provided, health centers can first better understand their patient populations and their individual needs. Furthermore, by assessing both patient need as well as the interventions implemented to address the need, health centers can demonstrate their value and seek adequate funding to continue providing quality care and expand services.

Conclusion

Implementation of the Screening Methods and Using Outreach and Enabling Services to Address Social Determinants of Health 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 SVP and move closer to health equity, health centers must work to identify the barriers to care in order to intervene and remove them. ES 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' needs.

[22] https://mhpsalud.org/portfolio/roi-toolkit/

APPENDIX A

Figure A. Final Change Map from Bay Area Community Health

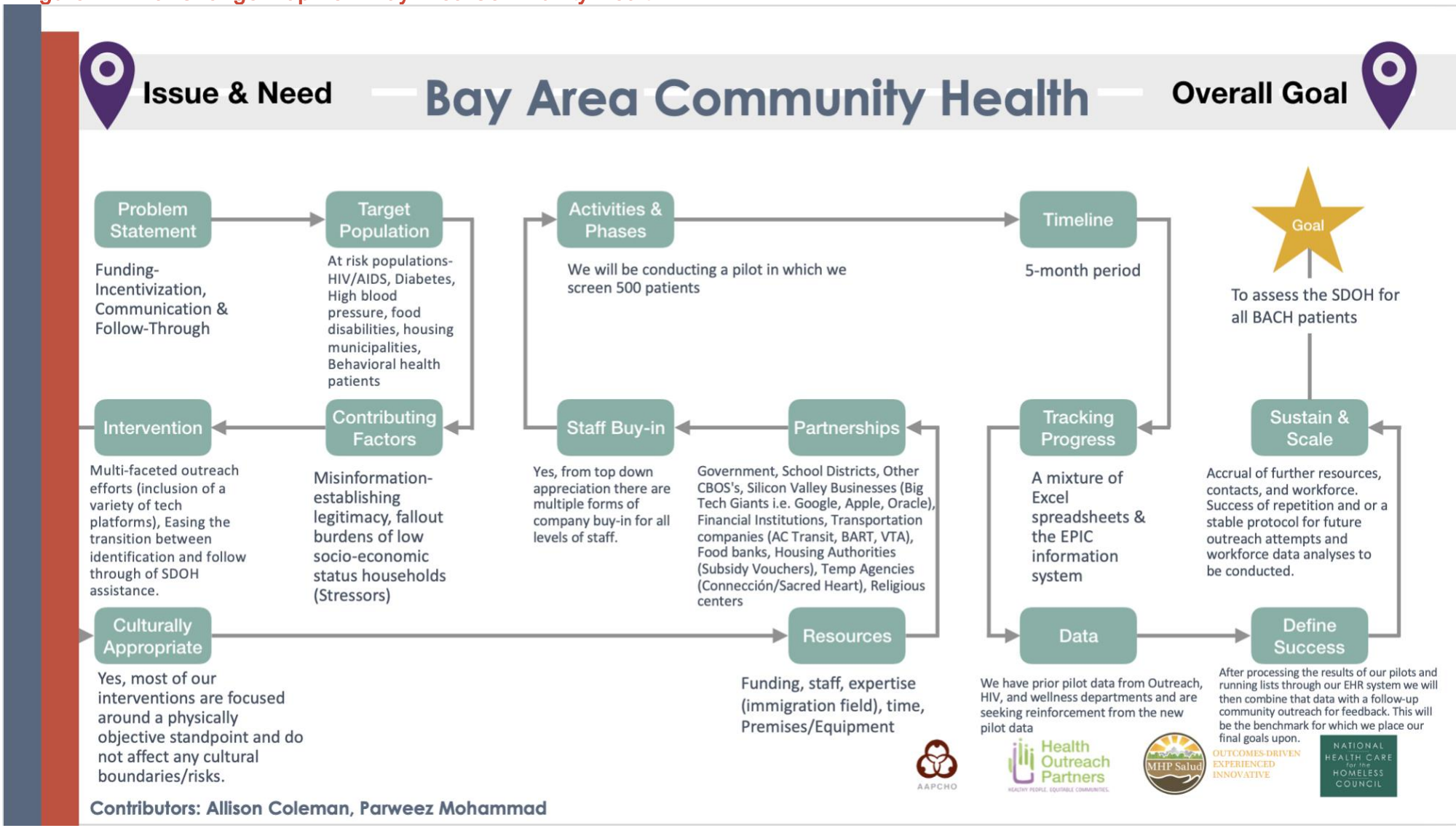


Figure B. Final Change Map from Family Health Centers of San Diego

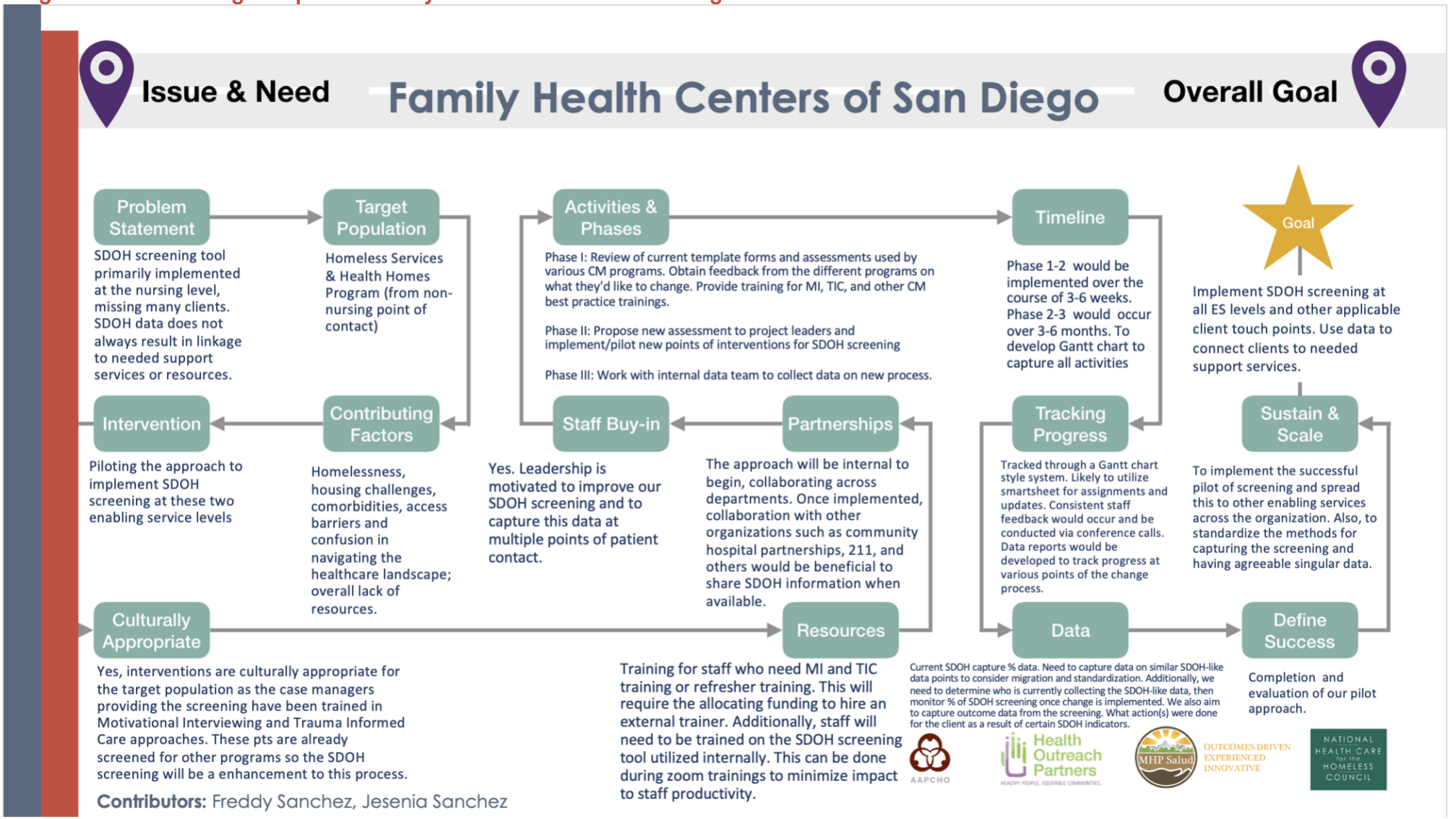


Figure C. Final Change Map from Chicago Family Health Center

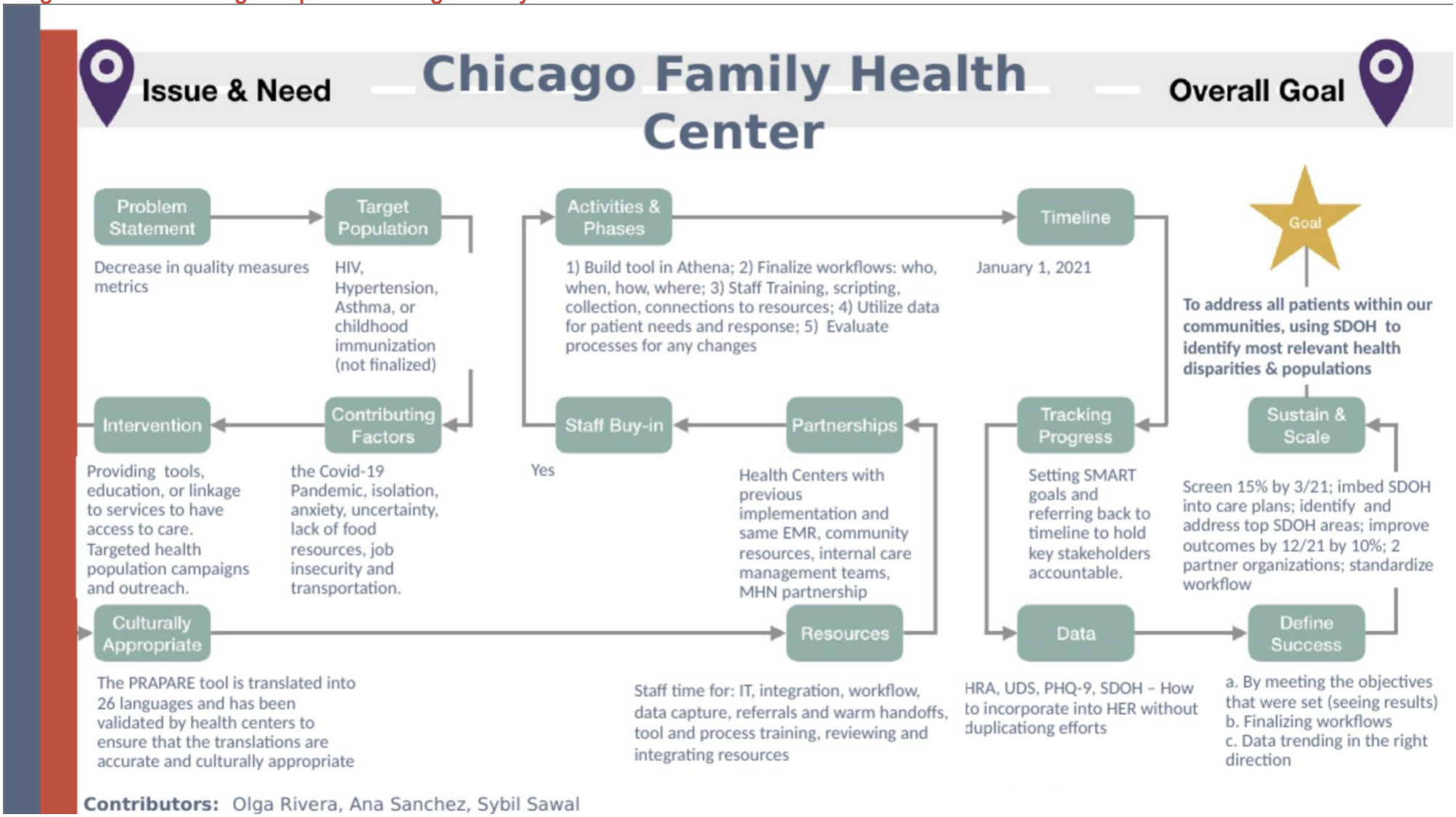


Figure D. Final Change Map from HealthSource Ohio

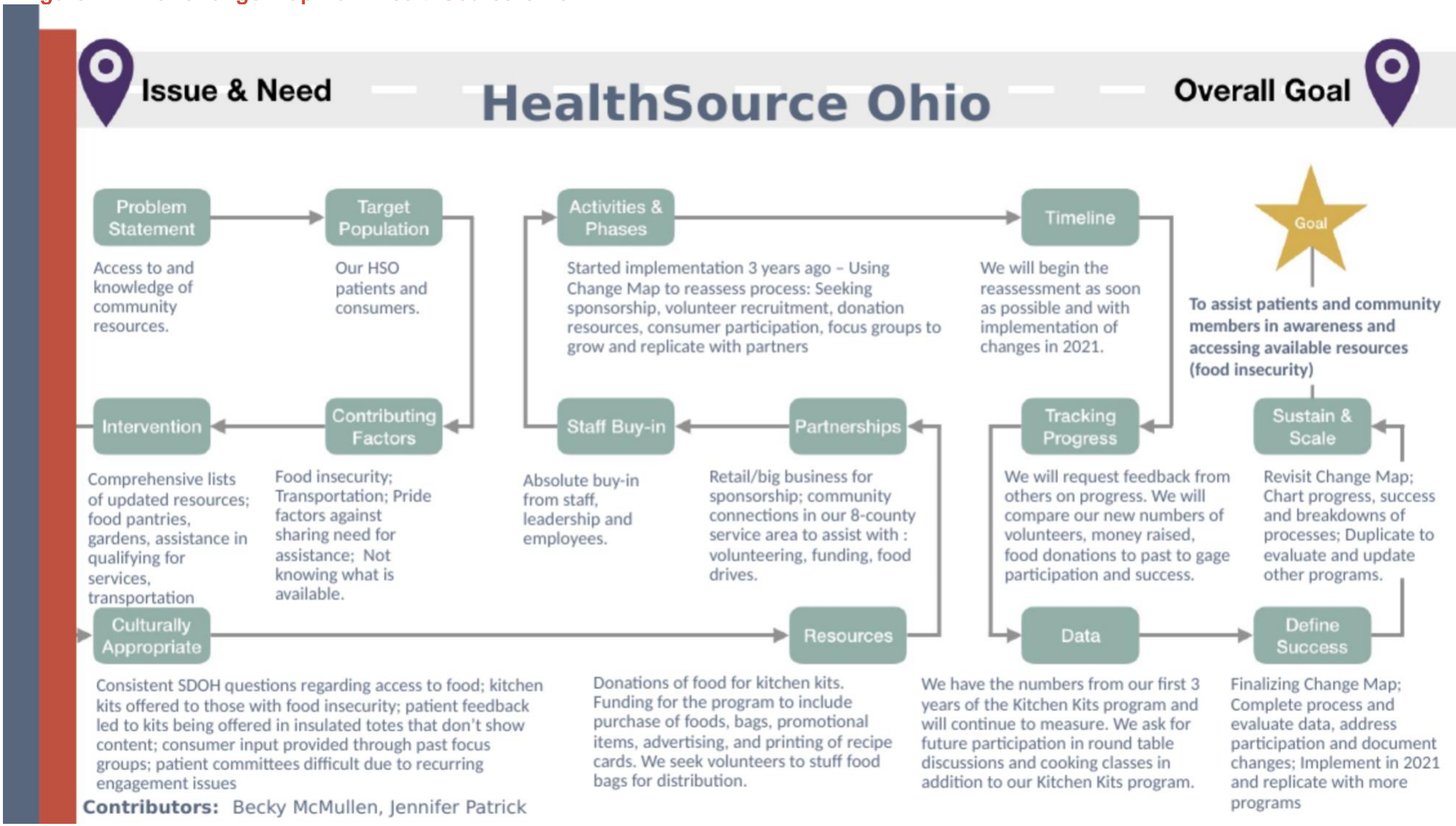
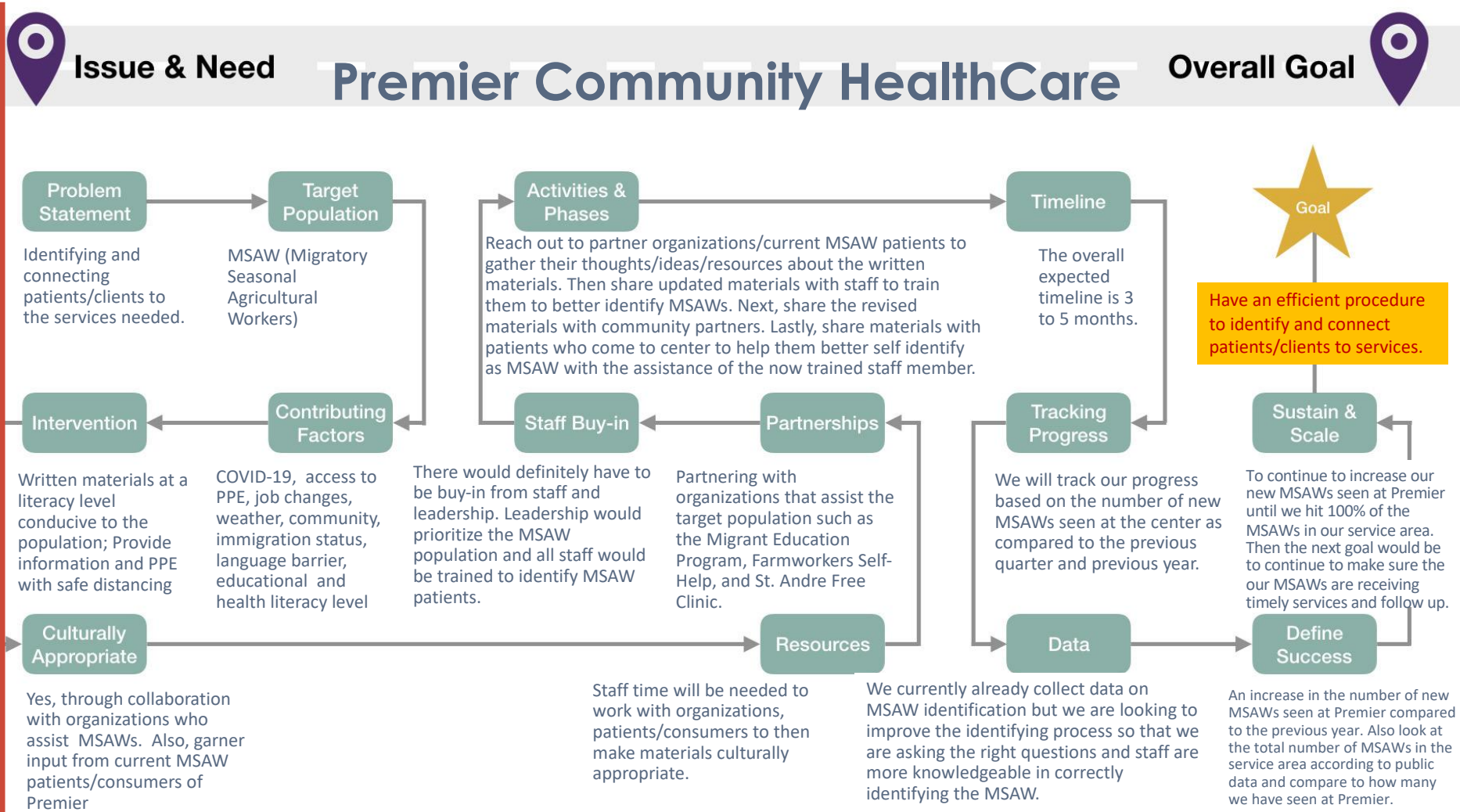


Figure E. Final Change Map from Premier Community HealthCare



Contributors: Manny Mayor, Isabelle Segovia

Figure F. Final Change Map from Ryan Health

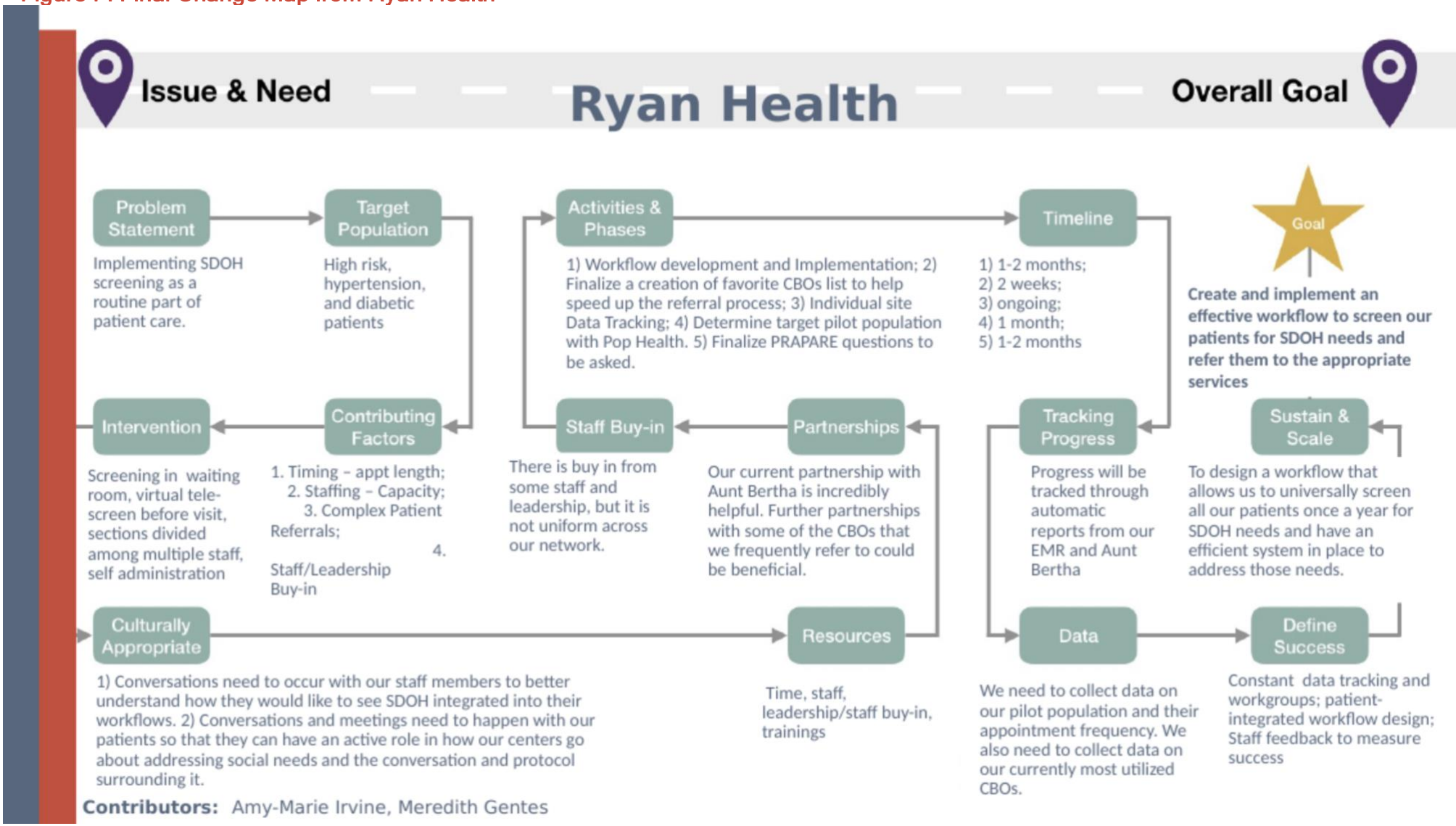


Figure G. Final Change Map from TCA Health

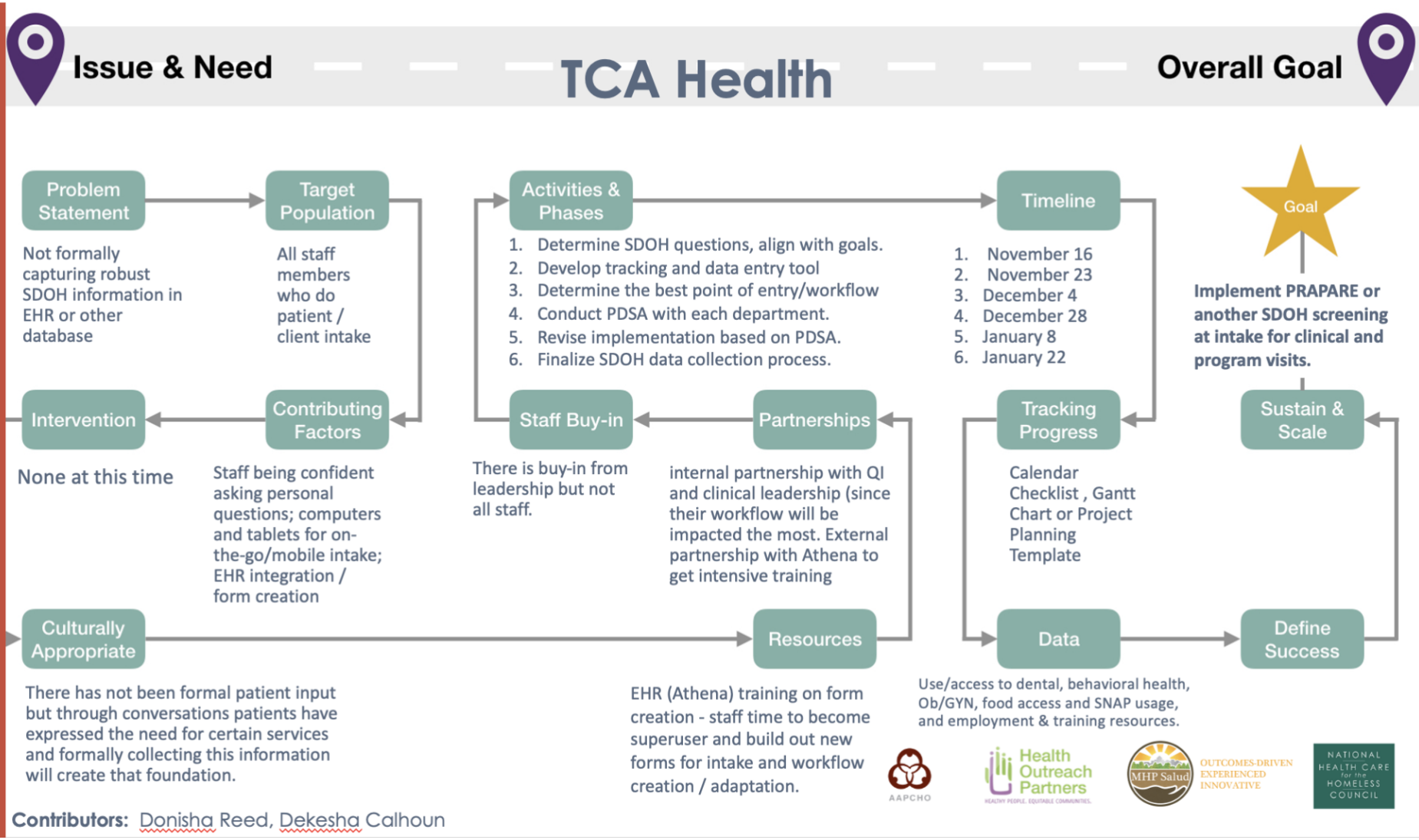
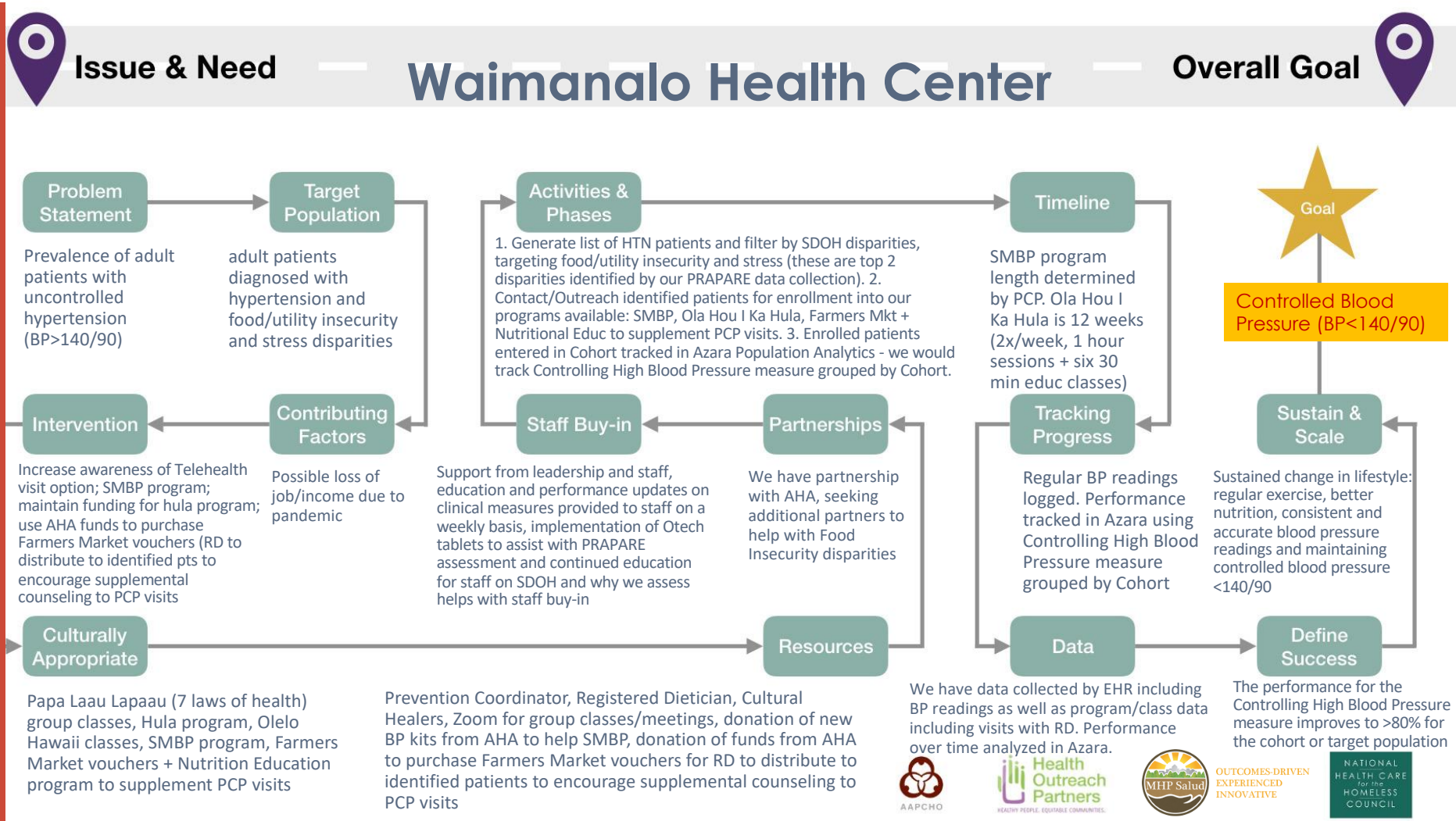
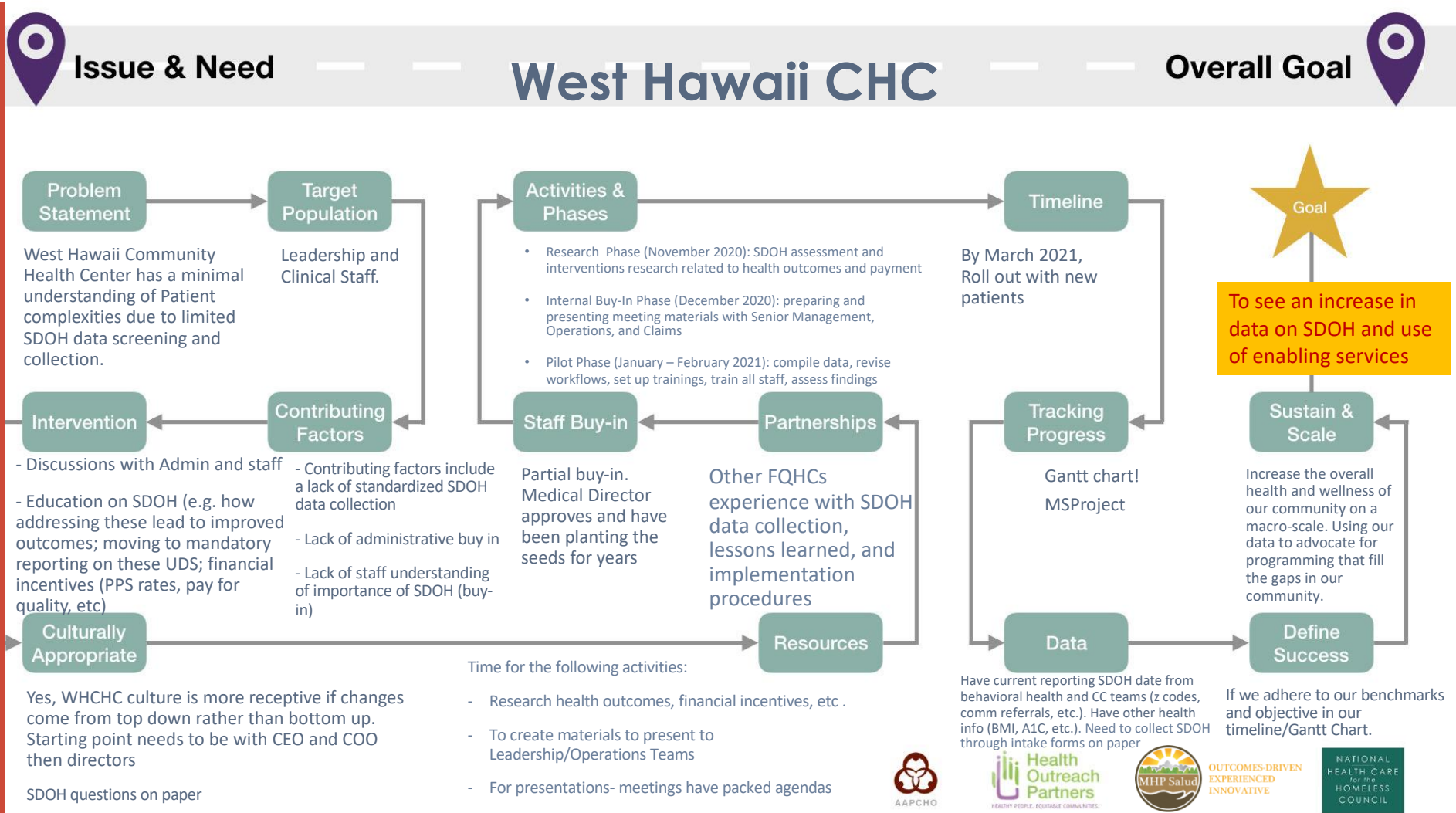


Figure H. Final Change Map from Waimanalo Health Center



Contributors: Nadine Owen, Christina K. Lee M.D.

Figure I. Final Change Map from West Hawaii Community Health Center



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