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

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INTRODUCTION & OVERVIEW OF LEARNING COLLABORATIVE

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

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

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

The Importance of SDOH Screening and Data Collection

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

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

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1. [https://www.nachc.org/health-center-issues/special-populations/](https://www.nachc.org/health-center-issues/special-populations/)
3. [https://www.nachc.org/about/our-health-centers/](https://www.nachc.org/about/our-health-centers/)
5. [https://www.cdc.gov/socialdeterminants/](https://www.cdc.gov/socialdeterminants/)
6. [https://www.cdc.gov/publichealthgateway/publichealthservices/pdf/ten_essential_services_and_sdoh.pdf](https://www.cdc.gov/publichealthgateway/publichealthservices/pdf/ten_essential_services_and_sdoh.pdf)
SDOH to facilitate change, not just in health outcomes, but in the conditions influencing those outcomes.

PARTICIPANT ENGAGEMENT

Execution of the Learning Collaborative & Participant Engagement

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

Timeline

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

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

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

Participants & Engagement

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

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

<table>
<thead>
<tr>
<th>Group, Staff Lead</th>
<th>Organization Name</th>
<th>Funding Stream*</th>
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<tr>
<td><strong>Group 1: Sakura Miyazaki, AAPCHO</strong></td>
<td>Belmont County Health Department</td>
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<tr>
<td></td>
<td>Family Health Centers of San Diego</td>
<td>330(e), (h), (i)</td>
</tr>
<tr>
<td></td>
<td>East Liberty Family Health</td>
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<td></td>
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<tr>
<td></td>
<td>Community Health Centers of South Florida, Inc.</td>
<td>330(e), (g), (h)</td>
</tr>
<tr>
<td>Group 2: Beleny Reese, HOP</td>
<td>HealthSource of Ohio</td>
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</tr>
<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td></td>
<td>Hill Pharmaceuticals</td>
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<tr>
<td></td>
<td>Hunter Health Clinic, Inc.</td>
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</tr>
<tr>
<td></td>
<td>Keystone Health</td>
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<td></td>
<td>Kodiak Health Center</td>
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<tr>
<td></td>
<td>Lone Star Circle of Care</td>
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<td></td>
<td>Marias Healthcare Services, Inc.</td>
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<th>Group 3: Hansel Ibarra, MHP Salud</th>
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<tr>
<td></td>
<td>Norwalk Community Health Center</td>
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<tr>
<td></td>
<td>Partnership Health Center</td>
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<td></td>
<td>Ryan Health</td>
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<tr>
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<td>One Health</td>
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<tr>
<td></td>
<td>Pillars Community Health</td>
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<td></td>
<td>Pittsburgh Mercy</td>
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<td></td>
<td>Primary Care Health Services, Inc.</td>
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<td></td>
<td>Star Community Health</td>
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<td></td>
<td>Unity Care NW</td>
<td>330(e), (h)</td>
</tr>
</tbody>
</table>

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

**Change Map Completion**

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

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\(^7\) [https://bphc.hrsa.gov/programrequirements](https://bphc.hrsa.gov/programrequirements)
process and its completion is again reflective of the stages of implementation that health centers and organizations were in at each stage of the Learning Collaborative (Figure 1).

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

EXPRESSED BARRIERS & PROPOSED SOLUTIONS

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

Cultural Appropriateness

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

During the learning collaborative sessions, the NTTAP faculty and participants discussed topics related to cultural appropriateness such as the five rights framework for SDOH screening, cultural humility, and trauma-informed care. Expanding on cultural appropriateness, participants in group discussions expressed the need to build trust with patients and community members to identify useful next steps and resources. Some participants shared their promising practices to address cultural
appropriateness. For example, one health center shared that they continuously involve the board (which includes patients) and another health center shared training programs implemented to address topics such as implicit bias and trauma-informed care. Through these session presentations and discussions, participants included different solutions in the change map to address cultural appropriateness. Common solutions for participants included utilizing the staff from shared backgrounds with the patient community as drivers for screening and leveraging connections with patients (e.g., the board, advisory committees) for feedback.

**Staff Buy-In**

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

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

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

**Operationalizing Screening**

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

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

**Data Utilization**

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

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

Quality Improvement

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

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

Partnership/Resources

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

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

Session Feedback

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

Table 2. Session and Series Evaluation Scores

<table>
<thead>
<tr>
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<th>Satisfaction</th>
<th>Confidence</th>
<th>Knowledge Gained</th>
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<tbody>
<tr>
<td>Session 1</td>
<td>4.12</td>
<td>3.70</td>
<td>3.12</td>
</tr>
<tr>
<td>Session 2</td>
<td>4.21</td>
<td>3.63</td>
<td>3.32</td>
</tr>
<tr>
<td>Session 3</td>
<td>3.75</td>
<td>3.20</td>
<td>3.10</td>
</tr>
<tr>
<td>Session 4</td>
<td>4.00</td>
<td>3.93</td>
<td>3.33</td>
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<tr>
<td>TOTAL SESSION AVERAGES</td>
<td><strong>4.02</strong></td>
<td><strong>3.62</strong></td>
<td><strong>3.22</strong></td>
</tr>
<tr>
<td>OVERALL EVALUATION</td>
<td><strong>4.5</strong></td>
<td><strong>4.1</strong></td>
<td><strong>3.9</strong></td>
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</table>

IMPACT OF LEARNING COLLABORATIVE

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

**Figure 2. Organizations’ current standings with screening for SDOH**

![Pie chart showing current standings of screening for SDOH](chart.png)
Seventy-five percent of respondents also stated that participating in the Learning Collaborative had a moderate to major impact on the implementation of screening for SDOH and data collection at their organizations (Figure 4). As a result of participating in the Learning Collaborative, about 88 percent of respondents reported that their organizations were either actively planning or have already implemented one or more lessons learned (Figure 5).
The average self-evaluated score of knowledge of standardized SDOH screening practices after participating in the Learning Collaborative was 7.9 out of 10, and the average score of knowledge of standardized Enabling Services data collection was 7.5, with 75 percent self-evaluating with a score of 8 or higher. Prior to participating in the Learning Collaborative, the average self-evaluation of both knowledge areas was 5.5 and 4.6, respectively.

**PARTICIPANT PROGRESS: THREE-MONTH FOLLOW-UP**

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

About one-third of respondents said they were considering implementing lessons learned from the Learning Collaborative, and another one-third were either actively planning or have already implemented one or more lessons learned. The final third of respondents reported that they had not yet discussed implementation of lessons learned at the time of response (Figure 8). It should be noted that the overall evaluation received a total of eight participant responses, while the three-month follow-up evaluation received six.
QUALITATIVE RESPONSES AND LESSONS LEARNED
In open responses, participants reported that it was helpful to hear from others that sites were not alone in their struggles to effectively integrate SDOH screening into daily practice. It was also noted that it was beneficial to hear from experts as well as others’ experiences with visual examples of processes to help talk and think through challenges and offer potential solutions. Feedback to inform the planning of year 3 of this Learning Collaborative include aiming to engage more team members in real time, and to increase the length and depth of breakout discussions when possible.

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

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

PREFACE TO YEAR 3
Implementation of the "Screening Methods and Strategies for Using Data on Outreach and Enabling Services to Address SDOH" Learning Collaborative highlighted many valuable takeaways for both participants and NTTAP faculty. In order to continue to improve the access to and quality of care for special and vulnerable populations and move closer to health equity, health centers must work to identify the barriers to care in order to intervene and remove them. Enabling Services provision and screening for SDOH are two crucial elements to this intervention. Data collected from providing these services gives health centers a powerful tool to address their patients’ needs in a sustainable way. However, standardizing data collection processes can present a significant challenge. Given each
health center’s unique position in the community, patient population, access to resources (e.g., human, financial, technological), workflow, etc., there are any number of variables that can challenge the process of standardization across the health center and even at the individual patient level.

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

Issue & Need

Contributor(s): Lucinda Balsome

Activity & Phases

Meet with grant writer. Input from peers during monthly QM Meeting

Timeline

ASAP

Overall Goal

Increase outreach of MNT services to include at least 75% of HIV client population at nutritional risk

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

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

Better referral process

Our health dept created a Preconception and inter-conception health survey to gather data from the community. The survey targeted women 18-44. The survey was used to find out what women need in the community to identify barriers.

1. Create advisory team with social service agencies and clinicians (Oct 2020 – Dec 2021)
2. Develop health assessment survey and outreach plan (Dec 2021 - March 2022)
3. Conduct health assessment survey (March 2021 - July 2021)
4. Collect Data (July 2021)
5. Interpret data (July 2021 – August 2021)
6. Action and evaluation plan (August 2021)
7. Implement program (Oct 2021 – Sept 2021)

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

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

Figure B. Final Change Map from Belmont County Health Dept.
Implementing a SDOH screening and referral to care as needed as part of routine patient care.

**Issue & Need**

- **Problem Statement**: Implementing a SDOH screening and referral to care as needed as part of routine patient care.
- **Target Population**: Pregnant OB patient population.
- **Activities & Phases**:
  1. Screening tool development
  2. Workflow development
  3. Referral process development
  4. Data tracking process creation
  5. Staff trainings
  6. Screening & referral process implementation
  7. Process evaluation & review
  8. Expand to all patients

**Intervention**

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

**Contributing Factors**

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

**Staff Buy-in**

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

**Partnerships**

- UNITE-NE
- Other CBOS would be helpful

**Resources**

- Time
- Staff
- Staff buy-in trainings
- Printed materials

**Timeline**

1. August 13th
2. August 31st
3. August 31st
4. August 3rd
5. September 30th
6. October 4th

**Tracking Progress**

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

**Sustain & Scale**

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

**Define Success**

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

**Contributor(s): Samantha Wall**

Figure C. Final Change Map from Charles Drew Health Center
Patients unable to get their medications on time

We will need materials of information in all English, Spanish and Creole. Electronic access to get in touch with the pharmacy with the use of a phone or tablet, a mobile unit or a delivery of medication program. 1. Having a mobile pharmacy van 2. Medication Delivery

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

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

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

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

We have the PREPARE data to address the SDOH

When we get to analyzing the implementation process

Contributor(s): Eunice Hines
**Underserved and lack of resources, assistance with housing, utilities, behavioral health, social supports.**

**Activities & Phases**

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

**Resources**

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

**Partnerships**

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

**Staff Buy-in**

CEO/CFO, leadership very supportive. Staff are more challenging. Providers want our departments to call patients directly, while were trying to enable patients reach out to us. Factors contributing are lack of access or. Knowledge to available resources

**Intervention**

More "hands-on" from health care providers

**Contribute Factors**

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

**Timeline**

*Deadline for use of SDOH questionnaire on waiting room kiosk was 8/2021. This deadline has been met but needs additional ‘Provider input’ to be successful. *Ideally there will be steady increase of patients completing questionnaire between 9/2021 – 12/2021. *Pamphlet of resources cold be made available by 12.2121

**Data**

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

**Define Success**

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

**Sustain & Scale**

Increased # of patients advocating for themselves

**Issue & Need**

East Liberty Family Health Care Center

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

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**Figure E. Final Change Map from East Liberty Family Health Care Center**
Inconsistent screening methods and lack of awareness of existing agency screenings

Pts enrolled/receiving services through department program

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

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

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

Community resources and enabling services will be vetted for cultural appropriateness.

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

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

Data from existing SDOH screenings

Integrated SDOH screenings and data tracking to support UDS reimbursement

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

UDS reimbursement improvement in health outcomes for patients.

Completed activities outline

Define Success

Sustain & Scale

Tracking Progress

Partnerships

Resources

Staff Buy-in

Activities & Phases

Timeline

Problem Statement

Intervention

Contributing Factors

Culturally Appropriate

Target Population

Issue & Need

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

Family Health Centers of San Diego

Figure F. Final Change Map from Family Health Centers of San Diego
Contributor(s): Jean Patrick, Logan Graham, Ellen Reilag

**Problem Statement**
- Mining and presenting the data from SDOH screenings to advocate for change and create impactful programming.

**Target Population**
- Strategic partnerships w community, Clermont County Safety Net Alliance or developing Brown County Alliance.

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

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

**Intervention**
- Monthly/quarterly review of screening results.

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

**Staff Buy-in**
- Leadership, case management and front line workers - time constraints need reliable resources across the board.

**Partnerships**
- Clermont County Safety Net Alliance, Aunt Bertha type resource, Community Connections/Partners.

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

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

**Resources**
- Current Clermont County SNA 21 L/online resources.

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

**Define Success**
- CNAs that highlight target populations or areas for improvement and then created connections to address those specific needs.

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**Issue & Need**

**Overall Goal**

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

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**Figure G. Final Change Map from Health Source of Ohio**
To develop a plan to collaborate our services to providers (i.e. Opioid users) and continue to train providers on the impact of Opioids to reduce overuse.

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

Activities & Phases:
Send letters to prescribers with a referral form.

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

Contributing Factors:
Discuss with the providers the perfect adherence to Opioids but not to maintenance medication.

Staff Buy-in:
Yes

Partnerships:
With prescribers

Resources:
1 CCHW and 1 Pharmacist, material funding

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

Culturally Appropriate:
yes

Assess case plans in 3-6 month intervals for progress and next steps to be off opioids. Follow up with MDs on outcomes of case plans. Celebrate with patients the benefits of being off opioids. Continue to monitor monthly fills and Kaspers to recovery.

Overall Goal:
To have providers refer persons that are dependent on Opioids to our Pharmacy for case planning and follow up until Opioid free.
We do not track patient utilization & satisfaction with community resources.

Target Population: Homeless patients who visit our Friday Shelter clinics.

Activities & Phases: Consult and collaborate with care teams, initiate consultation with referral system, develop network, develop workflows, test referral loop; implement and evaluate, quarterly evaluate SDOH status.

Intervention: Closed loop referral system that tracks referrals, utilization & satisfaction. Expand transportation assistance program. 100% completion of SDOH questionnaires annually.

Contributing Factors: Transportation, severe mental health issues, substance abuse, transient nature, other higher priorities (food, water, housing).

Staff Buy-in: Leadership - yes, staff - some (time is always a constraint especially short staffed working with homeless at shelters).

Partnerships: VA medication, orthodontics, specialists, special imaging, housing, transportation, food banks.

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

Timeline: One year.

Goal: Decrease impact of SDOH on our patients' overall health.

Sustain & Scale: Decrease impact of SDOH on our patients’ overall health.

Data: Current PREEPARE rate, current referral patterns/resources.

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

Culturally Appropriate: Yes.

Figure I. Final Change Map from Hunter Health.
Addressing SDOH in our patient community

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

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

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

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

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

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

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

Lack of awareness of SDOH

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

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

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

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

1-2 years

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

Contributor(s): Erin Harris

Figure J. Final Change Map from Keystone Health
Neighborhood Resilience Project

**Contributor(s): Bisrat Tesfagiorgis**

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**Issue & Need**

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

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

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

- **Intervention**
  - Cleaner facilities, more open trauma informed staff to welcome persons and assist with needs.
  - Poverty & Safety. We have a safe space but need more people to know about it and come to utilize it. Difficult to use tool and may receive pushback.

- **Contributing Factors**
  - Yes, from the leadership. There may need to be more work done to make sure all staff is on board.

- **Staff Buy-in**
  - SDOH partnership who understand the screening method. Although there is a partnership between university and professionals in apps.

- **Partnerships**
  - Continuous a – 1 week. B – 4 weeks. C. Weeks. D – 3 weeks.
  - 2 months a. 1 month b. 1 month c. 1 month d. 1 month

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

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

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

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**Overall Goal**

- **Timeline**
  - 1. 2 years. a. 3 months b. 2 months.
  - 2. 3 weeks a. 2 days b. 8 days c. 3 weeks
  - 4. 2 months a. 1 month b. 1 month c. 1 month d. 1 week

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**Culturally Appropriate**

- Those who would use the intervention are part of the target population, so they would be considered as part of the culture to a certain extent. There may be some push back regards to the length of the questionnaire. I am not certain how culturally appropriate or inappropriate it is.
Patients have communicated problems with accessing SDoH-related resources. After initial contact, there are issues with follow through and access to services.

**Problem Statement**
- Patients have communicated problems with accessing SDoH-related resources.
- After initial contact, there are issues with follow through and access to services.
- Cultural Humility Training for staff; providing referrals; Ensuring that written materials cater to all health literacy levels; Building referral assistance into our workflow.

**Target Population**
- To all patients receiving referrals.

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

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

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

**Staff Buy-in**
- Yes.

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

**Resources**
- Cultural Humility Training
- Time to modify printed materials & workflow

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

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

**Sustain & Scale**
- Establishing a referral process that renders maximum value to patients

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

**Culturally Appropriate**
- Yes. Many of our participating staff members are well-versed in community-specific needs around resource usage issues & health literacy & due to their years of experience with and close ties to patient panel members.
Identify appropriate staff to administer and implement follow up for needs.

**Problem Statement**

**Target Population**

Patients experience behavioral or mental health issues.

**Activities & Phases**

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

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

Staff training MA process, social work students process

Clinical Informatics: Data Analysis

**Timeline**

April: addition of housing & food insecurity to general medical intake.

July: Transportation added to general medical intake.

August: Education, incarceration, refugee status, social interaction added to initial/annual patient registration intake.

September: Referral to social work for any food housing and transportation positive screens. Social work warm handoff to students & will ask remaining 7 questions. October: define technology or in person roles that will screen pts annually on remaining 7 questions long term. Reinforce use of documenting SDOH screenings with PRAPARE smart form in HER. Enhance referrals to our Social work department and community resources.

**Intervention**

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

**Contributing Factors**

Highly stressful environments and knowledge of systems

**Staff Buy-in**

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

**Partnerships**

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

**Tracking Progress**

Azara Drvs – Measures for reporting SDOH assessment completion

**Resources**

Staffing and time primarily, expertise in staffing

**Data**

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

**Sustain & Scale**

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

**Define Success**

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

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**Culturally Appropriate**

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

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

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**Figure M. Final Change Map from OHC Missoula**
We do not consistently collect information on SDOH that impact our patients’ ability to reach optimal by using wrap around services.

**Issue & Need**

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

**Problem Statement**
We do not consistently collect information on SDOH that impact our patient’s ability to reach optimal by using wrap around services.

**Target Population**
Homelessness, chronic conditions, low-income households, substance use, DV/SA, mental health.

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

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

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

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

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

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

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

**Tracking Progress**
We will have weekly or biweekly meetings to track progress and revise timeline.

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

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

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

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

**Overall Goal**
To collect usable and meaningful SDOH data to assist patients with connections to wrap around services.

**Figure N. Final Change Map from Pillars Community Health**
Unsure/unaware of the level of use our practice has adopted of SDOH screening. A review of our HER shows no evidence of adoption of this practice.

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

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

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

By the end of this month, extract data on SDOH questions being asked. Next month – plan to increase assessment to all patients. New staff starts this week to address needs. An onsite food bank for immediate needs and a handout to give for future needs. We are currently short on care managers and are seeking to hire 2 more. Those positions will assist with other social determinants of health needs.

Contribute(s): Sarah Kidwell, Michael Turk

Figure O. Final Change Map from Pittsburgh Mercy

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

Goal

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

Define Success

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

Sustain & Scale

Connect patients to resources to improve SDOH.

Tracking Progress

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

Data

HER recently changed to add date SDOH questions asked.

Resources

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

Partnerships

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

Staff Buy-in

Absolutely

Intervention

Better staffing in care coordination.

Contributing Factors

Mental illness and substance use disorders/lack of follow up.

Problem Statement

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

Target Population

High risk population.

Activities & Phases

Gather data on frequency of SDOH questions being asked and answered recorded. Moving towards asking 100% of patients SDOH questions. Use new staff to address needs such as food insecurity.
How do we develop a workflow to ensure that PRAPARE screening is done routinely for patients?

**Target Population:** High risk primary care patients.

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

**Intervention:**
- Standardization SDOH screening and referral workflow, better relationships with nearby CBOS.
- No. While we can learn from research and past experiences, there has not been a significant patient input into the developing a workflow. Out workflow would benefit from presenting SDOH workflow to a patient advisory committee for feedback.

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

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

**Culturally Appropriate:**
- Network has nothing in place for patients to receive concrete services, providers left without resources to adequately service patients.

**Resources:**
- Staff funding are the most important resources.

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

**Tracking Progress:**
- Biweekly monitoring reports and monthly team check ins

**Sustain & Scale:**
- Universal screening for primary care patients 18+
- Better integration of social services as part of routine part of primary care
- Permanent staff dedicated to SDOH screenings and social services

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

**Overall Goal:**
- Universal annual SDOH screenings for all primary care patients 18+

**Goal:** Consistently screening at our target percentage

**Figure P. Final Change Map from Ryan Health**

**Contributor(s): Amie Marie Irvine, Ethan Bernhardt**
Contributor(s): Katie Stephens, Breanna Beach Duffy

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

**Target Population**
UCNW’s medical patient population (1799h, 930h NH) or UCNW’s VH population (495h, 1917 NH)

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

**Resources**
A visual screening tool (with pictures)
An option for screening through conversation (empathic inquiry) = staff time staff training
Integration with the EMR and social histories

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

**Staff Buy-in**
Not yet

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

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

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

**Timeline**
3-6 months

**Tracking Progress**
Meetings on the colander – decision made:
- Partners to work with
- Integration point with clinic workflows chose
- Screening tool chose
- Workflow created

**Sustain & Scale**
To be able to assess the SDOH needs of the UCNW population

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

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

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

**Figure Q. Final Change Map from Union Community Care**
Demonstrating the value of addressing SDOH needs within a medical setting

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

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

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

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

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

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

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

Figure R. Final Change Map from Unity Community Care

Contributor(s): Sarah Schwartz

Goal

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

Overall Goal

Union Community Care

Issue & Need