UNDERSTANDING & ADDRESSING SOCIAL NEEDS

A TOOLKIT FOR IMPLEMENTING A SOCIAL DETERMINANTS OF HEALTH SCREENING PROGRAM

101 Capitol Way N. Suite 200
Olympia, WA 98501
360.786.9722
wacommunityhealth.org
staff@wacommunityhealth.org

ACKNOWLEDGEMENTS

The Association would like to thank Neighborcare Health and HealthPoint for allowing their experiences and resources created during the PRAPARE Academy to inform and be included in the toolkit. We also want to recognize the National Association of Community Health Centers, the Oregon Primary Care Association, SIREN and other participating health centers for reviewing the toolkit.

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under cooperative agreement U58CS06845, State and Regional Primary Care Associations for $919,253.00, with 0% financed with non-federal sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

TABLE OF CONTENTS

ABOUT THIS TOOLKIT....5

CONTEMPLATE....6

- ASSESS READINESS....6

PLAN....9

- TEAM DEVELOPMENT....9
- IDENTIFY BASELINE EFFORTS....12
- SCREENING METHODOLOGY....14
- DESIGN WORKFLOW....19
- STAFF TRAINING....21

DO....24

- TRACK IMPLEMENTATION....24
- TRACK RESPONSES....25

STUDY....26

- COMPILE LESSONS LEARNED....26

ACT....29

- MAKE NEEDED CHANGES....29
- EXPAND YOUR PILOT....30
- LEVERAGE SDOH DATA....31

TOOLBOX....33

REFERENCES....35

ABOUT THIS TOOLKIT

The Washington Association for Community Health has created **Understanding & Addressing Social Needs: A Toolkit for Implementing a Social Determinants of Health Screening Program** to support you in identifying, understanding, and responding to your patients' social determinants of health (SDOH). The toolkit grew out of the Association's participation in the National Association of Community Health Center's (NACHC) PRAPARE Academy (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) from September 2017 to May 2018. During the Academy, Neighborcare Health and HealthPoint piloted the PRAPARE assessment tool in their health centers. If you are working with PRAPARE, we recommend reviewing NACHC's PRAPARE Implementation & Action Toolkit for helpful resources, best practices, and lessons learned. The Association conducted an environmental scan and learned that health centers in Washington are using a number of different SDOH screening tools, indicating a need for guidance in implementing a broad variety of tools in a standardized way. The term "health center" refers to types of health centers supported under section 330 of the Public Health Service Act (US Congress, 1944).

This toolkit is intended to provide a useful framework and resources for health centers that want to implement any SDOH screening tool for the first time, as well as those already using a tool that want to adjust it or achieve greater standardization. The toolkit covers the full range of implementation:

- Assess Readiness
- Team Development
- Identify Baseline Efforts
- Screening Methodology
- Design Workflow
- Staff Training
- Track Implementation
- Track Responses
- Compile Lessons Learned
- Make Needed Changes
- Expand Your Pilot
- Leverage SDOH Data

The framework of the toolkit may look familiar, as it is divided into the major phases *Plan*, *Do*, *Study*, and *Act* (PDSA), along with a preparatory *Contemplate* phase. This PDSA Worksheet from IHI is a useful template to learn more about PDSA cycles, or to use for organized tracking of your pilot. For easy access, there is also a toolbox at the end of the toolkit with direct links to each resource.

You are encouraged to reach out to the Association for support in implementation, including guidance through the toolkit, coaching and facilitation, data validation and screening tool implementation training, peer-to-peer network facilitation, and pilot data analysis.

CONTEMPLATE

ASSESS READINESS

GOAL

Make a decision about readiness to implement a social determinants of health screening program. Identify internal and external environments that may help or hinder implementation.

STEPS

- ☐ Assemble a review team
- ☐ Review the Association's toolkit
- ☐ Conduct an analysis
- ☐ Make a decision

ASSEMBLE A REVIEW TEAM

Assemble a review team to determine your health center's readiness to implement a social determinants of health screening program and identify internal and external environments that may help or hinder implementation. The review team should include representatives from health center departments that could implement the screening, support it, use the information collected, and work closely with community members to be screened. This should include organizational leadership and decision makers, as well as other staff such as information technology, clinic managers, providers, front desk staff, social workers, outreach staff, and community health workers.

Leadership staff can assess how the program fits into overall health center goals and whether it could get organization-wide support. Information technology staff can assess the health center's data capabilities and likely problem areas. Clinic managers can assess how the program will fit with other work already occurring, workflows, and staffing. Providers can assess how the information collected can be incorporated into their clinical work. Front desk staff can assess how the screening could fit into the patient visit, particularly the check-in process. Social workers, outreach staff, and community health workers can assess how the screening will be received by the community and how it aligns with current work to address patients' SDOH needs.

REVIEW THE ASSOCIATION'S TOOLKIT

The review of the toolkit is the first step in determining your health center's capacity for implementing a SDOH screening program. Your timeline for assessing readiness will depend on how you set up your process - whether you choose to hold a series of long meetings over a few days or whether you choose to use a point of contact to collect the relevant information over a period of weeks. Some of the considerations in this phase may need prior research or post-hoc research, some may be worked on concurrently and some may need to be addressed consecutively. The goal of the review is to make sure that everyone involved has a clear understanding of the roadmap and has an opportunity to provide input.

In reviewing the toolkit, the review team should focus on capacity, goals and costs. It is important to remember that SDOH data can be used at many levels to provide resources to patients and close the referral loop, to inform best practices by physicians, and to advocate for more community resources. All of these are valid reasons to collect data and all should be considered during the review process. However, even if you are only currently able to collect data to determine community needs you should still consider a collection effort.

CONDUCT AN ANALYSIS

Before you begin your implementation efforts it is important to consider your organizational goals, capacity, current systems, screening tools, and finances. This toolkit has provided some basic tools to help you determine where your strengths and gaps are.

- **SWOT ANALYSIS TEMPLATE**
  A SWOT analysis is used for identifying internal strengths and weaknesses and external opportunities and threats. Internal strengths and weakness will help you with a plan for things like training, internal technology needs, or assets. External opportunities and threats will help you focus on partnership development, population changes, and risks.

- **PEST ANALYSIS TEMPLATE**
  A PEST analysis is used for describing the political, economic, socio-cultural and technological environment you will be working in. This should be viewed as a "big picture" tool that can help you avoid influences that are out of your direct control, describe the business environment, manage change, and provide a clearer picture of your high-level needs and challenges. This could include, but is not limited to, policy changes, national/state/local requirements, Health Information Exchange (HIE) requirements, and new funding or funding gaps. You may want to

consider how your health center's work might align with other initiatives, such as Accountable Communities of Health (ACH) projects.

- WEST COUNTY HEALTH CENTER DISCOVERY KIT INFORMATION
- WEST COUNTY HEALTH CENTER DISCOVERY KIT
  The West County Health Center Discovery Kit is a collaborative approach to using data as an exploration tool for community partners and for human-centered design to co-create action plans.

MAKE A DECISION

Now that you've assessed how a social determinants of health screening program will fit into your health center operations, it's time to decide. Are you ready to implement a screening program?

If the answer is "no", the review team should plan for the future. If you want to start a SDOH screening program but analysis shows you aren't quite ready, how will you get to where you need to be? When do you want to be prepared to implement? Set a readiness goal, make a plan to reach it, and reconvene on a certain future date to reassess your readiness.

If the answer is "yes", the final task of the review team is to assemble the pilot project team and pass on responsibility for implementing the SDOH screening program. Summarize your reasoning for making the decision to implement a SDOH screening program and impart these reasons to the pilot project team.

PLAN

TEAM DEVELOPMENT

GOAL

Adequately prepare for implementation. Develop a pilot project team representative of various levels of staff that can provide input into the development and implementation of the pilot project.

STEPS

- ☐ Assemble a pilot project team
- ☐ Train pilot project team on SDOH
- ☐ Review the Association's toolkit
- ☐ Establish a pilot project charter

ASSEMBLE A PILOT PROJECT TEAM

Now that the review team has decided that your health center will implement a screening program, it's time for the pilot project team to get into the work. The role of the pilot project team is to plan, implement, monitor, and evaluate a pilot project to test implementation of your SDOH screening program. There may be significant overlap between members of your review team and pilot project team. As you form your pilot project team, make sure you include people familiar with the work, as well as those with some decision-making authority at the managerial or supervisory level. This will ensure subject matter expertise as well as your team's ability to drive the pilot forward effectively.

▶ IHI FORMING THE TEAM
This resource provides several example rosters of effective teams, which include the roles of clinical leader, technical expertise, day-to-day leadership, sponsor, and other suggestions for additional team members.

TRAIN PILOT PROJECT TEAM ON SDOH

As you begin your work as the pilot project team, it is important to build a common understanding of the social determinants of health. This will allow you to speak a common language as you navigate this work and ensure that understanding of concepts is shared among the team members. At this point in the process, it will also be helpful to verbalize why you are engaging in this work, laying a guiding support for the decisions to come.

“The social determinants of health (SDOH) are the conditions in which people live, work, play and age. They can encompass socioeconomic conditions, environmental conditions, institutional power and social networks” (World Health Organization, 2016). Although these conditions are not thought of as being part of standard clinical care, they can have profound effects on the development, course, and outcomes of specific diseases and overall health. Many measures of patient complexity are impacted, such as number of chronic conditions, hospital readmissions, and emergency room utilization. Research estimates that up to 80% of health outcomes can be attributed to upstream social determinants of health (Magnan, 2016).

Examples of SDOH include access to housing, education, job opportunities, quality of education, public safety, transportation options, exposure to crime and violence, language and literacy, access to emerging or current technologies, social support, and culture. Some physical determinants or “built environmental” determinants can also be considered along with social determinants and include sidewalks, bike lanes, green spaces, work spaces, exposure to toxic substances, physical barriers (especially for people with disabilities), and even weather.

Healthy People 2020 has identified five key areas (domains) that affect health outcomes: economic stability, education, social and community context, health and health care, and neighborhood and built environment (Office of Disease Prevention and Health Promotion, 2016). The World Health Organization also includes areas such as gender and early childhood development (World Health Organization, 2016). Prevention is the primary reason for addressing social determinants of health, whether to prevent additional complications of an existing condition or the development of new disease.

- UNC MODULE 2: DETERMINANTS OF HEALTH & HEALTH DISPARITIES
  This free training module form the University of North Carolina Institute for Public Health is one of six trainings included in the Introduction to Public Health in North Carolina training series. This module provides an overview of the factors that influence health and health-related behavior, and addresses differences in health status known as health disparities.

The Association is available to engage with your health center in discussions or more specific trainings around the social determinants of health.

REVIEW THE ASSOCIATION'S TOOLKIT

It is important to note that each phase of this toolkit has sections that may include goals and steps that can help guide your planning and design process. Some sections contain training resources and templates when appropriate. This initial pilot project team review will help orient you to your upcoming work and the resources available to you.

As you go through this review, you should document concerns, potential changes to workflow, training needs, knowledge gaps, and attitudes. This documentation will help inform your pilot project charter and identify any areas of potential difficulty.

ESTABLISH A PILOT PROJECT CHARTER

Your pilot project charter will be the guiding document throughout your pilot. After completing the charter, you will have team commitment to defined objectives and goals – your pilot project will have officially begun! This document will define the scope of your pilot and how you measure success. While the charter gives you a solid foundation to begin, it is important to return to it often to maintain focus, drive, and ensure sustainability. As you implement your pilot, you may learn information that leads to changes in your pilot project charter. Charters can be changed, but make sure your changes have been analyzed and approved by your pilot project team, including your sponsor (see *assemble a pilot project team*).

Keep in mind that understanding and addressing the SDOH needs of your patients requires an ongoing commitment, incorporated into your work and mission as a health center. Your pilot project is one of many that your health center may engage in as part of your ongoing SDOH efforts.

- PILOT PROJECT CHARTER TEMPLATE
  This document provides a brief overview of the purpose of a project charter, a description of its elements, and a fillable template to get you started.

IDENTIFY BASELINE EFFORTS

GOAL

Understand current efforts to enable staff to quantify outcome changes and to identify gaps in the process.

STEPS

- ☐ Map current collection efforts
- ☐ Map current resources
- ☐ Consider referral resource tracking
- ☐ Consider clinical information flow

MAP CURRENT COLLECTION EFFORTS

Before you start implementing your screening, you will want to identify whether you are currently collecting any of the information, who is collecting it, and where/when they are collecting it. In other words, what are your current baseline efforts? Please review the Association's crosswalk to determine who will need to complete it for a full picture of your organizations current work. This should act as a guiding document for the next steps in strategizing your SDOH screening implementation.

▶ SCREENING TOOL CROSSWALK

The Association has developed a crosswalk with PRAPARE which shows the PRAPARE domains in blue, called "Core Measures". This row can be modified to reflect the domains, questions, or categories of any SDOH tool you are planning on using. We recommend that you do not modify column A questions (in yellow).

MAP CURRENT RESOURCES

As you identify your baseline efforts in understanding and addressing social needs, it is important to identify current in-house and external resources. You should also discuss other available sources of referral information, such as your ACH or resource networks like Aunt Bertha, Washington 211, Community Health Bridge, or One Degree. What types of services can your health center provide? Do you have formalized partnerships with external organizations? Do you regularly refer patients to certain agencies? What do know about the efficacy of the resources you are using? It is useful to note the accessibility and organization of referral information across your health center.

- **COMMUNITY RESOURCE REFERRAL PLATFORMS**
  SIREN has developed a guide to the growing landscape of community resource referral platforms and the experiences of early adopters. The guide explores nine platforms with an analysis informed by interviews with organizations in the process of implementing a platform.

- **NEIGHBORCARE HEALTH RESOURCES TEMPLATE**
  Neighborcare Health used this spreadsheet to curate available local resources in various SDOH domains, and created a standard process for updating and maintaining the list. The spreadsheet is populated with resources relevant to Neighborcare Health, but you may use it as a template to populate with your own health center's resources.

CONSIDER REFERRAL RESOURCE TRACKING

As you prepare to test your pilot, consider the referral tracking needs you'll likely encounter and map your current process. Do you currently have a method for closing the referral loop – and what does that mean for your health center? Do you have a way of knowing if the patient reached the resource? Do you have a way of knowing if the patient's need has been fully addressed? How are you tracking this information and integrating it into your clinical information flow? If you foresee challenges in knowing what happens to a patient after referral to social resources, you may want to have a conversation with your most frequently utilized referrals about how to maximize communication. If you have difficulty identifying your current referral services, you can review the *enabling services documentation* information in this toolkit.

CONSIDER CLINICAL INFORMATION FLOW

Before you begin your screening implementation, discuss your internal clinical information flows. Identify how you plan to use the SDOH information collected by your screening program. Are your goals focused on informing providers to improve individual patient care? Will your Quality Improvement or Population Health departments use this data to inform future initiatives? Identify who will need to use the information, for what purpose, and keep these needs in mind as you move forward in selecting a tool and workflow. Decisions about information flow and access should lend themselves to usability for the people and purposes you've identified.

SCREENING METHODOLOGY

GOAL

Identify a screening tool and method to collect SDOH.

STEPS

- ☐ Research and identify a screening tool
- ☐ Consider EHR compatibility
- ☐ Ensure rigorous data collection
- ☐ Consider a pre-screening survey
- ☐ Consider feedback surveys

RESEARCH AND IDENTIFY A SCREENING TOOL

Identifying the tool you are interested in using may take research. Things to consider are consistency with local and state-wide initiatives, cost, time-constraints, complexity of questions, and validity of tools. We have included a crosswalk of common tool options, such as PRAPARE, CMS, WeCare, etc.

Kaiser Permanente has also completed a systematic review of social risk screening tools which can be found on their website. A summary of their review is included below.

- **SDOH DOMAINS CROSSWALK**
  The crosswalk provides a quick look at the domains and questions for five different SDOH screening tools. For a full review of the most validated tools, see the *Systematic Review & Quality Assessment* below.

- **SYSTEMATIC REVIEW & QUALITY ASSESSMENT**
  This presentation includes four systematic reviews of SDOH tools that were performed to evaluate the current state of multi-domain tools intended to screen for social needs in health care settings. Two of the reviews focus on pediatric settings, and two explore the effectiveness of screening for identifying social needs and providing referrals. One also describes the tool development process and one examines the methodological quality using COSMIN.

CONSIDER EHR COMPATIBILITY

Some screening tools have a template compatible with specific EHRs, a consideration which may be a factor in your decision-making process. Your EHR vendor may also provide a vendor-based SDOH screening template, which may vary in validity, usability, and standardization. Deciding which screening tool to use should be considered in conjunction with how each aligns with larger initiatives,

like ACH projects or Washington State Department of Health's State Health Assessment. If a question on your screening tool is not aligned with questions on other tools, it will restrict your ability to compare your health center's measures to others. For example, if your tool asks about housing quality and another tool asks about homelessness, those two questions would not be in alignment although they both ask about housing. Another consideration is how much support the vendor or other agencies (e.g. AAPCHO, OCHIN, NACHC) provide for free or for cost. In their work to pilot SDOH screenings, Neighborcare Health found that using a standard IT development cycle model helped keep down costs and keep the work on a time schedule.

You will also want to consider how the tool you choose will integrate into your IT workflow. For example, who will need to have access to the screening questions and/or screening data? Which tool will allow optimal ease of access? Different populations of focus may have different workflows (dental, behavioral health, patient panels, etc.) which may need to be adapted in order to get better validity and reliability from your respondents. The *ensure rigorous data collection* section in this toolkit has resources to help determine how your IT workflow may affect your data validity.

- NEXTGEN IT DEVELOPMENT CYCLE MODEL
  This document from Neighborcare Health provides an example of a standard IT development cycle model used to make group change requests for NextGen.
- NACHC EHR USER GROUPS
  These user groups may be helpful in troubleshooting and providing peer support for tool implementation or use. User Groups are available for NextGen, Athena Health, and eClinicalWorks.

ENSURE RIGOROUS DATA COLLECTION

The trainings, goals and activities in this section have been developed to help you plan your workflows in a way that reduces bias and to support the validity and reliability of your data.

Bias, in terms of surveys, is any systematic error in data collection. It can be introduced to any data collection in three basic ways: 1) through the design of the questions being asked, 2) through the design of the questionnaire, and 3) through the way the questions are administered.

Validity refers to the credibility or accuracy of your data. Validity needs to be considered in two contexts: internal validity and external validity. The amount of emphasis you put on external or internal validity depends, in large part, on what you are going to be comparing the data to.

Reliability is defined by asking "if someone else collected this data in exactly the same way, how likely are they to get the same answer?"

- **LITERATURE REVIEW ON BIAS**
  This document provides a summary of relevant research on this topic. Below is a table of studies included in the literature review conducted by the Association which discuss screening implementation and bias. Links to the original studies are included in the table below.

Name of the paper	Highlights of the paper
A catalog of biases in questionnaires	Identifies and categories 48 kinds of biases with examples and how to avoid these biases
Choosing a method to reduce selection bias: A tool for researchers	What is selection bias and methods to reduce selection bias
Information bias in health research: definition, pitfalls, and adjustment methods	Focuses on information bias and strategies to overcome in observation and experimental studies
A primer on the validity of assessment instruments	What is reliability and validity and how are they measured and determined
Principles and methods of validity and reliability testing of questionnaires used in social and health science researches	Understand the principles and methods of validity and reliability measurement tools
Collecting and applying data on social determinants of health in health care setting	Describes ways to collect data and target interventions at patient, institution and broader population level.

- **THINKING ABOUT IMPLEMENTING YOUR SDOH SCREENING**
  This document is a basic summary of the Washington Association for Community Health's *Screening Methodology & Data Validation* training.

- **SCREENING METHODOLOGY & DATA VALIDATION: PART 1**
  This training has been designed by the Association and is specific to screenings being implemented in low-resource primary care settings. This training module is intended for pilot staff, high-level administration staff (COOs, Medical Directors, Managers, etc.) and other staff who are designing the proposed workflows for the screening implementation. The Association can provide training on this module either through on-site presentation or presentations via webinar.

CONSIDER A PRE-SCREENING SURVEY

A pre-screening survey can help you identify patients with high needs, using less staff time than you might otherwise. A patient might fill out a pre-screening survey during check-in or while waiting to be roomed, indicating general areas of need or interest related to SDOH domains. Those that indicate interest or need will be your target population for a full SDOH screening. If you decide to use a pre-screening survey, you will need to include it in your workflow design. In later analysis of the data, you should also consider the effects a pre-screening survey might have had before you implement a screening program at scale.

- ROGUE COMMUNITY HEALTH PATIENT SUPPORT SURVEY
  The Rogue Community Health Patient Support Survey has been widely used as a pre-screening tool in many Oregon health centers.

CONSIDER FEEDBACK SURVEYS

Patient surveys can help you determine a variety of things about the experiences of the patients. It can provide information on perceived length, time, difficulty of questions or concepts, and comfort levels with staff, topic areas, or questions. When designing your patient survey, you should take care to balance the necessity of asking some questions against the potential discomfort of the patient. For example, questions on incarceration or domestic violence may make a patient feel uncomfortable but may also have high clinical significance. In such cases it may be more important to design your patient survey in a way that facilitates learning how to reduce your patients' discomfort rather than to decide whether the question should be included in your SDOH screening.

During their PRAPARE implementation pilot, Neighborcare Health used the following questions to assess their patients' experiences:

1. What did you think about the time it took to complete the PRAPARE screening?
2. Did you feel comfortable answering these questions?
3. Do you think this screening will help your medical team better address your needs?
4. Do you feel that the questions included in this screening have been asked by (our clinic) before?
5. If you have any other feedback, please write it below (note: when we watched these interviews, the patients did not fill anything out by hand, the interviewer recorded everything.

Throughout the pilot, make sure you understand the experiences and perspectives of your pilot implementation staff. Consider interviewing the pilot implementation staff before and after the pilot to collect information about how their assumptions matched their experience. The information you learn from pilot staff can be used to make changes in workflow, staff training, or messaging. This information will be helpful as you begin to scale your program, as you will be better able to anticipate challenges and share experiences with other staff engaging in the work. You may also want to record IT staff feedback as you proceed through your pilot. Some questions you may want to consider tracking along with your data are:

1. What ways can reporting be improved?
2. What lessons learned and best practices would you recommend?

- HEALTHPOINT STAFF FOLLOW-UP SURVEY
  This survey was developed by HealthPoint as a follow-up for each screening completed in their pilot. It includes questions for data validation as well as some staff opinion questions.

- NACHC STAFF PROCESS EVALUATION SURVEY
  This survey can provide an example of what questions you might ask your implementation staff.

DESIGN WORKFLOW

GOAL

Decide which workflow you will pilot.

STEPS

- ☐ Review workflow examples
- ☐ Choose or develop a pilot workflow
- ☐ Identify pilot implementation staff

REVIEW WORKFLOW EXAMPLES

SDOH screening questions can be asked by various position types throughout the patient visit. Take a look at existing workflows to begin imagining how a SDOH screening process might fit into your health center. As you consider some examples, take into account current tasks and responsibilities to find the SDOH flow that aligns with and compliments current staff workflows.

- **STRATEGIZING WORKFLOWS WEBINAR**
  This webinar presents considerations for choosing a workflow, including the "5 Rights" framework and sample workflows. Though this NACHC webinar features the PRAPARE tool, it will likely be useful in choosing your workflow for any screening tool. Along with this webinar, you might also want to review Chapter 5: Workflow Implementation in NACHC's PRAPARE Implementation & Action Toolkit, which includes sample workflow diagrams.

- **NEIGHBORCARE HEALTH PILOT WORKFLOW**
  Neighborcare Health used this workflow while testing a pilot for SDOH screening.

CHOOSE OR DEVELOP A PILOT WORKFLOW

Did your pilot project team find a workflow that might fit well in your health center? If yes, review it with the team, make any needed adjustments, and include any additional details. Perhaps none of the examples are quite right for your health center. If this is the case, use what you learned from the examples and develop a custom workflow with your pilot project team. Considering alignment and inclusion in other clinic processes could help you develop a SDOH workflow of your own. Make a final decision about the workflow you'll use for your pilot. Remember, you'll make more adjustments or choose another workflow to test using what you learn from the pilot!

No matter which workflow you choose, you should consider starting small. During the PRAPARE Academy, NACHC suggested using a 3 x 10 model to test a workflow. Choose three screening questions and ask them to 10 patients. Starting small can help you decide whether the chosen workflow is right for you.

The Rogue Community Health pre-screening survey provided in the *screening methodology* section is another workflow adaptation you might choose to make. A pre-screening survey can help target your efforts and will need to be embedded into the workflow design.

IDENTIFY PILOT IMPLEMENTATION STAFF

Identify a clinic site where you will perform your initial pilot. Specify a team of pilot implementation staff who will perform the work of running your pilot workflow. This is a test of the real thing – so make sure the staff positions on your pilot implementation staff reflect the positions indicated in the workflow. Before running the pilot, review the workflow with the implementation staff. It may be helpful to do a walkthrough in the clinic environment in which the pilot will take place. Collect the feedback of the implementation staff and make any agreed upon revisions. With the implementation staff, decide when the pilot run will take place.

Before running their SDOH screening pilot, Neighborcare Health asked the following questions to implementation staff:

1. How would your patients respond to this questionnaire?
2. How comfortable would you feel asking these questions?
3. When would you prefer to ask these questions (i.e., before the office visit, during the OV, after the OV, online, at another time)?
4. If the results were easily available, under what circumstances would you refer to the answers when treating a patient?

You might consider asking these or other questions to your staff before your pilot to begin the process of documenting feedback.

STAFF TRAINING

GOAL

Ensure staff are adequately trained to implement a new process.

STEPS

☐ Provide staff training

PROVIDE STAFF TRAINING

The pilot implementation staff should be adequately trained before testing the workflow. At a minimum, this step should involve ensuring that staff know what their work will entail, and why they are doing it. By the end of this step, the pilot implementation staff should be confident of the workflow they are about to test, understand the importance of social determinants of health, and be able to answer the question, "Why are we doing this?"

Additional training can be helpful in many ways, including addressing possible concerns revealed during the pre-implementation staff feedback step. In addition to equipping the pilot staff with the skills they need to be successful, this is also a test run for what types of training you'll want to focus on when you scale up collection efforts. What are the common needs, gaps, or anxieties among the pilot team, and what trainings might address them?

- TRAINING PLAN TEMPLATE
  This document provides some examples of the potential training needs of various position types and includes a template for you to plan how you will train your staff. While it was originally created for use with PRAPARE, it can be adapted for use with other tools.

Social Determinants of Health Overview

Your pilot project team previously discussed social determinants of health to come to a common understanding of concepts and establish shared reasons for engaging in this work. You may consider engaging the pilot implementation staff in similar training or discussion. The Association is available to assist with and join your health center in discussions or more specific trainings around the social determinants of health.

- **UNC MODULE 2: DETERMINANTS OF HEALTH & HEALTH DISPARITIES**
  This free training module form the University of North Carolina Institute for Public Health is one of six trainings included in the Introduction to Public Health in North Carolina training series. This module provides an overview of the factors that influence health and health-related behavior, and addresses differences in health status known as health disparities.

Rationale for Program

Staff members asked to participate in this program should understand the reasons for doing this work. Train the pilot implementation staff on the background, rationale, and goals to make the work meaningful for all involved and increase their engagement.

- **WHY COLLECT STANDARDIZED SDOH DATA?**
  This one-page infographic explains potential reasons for collecting standardized SDOH data, from the patient visit to the state levels.

Data Collection and Validation

I is for Investigation is a group of online trainings with detailed speaker's notes, guided discussion questions for individuals or groups, and additional resources. These modules are designed to be used for computer-based self-study, or as a face-to-face teaching tool for trainers for lunch-and-learn seminars or in-service trainings. These trainings are free and provide certificates of completion for each participant.

It may be valuable to include other sessions or to organize a training for the entire series (seven sessions, or about five hours of training total) for staff identified in the workflow such as community health workers, health educators, case managers, or medical assistants. This series can provide them with solid data collection skills and overviews and insights into how their efforts fit into larger data collection efforts.

- **I IS FOR INVESTIGATION SESSION 4: INTERVIEWING TECHNIQUES**
  The objective of this training is to reduce interviewer error by providing an overview of different methods of interviewing, standardization of interviews, interviewer training, interviewing techniques, and confidentiality.

- **I IS FOR INVESTIGATION SESSION 5: ANALYZING DATA**
  The objectives of this training are to learn to generate and interpret commonly used measures of association, confidence intervals, and statistical tests of significance. Although it is geared toward disease outbreaks, the methods can be adopted for surveillance as well.

The Washington Association for Community Health has designed a two-part data collection and validation training for use in health centers, titled *Screening Methodology & Data Validation*. The Association is available to engage in discussion and staff training on this topic.

- SCREENING METHODOLOGY & DATA VALIDATION: PART 2
  This training module can assist you in identifying points at which a validation process should take place, understand what is meant by validity and reliability and understand how design of a screening program affects aggregation and analysis of the data.

Patient-Centered Communication

It is important to ensure that staff are confident in their ability to ask sensitive questions of patients, and listen well to answers, in a way that is not offensive or traumatizing. The approaches below offer a variety of ways to cultivate this important skill in your health center.

- LISTENING WITH EMPATHY
  This free, self-paced module from the American Medical Association (AMA) can introduce your staff to new skills to improve patient communication.
- EMPATHIC INQUIRY
  Empathic Inquiry is a patient-centered approach to social determinants of health screening developed by the Oregon Primary Care Association (OPCA) which combines motivational interviewing and trauma-informed care, with input from patients, front line staff and community health leaders.
- MOTIVATIONAL INTERVIEWING
  Motivational Interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change that can help health center staff to implement the screening. The Motivational Interviewing Network of Trainers promotes high-quality practice and training.

Enabling Services Documentation

Tracking your health center's referral to enabling services can help you improve your data, understand the utilization of resources, and document health center work.

- ENABLING SERVICES DATA COLLECTION IMPLEMENTATION PACKET
  The Association of Asian Pacific Community Health Organizations (AAPCHO) created the Enabling Services Data Collection Protocol to improve data collection on essential services and better understand them and their impact on health care access and outcomes. The Enabling Services Data Collection Implementation Packet guides health centers who wish to codify and track enabling services. AAPCHO and Health Outreach Partners offer in-person training on the tool.

TRACK IMPLEMENTATION

GOAL

Capture what happened during pilot implementation.

STEPS

- ☐ Record patient and staff feedback
- ☐ Continue communication

RECORD PATIENT AND STAFF FEEDBACK

The feedback you collect using your patient and staff feedback surveys will be invaluable in knowing whether your messaging and staff training were sufficient. Ensure that the responses to both surveys are being collected and recorded by pilot implementation staff or pilot project team regularly.

CONTINUE COMMUNICATION

The pilot project team and pilot implementation staff should have a process to ensure robust continued communication throughout the pilot. Set up regular meetings spanning the pilot to make sure you have the needed time to discuss how the pilot is proceeding.

TRACK RESPONSES

GOAL

Capture initial data from first cohort.

STEPS

- ☐ Ensure proper documentation

ENSURE PROPER DOCUMENTATION

Proper documentation includes making sure your data is clean, using proper coding, and developing processes for validating and for reporting. We have provided two current coding resources below. We encourage you to contact the Association for the latest updates about ongoing work in coding for SDOH.

- **ICD-10 CODES FOR SDOH**
  This document was developed by HITEQ and outlines existing ICD-10 z-codes that are closely matched to NACHC's PRAPARE tool.

- **SIREN COMPENDIUM OF SOCIAL RISK FACTOR CODES**
  This is a more comprehensive document developed by SIREN that outlines existing LOINC codes for screening questions, ICD-10 Z-codes and SNOMED codes for multiple assessment domains, and SNOMED codes for interventions.

STUDY

COMPILE LESSONS LEARNED

GOAL

Evaluate your pilot and identify pain points or gaps, as well as successes. Remember to review your pilot project charter to measure success.

STEPS

- ☐ Assess workflow
- ☐ Assess reporting
- ☐ Assess population screened
- ☐ Assess messaging
- ☐ Assess training needs
- ☐ Assess resources and partnerships
- ☐ Assess referral tracking

ASSESS WORKFLOW

Now that you have completed a pilot run of your workflow, look back to assess whether the reality differed in any way from "planned" workflow and why. Staff feedback and patient feedback can be reviewed to learn what they thought worked well or needs to be improved and what changes they would like to see in the workflow. You may want to use data sources such as patient screening responses, staff and patient feedback surveys, and others to assess bias introduced in the workflow, time to complete the workflow, and potential cost and ability to scale.

▶ VALUE STREAM MAPPING WEBINAR
This webinar presents an overview of value stream mapping - a process which can determine which steps in a process add value - and which can be considered wasteful.

ASSESS REPORTING

During your planning you should have included the perspective of IT staff in identifying their role and needs. Now is the time to work with IT staff and/or your vendor to pull the reports you have decided on and review them with the pilot implementation staff. You may want to make adjustments after your PDSA for who reports will go to or how they will be analyzed. Some things you may want to consider during this step are:

- What is surprising in the reports?
- What are the key takeaways?
- What other data would be helpful to add, if any?

ASSESS POPULATION SCREENED

It is important to know whether changes need to be made to this workflow before scaling up. Assess whether the people who participated in your pilot are a population that is generalizable to your larger patient population, or if there are considerations needed when expanding. What effect did they have on the screening process and results, and what possible effects could it have when scaling up? If you're uncertain about how to assess these potential effects, refer to the information about screening validity, reliability, and bias in the *screening methodology* section.

ASSESS MESSAGING

It is important to assess messaging about the screening program to your patients, staff, the community at large and referral organizations. Was the program rationale well-communicated to all stakeholders? Were there issues in receptivity? Feedback from all groups as well as the data collected will indicate whether the messaging was appropriate, where gaps might exist and what changes need to be made.

▶ MESSAGING FOR SDOH
This pamphlet, developed by the Canadian Council on Social Determinants of Health, provides guidelines for factors that influence audience receptivity to messaging, the ingredients of effective messaging and considerations for tailoring them for priority audiences.

ASSESS TRAINING NEEDS

There are many factors to consider when assessing training needs including patient and staff feedback, assessing workflow, and the data collected. Once you've identified gaps or areas needing improvement, assess what types of training can be targeted there. Review your training plan template and make any needed changes, using suggested training areas as a guide (see *staff training* section).

ASSESS RESOURCES AND PARTNERSHIPS

Discuss whether resources and partnerships were available to meet all the identified needs, where there were gaps, and what resource areas had highest needs for your patients. To address gaps, consider meeting with current partners to discuss improvements in communication and connection to resources, developing a process for continuous communication to get feedback from partners to

inform future work, including communication about subjects such as patient satisfaction and education. You may also consider your vetting process for cultivating new partnerships and developing MOUs as you seek to fill gaps in needed patient resources. For areas that lack resources and partners, consider how to use policy and advocacy to address them.

- USING SDOH DATA TO CONNECT TO RESOURCES
  This case study from the HITEQ Center addresses the issue, "We asked the questions, now what do we do?" It includes information about identifying levels of risk, as well as using platforms such as 211 or Aunt Bertha to connect patients with community resources.

ASSESS REFERRAL TRACKING

Referral tracking is key to closing the loop, so patients get connected to the resources needed and health centers document their work addressing SDOH. It will be important to include whether the need of the patient has been met versus just a referral completed. For example, did the patient's diet improve or did they receive a referral to the food bank and apply for SNAP? You should also assess how providers can incorporate this information into the next clinic visit, including reviewing resource referrals and understanding whether the patient's need was met.

ACT

MAKE NEEDED CHANGES

GOAL

Using what you learned, make needed adjustments to your process.

IF NO CHANGES MADE

if there are no changes that need to be made after reviewing the pilot, then you are ready to move on to the Scaling phase.

IF CHANGES MADE

If you encounter changes that you'd like to make, return to the appropriate section of the Planning phase and try a new PDSA cycle including your changes.

EXPAND YOUR PILOT

GOAL

Increase the number of patients being screened using the same workflow.

STEPS

☐ Review impacts of scaling

REVIEW IMPACTS OF SCALING

Your health center will want to consider whether the timing is right to expand the reach of the screening program based on the pilot experience as well as other organizational considerations. Requesting feedback from staff and referral organizations about anticipated impact and challenges of going to scale could also be helpful. Leadership should be consulted for organizational considerations about alignment with other initiatives if scaling were to take place now. Health center leadership will need to assess how going to scale with the program fits into organizational goals and budget and whether it will be necessary to seek outside funding sources. Discussing needs with referral organizations, insurance carriers contracted with the health center, and state health agencies could be a good starting point to learn about funding opportunities.

▶ HOW DO SAFETY NET CLINICS PAY FOR SOCIAL CARE PROGRAMS?
This SIREN publication explores how health centers financially support SDOH activities informed by interviews with safety net clinics and other experts from government and community organizations.

LEVERAGE SDOH DATA

GOAL

Get the most out of your SDOH data by incorporating it throughout your work and beyond your health center.

STEPS

- ☐ Clinical quality process changes
- ☐ Payment
- ☐ Policy and advocacy
- ☐ Community partnerships

Your pilot project team previously had a conversation about the ways in which you might use SDOH data (see *consider clinical information flow* section). Now that you have completed at least one SDOH pilot, discuss what may have changed since that conversation. Are there new opportunities or ideas to get the most out of your SDOH data? Discuss how you may want to expand the use of your SDOH screening data in the future.

CLINICAL QUALITY PROCESS CHANGES

You've started collecting data about the social needs of your patients, and providers have begun using this knowledge to inform individual patient care. How might your health center use the information to make changes on a broader level? Are there improvements that can be made in your health center, in light of the most prevalent needs of your patients? You may use your data to identify best practices and design interventions for specific patient needs. As your HEALTH CENTER engages in continuous improvement, SDOH data can inform your QI priorities, initiatives, and processes.

PAYMENT

It is important to keep in mind that you may want to match or compare your data to other sources of data such as opensource neighborhood data, other clinical measures like disability status or chronic disease, or other demographic data such as zip code, age or number of addresses in the past year when thinking about negotiating contracts or providing information for payment reform or risk adjustment. Investments in Social Determinants data collection can take a long time to see results.

- [USING SDOH DATA IN RATE SETTING: MASSHEALTH RISK ADJUSTMENT MODEL]
  This is one example of how clinic level data was used at the state level in a risk adjustment model.

POLICY AND ADVOCACY

Knowledge about the social needs of your patients, backed up by reliable data, can be an important advocacy tool. Consider how your HEALTH CEN might use this information at the local, regional, or state level to inform policymakers, funders, and communities about what is needed to improve patient lives – both inside and outside of the clinic.

- A NEW WAY TO TALK ABOUT SDOH
  This guide from the Robert Wood Johnson Foundation discusses why we need a better way to talk about SDOH, along with best practices in engaging different audiences in the discussion.

COMMUNITY PARTNERSHIPS

When you have sufficient data about the most common social needs of your population as well as where there may be gaps in ability to respond to them, think about how you might expand and leverage community partnerships. Can your health center develop an internal program to address the most prevalent needs of your patients? Can these gaps in resources be addressed by creating new partnerships or strengthening existing ones? If you've discovered challenges with existing partners, you can make a plan about how you might improve communication, follow-up, or effectiveness.

- PARTNERSHIPS ASSESSMENT TOOL
  This assessment tool is designed for established partnerships to explore their development in several areas and strengthen the effectiveness of their partnership.

TOOLBOX

CONTEMPLATE

- SWOT ANALYSIS TEMPLATE
- PEST ANALYSIS TEMPLATE
- WEST COUNTY HEALTH CENTER DISCOVERY KIT INFORMATION
- WEST COUNTY HEALTH CENTER DISCOVERY KIT

PLAN

- IHI FORMING THE TEAM
- UNC MODULE 2: DETERMINANTS OF HEALTH & HEALTH DISPARITIES
- PILOT PROJECT CHARTER TEMPLATE
- SCREENING TOOL CROSSWALK
- COMMUNITY RESOURCE REFERRAL PLATFORMS
- NEIGHBORCARE HEALTH RESOURCES TEMPLATE
- SDOH DOMAINS CROSSWALK
- SYSTEMATIC REVIEW & QUALITY ASSESSMENT
- NEXTGEN IT DEVELOPMENT CYCLE MODEL
- NACHC EHR USER GROUPS
- LITERATURE REVIEW ON BIAS
- THINKING ABOUT IMPLEMENTING YOUR SDOH SCREENING
- SCREENING METHODOLOGY & DATA VALIDATION: PART 1
- ROGUE COMMUNITY HEALTH PATIENT SUPPORT SURVEY
- HEALTHPOINT STAFF FOLLOW-UP SURVEY
- NACHC STAFF PROCESS EVALUATION SURVEY
- STRATEGIZING WORKFLOWS WEBINAR
- NEIGHBORCARE HEALTH PILOT WORKFLOW

- TRAINING PLAN TEMPLATE
- UNC MODULE 2: DETERMINANTS OF HEALTH & HEALTH DISPARITIES
- WHY COLLECT STANDARDIZED SDOH DATA?
- I IS FOR INVESTIGATION SESSION 4: INTERVIEWING TECHNIQUES
- I IS FOR INVESTIGATION SESSION 5: ANALYZING DATA
- SCREENING METHODOLOGY & DATA VALIDATION: PART 2
- LISTENING WITH EMPATHY
- EMPATHIC INQUIRY
- MOTIVATIONAL INTERVIEWING
- ENABLING SERVICES DATA COLLECTION IMPLEMENTATION PACKET

DO

- ICD-10 CODES FOR SDOH
- SIREN COMPENDIUM OF SOCIAL RISK FACTOR CODES

STUDY

- VALUE STREAM MAPPING WEBINAR
- MESSAGING FOR SDOH
- USING SDOH DATA TO CONNECT TO RESOURCES

ACT

- HOW DO SAFETY NET CLINICS PAY FOR SOCIAL CARE PROGRAMS?
- USING SDOH DATA IN RATE SETTING: MASSHEALTH RISK ADJUSTMENT MODEL
- A NEW WAY TO TALK ABOUT SDOH
- PARTNERSHIPS ASSESSMENT TOOL

REFERENCES

Magnan, S. (2016, March 18). *Social Determinants of Health 101 for Health Care: Five Plus Five*. Retrieved from National Academy of Medicine: https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

Office of Disease Prevention and Health Promotion. (2016, March 18). *Healthy People.gov*. Retrieved from Social Determinants of Health: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

US Congress. (1944, July 1). *United States Code: The Public Health Service, 42 U.S.C. §§ 201-291n.* Retrieved from Office of the Law Revision Counsel United States Code: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section254b&num=0&edition=prelim#sourcecredit

World Health Organization. (2016, March 15). *Social Determinants of Health*. Retrieved from World Health Organization: https://www.who.int/social_determinants/sdh_definition/en/