ACTION PLAN WORKBOOK

A comprehensive guide to support your organization's efforts to plan and implement a systematic approach to identifying your patient's unmet social needs and navigating them to resources in their community.

Table of Contents

TABLE OF CONTENTS

ACTION PLAN WORKBOOK

SUPPLEMENTARY MATERIALS

ACTION PLAN

FOR A SOCIAL NEEDS PROGRAM

ACTION PLAN FOR A SOCIAL NEEDS PROGRAM

This document will guide early stage design and development of a social needs program and will also help evaluate or expand a current program. This document highlights key information to consider as you make your design decisions. Once you are ready to act, more detail will be required, and some information will evolve; however, this tool will help you move through future steps much more efficiently.

The Action Plan is broken up into sections that align with the key drivers Health Leads has identified as essential to a successful social needs program. We strongly suggest working as an interdisciplinary team to fill out each section. An ideal interdisciplinary team may include representatives from medicine, behavioral health, social work, registration staff, clinical support staff, executive leadership, community partners, and patients/clients. You will likely need to have conversations with individuals outside of your team and collect additional data to make certain planning decisions. In our experience, we have found these Action Plans are used as "living documents" that are iterated upon as information is learned, resources are obtained, decisions are made, etc. Your Action Plan can also help your team gather the necessary information for fundraising for your program, participate in cross-organization conversations about addressing gaps in care/services, and managing change within your organization.

Note on terminology: We understand that as health care is evolving, terminology evolves as well. In this workshop, we are referring to the individuals served by these efforts as "patients." However, we recognize that organizations may also refer to these individuals as "clients," "customers," "leaders", etc.

Table of Contents

SECTION ONE:
ARTICULATING YOUR VISION

VISION AND PURPOSE

As you embark on your journey to address patients' social needs as a standard part of care delivery, a clearly articulated vision will help your team stay focused on designing, piloting, implementing and sustaining a system that will successfully address the needs of your patients and community. It will also help you to effectively communicate to others why you are doing this work and how it will be valuable to your organization, your patients, and your community.

As a team, discuss and write down your answers to the questions below. Think broadly! Your ultimate vision may not be accomplished in the near term, and that's okay! Throughout this workshop we will support you in identifying the steps you need to take towards meeting your vision.

What are the motivations for addressing patients' social needs at your organization and in your community?	
What data/evidence is informing your call to action?	
What changes would you like to see as a result of your efforts to address patients' social needs?	
How will this work be different from or improve upon what you are doing now to address patients' social needs?	
What will success look like for your organization? For your patients? For your community? (Note: consider how you will measure success and use measurable terms where possible)	
As you begin this work, what are you most excited about? Most concerned about?	

SECTION TWO:
DEFINING YOUR AIM AND GOALS

STAKEHOLDER PRIORITIES

Consider the stakeholders from whom you will need support or input for your program to succeed. You may need to adjust the goals listed above after thinking this through. Get specific about which design decisions different stakeholders should be involved in and how.

Stakeholder	**Name(s) and Role(s) (if applicable)**	**What type of support is needed? Collaboration? Feedback? Decision-making/Approval?**	**How do you plan to engage this individual or group? (how often, when, etc.)**
Executive Sponsor(s)			
Clinical Champion(s)			
Patients			
Staff who address patients' social needs (Social workers, community health workers, patient navigators, etc.)			
Clinic staff who can support your work (MA, nurse, etc.)			
Community stakeholders (social service providers, local public health department, etc.)			
Others			

What are your lingering questions or next steps on engaging stakeholders

Are these draft decisions? What additional input do you need? From Whom? What questions do you still have?

Table of Contents

DEFINING YOUR TARGET POPULATION

Use this section to clarify the community of patients that will be the focus of your initial improvement work to address social needs. This section will guide your choice of which social needs to address and how to address them, as well as what resources you will need to support these goals. The community of patients described below may not include all the patients you hope to target long term- but it is where you plan to start.

What patient population(s) do you want to target with this initiative? What are their defining characteristics?	*E.g. age, gender, diagnoses, race, ethnicity, location (zip code or neighborhood), utilization of services, have or currently experienced a type of trauma, etc.*
In which clinic or other location does this population receive care?	*Clinic(s) where program will start, or another locale of patient population.*
What is the size of the initial patient population?	*Given what you outlined above, how many unique patients are seen annually? If you can't identify this number today, what steps do you need to take to do so?*
How many of these patients do you intend to serve in one year? What volume goals are required by your grant (if at all)?	*These should be identified upfront and may affect the initial design of your program.*
What is your rationale for initially focusing your work on this population?	*What gap or barriers to care does this group face? Why focus on them first?*

What are your lingering questions or next steps on defining your initial population?

Are these draft decisions? What additional input do you need? From Whom? What questions do you still have?

BUILDING PROGRAM AIMS AND GOALS

Clear aims and goals will focus your work and guide your design and implementation decisions. A clear aim statement will be measurable and specify how much improvement by when.

Example aim statements from Health Leads' partners can be found in the Aim Statement Guide.

At this stage, it may not be possible to assign hard numbers and dates to your aim statement. Make your best estimation for now but do be clear about WHAT you want to accomplish (aka your main outcome) and for WHOM (what population of patients). Use your Vision and Purpose work to inform your aim statement.

Create an aim statement: What are you trying to accomplish?	*Review your pre-work. Your team's motivations and definitions of success should inform your aim statement. Remember, a good aim statement will specify what, for whom, how much, and by when.* *While defining your Aims for expanding or building on your social needs strategy, feel free to consult IHI's Tips for Setting Aims document:* *http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTipsforSettingAims.aspx*
Choose measures (process and outcome): How will you know that you are accomplishing what you intend to?	*What measures will help you determine if you are reaching your aim? Are you able to track this measure currently? If not, how will you obtain the data?*
List your goal statements: What will you need to achieve in order to reach your aim?	*These goals should also be measurable and describe what will improve and by how much in a specific amount of time. We suggest thinking about what you want to accomplish in the next year to take smaller steps towards meeting your overall program aim.*
How will your work to address social needs support other programs/initiatives at your organization?	*E.g. Complex Care Management, Patient Centered Medical Home, Behavioral Health Integration*

SECTION THREE:
SCOPING YOUR INTERVENTION

DEFINING SCOPE OF SERVICE:
SOCIAL NEEDS CATEGORIES AND RESOURCE CONNECTIONS

The social need domains that you selected are a fundamental building blocks for your intervention. When choosing, consider:

- What is the value of each category or resource for both patients and staff (financial value, practical value, emotional value, and organizational value)?
- Are resources available in your community to address these needs, and what common barriers exist?
- Does the workforce you choose have the time and skills for the social need domains you will be able to address? If not, will training be made available?
- For which social needs categories do staff at your organization already facilitate patients access?
- Based on your data and community engagement efforts, what are the most common, highest priority needs for the target population?

Use the supplementary Scope of Service Decisions and Targets tool provided in Excel to identify the social needs categories that you will aim to connect patients to in the next year.

Instructions - Scope of Service Decisions and Targets Tool

- Use the **drop down choices in column A** to identify the social need categories that will be part of your program initially. Please note that this will likely change over time!
- Use the **drop down choices in column E** to identify the level of support you will be providing to patients in each sub-category. These can be different for each sub-category and should reflect what your organization has the capacity to provide. This can also change over time.

What are your lingering questions or next steps on the scope of your referral and navigation services- either on the social need domains you've chosen, the resource types you've focused on, or the specifics of the support that you will provide?

Are these draft decisions? What additional input do you need? From Whom? What questions do you still have?

SECTION FOUR:
DEVELOPING A SCREENING WORKFLOW

SCREENING FOR SOCIAL NEEDS

A sustainable screening process will ultimately be essential to connecting patients with the resources they need and want to be healthy. Your starting point for screening will depend on your program's capacity. The questions below will help define a starting point, and going forward, you will build on this and need to develop detailed workflows.

When it comes time to choose a specific screening tool, consider consulting Health Leads' Screening Toolkit.

How are you currently collecting information from patients on their social needs?	*Comprehensive health assessment, documenting needs as they come up in conversations with patients, etc.*
If you aren't currently screening patients, what tool, or questions will you use? If you are screening patients for social needs, do you want to add or modify any questions? If so, how?	*Do you need a tool that has clinically validated questions? Will you screen for needs which you cannot provide services?*
Where will screening fit in the workflow of your operations? Who will be affected?	*Developing a process map may be a helpful activity.*
Given the initial screening population you have defined, how many patients per year are likely to require services?	*How many patients would you expect to screen positive for a resource need? How many would want to engage with you on these needs?*
What is the process for taking action when a patient screens positive? Outline a set of potential steps with the staff/roles involved.	*It is unlikely that this will be a single process depending on what needs are identified. Conducting an intake can help ensure that patients get connected to the staff and resources that can best support them.*
Are you intending to screen for emergent needs? If so, will your team address these needs with patients? What other teams/staff might you need to involve with these cases?	*Emergent needs include: mental health crisis, interpersonal violence, substance use, emergency shelter, etc.*

What are your lingering questions or next steps with screening patients for social needs?

Are these draft decisions? What additional input do you need? From Whom? What questions do you still have?

SECTION FIVE:
BUILDING YOUR WORKFORCE & CARE TEAM

SOCIAL NEEDS TEAM

In this section, start to identify key roles while considering capacity and sustainability for staff. Use the table below to start designing your staffing plan. For "initial capacity" please indicate how much time (e.g. FTE, hours, etc.) your staff or volunteers will have at the start of your program to devote to these activities.

Function	Staff/Roles and Initial Capacity	New or Existing Workforce	Additional Training and Supervision Required
Screening			
Intake for positive screens			
Navigation to resources			
Managing the community resource inventory			
Building/maintaining partnerships with community providers			
Measurement and data collection			
Gathering patient feedback			
Project management			

What are your lingering questions or next steps with your staff planning?

Are these draft decisions? What additional input do you need? From Whom? What questions do you still have?

SECTION SIX:
MEASURING SUCCESS:
DATA COLLECTION & ANALYTICS

MAINTAIN A COMMUNITY RESOURCE INVENTORY

Earlier, you considered which social needs you would address and for which patients. Now it's time to think through how you will find and maintain the right set of resources. The following questions below will guide your resource directory development.

Where does resource information already exist?	*E.g. an excel sheet, a binder, your social work team, 211, etc.*
Where will information on community resources be stored and maintained going forward?	*E.g. a binder, spreadsheet, database*
Who will find new resource information to start? What internal teams have resource information that you could tap?	*A specific person or team that can find resources and supporting information at program launch. (e.g., John Smith for 20 hrs./week for 4 weeks) Will there be specific resources you start with based on geography, highest needs, etc.?*
Who will the community resource inventory be made available to?	*Clinic staff, clinicians, community partners, etc.*
What do you know about the community based organizations you currently work with? What do you wish you knew?	*Consider the quality of services, responsiveness, what patients can expect, etc.*
How will you maintain accurate contact information for the resources in your community?	*Who is responsible for this work?*
What organizations are highest priority for establishing or deepening your relationship with to best meet the needs of your community?	*What do they have and what gaps exist? Who is responsible for building the relationship?*

What are your lingering questions or next steps with maintaining a community resource inventory?

Are these draft decisions? What additional input do you need? From Whom? What questions do you still have?

MEASURES AND DATA COLLECTION

A solid measurement strategy should reflect what you are seeking to accomplish and the key processes involved. It will provide data that you can use to understand your progress, identify opportunities for improvement, and allow you to share your successes and challenges with leadership, funders, and other stakeholders. Since measuring and evaluating your program is a specific set of activities that you need to budget for and allocate staff capacity to complete, we recommend planning your approach from the beginning.

Use the table below to start building your measurement strategy. We recommend reviewing your stakeholder map, aims, goals, and measures. You may also want to review any processes you have defined and think about where opportunities for data collection exist.

Measure Type	**How will the data be collected? (when, where, by whom)**	**Does a baseline exist?**	**How often will the data be reviewed?**
List the **Outcome** measures you plan to track (see response from week 1):			
List the **Process** measures you plan to track (see response from week 1):			

Your program data can also be a tool to help you identify disparities in services or resource connections across patient populations (e.g. race/ethnicity, geography, gender, age, etc.). Reviewing data across different patient populations can help you identify opportunities to improve your program and more effectively engage certain patients.

What type of disparities in care, service delivery, or health outcomes require the greatest attention?	
How will you identify these disparities in your data?	

SECTION SEVEN:
REVIEW, REVISE & IMPLEMENT

REVIEW ACTION PLAN

Look back at your Action Plan and make sure all the pieces fit together. Some key questions to consider during your review:

- Does the Workforce skillset match with the scope of services you chose?
- Does the volume goal for year one aligns with the overall aim?
- Does your patient population match with your scope of service?
- Do your SMART Aims and Goals reflect what you are trying to accomplish? Will these support you to show the value of your program?
- Will your defined metrics help track to your goals?

NEXT STEPS

Each week you have been formulating key steps in your Action Plan. Review these next steps as a team and prioritize what your team will work on over the next six months.

What steps does your team need to take in the next 6 months?	
What does your team need to complete in the next year?	

APPENDIX:

SUPPLEMENTARY MATERIALS

AIM STATEMENT GUIDE

AIM STATEMENT GUIDE

A good aim statement will help your team to articulate your commitment to achieve measurable improvement within a specific timeline, gain clarity and set expectations, and create a shared language to communicate about your work. As you develop your program aim, discuss the following questions with your team:

1. **What are we trying to accomplish? What are the benefits/outcomes?**
2. **Who benefits? What population will we serve?**
3. **When do we hope to reach our program goals?**
4. **How will we measure our goals? What are our targets for improvement?**
5. **What are we trying to accomplish? What are the benefits/outcomes?**
6. **Who benefits? What population will we serve?**
7. **When do we hope to reach our program goals?**
8. **How will we measure our goals? What are our targets for improvement?**

Example Aims:

1. **Aims:**
   a. By 2018, reduce emergency department visits among all patients served by the internal medicine clinic by 20%
   b. By 2018, reduce hospital admissions among all patients served by the internal medicine clinic by 30%.

   Goals:
   a. Engaging a well-trained base of student-volunteers serving as BSWH Community Advocates in various clinical and community settings, to assess social needs of 80% of internal medicine patients and navigating them to targeted community resources

2. **Aims:**
   a. By 2019 non-emergency department use is reduced by 50% for pregnant women in the pilot.
   b. By 2019 SF Detention Center recidivism is reduced by 25% for pregnant women in the pilot.
   c. By 2019 75% of pregnant women access prenatal care in the first trimester of pregnancy.

   Goals:
   a. By July 2019, 95% of pregnant women at LFMC will be screened for social needs
   b. By July 2019, 75% who screen positive will be connected to resources that address their priorities e.g.: safe housing, access to food, utilities, transportation and access to health insurance and medical care

3. **Aim:** Identify high-risk individuals and implement social needs screening to ultimately reduce suicide attempts by 50% for all ages (particularly ages 35+) within a 24-month period.

4. **Aim:** We will decrease preterm birth (gestation age <37 weeks) in one neighborhood by 10% by June 30, 2018.

Tips for Setting Aims

Source: The Institute for Healthcare Improvement
(http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTipsforSettingAims.aspx)

1. **State the aim clearly.** Achieving agreement on the aim of a project is critical for maintaining progress. Teams make better progress when they are very specific about their aims. Make sure that the aim statement describes the system to be improved, and the patient population. In addition, ensure that the aim gives guidance on the approaches to improvement.

2. **Include numerical goals that require fundamental change to the system.** Teams are more successful when they have unambiguous, focused aims. Setting numerical goals clarifies the aim, helps to create tension for change, directs measurement, and focuses initial changes. For example, the aim "Reduce operating room time" is not as effective as "Reduce operating room time by 50% within 12 months." Including numerical goals not only clarifies the aim but also helps team members begin to think about what their measures of improvement will be, what initial changes they might make, and what level of support they will need.

3. **Set stretch goals.** A "stretch" goal is one to reach for within a certain time. Setting stretch goals such as "Reduce operating room time by 50% within 12 months" communicates immediately and clearly that maintaining the status quo is not an option. Effective leaders make it clear that the goal cannot be met by tweaking the existing system. Once this is clear, people begin to look for ways to overcome barriers and achieve the stretch goals.

4. **Avoid aim drift.** Once the aim has been set, the team needs to be careful not to back away from it deliberately or "drift" away from it unconsciously. The initial stretch goal "Reduce operating room time by 50% within 12 months" can slip almost imperceptibly to "Reduce operating room time by 40%" or "by 20%." To avoid drifting away from the aim, repeat the aim continually. Start each team meeting with an explicit statement of aim, for example, "Remember, we're here to reduce operating room time by 50% within 12 months," and then review progress quantitatively over time.

5. **Be prepared to refocus the aim.** Every team needs to recognize when to refocus its aim. If the team's overall aim is at a system level (for example, "Reduce adverse drug events in critical care by 30% within 12 months"), team members may find that focusing for a time on a smaller part of the system (for example, "Reduce adverse drug events for critical care patients on the cardiac service by 30% within 12 months") will help them achieve the desired system-level goal. Note: Don't confuse aim drift or backing away from a stretch goal (which usually isn't a good tactic), with consciously deciding to work on a smaller part of the system (which often is a good tactic).

SAMPLE RESOURCE TEMPLATE

Below is sample resource template. You would collect this information for each resource.

Resource Information	
Agency or Organization Name:	
Street Address:	
City / Town:	
Zip Code:	
Phone:	
Website:	

Eligibility	
Who the service is for (Eligibility Requirements)?	
Cost / Insurance Information:	
Languages Offered / Details?	

Referrals	
What Will You Be Referring For?	
Process for Accessing this Service?	
Is a Referral Required?	
Who can Submit a Referral?	
Anything else that might be useful when making a Referral?	
Documents Needed (please include URL if possible.)	