Health Leads

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 correspond with the content covered in the weekly virtual sessions of the *Workshop 201: Designing an Effective Social Needs Intervention.* However, your team will likely need to iterate on this plan over time. We strongly suggest working as a team to fill out each section. You will likely need to have conversations with individuals outside of your team and collect additional data to make certain planning decisions. You will have an opportunity to submit your Action Plan for feedback from one of our Health Leads experts at the mid-point and at the end of the workshop.

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.

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VISION AND PURPOSE – PRE-WORK

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?	Better help people's health and well being Help community people who don't know or are afraid to ask for help due to legal status Help people who do not ask for help due to the severity of depression
What data/evidence is informing your call to action?	Time studies, chart reviews, ER history
What changes would you like to see as a result of your efforts to address patients' social needs?	Patients not being afraid to ask for help Better health outcomes
How will this work be different from or improve upon what you are doing now to address patients' social needs?	This will be more organized and process oriented.
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*)	Better resource guide and work flow chart Patients being more comfortable asking for help Ability to ensure successful referrals
As you begin this work, what are you most excited about? Most concerned about?	Excited about helping others manage their own health Concerned about workflow

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STAKEHOLDER PRIORITIES – WEEK 1

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)	Suzanne		
Clinical Champion(s)	Pat		
Patients		Feedback, awareness of needs	Focus groups, surveys,
Staff who address patients' social needs (*Social workers, community health workers, patient navigators, etc.)*	Veronica R		On planning team
Clinic staff who can support your work (*MA, nurse, etc.*)	Kathy, Jenna, Wendy, Patty		On planning team
Community stakeholders (*social service providers, local public health department, etc.*)	Garden Quarter, Head start, United Way, Sample County Community Foundation	Input on content, feedback on tools, and financial support when appropriate	Focus groups, key informant interviews and discussions
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?

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DEFINING YOUR TARGET POPULATION –WEEK 1

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?	*All patients , with a focus on Hispanics (?) who may not know what services are available. Pilot program will roll out on a few days/week, depending on availability of volunteers. Changes will be made after evaluating flow and process.*
In which clinic or other location does this population receive care?	*CL as well as outreach sites and mobile health sites as well as Sample Hospital with Celebremos.*
What is the size of the initial patient population?	*2000 unique patients*
How many of these patients do you intend to serve in one year? What volume goals are required by your grant (if at all)?	*500 in the first year - still under discussion*
What is your rationale for initially focusing your work on this population?	*Hispanics face a variety of barriers to receiving high quality health care. Some are a result of their low socioeconomic status, others are due to the specific features of the population. This may help manage personal responsibility for their health and make them better advocates for their neighbors and families.*

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

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BUILDING PROGRAM AIMS AND GOALS – WEEK 1

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?	*Decrease wait time for patients (eliminate NPs from doing the SDOH assessment)* *Screen all patients for SDOH* *Reduce ER visits among the clients*
Choose measures (process and outcome): How will you know that you are accomplishing what you intend to?	*Time Studies, EMR reviews, ER historical data*
List your goal statements: What will you need to achieve in order to reach your aim?	*Within six months, 25% of patients will be screened.* *Within six months, 50% of screened patients will have been successfully navigated to additional services.* *Within three months, a formalized volunteer training program will have been developed and piloted.* *Within three months, a documentation process will have been developed and implemented.* *Within 2 months, all staff will be in serviced on the program, goals and change process.*
How will your work to address social needs support other programs/initiatives at your organization?	*This program will blend into the Patient Navigator role, and will include the VISTA volunteer who will be onboard in the summer. Additionally, it may be a way to utilize volunteers in a more robust way.*

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DEFINING SCOPE OF SERVICE: SOCIAL NEEDS CATEGORIES AND RESOURCE CONNECTIONS – WEEK 2

The social need domains that you choose to focus on are a fundamental building block 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 *Scope of Service Decisions and Targets* tool to identify the social needs categories that you will aim to connect patients to in the next year.

<u>Instructions:</u>

1) Review the need categories, sub-needs within each category, and descriptions listed in the tool as a team. Indicate which social needs you will include in your initial scope of service by choosing either “Yes” or “No” in column A for each social need listed.
2) For each need category included in your scope of service, please indicate:
    a. The type of support patients will receive from your staff to access these resources
3) On tab 2 of the spreadsheet, input contact information to known resources available in your community. This will help you build your resource directory if you do not currently have one available.

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?

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SCREENING FOR SOCIAL NEEDS– WEEK 3

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?	*We have signs in the clinic rooms offering additional help, often times nurses or interpreters will query the patient, but not a systematic screening.*
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?	*We will not screen for services we cannot provide. We currently have an intern working on a resource directory that is much more specific and user friendly than existing ones.*
Where will screening fit in the workflow of your operations? Who will be affected?	*We would like to develop a process map. (attached)*
Given the initial screening population you have defined, how many patients per year are likely to require services?	*We believe that up to half of those screened would need services, as we serve a very needy population to begin with.*
What is the process for taking action when a patient screens positive? Outline a set of potential steps with the staff/roles involved.	*We are looking at a triage approach, where easier needs can be handled by a volunteer, with increasing complexity moving up to staff positions. See attached flow sheet.*
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?	*Some – we already screen for domestic violence and mental health. We may not screen for emergency housing because we have little in our county.*

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

we are still in the process of gathering more information on all services available in the county.

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SOCIAL NEEDS TEAM– WEEK 4

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		Volunteers	Yes
Intake for positive screens	VISTA (2 years)	Volunteers (including VISTA), depending on severity	Yes
Navigation to resources	Patient Navigator, depending on severity	Volunteers (including VISTA), depending on severity	Yes
Managing the community resource inventory	VISTA (2 years)	Volunteers	Yes
Building/maintaining partnerships with community providers	Executive Director, Clinical Manager, Patient Navigator, Wellness Coordinator	VISTA, Patient Navigator	No
Measurement and data collection	Executive Director, Clinical Manager, Patient Navigator, Wellness Coordinator	Volunteers	Yes – looking at measurement tools currently
Gathering patient feedback	Patient Navigator, Wellness Coordinator, Mobile Health Team, Front Office		NO
Project management	Executive Director,		No

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

Draft decisions

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MAINTAIN A COMMUNITY RESOURCE INVENTORY– WEEK 5

In the first two weeks, 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?	*Currently utilize a binder (Patient Navigator, and one on RN side) as well as People In need Resource Guide. Working with public health intern on updating, and putting patient friendly information in there that can be shared.*
Where will information on community resources be stored and maintained going forward?	*A database stored on the Access Drive, but also some type of decision tree that can help guide people to the best resources. VISTA can be the prime 'updater' of information, although trained community volunteers can also do this on a regular basis.*
Who will find new resource information to start? What internal teams have resource information that you could tap?	*Currently in progress with public health intern.*
Who will the community resource inventory be made available to?	*All clinic staff and volunteers. Currently talking with United Way to look at how this could be shared.*
What do you know about the community based organizations you currently work with? What do you wish you knew?	*It would be good to have an actual point person for contact. For organizations that have them, an intake coordinator may be perfect. Working with the Mental Health Board to buy into this program and encourage/fund part of a position at several currently funded agencies.*
How will you maintain accurate contact information for the resources in your community?	*VISTA will be primarily responsible for this work, whether on own or be delegating. Info will be updated by phone calls, information from Intake Coordinator's meetings, Network Council, United Way meetings, etc.*
What organizations are highest priority for establishing or deepening your relationship with to best meet the needs of your community?	*Sample (substance abuse), Housing Authority, various Example, townships*

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

Want to be sure to delineate what services can be accessed without citizenship. Also need to know where bilingual services are available.

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

MEASURES AND DATA COLLECTION - WEEK 5

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 from Week 1. 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): Per your aim and goals: Immediate, intermediate and longer-term health impacts: Mental health status Healthcare utilization/cost impacts: *ER visits reduced*	VISTA will collect data on daily screenings. Will consult with Patient Navigator about referrals. Volunteers will follow up with patients to determine success of referrals. Information will be tracked in EMR. And shared with ED and Board	No	Weekly initially, then monthly
List the **Process** measures you plan to track (see response from week 1): Measure: Patients screened/served: Metrics: • # screening tools handed out • % completed • % screen positive • % positive who resource	VISTA will collect data on daily screenings. Will consult with Patient Navigator about referrals. Volunteers will follow up with patients to determine success of referrals. Information will be tracked in EMR. And shared with ED and Board	No	Weekly initially, then monthly

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community resource referrals Measure: Patient use of referral Metrics: • (down the road?) - % patients successfully connected to community resource. • % of patients who report resolving a social need.			

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?	*We think transportation will be a big issue, as well as access to services if a patient is undocumented. Financial issues will always rise to the top, but we hope to help increase availability of dollars by helping patients qualify for programs they are eligible for.*
How will you identify these disparities in your data?	*We will track positive screenings and compare month over month. We will also track unsuccessful referrals by category to help identify gaps.*

REVIEW OF AIMS AND GOALS – WEEK 5

Look back at your Program Aims and goals from Week 1. Considering what you have learned during this workshop and the decisions you recorded in this Action Plan, do you need to revise these? If so, please write your revised aim statement and goal statements below (if necessary).

Program Aim Statement:	

Goal statement(s):	

REVIEW ACTION PLAN – WEEK 5

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 align with the overall aim?
- Does your patient population match with your scope of service?
- Will your defined metrics help track to your goals?

NEXT STEPS – WEEK 5

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?	*Recruit VISTA, engage potential funding sources (United Way, Mental Health Board, Sample County Community Foundation) pilot screening tool, recruit initial volunteers, develop volunteer training program, finalize documentation procedures, train staff on program, THINK OF A NAME!*
What does your team need to complete in the next year?	*Must review initial progress, make changes where needed, ensure resources are kept up to date, look at expansion with other community agencies*

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