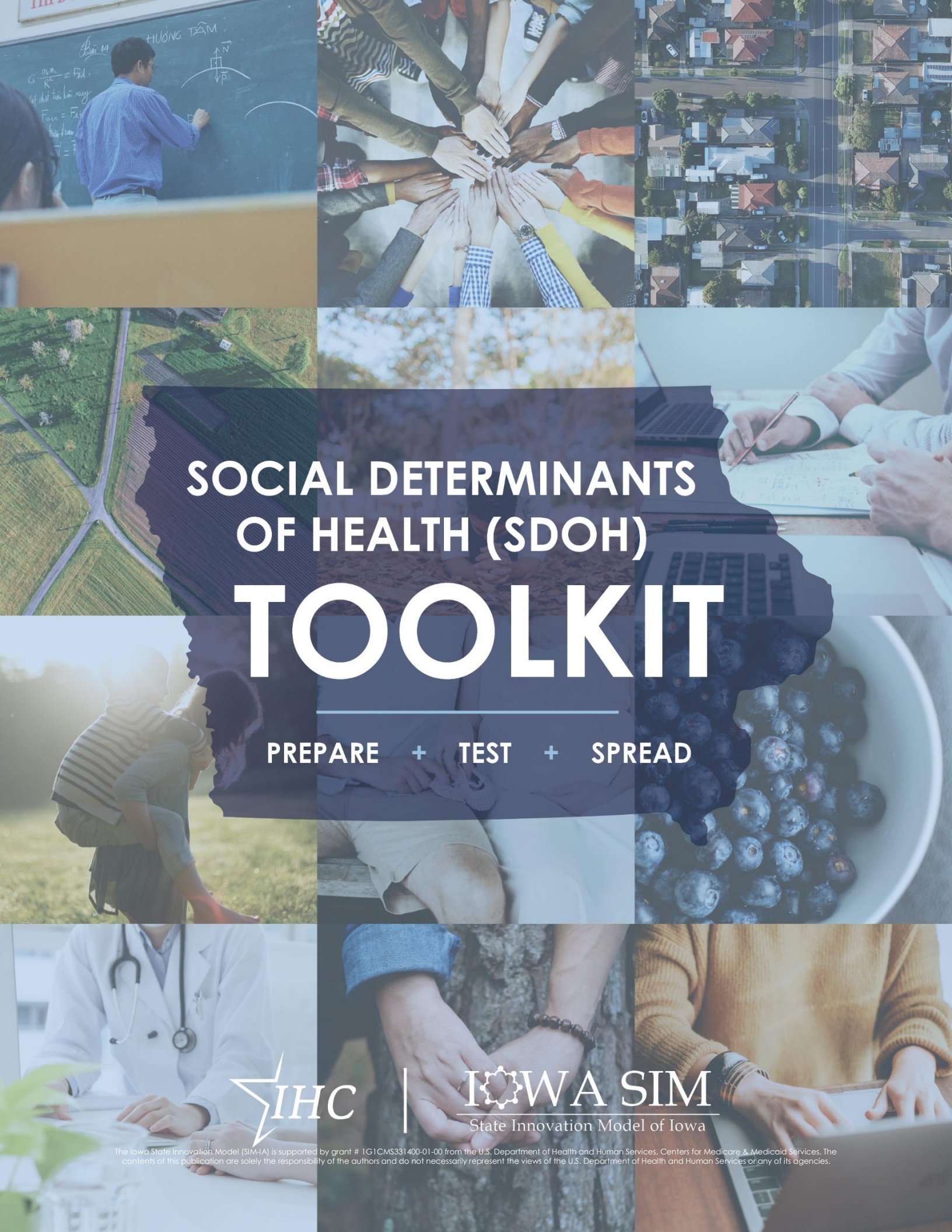

SOCIAL DETERMINANTS OF HEALTH (SDOH) TOOLKIT

PREPARE + TEST + SPREAD

IHC | IOWA SIM
State Innovation Model of Iowa

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INTRODUCTION

BACKGROUND

As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important to have tools and strategies that identify the upstream socioeconomic drivers of poor outcomes and higher costs. With data on the social determinants of health (SDOH), health centers and other providers can define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients and advocate for change in their communities while demonstrating the value brought to patients, communities and payers.

Implementing a SDOH screening tool within a clinical setting results in better patient and family engagement. Talking through the SDOH screening tool with a patient and/or family allows those who are asked the SDOH questions to identify unmet needs and barriers they anticipate or are currently experiencing. Further, this also allows them to be empowered and engaged with their care team when prioritizing what may be most important to them. Rather than developing solutions based on what is believed to be impacting patients, SDOH data allows providers and communities to better identify barriers while working together to resolve them.

One of the pilot sites was able to work directly with their area transit authority to make improvements to transportation access to their clinic based on the PRAPARE data. The devised solution is also resulting in the clinic's funding for transportation going further as a more cost-effective approach was identified.

A DEMONSTRATION IN IOWA

Through support from Iowa's State Innovation Model (SIM), funding from the Iowa Healthcare Collaborative (IHC), the Iowa Primary Care Association (Iowa PCA) supported implementation of one such screening tool – the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) – at health centers in Iowa that are also included as members of IowaHealth+ (a health center led ACO). These health centers, with two centers dependent upon the electronic health record (EHR) content being developed and loaded by the EHR vendor during this contract period, will join two health centers in Iowa who served as national pilots, Peoples Community Health Clinic in Waterloo and Clarksville, Siouxland Community Health Center in Sioux City and South Sioux City, Nebraska. The 11 health centers that make up IowaHealth+ serve patients from 36 counties in Iowa. Every year, 150,000 patients are served in service areas encompassing six of the seven Community and Clinical Care management initiatives (C3s). While screening 150,000 Iowans with a SDOH tool is not probable at this stage, these health centers will survey enough patients to allow for meaningful and statistically valid analysis. This will be the first opportunity for Iowa to conduct rigorous analysis on social determinants of health on a nearly statewide basis.

In order to visualize these data at both the Health Center and Network level, an analytics solution was developed utilizing Microsoft SQL Server and Tableau software. Data from each of the EHRs are extracted nightly, transformed from their proprietary data structures to create an analytical dataset comprised of the individual assessments performed. Data are then supplemented with patient demographic information and other data elements related to the PRAPARE content areas (e.g., monthly income, etc.) and loaded into a multi-tenant database that provides the ability to visualize the data at the network level while still keeping data from the individual centers logically separated. The data form the basis of a

series of interactive graphic visualizations that summarize the data in a variety of different ways and allow users to explore the relationships among the data elements.

Collected data from SDOH screenings are valuable at three levels:

- At the point of care to inform care planning, patient referral and empathetic patient engagement.
- At the community response level to assess capacity to meet patient needs.
- For statewide policy and payment reform.

Through this demonstration in Iowa, IHC acquired this implementation toolkit for SDOH screening that can be shared with interested providers, health systems, communities and Accountable Care Organizations across the state.

ORGANIZATION OF TOOLKIT

The toolkit is organized around the three stages of SDOH: Prepare, Test and Spread. The key concepts are organized under each of the stages (Espersen, 2013). This toolkit provides existing and new tools for each of the 21 concepts with guidance related to when an organization may want to use each tool or concept. Links to previously developed tools are included in the concept areas but are also included in the toolkit as websites and electronic resources because URLs tend to move or "break" over time.

PREPARE

- Understand the community
- Align with strategic plan
- Assess your organization
- Pick a tool
- Practice asking questions
- Find your clinical champion
- Create your resource matrix
- Brainstorm workflows
- Script for all audiences
- Ensure support for staff

TEST

- Test your reporting
- Trial workflows
- Track progress
- Get feedback from patients
- Monitor referral completion

SPREAD

- CQI
- Share your story
- Develop new partnerships
- Advocate for population level resources and policy changes

STAGE 1: PREPARE

When setting up an SDOH initiative for success, the Prepare Stage is important because it helps organizations understand the issues that face the community they serve, ensure the initiative fits well within their organizational culture and tailor solutions to meet staff and patients "where they are at" in order to ensure person-centered care.

CONCEPT: UNDERSTAND THE COMMUNITY

Knowing your community is essential to identifying priority social determinants of health and being able to address them without further exacerbating inequities. Data that highlight potential disparities, community perception of issues and values held by community members and mapping resources and gaps in resources are all part of this knowledge.

TOOL	WHEN TO USE THIS TOOL
Windshield Tours	Windshield tours are observations made from a vehicle, similar to walking surveys that are conducted when walking. When you need an objective view of a community or neighborhood and to observe assets and potential barriers that community members take for granted or do not know about.
Asset Mapping	A toolkit on assessment mapping for when an in-depth, strengths-based approach is needed for improved quality and alignment of resources and/or policies in a community. This is appropriate for a larger scale project or investment, when significant changes or program development is needed.
PhotoVoice	PowerPoint presentation by Hunger Free Colorado providing a Case Study and Toolkit for PhotoVoice. PhotoVoice is an evidence-based, storytelling process that combines photography (and sometimes videography) and social action.
Social Determinants of Health Issue Brief #6	A clinical leader knowledgeable on the impact and importance of addressing SDOH needs within a primary care setting can be a valuable resource to clinical support staff who are doing the brunt of the social determinant of health work. This tool provides a comprehensive guide reviewing a core set of SDOH questions that practitioners can raise and respond to during primary care visits.
Understand Health Disparities in Your Geographical Area	Interactive maps can be used to demonstrate the extent of SDOH issues in a specified geographic area. However, these should be used with caution and care should be used in examining potential gaps due to limitations in each data source used. + **https://www.neighborhoodatlas.medicine.wisc.edu/mapping** + **https://www.opportunityatlas.org/** + **http://www.countyhealthrankings.org/**
Increasing Participation and Membership	This toolkit provides guidance for increasing participation and engaging stakeholders in SDOH initiatives.

CONCEPT: ALIGN WITH STRATEGIC PLAN

Social determinant of health initiatives many times can be misperceived as "one more thing to do" or the "new flavor of the month." Aligning with current efforts and ensuring stakeholder understanding that this will directly impact goals is key to success and to stakeholder buy in.

TOOL	WHEN TO USE THIS TOOL
Why Collect Standardized Social Determinants of Health Data? **PowerPoint**	This infographic explains the value of collecting SDOH data. It is accompanied by a presentation that gives more detail on SDOH data in context of Value-Based Payment, as well as including some common ICD-10 codes that can be used to capture SDOH data.
Measuring Social Determinants of Health Among Medicaid Beneficiaries: Early State Lessons	This issue brief describes the efforts of early adopters in SDOH collection by Medicaid agencies.
Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value-Based Purchasing	This issue brief from AcademyHealth provides advice for Medicaid and Managed Care Organizations by evaluating lessons from previous SDOH interventions.
Health Leads Articulating Your Vision (Page 6)	This Health Leads resource guides teams through key questions needed to understand the vision of identifying and addressing SDOH.
Developing Strategic and Action Plans	For organizations that do not currently have strategic plans, this resource can help develop a mission and vision and creates strategies and activities to move toward health equity.
Blueprint for Complex Care: A Strategic Plan for Advancing the Field	This report looks at the current state of care for vulnerable individuals and provides a strategic vision to support multidisciplinary innovations and advancement in the improved care for individuals with complex health and social needs.

CONCEPT: FIND YOUR CLINICAL CHAMPION

TOOL	WHEN TO USE THIS TOOL
Incorporating Additional Social Determinants of Health Screening into Primary Care Check-Ups: A Practical Guide	A clinical leader with legitimacy and credibility can help allay fears and misgivings of other clinical staff, as well as provide a resource to clinical support staff who may be doing the brunt of the social determinant health work. This guide talks about identifying and developing clinical champions, informed providers, as well as modules that are useful in teaching potential champions about social determinants of health.
Healthcare Experience Foundation Growing Physician Champions	This tool explains qualities and attributes of clinician champions and development models. It includes a potential physician champion evaluation tool and role description.
Training Primary Care Residents on Social Determinants of Health	This comprehensive curriculum for residents includes the following modules: + Defines learning objectives for training residents on the importance and impact of SDOH. + Provides teaching content on SDOH learning objectives. + Recommends learning experiences for residents that support fulfillment of the learning objectives. + Defines evaluation measures for assessing resident fulfillment of the learning objectives.

	+ Includes an appendix of items that can serve as teaching tools. + References additional resources for each of the curriculum's topic areas.
COMPASS Lessons Learned: Physician Champions	This brief by COMPASS describes the traits, actions and skills of physician champions and highlights how to identify and support physician champions.

+ CONCEPT: ASSESS YOUR ORGANIZATION

An internal assessment guides what areas you need to focus more on and helps an organization to make decisions that will allow their initiative to have the greatest positive impact on their population. This section contains a variety of readiness assessments related to social determinant of health initiatives.

TOOL	WHEN TO USE THIS TOOL
PRAPARE Readiness Assessment (NACHC)	The PRAPARE Readiness Assessment Tool can be used to help identify your organization's readiness to implement PRAPARE. The assessment can inform where your organization is at and help you decide where you want your organization to be as well as provide guidance on how to become 'highly prepared.'
Moving Upstream to Achieve the Quadruple Aim (Slide 35)	The "Upstream Readiness Assessment" is a tool that can be used to help identify your organization's readiness to implement a SDOH initiative.
	After conducting an Organizational Readiness Assessment, this guide is the next step for questions around business case, decision points, project management and training that allows leadership to begin thinking about parameters for the organization's implementation team. These parameters are then integrated into the SDOH Training Workshops.
SDOH Implementation Guide	This planning checklist is a tool to use in determining your organizational readiness and capabilities to implement an SDOH project.
Victorian Healthcare Association Population Health Planning Framework	The PRAPARE Readiness Assessment Tool can be used to help identify your organization's readiness to implement PRAPARE. The assessment can inform where your organization is at and help you decide where you want your organization to be as well as provide guidance on how to become 'highly prepared.'

+ CONCEPT: PICK A SCREENING TOOL

A number of screening tools already exist and have different benefits depending on your population. Pick one that best meets your current workflow design and community needs.

TOOL	WHEN TO USE THIS TOOL
Accountable Health Communities Screening Tool	This screening tool was designed for Accountable Healthcare Communities participants, but any organization can use the assessment to guide treatment plans and make referrals.
Health Leads Screening Toolkit	This screening tool includes English and Spanish basic screening tools, additional measures and validation status and grade level of questions.

PRAPARE	The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' SDOH.
WE CARE	WE CARE (Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education) is a clinic-based screening and referral system developed for pediatric settings. The 12-question WE CARE screening tool assesses needs in six domains.
A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability, Appendix C	The "A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability" funded by CMS provides a list of SDOH Surveys and Tools compiled by the National Quality Forum. The list is located in Appendix C.

CONCEPT: PRACTICE ASKING QUESTIONS

This is a very important step to a SDOH initiative – being able to communicate effectively with patients is key to accurate identification and resolution of SDOH. These tools help with asking difficult questions and an overall philosophy on how to ask about social needs.

TOOL	WHEN TO USE THIS TOOL
A Strengths-Based Approach to Screening Families for Health-Related Social Needs	This tool provides insight and tips for screening families on social needs in a manner that acknowledges and builds upon their strengths.
Waianae Coast Comprehensive Health Center video: PRAPARE to be Interrogated	This video demonstrates inquiry about SDOH using a "checklist" question method versus conversation method.
Oregon Primary Care Association Video: Empathic Inquiry: A Patient-Centered Approach to Social Determinants of Health Interviewing	This video demonstrates inquiry about SDOH utilizing principles of motivational interviewing, Trauma-Informed Care and affirmation of patient strengths.
Patient-Centered Social Determinants of Health Screening Conversation Guide	This conversation guide explains the fundamentals of engaging, empathizing, supporting and action planning and how to implement these concepts to facilitate effective screening.
OPCA Patient-Centered Social Determinants of Health Screening Observer Checklist	This is an observer checklist that helps assess the fundamentals of engaging, empathizing, supporting and action planning that will facilitate effective screening.
Challenging Conversations	This tool provides access to quick tips that relate to a variety of emotional conversations that can occur with patients and families.

Futures without Violence IPV Provider Training	This tool includes resources and tips on responding to intimate partner violence.

CONCEPT: CREATE YOUR RESOURCE MATRIX

Before asking about a patient's needs, it is necessary to know what resources are available to address those needs. These resources help identify community resources as well as how to organize them.

TOOL	WHEN TO USE THIS TOOL
Aunt Bertha	This offers a free search for resources plus paid packages for more robust support and tools.
NowPow	NowPow partners with healthcare providers and community-based organizations to identify these needs, provide highly matched referrals, facilitate closed loop referrals, support bi-directional patient engagement and document referral outcomes.
211 Iowa	This is an online compilation of resources in Iowa and Nebraska.
Digital Health Products for Complex Populations	This is used to explore additional Digital Health Products that are available. It is compiled by the Center for Health Care Strategies, Inc.
The Upstream Strategy Compass™	This is used when healthcare systems and their community partners need to understand local needs as well as the opportunities to improve specific social determinants of health for priority patient populations. This includes levels of prevention (i.e. primary, secondary, and tertiary) and levels of intervention (i.e. individual, organizational, community) to organize needs and interventions.
Where Is Care	"Where Is Care" is an online community of free and subsidized health and social services. Their goal is to help low-income uninsured and underinsured patients access the help they need by quickly identifying organizations close by with the ability to provide the care patients need.
Health Leads Community Resource Inventory Guidance (Pages 18-27)	This Health Leads resource guides teams through key questions to guide development of a resource inventory and provides a template to collect comprehensive information for resources.

CONCEPT: BRAINSTORM WORKFLOWS

Different organizations have different roles and office configurations. These resources provide guidance on how to adapt current workflows to integrate SDOH screening.

TOOL	WHEN TO USE THIS TOOL
PRAPARE Workflow Implementation	This is used to think through and choose from workflow scenarios that include "when", "who", and "how".
Western Colorado Accountable Health Communities Model (Pages 9-13)	This provides workflow guidance developed by Western Colorado Accountable Health Communities Model geared towards pediatric populations.

Example Workflows from Oregon Primary Care Association (Pages 26-30)	This is used to examine workflow scenarios that include high-level workflow maps and pros and cons of each.
Health Leads Action Plan Workbook – Workflow (Page 14)	This is used to pose questions to your implementation team in consideration of adopting a SDOH workflow.
Healthy Lead Action Plan Workbook – Workflow Example (Page 8)	This is an example of a completed Healthy Leads Action Plan Workflow.
Strategizing Workflows to Implement PRAPARE to Collect Standardized Non-Clinical Data	The objectives of this webinar are: + Apply strategies to determine which workflow works best in your organization's setting. + Compare and contrast different workflow models for collecting standardized data on the social determinants of health using PRAPARE. + Outline ways to use clinic staff to respond to socioeconomic needs identified.

+ CONCEPT: SCRIPT FOR ALL AUDIENCES

An important step to identifying SDOH is to let the patient know why you are asking about social needs and how the information will be used. These resources help organization create scripts not only for patients, but for staff and other stakeholder concerns.

TOOL	WHEN TO USE THIS TOOL
Scripting Examples for SDOH Screening	This is used to provide staff conversation starters when screening patients for SDOH. Developed by the Michigan Department of Health and Human Services for SIM participants.
Western Colorado Accountable Health Communities Model (Page 11)	A script developed by Western Colorado Accountable Health Communities Model.
PRAPARE Engaging Key Stakeholders	This part of the PRAPARE implementation toolkit includes messaging materials and key points to use when engaging staff, board and patients, but can be used when implementing a SDOH screening tool.

+ CONCEPT: ENSURE SUPPORT FOR STAFF

Addressing social determinants of health many times uncovers trauma in a patients past or current life. A trauma informed workplace includes not only tools for dealing with patient's trauma, but primary and secondary trauma for staff as well. It is necessary to be mindful of staff needs and potential trauma, and to be prepared to respond to their needs.

TOOL	WHEN TO USE THIS TOOL
Preventing Secondary Traumatic Stress	Staff can be affected by daily exposure to patients' pain and distress. This site includes warning signs of secondary trauma and self-care tips to prevent secondary trauma at work and outside of work.
Trauma and its Relevance to Health Care, Part 1: Primary Care and Trauma: Prevalence, Impact, and Implications for Practice	A webinar to provide a general overview of the impact of trauma in a primary care setting and how to address health care practices with a trauma-informed care approach. The **second webinar in the series** addresses asking and effectively responding to trauma, and the **third** discusses the 10 domains of trauma informed organizational change and highlights case studies on promoting such change.
Michigan Policy and Procedure: TRAUMA-INFORMED PRACTICE	This Trauma-Informed Practice Policy example helps when guidance is needed around TIC policy formation.
Trauma Informed Care Sustainability Guide	This guide can be used when your organization has implemented trauma informed care and needs to examine the sustainability of the initiative. SAMHSA developed resource.
Standards of Practice for Trauma Informed Care	A tool to assess your organization related to trauma informed care standards of practice and provide information to plan and monitor progress.

STAGE 2: TEST

The test stage builds organizational confidence in the initiative. These resources guide practices in small tests to ensure effective messaging, workflows and project management, as well as build person-centered care within the organization and with organizational partners.

CONCEPT: TEST YOUR REPORTING

Identify a data strategy from the beginning to avoid scope creep and identify opportunities for improvement. These resources present a variety of strategies on data use and reporting.

TOOL	WHEN TO USE THIS TOOL
PRAPARE Chapter 6: Develop a Data Strategy	Use this tool to develop a reporting strategy and system so data can be effectively communicated to providers, partners, payers, policymakers and other stakeholders.
Health Leads Measures and Data Collection Guidance (Page 19)	This worksheet can help a healthcare team think through what data to monitor progress and think through outcome data to show project impact.
Data Documentation of PRAPARE for Implementation	Coding specifications and instructions defined for PRAPARE measures to help develop an internal SDOH database that eventually integrates with other data sources. Although specific to the PRAPARE tool, this can be adapted by replacing domains with domains covered by other tools and by replacing the answer options with those specific to your EHR templates.
PRAPARE Reporting Requirements Spreadsheet	Guidelines and template for reporting aggregate data as a result of your PRAPARE pilot period. Although specific to the PRAPARE tool, this can be adapted by replacing domains with domains covered by other tools and by replacing the answer options with those specific to your EHR templates.

Developing a Data Dashboard for PRAPARE Data	This tool includes a webinar recording, PowerPoint slides and transcription of the webinar that demonstrates the use of Tableau in data driven decision making and tracking of SDH screening. This is specific to PRAPARE, but lessons learned can be applied to any EHR embedded SDOH screening tool.
Aim Statement Guide (Pages 24 and 25)	Setting a quality aim helps a successful implementation by setting a target your team can achieve and a benchmark with which to monitor progress. This guide outlines questions for your team in setting the aim and provides example aims and other tips for aim statements.

CONCEPT: TRIAL WORKFLOWS

These resources help with small tests in adapting workflows to integrate SDOH screening to improve efficiency and effectiveness of your interventions.

TOOL	WHEN TO USE THIS TOOL
Social Determinant of Health Role Play Worksheet	Before launching an SDOH screening tool, role playing various workflows can debunk assumptions that may impede effective screening. Use this worksheet to guide your team through role playing.
IHI PDSA Worksheet	When first rolling out implementation, organizations will test the process on a few patients at a time until tests yield the desired result. The IHI PDSA Worksheet template is used to track changes to your social determinant of health processes as you work through these small tests.
Clinical Decision Support Quality Improvement Worksheet	This worksheet and instructional material help organizations think through workflows and define activities to ensure SDOH data collection best meets your organization and population health needs.
IHI Tool: Daily Huddles	Communication while testing workflows helps improve efficiency, effectiveness and satisfaction. The IHI Daily Huddle tool is a brief yet comprehensive guide that includes the benefits of huddles, tips and example agenda template for huddles. The huddle agenda template "safety and concerns" can be replaced with "SDOH assessment and referrals."

CONCEPT: TRACK PROGRESS

These resources can help with monitoring and achieving your goals related to social determinants of health. Ability to track and communicate the status of a project is critical to the success of an initiative and these tools provide varied levels of support for progress tracking.

TOOL	WHEN TO USE THIS TOOL
PRAPARE Progress Tracking	This Excel file details tasks that need to be completed for full PRAPARE implementation and identifies resources to help complete them. It also allows the user to track estimated timeframe, responsible staff and other notes.
IHI Visual Management Board	This resource from IHI describes how to use a visual management board to provide simple information about a project's process and display qualitative and quantitative data.

Health Leads Review Action Plan (Page 21)	This brief action plan review from Health Leads is another option for thinking through implementation progress and next steps.
Minnesota Department of Health Training and Tools: Gantt Chart	This resource from the Minnesota Department of Health describes what a Gantt chart is, how to use it and provides an example form so you can build your own.
IHI QI Project Management	This tool from IHI discusses strategies to keep your project on track and offers specific ideas to implement those strategies.

CONCEPT: GET FEEDBACK FROM PATIENTS

The healthcare system is not where social determinants of health have traditionally been identified and acted upon. SDOH can also be laden with stigma and answering questions about these social needs can be uncomfortable to some patients. Involving patients in your SDOH initiative can overcome such barriers.

TOOL	WHEN TO USE THIS TOOL
Engaging Patients in Improving Ambulatory Care	This toolkit funded by the Robert Wood Johnson Foundation is a comprehensive resource on involving patients in quality improvement, from recruitment, orientation, setting up infrastructure and support and fostering partnership. There are also a series of videos on the website: **https://www.rwjf.org/en/library/research/2013/03/engaging-patients-in-improving-ambulatory-care.html**
PfP Strategic Vision Roadmap for Person and Family Engagement	The Partnership for Patients Roadmap for PFE provides a shared vision for Person and Family Engagement, identifies the intersection of PFE and health equity and describes the six PFE strategies that meet the five PFE metrics.
Patient Engagement in Quality Improvement Toolkit	This toolkit discusses what patient engagement is and provides worksheets and other resources to help organizations engage patients in their work. Davis S, Gaines ME, Pandhi N. Patient Engagement in Redesigning Care Toolkit, Version 2.0. Center for Patient Partnerships, UW Health, Primary Care Academics Transforming Healthcare, UW Health Innovation Program; 2017. Available at: **http://www.hipxchange.org/PatientEngagement**
Patient Partner Welcome Packet	This is an editable patient volunteer packet for individuals interested in serving as patient quality improvement advisors.
Patient Experience Improvement Toolkit	This toolkit includes patient experience assessment, methods to audit your facility and sustaining improvements in patient experience. It was developed for Family Planning agencies but can be tailored to any health care organization.
LGBT Welcoming Toolkit for Primary Care Practices	This toolkit provides instruction for primary care practices to create welcoming environments for LGBT patients.
Cultural Competency Resource Guide	The Southeastern Healthy Equity Council created this resource guide that discusses training considerations, interpretation, working with specific populations and provides additional cultural competency resources.

CONCEPT: MONITOR REFERRAL COMPLETION

While social determinants of health are not necessarily easy to resolve, they cannot begin to be resolved unless the patient is able to access needed help. This section includes guides on how to appropriately close referrals as well as some more basic materials such as job descriptions and referral data sharing.

TOOL	WHEN TO USE THIS TOOL
Primary Care Team Guide: Referral Management	This guide provides action steps, tools and resources for each component of referral management. Although designed for clinical referrals, the same concepts apply to SDOH referrals.
Referral Coordinator Job Description	Macoll Institute for Healthcare created this guide that provides skills, tasks and various referral coordinator job descriptions.
Data Sharing, Care Coordination and Population Health: Recommendations to Make Your Journey Easier	This is a comprehensive case study of the San Diego's Community Health Information Exchange that provides recommendations on technical architecture, engaging partners, patient matching, patient consent and population health, all elements that support a more comprehensive, robust referral management capability.
Request for Proposal Template for Health Information Technology	This RFP template is intended to aid providers and health IT implementers throughout the EHR vendor selection process. This template can be used to structure requests for vendors to send proposals on the specific health IT that needs to be acquired. The template has limited but critical questions regarding referral functionality.
Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era	This IHI tool describes a nine-step, closed-loop process in which all relevant patient information is communicated to the correct person through the appropriate channels and in a timely manner

STAGE 3: SPREAD

The spread stage is for organizations that have robust screening and interventions that effectively address patient need. These resources help garner additional support for accountable communities and help organizations continue to improve processes to best serve their patients and staff.

CONCEPT: CQI

Implementing a social determinant of health initiative requires healthcare workers to step outside of their traditional roles and therefore workflows may need to be refined and tested multiple times. Similar to healthcare, our socioeconomic environment is in flux. It requires flexibility and monitoring to ensure we provide the most benefit and least harm to patients. Adopting continuous quality improvement tools can help advance your SDOH efforts.

TOOL	WHEN TO USE THIS TOOL
IHI White Paper: Sustaining Improvement	This white paper contains an organizational framework, guidance on how to implement these practices and includes a case study example of how to implement standard work.

Community Tool Box: Maintaining Quality Performance	This chapter of the Community Tool Box teaches how to assure quality performance and oversight and includes sections on achieving and maintaining quality performance, establishing oversight mechanisms and creating a formal public reporting process.
Framework for Effective Board Governance of Health System Quality	This tool from IHI includes a framework, an assessment tool and guides to support oversight of quality programs.

CONCEPT: SHARE YOUR STORY

Storytelling is a powerful tool to engage and motivate staff and partners, especially with difficult or deep-seated changes. These tools can help with coaching SDOH leaders on storytelling as well as organizing stories for external use, such as for policy, advocacy and funding.

TOOL	WHEN TO USE THIS TOOL
Video-storytelling: A Step-by-Step Guide	This IHI tool gives step by step instructions for producing video stories for use in quality improvement.
Wide Angle Lens	Interactive learning modules that can help build capacity for storytelling.
Sample Storybank	Sample storybank that can be tailored to meet your needs in tracking stories for use in advocacy.
Introduction to Storytelling	This tool describes elements of a good story and how they can be used strategically. It also includes a template to collect stories and get permission to use them, as well as a storytelling worksheet template to maximize your story's impact.
Clinical Data Management Systems Discuss the PRAPARE Assessment	PRAPARE helps providers collect the data needed to better understand and act on their patient's social determinants of health. This IHC SIM Unplugged YouTube video is hosted by Clinical Data Management Systems, who specialize in data management and reporting systems with an emphasis on the analysis of healthcare data.

CONCEPT: DEVELOP NEW PARTNERSHIPS

Partnerships are essential to addressing social determinants of health. This section provides tools and best practices related to data, finance, coordination, governance and other key activities related to forming community-driven solutions to SDOH.

TOOL	WHEN TO USE THIS TOOL
Integrating to Improve Health: Partnership Models between Community-Based and Health Care Organizations	This matrix tool aids partners in selecting appropriate service models, financial relationships, data sharing and governance.
Health Care and Community-Based Organization Partnership: What Does It Cost?	This Excel spreadsheet helps partnerships estimate their total cost to ensure a sustainable partnership model.

Community Information Exchange Toolkit	This toolkit is designed to assist communities interested in learning how to harness the value of cross-sector collaboration and data sharing to develop a Community Information Exchange (CIE) that enables a network of health, human and social service providers to deliver coordinated, person-centered care to address social determinants of health to improve population health.
Community Tool Box: Creating and Maintaining Partnerships	This chapter of the Community Tool Box provides guidance on convening community partners to address a shared goal.
Advancing Health Care and Community-Based Organization Partnerships to Address Social Determinants: Lessons from the Field	This webinar from Center for Health Care Strategies highlights promising strategies for creating and sustaining healthcare and CBO partnerships that address SDOH.
The ROI Calculator for Partnerships to Address the Social Determinants of Health	This calculator helps organizations develop a business case by considering financial implications of the person-centered care they are providing.

CONCEPT: ADVOCATE FOR POPULATION LEVEL RESOURCES AND POLICY CHANGES

Social determinants of health are influenced by individual and neighborhood factors, but they are also significantly shaped by environmental and policy factors. This section provides tools to address the societal influences on a person's health and a community's wellbeing.

TOOL	WHEN TO USE THIS TOOL
NACHC PRAPARE Toolkit Chapter 9	This part of the NACHC PRAPARE toolkit will give your organization ideas and examples on how to address SDOH at the patient level in both clinical and non-clinical settings, but also gives examples on how to mitigate SDOH at the community level.
Let's Talk Advocacy and Health Equity	This tool from the National Collaborating Centre for Determinants of Health describes types of advocacy to produce desired actions.
Community Tool Box: Getting Grants and Financial Resources	This chapter of the Community Tool Box walks organizations through developing a plan for financial sustainability, creating a business plan and applying for grants.
Robert Wood Johnson Foundation A New Way to Talk about Social Determinants of Health	This guide describes a better way to talk about health equity and SDOH, and how to appeal to board audiences.
IHI Achieving Health Equity White Paper	This framework includes the components of making health equity a strategic priority, structures and processes to support health equity work, and developing partnerships with community organization. It also discusses the business case for health equity.