Hi everyone,

I'm here today to talk to you about the new HRSN screening workflow. As you know, we've been working hard to improve our screening process, and we believe that this new workflow is the best way to do it.

Here are the steps in the new workflow:

1. While booking the visit either online or via the call center, the patient receives an SMS with a link to the electronic core HRSN screening tool.
2. After filling out the form, the system directs the patient according to their score. Patients with positive screening for any of the 5 core domains will be directed to book a virtual short visit with the social worker.
3. The social worker assesses the patient's severity of needs. If the patient is classified as having a severe HRSN, the system will refer them for further assessment by the physician. Otherwise, they will be directed to appropriate community resources.
4. The physician will assess only patients with severe HRSN, explain to them how important the support for their social needs is for their health outcomes, and refer them to the appropriate community resources.
5. The system automatically generates both real-time dashboards and periodic reports about the important KPIs, such as the percent of screened patients among all Medicare beneficiaries seen in the site over a specific period.
6. However, a backup simple paper-based workflow is kept for downtime periods.

This new workflow has several benefits:

- It is more efficient and saves staff time.
- It provides better patient engagement and allows for more timely monitoring of the screening process.
- It generates data that can be used to improve the screening process over time.

I know that change can be difficult, but I'm confident that this new workflow is the best thing for our patients and our organization. I'm asking for your help in making this a success.

Here are some things that you can do to help:

- Be enthusiastic about the new workflow and encourage your colleagues to get on board.
- Provide feedback on the new workflow so that we can make it even better.
- Use the data generated by the new workflow to improve your own practice.

In 2018 the rate of discharges per 100000 population due to nutritional anaemia was 2 times higher in Louisiana than New Jersey that is associated with more poverty. In 2020 coronary heart diseases prevalence was 2 times higher in Bainville than Ascension that is associated with more housing insecurity. With your cooperation, we could save a child from anaemia or an adult form heart attack!

I know that we can do this. We have a talented and dedicated team, and we're all committed to making a difference in the lives of our patients.

Thank you.