Project Charter

Project Description / Purpose

Project Name:	Equity in Health: Bridging Gaps for a Healthier Community
Clinic:	All Denova Clinics
Process:	Utilizing the information gathered from the SDOH screeners to identify inequities
TIP 2.0 Process Milestone:	**Adult BH/Adult PCP/Peds BH/Peds PCP:** Identify Health Inequities and Health-related social needs (HRSNs) prevalent within the population attributed to the practice and implement plans to reduce inequities.

Project Description / Purpose

The project involves utilizing Social Determinants of Health (SDOH) data to design and implement plans aimed at reducing identified health inequities within a specific population or community. Social determinants of health are the conditions in which people are born, grow, live, work, and age, and they can significantly impact health outcomes. These determinants include factors such as socioeconomic status, education, employment, access to healthcare, housing, and the physical environment.

The purpose of this project is twofold:

Identifying Health Inequities: The first step is to identify existing health inequities within our patient population. This involves analyzing data related to health outcomes, access to healthcare services, and social determinants of health. By understanding the specific factors contributing to health disparities, the project can pinpoint areas of intervention.

Implementing Strategies: Once health inequities are identified, the project aims to implement targeted strategies to address the underlying social determinants of health contributing to these disparities. This will be done by looking to build partnerships with organizations that provide the identified need.

Project Overview

Problem Summary:	Currently, we are collecting the SDOH data, but we are limited in analyzing that information to identify health inequities and health-related social needs. The information is captured in our electronic medical record, but it is not easily extrapolated into meaningful information.
Desired Outcome(s):	The desired outcomes of this project are: - Utilize our existing ODBC connection to build Tableau reports to aggregate demographic, clinical, and SDOH scoring data. This report will serve as a bridge as we move from our existing EHR to an upgraded system with more robust population health reporting. - Design a seamless reporting system to minimize trends to data points while implementing a new EMR system. Anticipated implementation will be Q4 2024/Q1 2025. - Data analysis will guide needed interventions. Anticipated area of focus to be on transportation to and from medical and behavioral health treatment.
Benefits:	As an integrated ambulatory practice, we recognize that screening for health-related social needs offers substantial benefits that enhance patient care and outcomes. By identifying and addressing factors such as housing instability, food insecurity, transportation challenges, and social isolation within the outpatient setting, healthcare providers can offer a more comprehensive and patient-centered approach. This integration allows for immediate referrals to social services and community resources,

	ensuring that patients receive the necessary support to manage their health conditions effectively. Consequently, this proactive strategy can prevent complications, reduce emergency room visits, and decrease hospital readmissions, ultimately leading to better health outcomes and lower healthcare costs. Moreover, incorporating social needs screening into the routine workflow of an integrated ambulatory practice fosters stronger patient-provider relationships. When patients see that their healthcare team cares about their overall well-being, including their social circumstances, they are more likely to trust and engage with their providers. This trust is crucial for effective chronic disease management and adherence to treatment plans. Additionally, by addressing social determinants of health, the practice can help mitigate health disparities, promoting greater health equity among its patient population. This holistic approach not only improves individual patient experiences but also strengthens the overall effectiveness and efficiency of the healthcare system.

Timeline

	Description of Task and Completion Dates
Task 1	*Create sub-committee to TI related project.*
Task 2	*Policy & procedure drafts to Policy Advisory Committee – 7/25/24*
Task 3	*Validate reporting workflow with IT&S team for G- and Z-codes associated with HRSN– 8/01/24*
Task 4	*Initial reporting workflow for patient population demographic data and HRSN scoring domains with IT&S team – 8/30/24*
Task 5	*Final review and validation of data – 9/15/24*
Task 6	*Data analysis complete – identify targeted intervention based on findings – 9/30/24*

Project Scope

In Scope Project Objectives
1. Assessment and Planning • Needs Assessment: Conduct a comprehensive assessment to identify the specific social determinants of health that most affect the patient population served by the practice. • Stakeholder Engagement: Continued engagement with Contexture and Unite Us advisors. 2. Development and Integration • Workflow Integration: Evaluate the current screening process to ensure it is seamless and efficient. This includes determining when and how screenings will be conducted (e.g., during patient intake, annual exams, etc.). • Training: Provide training for all staff members, including clinicians, nurses, and administrative personnel, on the importance of social needs screening and how to use the screening tools effectively. 3. Referral and Follow-Up • Referral Process: Review existing referral process to connect patients with the appropriate services and ensure follow-up for opportunities for improvement. 4. Data Management and Evaluation

- Data Collection: Implement systems to collect and manage data on social needs screening outcomes, referrals, and patient health outcomes.
- Monitoring and Evaluation: Continuously monitor the program's effectiveness and impact on patient health outcomes, using metrics such as reduction in emergency room visits and hospital readmissions, and patient satisfaction.
- Quality Improvement: Use the data to identify areas for improvement and make ongoing adjustments to the screening and referral processes.

Out of Scope Project Objectives or Activities

1. Hiring additional staff
   - The project will focus on expanding the knowledge of existing staff and workflows.

Project Team

Team Lead:	Laura McLarty	**Project Champion:**	Angela Roumain
Process Owner:	Sam Statom	**Process Manager:**	Brianna Brown

Stakeholders			
Stakeholder	**Title**	**Department**	**Organization**
Henry Haun	Director of Patient Experience	Engagement Center	Denova Collaborative Health
Elisa Kalakosky	Clinic Director	Operations	Denova Collaborative Health
Laura Aldridge	Clinic Director	Operations	Denova Collaborative Health

Project Team Members	
Name	**Team Role**
Anthony Montoya	Patient chart creation
Alex Mercado	EMR input
Sam Statom	Tableau
Kelly Haskins	SDOH collection
Kimbralon Barnes	SDOH collection

Signatures

Process Owner	
Project Champion	
Team Leader	