## Project Description / Purpose

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| **Project Name:** | Social Determinants of Health Screening |
| **Clinic:** | Arbor Medical Partner practices |
| **Process:** | Distribution of screening tool, documentation of results, and closed loop referral process for needed concerns |
| **TIP 2.0 Process Milestone:** | *Milestone 3* |
| **Project Description / Purpose** | |
| *Screening for health-related social needs (or social determinants of health) allows a clinician to assess a comprehensive history of lifestyle and social factors that impact health. Screening for HRSN has demonstrated a positive impact on health outcomes, decrease in emergency room visit, and improved establishment of healthy habits. Barriers to seeking health care, lifestyle choices, and/or safety are easier to identify and interventions offered. Screening in a pediatric primary care practice impacts both the pediatric patient and the overall health of the family.* | |

## Project Overview

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| **Problem Summary:** | *Consistent and universal screening for health-related social needs of the pediatric population improved health outcome and reduces overall healthcare costs. Screening has also been demonstrated to decrease health disparities. Variable studies have suggested that 19-65% of families screened report at least one HRSN. Of those who reported a HRSN, 22-58% accepted resources to address these needs. Barriers include time limits to address such issues, clinicians feeling unable to address identified needs, trust and/or reluctance of patients to divulge concerns. A recent study suggests that patients are more likely to answer HRSN screening electronically versus paper. While access to internet is also a barrier, having access to inoffice electronic screening can help relieve this. Thus this program strives to assess HRSN to improve health behaviors and outcomes while decreasing barrier and disparities in receiving care.* |
| **Desired Outcome(s):** | 1. *Institute and increase routine HRSN (SDOH) screening annually* 2. *Establish relationship with community based referral source to address identified needs on screening* 3. *Connect families with identified needs with community resources* 4. *Decrease barriers to receiving health care* 5. *Create efficient and effective screening workflow that* |
| **Benefits:** | With effective screening that limits barriers and a workflow that connects needs with resources, a decrease in social needs that negatively impact health are decreased and health outcomes in children, family and later adults are improved. |

## Timeline

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|  | **Description of Task and Completion Dates** |
| **Task 1** | *Assessment of current strategies for assessing HRSN within Arbor practices – Feb 29, 2024* |
| **Task 2** | Research and choose a evidence based HRSN screening tool – March 30, 2024 |
| **Task 3** | Develop relationship with community based referral organization and secure resources needed for closed loop referral process - April 30, 2024 |
| **Task 4** | Develop workflow for administering screening tool and secure resources needed - April 30, 2024 |
| **Task 5** | Pilot screening workflow in 2 Arbor practices – May 20, 2024 |
| **Task 6** | Assess workflow and adjust elements to improve screening process and referral system – June 15, 2024 |
| **Task 7** | Educate clinician and staff in all practice on workflow for administering screening tool and connecting families with community resources – June 25, 2024 |
| **Task 8** | Initiate screening/referral workflow for all Arbor practices – July 8, 2024 |

\* Add new rows as needed.

## Project Scope

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| **In Scope Project Objectives** |
| *Objective for this project is to utilize quality improvement strategies to establish an effective and efficient HRSN (SDOH) screening workflow for pediatric primary care practices of Arbor Medical Partner that includes a closed loop referral process that connects families with needs with a community based referral resource.* |
| **Out of Scope Project Objectives or Activities** |
| This project does not address area for which additional screening tools are utilized, such as behavioral health diagnosis or developmental delay. No additional staff can be hired to meet these objectives, and minimal impact should be made on current clinician and staff visit length. |

## Project Team

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| **Team Lead:** | Arbor Social Work – and Karen Eynon | **Project Champion:** | Karen Eynon |
| **Process Owner:** | Raegan Post | **Process Manager:** | Karen Eynon |

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| **Stakeholders** | | | |
| **Stakeholder** | **Title** | **Department** | **Organization** |
| *Karen Eynon* | *Regional Lead Clinician* | *Pediatrics* | *Arbor Medical Partners* |
| *Lisa Engel* | *Senior Regional Medical Director* | *Pediatrics* | *Pediatric Associates* |
| Tricia Juba | Director of Operations | Pediatrics | Arbor Medical Partners |
| Sally Kikuchi | Vice President of Operations | Pediatrics | Pediatric Associates |

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| **Project Team Members** | |
| **Name** | **Team Role** |
| *Ean Goldberg* | *Social Worker – SDOH Referral coordinator* |
| *Karen Eynon* | *Regional Lead Clinician – TI program coordinator* |
| Raegan Post | Program Logistics Coordinator |
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## Signatures

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| **Process Owner** |  |
| **Project Champion** |  |
| **Team Leader** |  |