## Project Description / Purpose

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| **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:** | *Milestone 3* |
| **Project Description / Purpose** | |
| *The project involves utilizing Social Determinants of Health (SDOH) data.* | |

## Project Overview

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| **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

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

\* Add new rows as needed.

## Project Scope

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| **In Scope Project Objectives** |
| *Assessment and Planning* |
| **Out of Scope Project Objectives or Activities** |
| *Hiring additional staff* |

## Project Team

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| **Team Lead:** |  | **Project Champion:** |  |
| **Process Owner:** |  | **Process Manager:** |  |

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| **Stakeholders** | | | |
| **Stakeholder** | **Title** | **Department** | **Organization** |
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| **Project Team Members** | |  |
| **Name** | **Team Role** |  |
| Kim Briggs | Kim Briggs |  |
| Kim Briggs | Kim Briggs |  |
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## Signatures

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