Social Determinants of Health Improvement Action Network

WORKSHOP
FEBRUARY 11, 2020

GREAT LAKES
PARTNERS FOR PATIENTS

Illinois | Michigan | Wisconsin
Powered by the MHA Keystone Center

Accelerating Improvement at the Point of Care

TODAY'S AGENDA

- Welcome and Introduction
- National SDoH Work
- Westside ConnectED Story
- Action Planning
- Participant Sharing
- Wrap-up and Next Steps

Welcome

Kim Werkmeister, BA, RN, CPHQ, CPPS
Improvement Advisor
Cynosure Health

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Illinois Health and Hospital Association

Adam Kohlrus
Assistant Vice President, Quality, Safety and Health Policy
Illinois Health and Hospital Association

Kelly McMahon
Manager, Quality, Safety and Health Policy
Illinois Health and Hospital Association

Improvement Action Network Timeline

January 16
- 9:30-10:30 CT/10:30-11:30 ET
  - Kick-off webinar
  - Setting the stage and review of tools

January 30
- 9:30-10:30 CT/10:30-11:30 ET
  - Shared learning call

February 11
- 9:00-1:00 CT/10:00-2:00 ET
  - In-person, regional workshop
  - Facilitated by IHA staff, subject matter experts, and mentor facilities

February 27
- 9:30-10:30 CT/10:30-11:30 ET
  - Shared learning call

March 12
- 9:30-10:30 CT/10:30-11:30 ET
  - Shared learning call

March 26
- 9:30-10:30 CT/10:30-11:30 ET
  - Wrap-up Webinar
  - Review lessons learned and plan for sustainability

National SDoH Work

Report from the National Academies

- Integrating social care into health care delivery holds the potential to achieve better health outcomes for the nation and address major challenges facing the U.S. health care system.

- Improving health and reducing health disparities is likely to depend, in part, on improving social conditions and decreasing social vulnerability.

Report available at: http://nationalacademies.org/hmd/Reports/2019/integrating-social-care-into-the-delivery-of-health-care

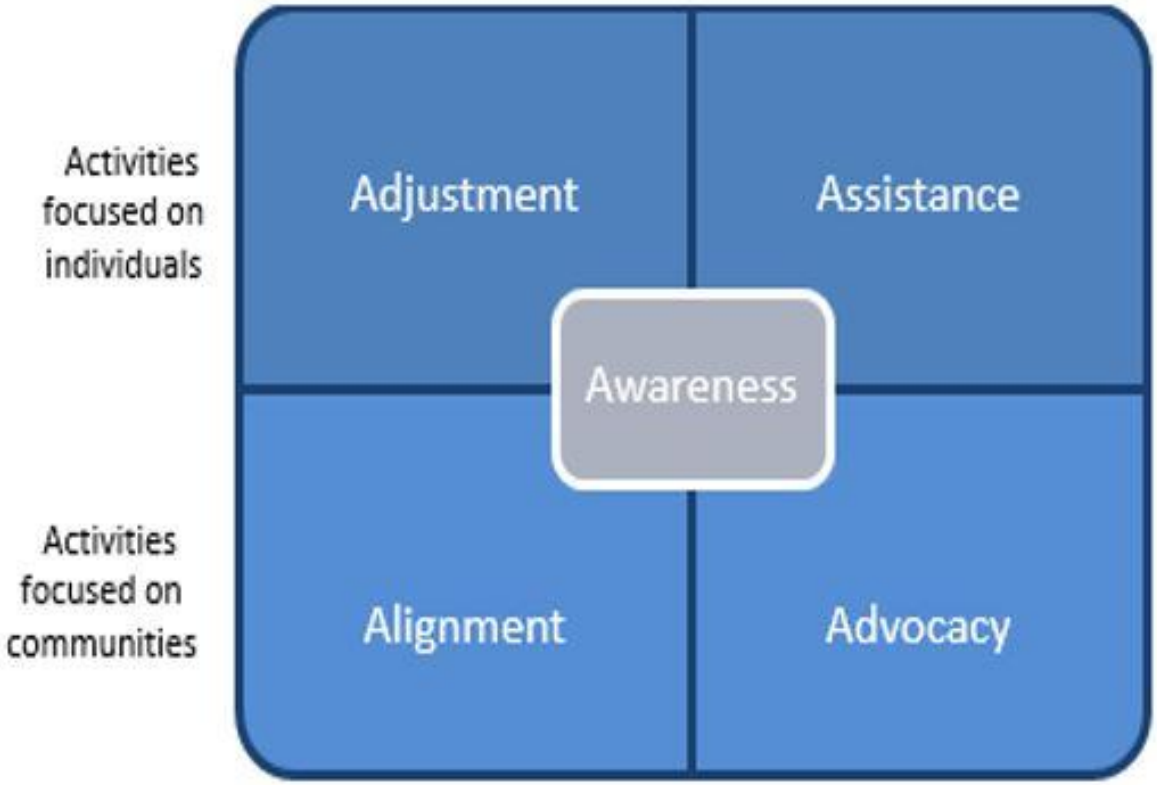
Three Key Needs

- Workforce – are we engaging and training those with the potential to be most effective? Social workers, community health workers, others
- Data and Digital Tools – are we building the infrastructure to use digital tools to integrate activities and provide services?
- Financing – are payment models being updated to include social services-related health care?

National Academies Recommendations:

- Design health care delivery to integrate social care into health care, guided by the five health care system activities—awareness, adjustment, assistance, alignment, and advocacy.
- Build a workforce to integrate social care into health care delivery.
- Develop a digital infrastructure that is interoperable between health care and social care organizations.
- Finance the integration of health care and social care.
- Fund, conduct, and translate research and evaluation on the effectiveness and implementation of social care practices in health care settings.

Five Activities to Facilitate Integration



Retrieved from: http://nationalacademies.org/hmd/Reports/2019/integrating-social-care-into-the-delivery-of-health-care

What Does This Look Like at the Hospital Level?

TABLE Transportation-Related Examples Highlighting Different Social and Health Care Integration Activities

Awareness			
Ask people about their access to transportation.			
Adjustment	**Assistance**	**Alignment**	**Advocacy**
Reduce the need for in-person health care appointments by using other options such as tele-health appointments.	Provide transportation vouchers so that patients can travel to health care appointments. Vouchers can be used for ride-sharing services or public transit.	Invest in community ride-sharing or time-bank programs.	Work to promote policies that fundamentally change the transportation infrastructure within the community.

Retrieved from: http://nationalacademies.org/hmd/Reports/2019/integrating-social-care-into-the-delivery-of-health-care

Challenges to Engaging Stakeholders

- How do we measure success?
- Is there a ROI for addressing SDOH?
- Where do we find our partners in this work?

Westside ConnectED

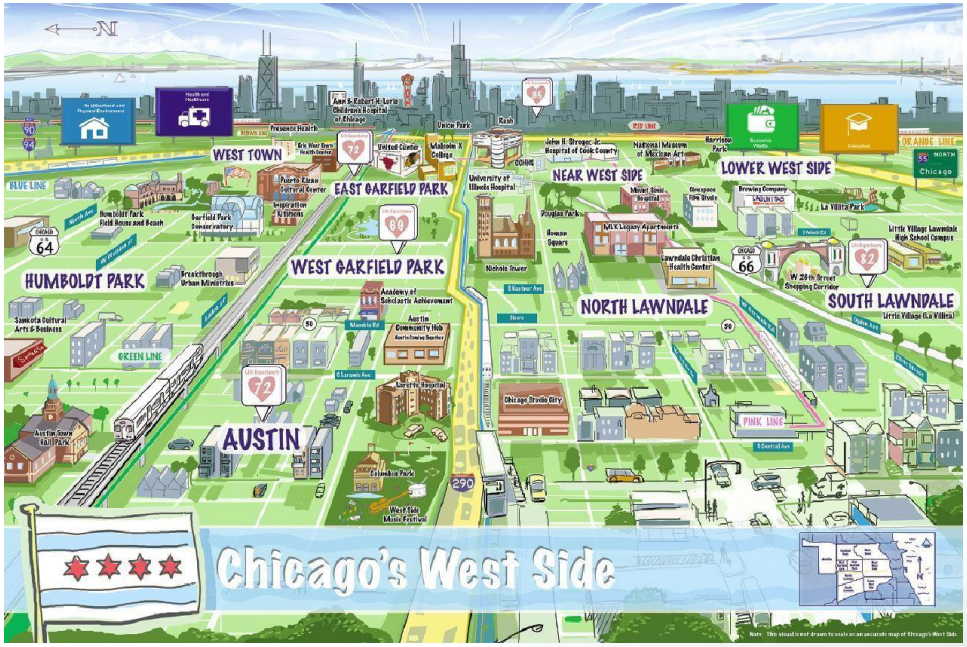
Pam Davis, LCSW

Department Director

Ann Grelecki

Director of Government Grants and Advocacy

Westside ConnectED



West Side ConnectED

Hospitals

+

Community Partners

Westside ConnectED

Sinai Health System

Stacy Ignoffo

Director of Community Health Innovations

Rush University Health

Teresa Berumen

Lead Community Health Worker

Christopher Nolan, MPA

System Manager, Community Health and Benefit

Phase 1

1

ESTABLISH PARTNERSHIPS AND ASSESS CAPACITY

"Looking at the cost savings from similar models shows that meeting the social needs of patients resulted in an overall reduction of 10% in health care costs over the subsequent 12-month period which amounted to an average of $2,443 per patient."

Who Is Involved?

- Leadership (executive sponsorship)
- Community-based organizations (CBO)
- Physician (ED or facility medical director)
- Nursing
- Social work/case management
- Patient Family Advisory Council (PFAC)

"Having relationships with community based organizations is key. Being able to connect people to food only one block away from their home was a success. That same patient later saw the hospital screener and let them know how much they had appreciated the help."

Key Steps

- Make the case with hospital leadership and ED staff for implementing a screen for Social Determinants of Health (SDoH) [1] [2]
- Identify key champions (physician leadership or executive sponsorship) and key team members (nursing, social work, case management, etc) within the hospital
- Establish and build a relationship with a CBO and identify their capacity for referrals [3]

"Identify the partners and develop relationships early. Be mindful of what organizations can commit to capacity wise. An organization may have the will, but it's important to make sure they have the capacity to execute on referrals."

05

REFERENCE MATERIAL

1. Community Referral & Resource Platforms: WCED Toolkit: Other Helpful Resources
2. Wellcare Study
3. WCED Tool Kit: Community Clinical Partnerships 101
4. IHA Patient and Family Engagement Tools

Phase 2

2

DESIGN SCREENING WORKFLOW

Who Is Involved?

- Department leaders
- Screeners
- Social Workers
- Patient Access
- Nursing
- Community Health Workers
- Patient Care Navigator
- Project Champions
- Emergency Department Staff
- IT/Decision Support
- Care Managers

"It is so important to make sure you refer patients to places that speak their language, which is not always easy to do."

"30% of low acuity patients at our hospital screen for food insecurity. We know this because of data collection."

Key Steps

- [x] Integrate SDOH screening within current ED workflows [1] [2]
- [ ] Identify screeners
- [ ] Determine which patients will be screened for SDOH [3]
- [ ] Determine which SDOH(s) to screen for
- [ ] Develop and/or choose a SDOH screening tool [4] [5]
- [ ] Determine how data will be tracked and stored
- [ ] Include which community resources/platforms as appropriate [6]
- [ ] Develop closed-loop referral process for patients services based on SDOH screening results
- [ ] Develop a system to track and monitor data [7]

07

REFERENCE MATERIAL

1. Rush Workflow
2. WCED Toolkit: Integrating into Existing Workflows
3. WCED Toolkit: Identifying SDoH to be Addressed in Hospital EDs
4. WCED Toolkit: Creating SDoH Screening Tool
5. WCED Screening Questions
6. WCED Toolkit: Utilizing Technology to Identify and Refer to Appropriate Local Resources
7. WCED Toolkit: Data Collection, Analysis and Reporting

Phase 3

3

SCREEN AND REFER PATIENTS

Who Is Involved?

- Project champions
- Screeners
- Trainers
- Patients
- Case Management
- Social Work
- Navigator
- CBOs

> "It's important to ask the patients for their permission to ask them the questions and explain to patients that the hospitals' social work department is here to help them

Key Steps

- Train SDoH screeners to conduct screening, on ED protocols, and available SDoH community resources and challenges [1] ☑
- Conduct shadow training sessions with screeners ☐
- Develop a script that explains why SDoH screening questions are being asked [2] [3] ☐
- Get informed consent from patient ☐
- Evaluate patient's response to screening questions and identify next steps based results [4] ☐
- Access community resource platforms as appropriate ☐
- Identify appropriate CBO with capacity for referrals (based on the services provided) ☐
- With patient consent, provide an in person navigation referral ☐

10

REFERENCE MATERIAL

1 USDA Screening Tool Guide
2 Rush SDoH Scripting
3 Rush-SDoH Scripting #2
4 UI Health Social Determinants of Health Screening Decision Table

Break

Implementing the Playbook in Your Organization

Social Determinants of Health (SDoH) Screening in Emergency Departments

A Playbook for Implementing Social Determinants of Health Screening in the Emergency Department in Partnership with Your Community-based Organizations

Illinois Health and Hospital Association

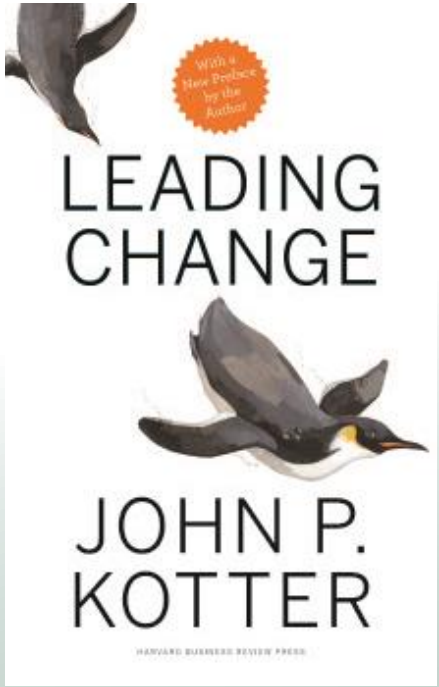
The CATHOLIC CHARITIES OF THE ARCHDIOCESE OF CHICAGO

West Side ConnectED

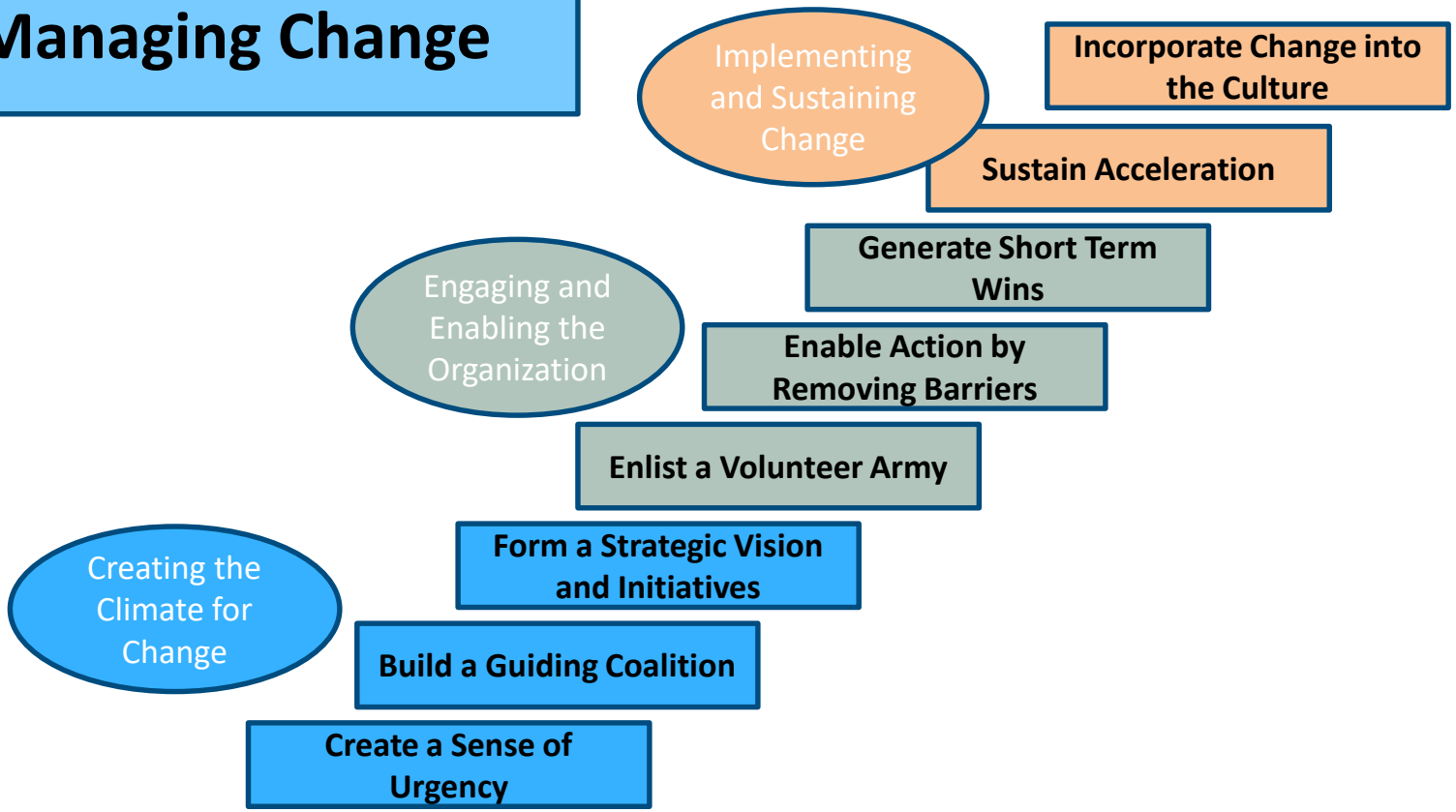
GREAT LAKES PARTNERS FOR PATIENTS

Leading Change: The Kotter Model

- John Kotter – Harvard Business School Professor
- 8 Step Model for Leading Change
- Also used in TeamSTEPPS



The Kotter 8-Step Process for Managing Change



What can we learn from this model?

Rules and Myths of Engagement

Showing the data is sufficient to drive change

MYTH

Rule of Engagement #1: Connect to the Core

Our team must be able to see that:

- The work is meaningful
- They are part of something big
- Their contributions matter

Do This, Not That

Do This

- Describing how an improvement project fits into the bigger picture
- Aligning the project with professional identity
- Show how staff work has impacted the project

Not That

- Sharing medical literature passively
- Doing something just because licensing / accreditation says you must
- Creating and disseminating a policy

Everyone engages at the same time

MYTH

Rule of Engagement #2: Engage the Engaged

- Work with the willing, as we only have to engage 10-20% (the innovators, the early adopters, and a few early majority members) to reach a tipping point
- Identify improvement champions
- Start small (think PDSA cycles for improvement)

Do This, Not That

Do This

- Seek champions who are opinion leaders
- Start small on a project with a few key participants
- Spread after early adopters work out most of the bugs for a new process (PDSA)

Not That

- Starting with an entire department
- Getting “buy-in”
- Trying to convince a laggard first
- Utilizing an early adopter who has little credibility

The same message works for everyone

MYTH

Rule of Engagement #3: Customize Communication

The ***messenger*** matters

The ***message*** matters

The ***medium*** matters

Depends on:

- Receiver's readiness for communication
- The type of response you want the communication to evoke
- Make your message "sticky"

Do This, Not That

Do This

- Choose the messenger wisely
- Adapt your message to the stage of implementation and the readiness of your audience
- Simplify your message

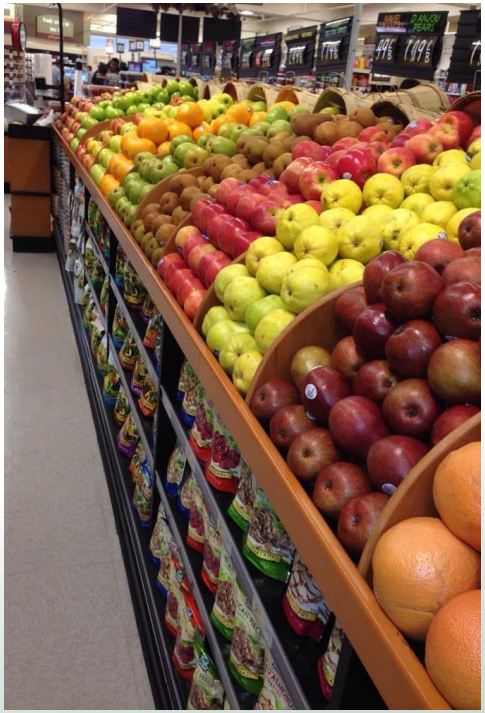
Not That

- Don't worry about the messenger
- Assume only people with a title can communicate
- Use only e-mail to "get the word out"
- Using the same speech and arguments for change to everyone

Every new intervention, process, idea is equally easy to implement

MYTH

Rule of Engagement #4: Align and Segment



- Connect improvement work to organizational priorities and other work in progress
- Celebrate small wins
- Don’t try to do it all at once

Do This, Not That

Do This

- Rolling out a project where it is most likely to be successful
- Developing an organizational goal with all levels participating
- Adapting implementation approaches to the specifics and challenges of each intervention

Not That

- Trying an intervention on the hardest group of patients
- Developing a rigid work plan based on prior experience
- Running multiple simultaneous projects with the same strategy

Crossing the Gaps by Engaging Partners

Phase 1: Where are the gaps?

1

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Phase 1: Addressing the Gaps

- How far along are we with each task?
- Which task is our highest priority right now?
- Who is currently engaged in implementing that task?
- Who still needs to be engaged?

Use the Action Plan Worksheet to build your plan

Phase 2

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Phase 3: Addressing the Gaps

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Use the Action Plan Worksheet to build your plan

What Can We Learn From Synchronous Fireflies?

Now it's your turn!

Next Steps

- Continue to work through your action plans
- Shared learning call on February 27 at 9:30CT/10:30ET