Quality Improvement Program – New Jersey (QIP – NJ) Social Determinants of Health Learning Collaborative (SDOH LC)

Change Package

PCG
Last Update: June 2024

PUBLIC CONSULTING GROUP

Contents

Sources

The content of this Change Package was developed by the New Jersey Department of Health (DOH), Office of Healthcare Financing in partnership with Public Consulting Group (PCG). It has been adapted from many sources which are cited directly in the change package tables below. The strategies were developed and edited based on the opinion of an interprofessional panel of experts.

Expert Panelists

Two expert panels were established to support DOH in the policy design and implementation of the QIP-NJ SDOH LC. The expert panels were comprised of an interprofessional group of experts that represent a variety of perspectives in healthcare, screening and referrals to health related social needs services, and promotion of patient centered care. The expert panels met via videoconference and provided written recommendations to support SDOH LC program design and development of the SDOH LC Change Package, Pre-Work Handbook and Measurement Strategy. This SDOH LC Change Package outlines detailed recommendations for best practices and a measurement strategy that will support a data-driven approach to systematic improvements in the treatment of SHTN with a focus on addressing disparities and inequities in outcomes.

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SDOH LC Key Driver Diagram

KEY DRIVER DIAGRAM:

QUALITY IMPROVEMENT PROGRAM — NEW JERSEY (QIP-NJ)
SOCIAL DETERMINANTS OF HEALTH (SDOH) LEARNING COLLABORATIVE (SDOHLC)

SDOHLC AIM

By May 2025, NJ acute care hospitals participating in QIP-NJ will ensure that at least 50% of patients with an identified social need subsequently initiated services to address that need within 30 days of discharge, ensuring that patients received a trauma-informed and culturally humble care experience at all stages of care.

Hospitals will choose to focus their efforts on at least one of the following domains based on the greatest need at your hospital:

- Housing Supports
- Meal Supports
- Transportation Supports

	PRIMARY DRIVERS	SECONDARY DRIVERS
1	Patient Experience	**1.1** Customize SDOH survey questions and communication to align with the needs, literacy levels, language and preferences of the target population. **1.2** Incorporate feedback from those at every part of care process (i.e. social workers, patient navigators, etc) and patient experience data into care processes.
2	Leveraging Technology and Data-Tracking Systems	**2.1** Establish a data-tracking system to monitor the entire screening-to-service process to identify gaps and inefficiencies in workflows. **2.2** Establish referral tracking capabilities to ensure follow-up and closure of identified social needs. **2.3** Review data regularly to screen for any potential trends and patterns.
3	Establishing Referral Protocols with Networks of Strategic Partners	**3.1** Develop partnerships with community organizations and service providers to facilitate referrals for social needs. **3.2** Create clear pathways and protocols for referring patients to appropriate resources and support services.
4	Staffing and Coordination	**4.1** Ensure oversight of screening and referral process. **4.2** Train staff to execute screening with a trama-informed and culturally humble approach and to follow established protocols/workflows. **4.3** Utilize Community Health Workers (CHWs), Peer Support Specialists, Doulas to support screening capacity, reach and success. **4.4** Ensure that the staff reflects the community they are working with.
5	Integrating Universal Screening into Clinical Workflows	**5.1** Distribute screening materials to patients upon registration, making it a standard part of the intake process. **5.2** Incorporate screening into routine surveys or assessments administered during clinic visits to streamline implementation and avoid low screening rates. **5.3** Develop next steps for addressing screening results that require further action, including follow-up assessments and referrals.

1. Patient Experience

Secondary Driver	Detailed Change Ideas	Resources / Links	References
1.1 Customize SDOH survey questions and communication to align with the needs, literacy levels, language and preferences of the target population.	Do not assume patient literacy levels. Train team on best practices in assessing literacy levels to identify best methods to communicate with individual patient, administer screening survey, etc.		Carolyn Berry, Margaret Paul, Rachel Massar, Roopa Kalyanaraman Marcello, and Marian Krauskopf, 2020: Social Needs Screening and Referral Program at a Large US Public Hospital System, 2017. American Journal of Public-Health 110, S211_S214, https://doi.org/10.2105/AJPH.2020.305642 Trochez, R. J., Sharma, S., Stolldorf, D. P., Mixon, A. S., Novak, L. L., Rajmane, A., Dankwa-Mullan, I., & Kripalani, S. (2023). Screening Health-Related Social Needs in Hospitals: A Systematic Review of Health Care Professional and Patient Perspectives. Population health management, 26(3), 157–167. https://doi.org/10.1089/pop.2022.0279 Shi, M., Fiori, K., Kim, R. S., Gao, Q., Umanski, G., Thomas, I., Telzak, A., & Chambers, E. (2023). Social Needs Assessment and Linkage to Community Health Workers in a Large Urban Hospital System. Journal of primary care & community health, 14, 21501319231166918. https://doi.org/10.1177/21501319231166918 Kreuter, M. W., Thompson, T., McQueen, A., & Garg, R. (2021). Addressing Social Needs in Health Care Settings: Evidence, Challenges, and Opportunities for Public Health. Annual review of public health, 42, 329–344. https://doi.org/10.1146/annurev-publhealth-090419-102204 Inguito, K., Joa, B., Gardner, J., Fung, E. N., Layer, L., & Fritz, K. (2023). Differentials and predictors of food insecurity among Federally Qualified Health Center target populations in Philadelphia: a cross-sectional study. BMC public health, 23(1), 1323. https://doi.org/10.1186/s12889-023-16208-3 Nelson, L. A., Pennings, J. S., Sommer, E. C., Popescu, F., & Barkin, S. L. (2022). A 3-Item Measure of Digital Health Care Literacy: Development and Validation Study. JMIR formative research, 6(4), e36043. https://doi.org/10.2196/36043 Anderst A, Hunter K, Andersen M, et al. Screening and social prescribing in healthcare and social services to address housing issues among children and families: a systematic review. BMJ Open 2022;12:e054338. doi: 10.1136/bmjopen-2021-054338 Ng et al. (2023). Screening for unstable housing in a healthcare setting. Public Health Review. https://doi.org/10.3389/phrs.2023.1606438
	Offer both verbal and written explanation of screening forms.		
	Seek patient feedback on SDOH screening surveys or patient experience surveys.	See Appendix D of SDOH LC Pre-work Handbook for a tool for surveying patient experience. Also, see SDOH LC Measurement Strategy, measure #2.	
	Use evidence-based assessment tools to align with industry standards and benchmarks, including • Use a QIP-NJ approved tool: i.e., PRAPARE or the AAFP SDOH tool. • Consider other evidence-based tools to inform and enhance your practices: o Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool o Hunger Vital Signs Screening Tool o Digital Health literacy's 3-question Tool o Assessing Housing Needs and Risks – National Reentry Resource Center	AHC HRSN Screening Tool Hunger Vital Signs Screening Tool Assessing Housing Needs and Risks – National Reentry Resource Center Social Needs Screening Tool Comparison Table | SIREN (ucsf.edu)	
1.2 Incorporate feedback from those at every part of care process (i.e. social	Find ways to reinvest QIP-NJ funds back into program for sustained improvements in patient experience.		Vindrola-Padros, C., Brage, E., & Johnson, G. A. (2021). Rapid, Responsive, and Relevant?: A Systematic Review of Rapid Evaluations in Health Care. American Journal of Evaluation, 42(1), 13-27. https://doi.org/10.1177/1098214019886914

workers, patient navigators, etc) and patient experience data into care processes.	Incorporate patient into process of making care plan by asking them, “what can make the solutions offered after this encounter successful?"	-	https://journals.sagepub.com/doi/full/10.1177/1098214019886914 Anthea Asprey, John L Campbell, Jenny Newbould, Simon Cohn, Mary Carter, Antoinette Davey and Martin Roland British Journal of General Practice 2013; 63 (608): e200-e208. DOI: https://doi.org/10.3399/bjgp13X664252 https://bjgp.org/content/63/608/e200.short
	Complete Rapid Evaluations with feedback loops to staff and stakeholders. Be sure staff believe in the evaluation/survey design at the outset to increase buy-in of results and lessons learned.		
	Host a peer-facilitated focus group with peer specialists, CHWs or doulas on staff. Community based organizations often have patient advisory councils that could be leveraged as part of your strategic relationship. Peer support specialists and other staff could help form a new focus group with patients. Your organization may already have a patient advisory board that could provide feedback.	Amplify: A consumer voices bureau - Camden Coalition (https://camdenhealth.org/work/amplify/)	

2. Leveraging Technology and Data-Tracking Systems

Secondary Driver	Detailed Change Ideas	Resources / Links	References
2.1 Establish a data-tracking system to monitor the entire screening-to-service process to identify gaps and inefficiencies in workflows.	Meaningfully engage with/ participate in a regional health hub to improve data sharing with local partners. • Camden Coalition • Trenton Health Team • Greater Newark Healthcare Coalition • Health Coalition of Passaic County • Acenda Integrated Care	Best practices in data-sharing to promote equity for BIPOC patients: https://www.chcs.org/resource/a-community-centered-approach-to-data-sharing-and-policy-change-lessons-for-advancing-health-equity/	Carolyn Berry, Margaret Paul, Rachel Massar, Roopa Kalyanaraman Marcello, and Marian Krauskopf, 2020: Social Needs Screening and Referral Program at a Large US Public Hospital System, 2017. American Journal of Public-Health 110, S211_S214, https://doi.org/10.2105/AJPH.2020.305642 Lanese, B. G., Abbruzzese, S. A. G., Eng, A., & Falletta, L. (2023). Adequacy of Prenatal Care Utilization in a Pathways Community HUB Model Program: Results of a Propensity Score Matching Analysis. Maternal and child health journal, 27(3), 459–467. https://doi.org/10.1007/s10995-022-03522-2 Zeigler, B. P., Redding, S., Leath, B. A., Carter, E. L., & Russell, C. (2016). Guiding Principles for Data Architecture to Support the Pathways Community HUB Model. EGEMS (Washington, DC), 4(1), 1182. https://doi.org/10.13063/2327-9214.1182 Beidler, L. B., Razon, N., Lang, H., & Fraze, T. K. (2022). "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. Journal of general internal medicine, 37(16), 4160–4167. https://doi.org/10.1007/s11606-022-07531-3 Nehls, N., Yap, T. S., Salant, T., Aronson, M., Schiff, G., Olbricht, S., Reddy, S., Sternberg, S. B., Anderson, T. S., Phillips, R. S., & Benneyan, J. C. (2021). Systems engineering analysis of diagnostic referral closed-loop processes. BMJ open quality, 10(4), e001603. https://doi.org/10.1136/bmjoq-2021-001603 cl-final.pdf (childrennow.org)
	Connect to a local Pathways Community Hub model to improve relationships with community-based organizations and training community health workers, etc.	Health Coalition of Passaic County (HCPC) Passaic County https://healthcoalitionpc.org/	
	Connect with UniteUS and engage with FindHelp.org to assure appropriate patient referrals are identified, available, and accessible and ensure a closed loop resource and referral platform. *(*The Camden Coalition has used FindHelp to quickly stand up new screening and track patient results, referrals, and connection to services.)*	https://www.findhelp.org/find-social-services/new-jersey Unite New Jersey (uniteus.com)	
	Track patient follow-up with referral resource within 1 month to assure true "closed loop referral process".	See SDOH LC Measurement Strategy, measure # 1	

2.2 Establish referral tracking capabilities to ensure follow-up and closure of identified social needs. (Berry)	Choose an electronic platform to capture referrals and connection of patient to services, ex. the EHR (additional documentation), UniteUs, or FindHelp.	NJDOH has contracted with UniteUS as the referral platform for the Colette Lamothe-Galette Community Health Worker Institute. Also, Acenda Integrated Health is serving as the Statewide CHW Hub. Explore partnerships like these with these existing resources.	Carolyn Berry, Margaret Paul, Rachel Massar, Roopa Kalyanaraman Marcello, and Marian Krauskopf, 2020: Social Needs Screening and Referral Program at a Large US Public Hospital System, 2017. American Journal of Public-Health 110, S211_S214, https://doi.org/10.2105/AJPH.2020.305642 Lee, J. S., MacLeod, K. E., Kuklina, E. V., Tong, X., & Jackson, S. L. (2023). Social Determinants of Health-Related Z Codes and Health Care Among Patients With Hypertension. AJPM focus, 2(2), 100089. https://doi.org/10.1016/j.focus.2023.100089 McCormack, L. A., & Madlock-Brown, C. (2021). Social Determinant of Health Documentation Trends and Their Association with Emergency Department Admissions. AMIA ... Annual Symposium proceedings. AMIA Symposium, 2020, 823–832. Molina, M. F., Pantell, M. S., & Gottlieb, L. M. (2023). Social Risk Factor Documentation in Emergency Departments. Annals of emergency medicine, 81(1), 38–46. https://doi.org/10.1016/j.annemergmed.2022.07.027 Ryus, C. R., Janke, A. T., Granovsky, R. L., & Granovsky, M. A. (2023). A National Snapshot of Social Determinants of Health Documentation in Emergency Departments. The western journal of emergency medicine, 24(4), 680–684. https://doi.org/10.5811/westjem.58149 Bhavnani, S. K., Zhang, W., Bao, D., Raji, M., Ajewole, V., Hunter, R., Kuo, Y. F., Schmidt, S., Pappadis, M. R., Smith, E., Bokov, A., Reistetter, T., Visweswaran, S., & Downer, B. (2023). Subtyping Social Determinants of Health in All of Us: Network Analysis and Visualization Approach. medRxiv : the preprint server for health sciences, 2023.01.27.23285125. https://doi.org/10.1101/2023.01.27.23285125 He, Z., Pfaff, E., Guo, S. J., Guo, Y., Wu, Y., Tao, C., Stiglic, G., & Bian, J. (2023). Enriching Real-world Data with Social Determinants of Health for Health Outcomes and Health Equity: Successes, Challenges, and Opportunities. Yearbook of medical informatics, 32(1), 253–263. https://doi.org/10.1055/s-0043-1768732
	Capture and align Z codes for SDOH-related services in EHR platforms in in-patient and emergency department settings.		
	Use Healthcare Cost and Utilization Project (HCUP) data to capture Z codes & SNOMED codes.		

2.3 Review data regularly to screen for any potential trends and patterns.	Analyze key demographics monthly (ex. race, ethnicity, gender identity, payer) across key metrics (ex. positive screens, acceptance of referral support, connection to services)	R3 Report – The Joint Commission. New Requirements to Reduce Health Care Disparities. (https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf) Avoiding the Unintended Consequences of Screening for Social Determinants of Health | Health Disparities | JAMA | JAMA Network (https://jamanetwork.com/journals/jama/article-abstract/2531579)	

3. Establishing Referral Protocols with Networks of Strategic Partners

Secondary Driver	Detailed Change Ideas	Resources / Links	References
3.1 Develop partnerships with community organizations and service providers to facilitate referrals for social needs.	Assess the organization to ensure it adequately meets the needs of your patients and provides accessible and equitable care for all patients, especially those on Medicaid.	Evidence-based assessment and engagement protocols, professional treatment standards (e.g. World Professional Association for Transgender Health (WPATH) standards for Trans Care). "The nine dimensions of authentic community engagement" inspire-nine-dimensions.pdf (camdenhealth-website-media.nyc3.digitaloceanspaces.com)	Sara S. Bachman, Madeline Wachman, Leticia Manning, Alexander M. Cohen, Robert W. Seifert, David K. Jones, Therese Fitzgerald, Rachel Nuzum, and Patricia Riley, 2017: Social Work's Role in Medicaid Reform: A Qualitative Study American Journal of Public Health 107, S250_S255, https://doi.org/10.2105/AJPH.2017.304002 Implementation of cross-sector partnerships: a description of implementation factors related to addressing social determinants to reduce racial disparities in adverse birth outcomes (frontiersin.org) Hughes, S., Aiyegbusi, O. L., Lasserson, D., Collis, P., Glasby, J., & Calvert, M. (2021). Patient-reported outcome measurement: a bridge between health and social care?. Journal of the Royal Society of Medicine, 114(8), 381–388. https://doi.org/10.1177/01410768211014048 Hutchings, H., Behinaein, P., Enofe, N., Brue, K., Tam, S., Chang, S., Movsas, B., Poisson, L., Wang, A., & Okereke, I. (2024). Association of Social Determinants with Patient-Reported Outcomes in Patients with Cancer. Cancers, 16(5), 1015. https://doi.org/10.3390/cancers16051015 Kamran, R., Jackman, L., Chan, C., Suk, Y., Jacklin, C., Deck, E., Wietek, N., Stepney, M., Harrison, C., Jain, A., & Rodrigues, J. (2023). Implementation of Patient-Reported Outcome Measures for Gender-Affirming Care Worldwide: A Systematic Review. JAMA network open, 6(4), e236425. https://doi.org/10.1001/jamanetworkopen.2023.6425 Kaur, M. N., Tsangaris, E., Dey, T., Deibert, S., Kueper, J., Edelen, M., & Pusic, A. L. (2022). Using patient-reported outcome measures to assess psychological well-being in a non-representative US general population during the COVID-19 pandemic. Journal of patient-reported outcomes, 6(1), 116. https://doi.org/10.1186/s41687-022-00526-y
	Identify key staff/contacts at the community based organization and hospital and convene regular meetings.		
	Establish shared goals for how the hospital and CBO will work together, ensuring there is a vision that mutually benefits each organization while best serving patients' needs. Consider group model building or similar participatory approach with key stakeholders to identify shared goals and procedures.		Agonafer, E. P., Carson, S. L., Nunez, V., Poole, K., Hong, C. S., Morales, M., Jara, J., Hakopian, S., Kenison, T., Bhalla, I., Cameron, F., Vassar, S. D., & Brown, A. F. (2021). Community-based organizations' perspectives on improving health and social service integration. BMC public health, 21(1), 452. https://doi.org/10.1186/s12889-021-10449-w Hovmand, P.S. (2014). Community based system dynamics. Springer. https://link.springer.com/book/10.1007/978-1-4614-8763-0 "Because There's Experts That Do That": Lessons Learned by Health Care Organizations When Partnering with Community Organizations - PMC (nih.gov)

	Establish workflows for referrals and connection to services that are sustainable. Establish a warm handoff process as part of your referral workflow. Use established guidelines, frameworks, and protocols that are already known as best practices for these workflows.		Sanderson, D., Braganza, S., Philips, K., Chodon, T., Whiskey, R., Bernard, P., Rich, A., & Fiori, K. (2021). "Increasing Warm Handoffs: Optimizing Community Based Referrals in Primary Care Using QI Methodology". *Journal of primary care & community health*, *12*, 21501327211023883. https://doi.org/10.1177/21501327211023883
3.2 Create clear pathways and protocols for referring patients to appropriate resources and support services	Implement requirements and standards set for hospitals that are American Nurses Credentialing Center (ANCC) magnet-certified to improve referral processes.		Abuzied, Y., Al-Amer, R., Abuzaid, M., & Somduth, S. (2022). The Magnet Recognition Program and Quality Improvement in Nursing. Global journal on quality and safety in healthcare, 5(4), 106–108. https://doi.org/10.36401/JQSH-22-12
	Use Joint Commission Requirements and industry best practices for patient referral and case management protocols.	https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf	Hudon, C., Chouinard, M. C., Pluye, P., El Sherif, R., Bush, P. L., Rihoux, B., Poitras, M. E., Lambert, M., Zomahoun, H. T. V., & Légaré, F. (2019). Characteristics of Case Management in Primary Care Associated With Positive Outcomes for Frequent Users of Health Care: A Systematic Review. Annals of family medicine, 17(5), 448–458. https://doi.org/10.1370/afm.2419 Giardino AP, De Jesus O. Case Management. [Updated 2023 Aug 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK562214/ Putra, A. D. M., & Sandhi, A. (2021). Implementation of nursing case management to improve community access to care: A scoping review. Belitung nursing journal, 7(3), 141–150. https://doi.org/10.33546/bnj.1449 Tahan, H. M., Kurland, M., & Baker, M. (2020). Understanding the Increasing Role and Value of the Professional Case Manager: A National Study From the Commission for Case Manager Certification: Part 1. Professional case management, 25(3), 133–165. https://doi.org/10.1097/NCM.0000000000000429 Tahan, H. M., Kurland, M., & Baker, M. (2020). The Evolving Role of the Professional Case Manager: A National Study From the Commission for Case Manager Certification: Part 2. Professional case management, 25(4), 188–212. https://doi.org/10.1097/NCM.0000000000000439

	Develop clear communication protocols for sharing information for care coordination (ex. weekly calls, monthly meetings or case conferences) to observe the quality of your working relationship with community based organizations and the effectiveness of the workflows established to meet patient needs. Incorporate the voice of people with lived experience to inform referral pathways/workflow.		Case Management Society of America (CMSA) (2022). Standards of Practice for Case Management; Author: Brentwood, TN Improving patient well-being in the United States through care coordination interventions informed by social determinants of health - Singer - 2022 - Health & Social Care in the Community - Wiley Online Library Children With Special Needs: Social Determinants of Health and Care Coordination - Aaron Pankewicz, Renee K. Davis, John Kim, Richard Antonelli, Hannah Rosenberg, Zekarias Berhane, Renee M. Turchi, 2020 (sagepub.com) Primary Care Case Conferences to Mitigate Social Determinants of Health: A Case Study From One FQHC System (ajmc.com) Interprofessional Case Conference Enhances Group Learning an... : Journal of Continuing Education in the Health Professions (lww.com)

4. Staffing and Coordination

Secondary Driver	Detailed Change Ideas	Resources / Links	References
4.1 Ensure oversight of screening and referral process.	Assign a dedicated program coordinator to oversee implementation and monitoring of the screening program. (Bachman, Berry). Identify a key referral/intake staff at the partner CBO to be the primary contact for referrals and communicating data.		
	Contact patient through their preferred method within 24 hours of discharge and ensure that referral connection was made.		
	Identify best ratio of QIP-NJ team (or other staff available to support referrals) members to high-risk patients served.		
4.2 Train staff to execute screening with a trauma-informed and culturally humble approach and to follow established protocols/workflows.	Use trauma-informed interventions with requisite training for staff.	Center for Healthcare Strategies: Trauma-Informed Implementation Center Trauma-Informed Care Resource Center, examples of trauma informed program implementation. https://www.traumainformedcare.chcs.org/trauma-informed-care-in-action/	
	Train staff to use inclusive language.		

4.3 Utilize Community Health Workers (CHWs), Peer Support Specialists, Doulas to support screening capacity, reach and success.	Hiring and training NJ-funded CHWs. Hospitals should use trained, certified, credentialed CHWs to support roles such as making referrals, addressing SDOH needs, and track connections to care. (For groups who have not or are unable to hire certified CHWs, consider reviewing the roles and competencies they have to train your available staff to serve similar functions. Consider helping available staff pursue CHW certification if possible). Avoid only using CHWs for administrative tasks.	The Colette Lamothe-Galette Community Health Worker Institute is a statewide training Institute for CHWs. https://www.nj.gov/health/fhs/chwi/ New Jersey Community Health Worker Hub https://www.njchw.org/ NCQA and Penn Medicine - CRITICAL INPUTS FOR SUCCESSFUL COMMUNITY HEALTH WORKER PROGRAMS. A White Paper. November 2021. https://www.ncqa.org/wp-content/uploads/2021/11/Critical-Inputs-for-Successful-CHW-Programs_White-Paper_Final.pdf. Alma is an evidence-based, peer mentoring program created by and for new and expecting mothers experiencing depression, anxiety and/or stress. Alma pairs mothers with trained Peer Mentors who have experienced similar challenges during or after pregnancy and can offer support to new moms. http://www.snjpc.org/alma Community Health Worker/Peer Workforce: Recruiting and Hiring for Social Determinants of Health Screening Best Practices Guide and Findings from COVID-19 Pandemic. (https://nhchc.org/wp-content/uploads/2021/07/CHWs-Peer-Specialist-Recruiting-and-Hiring-for-Social-Determinants-of-Health-Screening52.pdf)	Carolyn Berry, Margaret Paul, Rachel Massar, Roopa Kalyanaraman Marcello, and Marian Krauskopf, 2020: Social Needs Screening and Referral Program at a Large US Public Hospital System, 2017. American Journal of Public-Health 110, S211_S214, https://doi.org/10.2105/AJPH.2020.305642
	Provide funding to station CHWs within CBOs that your team has developed a strategic relationship with to facilitate referral flow. Provide these CBO partners with criteria, protocol, and support to hire CHWs or similar staff.		

	Integrate a peer workforce into your staff, ensuring staff awareness and respect of the peer workforce as the 'human' experts on the care team to support building patient trust and improving communication and connection to services.	Peer Support Toolkit for integrating peer workforce. (https://dbhids.org/wp-content/uploads/2024/02/PSToolkit-2023.pdf). *-There are sections on implementing peer/patient boards and peer staff with integration checklists.* *-Practice 6 and Practice 7, starting on page 78, covers integrating peer staff into assessment and planning processes, and how to look outside of the clinical mindset.* *-Practice 15 looks at SDOH and developing community partners with the People with Lived Experience (PWLE) workforce.* *-Practice 16 provides a guide for long- and short-term aftercare, applicable to follow-up with social needs.*	

4.4 Ensure that the staff reflects the community they are working with.	Use inclusive language and hiring practices to ensure that the communities being served have representation in the pertinent care settings.	American Psychological Association Inclusive Language Guide: https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines. NIH Inclusive and Gender Neutral Language: https://www.nih.gov/nih-style-guide/inclusive-gender-neutral-language World Professional Association for Transgender Health: Standards of Care, 7th ed.: https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf Valantine HA. NIH's scientific approach to inclusive excellence. The FASEB Journal. 2020; 34: 13085–13090. https://doi.org/10.1096/fj.202001937	

5. Integrating Universal Trauma-Informed Screening into Clinical Workflows

Secondary Driver	Detailed Change Ideas	Resources / Links	References
5.1 Distribute screening materials to patients upon registration, making it a standard part of the intake process.	Implement universal screening for all patients to reduce administrative burden of organizing change and ensure comprehensive data collection, and avoiding selective screening practices so patients do not feel singled out. *Screening needs to have a specific purpose:* *- Identify need?* *- Secure funding?* *- Target individuals for follow-up/referral?* *Just because hospitals/networks may not have a service solution to every need does not mean you shouldn't necessarily be screening, but you also shouldn't be collecting data needlessly.*		
	Have teams identify specific screening needs and articulate purpose to promote buy-in.		

5.2 Incorporate screening into routine surveys or assessments administered during clinic visits to streamline implementation and avoid low screening rates.	Be aware of Joint Commission requirements while establishing workflow.	Hospitals are now required under Joint Commission and CMS to assess and screen all patients for social needs. [Organizations] determine which health-related social needs to include in the [patient] assessment. Examples of a [patient's] health-related social needs may include the following: • Access to transportation • Difficulty paying for prescriptions or medical bills • Education and literacy • Food insecurity • Housing insecurity • best indicators of housing risk include [in]ability to afford monthly housing costs, past eviction, ever homeless or doubled up • Worst Case Housing Needs | HUD USER Health-related social needs may be identified for a representative sample of the [organization's] [patients] or for all the [organization's] [patients].	
5.3 Develop next steps for addressing screening results that require further action, including follow-up assessments and referrals.			