

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

**Pre-Work Handbook**

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# Background

## The QIP-NJ Social Determinants of Health Learning Collaborative

To support hospitals in their effort to create sustainable community partnerships relative to the behavioral health and maternal populations and drive systemic improvements in care, the New Jersey (NJ) Department of Health (DOH), in partnership with Public Consulting Group (PCG[[1]](#footnote-2)), has designed a data-driven Learning Collaborative. The QIP-NJ Social Determinants of Health Learning Collaborative (referred to as the “SDOH LC”) is based on a proven model from the Institute for Healthcare Improvement (IHI), called the Breakthrough Series (BTS) Collaborative. The SDOH LC will rely upon a holistic and multi-faceted approach involving the entire continuum of care and will target behavioral health & maternal populations within inpatient and emergency departments (EDs) as priority settings to test changes for improvements in care processes and outcomes for the NJ Medicaid population.

The SDOH LC will operate as a sprint-cycle collaborative for accelerated improvements between the end of September 2024 and February 2025. To support participant quality improvement efforts, a prework webinar, two learning session events, and four to five Monthly Coaching Sessions will be held during this time frame.,

## Purpose of this Document

The Pre-work Handbook guides teams through steps to ready themselves for successful participation in the SDOH LC, including forming a strong team and assessing the current state of your system’s ability to address your patients’ SDOH needs. Your team should plan to work through the activities in this handbook from July – September 2024 in advance of the first Collaborative Learning Session.

## SDOH Aim

By February 2025, NJ acute care hospitals participating in QIP-NJ will ensure that at least 50% of patients with an identified social need[[2]](#footnote-3) subsequently initiate services to address that need within 30 days of discharge, ensuring that patients receive 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.

* Housing Supports
* Meal Supports
* Transportation Supports

How can a team define what level of services would adequately address a patient’s needs in each domain?

**Teams should strive to have patients themselves define what level of services they need in each domain to meaningfully address their own needs. Program planners have provided the following suggestions to help teams envision and plan to provide a meaningful level of support in our key domains of focus.**

* **Housing Supports:**

A patient is connected to either permanent, transitional or emergency housing services which can include an actual shelter, rental assistance or eviction assistance. Connections ideally take place with a warm handoff. Consider establishing connections for patients with Continuum of Care (CoC) housing agencies who have capacity. Note that each agency has varied eligibility criteria and the eligibility criteria of the organization you attempt to establish a relationship with during the Collaborative may impact how you collect data and which sub-populations you focus on in your improvement efforts to establish more successful connections to services. For instance, if an organization focuses on veterans this may be the population you focus your tests of change and data collection on in this short-term Collaborative.

* **Meal Supports:**

This could include medically supported meals, healthy meal delivery and connection to food benefits like SNAP and WIC. Hospital teams should be prepared to provide emergency meals and vouchers to patients and families, in addition to connecting patients to long term support through programs like SNAP / WIC. For patients not eligible for SNAP / WIC, teams should consider identifying additional community-based resources that provide meal and food support.

* **Transportation Supports:**

Transportation services should consider access to general care providers like taxi/Uber/Lyft in addition to wheelchair, ambulance and other accessible modes of transport. Transport should be arranged for all scheduled or planned appointments. If a patient takes public transportation, clear instructions in the patient’s preferred language must be provided and the care team should inform the patient of the cost of travel and assure that the patient can afford that cost of travel, providing vouchers or other options if the cost is not affordable.

More details on the SDOH LC, including the Charter, Change Package, and Measurement Strategy can be found on the [QIP-NJ website](https://qip-nj.nj.gov/Home/lc).

# SDOH Checklist: Preparing to Participate

Learning Session 1 of the SDOHLC will occur in September 2024[[3]](#footnote-4). To prepare your team for the session, DOH suggests completing these activities before you attend. Program planners have mapped the activities with a suggested timeline to help you focus your efforts. They include:

July 2024:

* Forming an effective SDOH LC Team
	+ Identify the interdisciplinary team members and an executive sponsor. In Appendix A, see suggested team members, role descriptions, and estimated time commitments.
* Understand the strengths and opportunities that exist in your system using the assessment tool in Appendix B.
* Convene your team and hold your kickoff meeting. See a suggested agenda for a kickoff meeting in Appendix C.

August 2024:

* Conduct interviews with staff and patients/support people to explore your system's current strengths and opportunities (see guiding questions in Appendix D).
* Calculate 3-6 months of baseline performance on the SDOH LC’s core measures. Information and guidance on data collection and reporting for the SDOH LC measures, including the [measurement strategy](https://qip-nj.nj.gov/Documents/SDOHLC/Measurement_Strategy_SDOHLC_Cleanforposting.pdf), can be found at <https://qip-nj.nj.gov/Home/lc>. Additional guidance will be issued to support teams in this effort.

September 2024:

* Learning Session 1 Preparation
	+ Ensure all team members have the details for Learning Session 1 (LS1) and plan to attend. LS1 registration and agenda information will be posted on the SDOH LC website found at <https://qip-nj.nj.gov/Home/lc> in addition to communications to all participating teams as details are established. LS1 is slated to take place in late September 2024.
	+ Prepare Team Storyboard for LS1. The storyboard template and instructions will be posted on the [SDOH LC portal](https://qip-nj.nj.gov/Account/Login?userType=SDOH) by July 2024. The template will reflect your team’s learnings from the activities in this Pre-work handbook. Participants will be notified when the Learning Session 1 event details are posted online.

# Appendix A: Forming a SDOH Team

All teams joining the SDOH LC are encouraged to form teams that include the following recommended roles:

1. One Executive Leader.
2. One Project Leader (one of the team members listed below who will be the primary point of contact and will manage the SDOH LC team).
3. Clinical Co-Leads, a champion from each setting you plan to focus on (i.e., ED and in-patient, or general ED and Obstetric ED, etc.).
4. One Measurement Lead / Information Technology (IT) champion.
5. One or more clinical or administrative care team members who support care in inpatient departments, which support birthing and/or behavioral health populations.
6. One or more clinical and administrative care team members who support care in the ED, which supports birthing and/or behavioral health populations.
7. One or more representatives from key community-based providers or organizations who provide SDOH services for birthing or behavioral health populations.
8. One or more patients and/or chosen family representatives with lived experience.

Time commitment for team roles is approximated below, acknowledging that time spent on the work will vary by site depending on the specific changes chosen and internal pace of the work. We recommend that hospitals form teams with enough people to fulfill the roles described below. Hospitals can assess their own resourcing and environment to determine how many people should be on their team. Some team members may have multiple roles.

|  |  |  |
| --- | --- | --- |
| Team member  | Role  | Time commitment  |
| Executive Leader  | * Creates and promotes the vision of the new system.
* Allocates the time and resources needed to achieve the site’s aim.
* Provides guidance in identifying team members.
* Assists as needed in engaging community stakeholders.
* Champions the scale-up of successful changes throughout the organization and among its community partners.
* Helps remove institutional or administrative barriers that hinder team progress.
* Attends special leadership track sessions at Learning Sessions and during action periods (if applicable)
 | 2-3 hours/month |
| Project Leader | * Serves as primary point of contact with SDOH LC Planning Team.
* Keeps teams moving forward to achieve the project aim.
* Responsible for reminding the SDOH LC team of the dates, times, and location of meetings and that there are minutes of the meetings recorded to track the team's progress and assignments.
* Participates in tests of change.
 | 1-2 day(s)/month |
| Clinical Leads  | * Responsible for overseeing the progress of the respective provider, nursing, social work or other staff teams in achieving the project aim.
* Encourages interdisciplinary accountability and teamwork.
* May serve as Project Leader, see above.
 | 5-6 hours/month  |
| Measurement Lead / IT analyst  | * Assists teams in accessing IT systems for measurement.
* Supports integration of successful changes into IT systems as required.
* Brings expertise in IT systems and how they can be leveraged to support change.
 | Variable  |
| Clinical & Staff representatives  | * Brings clinical or other frontline expertise to the discussion, choosing and testing change ideas.
* Champions the project with peers.
* Participates in tests of change.
 | 4-5 hours/month |
| Community provider/organization representatives  | * Bring expertise to the discussion, choosing and testing change ideas.
* Share insight and experience in leveraging community support.
* Champions the project within own organization.
* Participates in tests of change.
 | 4-5 hours/month |
| Patient and chosen family representatives  | * Brings expertise as a context expert and person with lived experience of care or caregiving to discussion, choosing and testing change ideas.
* Participates in tests of change.
* Provide feedback and help develop patient-facing processes and resources across all touchpoints of care.
 | 2-3 hours/month |

# Appendix B: System Review

It is important for SDOH LC teams to gain an understanding of their current system related to the improvement strategies detailed in the [Change Package](https://qip-nj.nj.gov/Documents/SDOHLC/SDOHLC_Change_Package_FINAL.pdf). Collecting and reflecting on the information below can help your SDOH LC team identify the strengths and opportunities within your system, which can guide discussion during your onboarding session with SDOH LC faculty or your own leadership and improvement team. For example, if your SDOH LC team does not have a formal structure to collect patient feedback, then your team should plan to address this gap in your onboarding session with program faculty or with your team in the pre-work period.

**Who do you serve?**

1. What do you know about the patients who are admitted to inpatient or emergency settings at your organization?
* Age breakdown
* Self-identified Race, Ethnicity and Language
* Self-identified Sexual Orientation and Gender Identity
* Neighborhoods where they reside
* Payer mix of Medicaid Fee for Service vs. Medicaid Managed Care compared to the rest of your patient population (based on the most recent data available for your entire patient population)
* Self-identified SDOH needs specifically related to housing supports, housing stability, meal supports and transportation.
1. Please tell us about the volume of patients in your hospital’s inpatient settings:
	1. Average # of patients per day
	2. Average # of patients per month
	3. Average # patients with successful connections to Community-based Organizations (CBOs) per month
2. Please tell us about the volume of patients in your hospital’s ED:
3. Average # of patients per day
4. Average # of patients per month
5. Average # patients with successful connections to Community-based Organizations (CBOs) per month
6. Average % of patients covered by Medicaid each month.

**What has been done and what is currently in process?**

1. Do you have a way of measuring patient experience? Does it include questions around equity and/or respectful care?
2. Have all clinical staff been educated on:
	1. Importance of SDOH in patient health?
	2. How to screen for SDOH?
	3. How to interview patients?
	4. Referral process to a community provider for SDOH, including confirming availability and accessibility?
3. Does your hospital system currently employ CHWs, Doulas, or peer recovery support specialists?
	1. What specific roles are these professionals currently playing in your system/team/clinical workflows? Include specific tasks.
	2. What additional staffing or resources are needed to effectively connect patients to SDOH services from the inpatient or ED settings?
4. What resources are available within your organization to address housing instability or homelessness?
	1. # of dedicated staff members, programs, departments, etc., focused on community partnerships and social services related to housing
	2. How are patients identified and referred to housing supports?
	3. List of programs or initiatives focused on housing stability
	4. Average # of referrals made per month
5. What resources are available within your organization to address food insecurity and providing meal support services?
	1. # of dedicated staff members focused on connections to meal support services
	2. How are patients identified and referred to meal support services?
	3. List of existing programs or initiatives focused on meal support services
	4. Average # of referrals made per month to meal support services
6. What resources are available within your organization are focused on providing transportation support services?
	1. # of dedicated staff members focused on connections to transportation support services
	2. How are patients identified and referred to transportation support services?
	3. List of hospital-provided transportation services
	4. List of community-based programs or initiatives focused on transportation support
	5. Average # of referrals made per month
7. What is the EHR system vendor used by behavioral health and maternal health teams? How does it support identifying your patients’ health related social needs and connecting patients to services?
8. What other population health management or other data warehouse system vendor do behavioral health and maternal health teams use?
9. Please identify and discuss your hospital’s quality improvement data strategy:
	1. Does your hospital have a process for collecting data on making successful connections to services after a referral to a CBO? If yes, what works well and what could be improved?
	2. Does your hospital have a data dashboard that includes referral coordination performance metrics?
		1. If yes, does your hospital have a process for sharing dashboard performance data to hospital staff and leadership? How does this data inspire action or change on your team?
	3. Does your hospital have data-sharing agreements with any CBOs providing services related to housing, meal supports and transportation? List the organizations and discuss the current state of and satisfaction with your working relationship with that organization with your team.
	4. Does your hospital utilize Unite Us or FindHelp, or participate in any data sharing through NJ-based regional health hubs or health information exchanges?
		1. If yes, discuss how the team uses these platforms to support SDOH screening and connection to services.
		2. If not, discuss how your hospital tracks community-based services if at all.
	5. Does your hospital have a process for stratifying referral coordination performance metrics by[[4]](#footnote-5):
		1. Race?
		2. Ethnicity?
		3. Sexual Orientation and Gender Identify?
		4. Payer?
		5. Other social characteristics?
		6. If yes to any of the above options, does your hospital have a process for sharing this stratified performance data to hospital staff and leadership?
10. Does your hospital have a structured approach to obtain patient and family feedback about their experiences with referrals and initiating services with CBOs who provide SDOH related services?
	1. If “yes,” does your hospital use patient and family feedback in decision making or development of hospital/unit policies, procedures, or programs focused on sustainable partnerships with CBOs?
	2. How has your team acted on patient feedback? Explore and discuss these instances with your team and describe your process.
11. Does your hospital have an established protocol for completing referrals?
	1. If yes, does it include a follow-up timeline? What is that timeline?
	2. If yes, what is the frequency?
12. Does your hospital have the capacity to provide resources to partner CBOs to enhance their ability to provide necessary services and/or hire a CHW or other dedicated staff to help address SDOH needs and track connections to care? Explore this concept with your team as it can inform how to approach a mutually beneficial strategic relationship with a community-based organization providing SDOH related services.
13. What specific challenges or barriers does your organization face while making referrals, particularly referrals to address housing, meal support, and transportation for your patient population?

**Communication Plan**

1. In past improvement projects, what strategies, tools, and techniques did the improvement team utilize to effectively communicate with other colleagues and leadership?
2. How will you/your improvement project team communicate with providers, staff, and leadership about the work being done to improve referral pathways to SDOH services?
3. How will you build and maintain excitement, commitment, and momentum for the SDOH Learning Collaborative effort?
4. How will you sustain engagement in addressing SDOH needs at your organization?

# Appendix C: Team Kickoff Meeting Agenda

Once your improvement team has been selected, the team should meet with their identified Executive Leader and Project Leader to discuss the following:

* Why this project matters to each member of the team.
* The aim of the SDOH LC and implications for your own hospital or health system regarding current and future state.
* Current, past, or planned SDOH improvement initiatives your hospital has undertaken or will undertake to address the needs of your communities and what you can leverage or learn from those experiences. (Review Appendix B for questions to discuss as a group to assess your system’s current state).
* Current, past, or planned improvement initiatives your hospital has undertaken or will undertake to eliminate inequities for your patients, related to existing Diversity, Equity and Inclusion initiatives, that can be leveraged by your SDOH LC team to achieve equitable improvement in improved referral pathways to SDOH related services.
* Project team roles and responsibilities.
* The plan for your team completing the Pre-work Activities and review of any information already gathered, specifically the questions listed in Appendix B, Appendix D and the baseline data collection.
* Select a date and time each week or every other week when the SDOH LC hospital-based team will meet to track progress toward their project aim.

# Appendix D: Guiding Questions for Stakeholder Interviews

In addition to better understanding the current health care systems and processes related to serving the SDOH related needs of your patients, SDOH LC teams will benefit from learning about the different and diverse experiences of others operating within the system. Teams should perform qualitative interviews with the stakeholders identified below to learn how the current systems are successful, how they could be improved, and how all the people within those systems are impacted. The questions below were developed by the Institute for Healthcare Improvement (IHI) to guide collaborative initiatives across a range of topics and adapted by SDOH LC program planners.

1. Guiding Questions for Conversations with Patients and Support Network
Note: Please use additional questions and/or adapt the ones included below as needed. These are intended as a guide to support your SDOH LC teams in effective conversations.

[Insert hospital name] appreciates you sharing your experience as a patient (or support person) with us. Your experience will help [insert hospital name] better understand how to best support those with health-related social needs.

* Please describe your overall experience related to SDOH screening and support to connect to supportive services while receiving care in our hospital.
* How well did providers, nurses, and other clinical and non-clinical staff (CHW, doulas, Peer Support Specialists, etc.) communicate with you during your admission/visit? What did they do well? What could have gone better?
* How could your emergency department or inpatient experience have been improved?
* Did you feel that you were treated with dignity and respect? If not, why not?
* Did you feel your preferences and desires were respected during your admission/visit? Did you feel listened to by those involved in your care? If not, why not?
* How could your experience at the community-based organization we referred you to have been improved?
* Did you feel confident in your ability to care for yourself or seek additional services when you were discharged from the hospital? If not, why not?
* What kind of education did you receive about your health-related social needs and how to connect with desired services while you were in the hospital?
* Looking back on your experience at our hospital, what do you wish that our staff had known? What would you have told them about your experience?
* What advice do you have for those who are working to improve care for patients with health-related social needs?
1. Staff Interview Questions
	* Can you recall an experience when you felt that we provided excellent care for a patient with SDOH/health-related social needs?
		1. What went well for the patient?
		2. What went well for you?
		3. What would you have done differently during the care experience?
	* Can you recall an experience when you felt that we did not provide the best care for a person with SDOH/health-related social needs?
		1. What went wrong?
		2. What could have gone better for the patient?
		3. What could have gone better for you?
	* Can you recall a time where we failed to provide care with dignity and respect for patients with health-related social needs or from marginalized populations? What do we need to do to improve on that experience?
	* What barriers do you face in providing adequate care for patients with SDOH/health-related social needs?
	* Have you worked in partnership with CHWs, doulas or peer specialists? Did that improve your ability to meet patient’s SDOH needs? How or how not?
	* What could help you better care for patients with SDOH/health-related social needs?

# Appendix E: SDOH LC Developers

**DOH**:

DOH, through its Office of Health Care Financing (OHCF), is responsible for implementing and overseeing the successful administration of QIP-NJ. QIP-NJ is a Medicaid pay-for-performance initiative open to all acute care hospitals in NJ and is focused on improving maternal health and BH health outcomes for the NJ Medicaid population, effective July 1, 2021, as approved by the Centers for Medicare and Medicaid Services. For more information, please visit the QIP-NJ website at https://qip-nj.nj.gov/Home/Index. In addition, the OHCF is the sponsor of the SDOH LC, in partnership with PCG.

**PCG**:

PCG is a leading public sector solutions implementation and operations improvement firm that partners with health, education, and human services agencies to improve lives. Founded in 1986 and headquartered in Boston, Massachusetts, PCG employs over 2,500 professionals in more than 50 offices worldwide. PCG offers in-depth programmatic knowledge and regulatory expertise to help state and municipal health agencies and providers respond to regulatory change, improve access to health care, optimize reimbursement, maximize program revenue, improve business processes, and achieve regulatory compliance. Using industry best practices, PCG helps health organizations deliver quality services with constrained resources to promote improved client outcomes. For more information about PCG, please visit their website at <https://www.publicconsultinggroup.com/>.

1. PCG, Public Consulting Group, is a contracted partner of DOH that is assisting with the design, implementation, and oversight of QIP-NJ. [↑](#footnote-ref-2)
2. Teams will be encouraged to target a subset of their population that reflect the target population or services your team chooses to focus on during this Collaborative sprint. Data sampling will also be encouraged to increase efficiency and reduce burden on participating teams. [↑](#footnote-ref-3)
3. LS1 will take place on either September 26th or September 27th. Teams will be updated when the date is finalized. [↑](#footnote-ref-4)
4. Note that NJ passed Bill A4385, An Act concerning the recording of patients’ demographic information and amending P.L.2021, c.454. DOH first issued guidance to acute care hospitals and clinical labs in 2022. Those memos are posted in the SDOH Collaborative participant portal resources page. [↑](#footnote-ref-5)