HEALTH LEADS CHANGE PACKAGE APRIL 2017

The Health Leads Change Package is designed to guide health care delivery organizations through the process of addressing patients' social needs as a standard part of quality care. It defines key drivers of success and recommended changes and strategies that, when implemented, will help teams improve quality and advance towards their aim.

The **driver diagram** provides a visual display of the theory of change in a system—our best theory for what it takes to have an effective social health intervention in a health care setting. It lays out the causal pathway between our main areas of focus (i.e., primary and secondary drivers) and our desired outcome. The primary drivers are the major system components that contribute directly to achieving the aim, and the secondary drivers are more specific elements that contribute to moving the primary drivers.

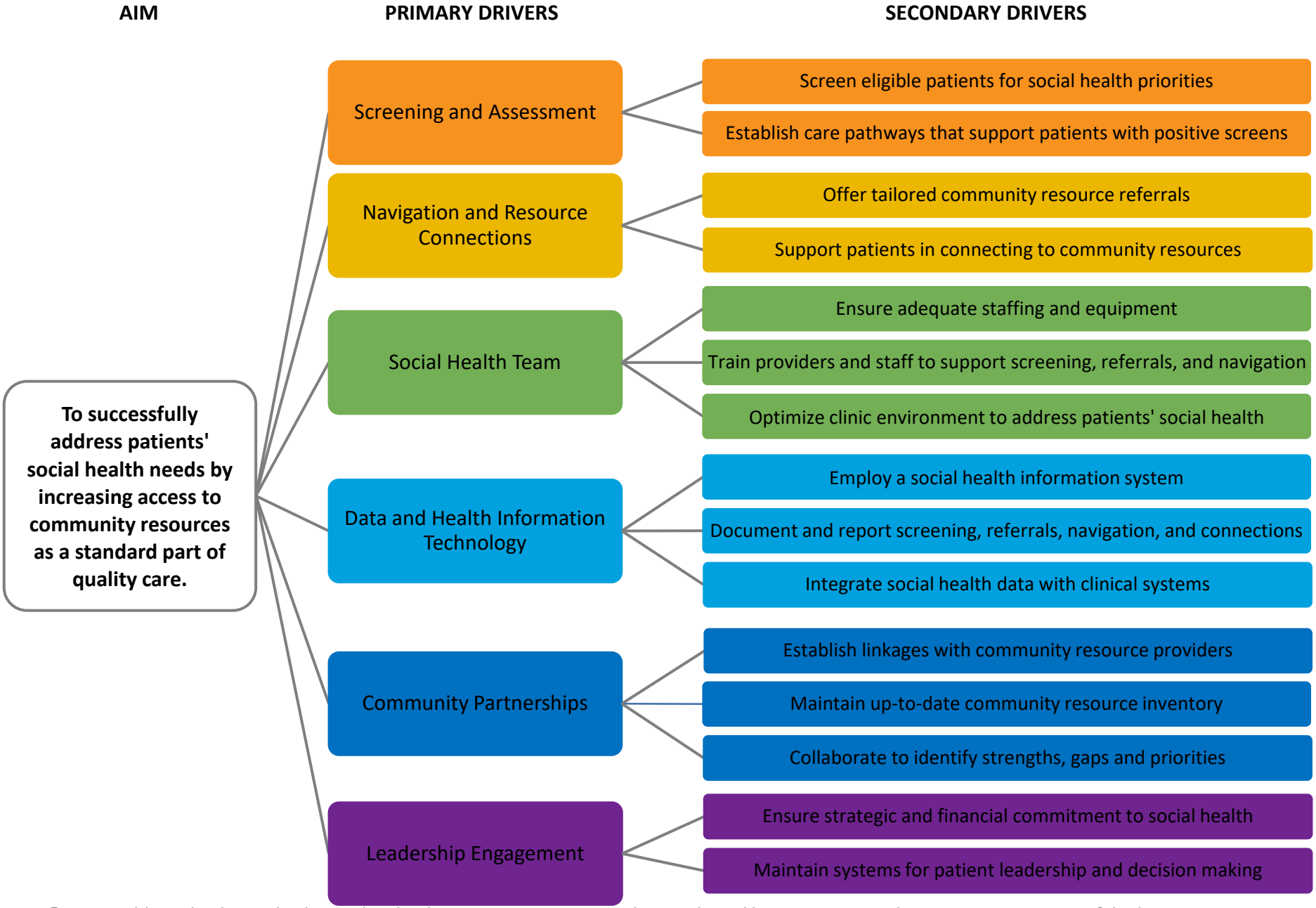
The **change package** takes our driver diagram one step further by breaking down the secondary drivers into specific, actionable changes for testing. This includes changes in the ways services are organized and delivered and changes to technical content, standards, and procedures. This menu of recommended changes is rooted in the successful practices of high performing health care organizations across the country who have partnered with Health Leads to build effective social health interventions, and in the contributions from subject matter experts as well as emerging research evidence.[1]

This change package is intended to provide a blueprint for action from which health care teams select and prioritize changes, and test ways to operationalize and spread them in their local contexts and settings. When used in the context of a multi-organizational collaborative, the change package also serves to enable shared learning and accelerated improvement across participating teams.

The drivers and change ideas presented here focus on individual patient-level interventions. We recognize that, in addition to such interventions, community-level organizing, advocacy, and investments are essential to create lasting improvements in community health.

[1] See the Social Interventions Research & Evaluation Network (SIREN) Evidence Library: https://sirenetwork.ucsf.edu/tools/evidence-library.

HEALTH LEADS DRIVER DIAGRAM



HEALTH LEADS CHANGE PACKAGE

1. PRIMARY DRIVER: SCREENING AND ASSESSMENT	
Secondary Drivers	**Change Ideas**
1.1 Screen eligible patients for social health priorities	• Define resource areas of focus in the context of patient priorities, organizational capacity, community resource availability, and expected health benefits • Determine criteria for which patients to screen and when • Establish workflow for screening target patient population • Modify or add staff roles and responsibilities to support screening process • Develop/adopt standardized screening tool that meets patients' language and literacy needs
1.2 Establish care pathways that support patients with positive screens	• Communicate screening results to members of the care team • Establish process for triaging patients who screen positive and confirm their desire for resources • If not using an integrated approach to care, institute protocols for warm real-time or asynchronous hand-offs between providers and social health team • Identify and document patient priorities and goals through a timely assessment
2. PRIMARY DRIVER: NAVIGATION AND RESOURCE CONNECTIONS	
Secondary Drivers	**Change Ideas**
2.1 Offer tailored community resource referrals	• Identify appropriate community resource referrals to meet patients' identified social health needs and priorities • Provide standardized and regularly updated resource information to patients via printouts, brochures, information sheets, emails, etc. • Include internal (e.g., social work or food program) referrals in referral workflow
2.2 Support patients in connecting to community resources	• Define levels of support or navigation available to enable patients to connect to community resources • Develop standardized protocols by which navigation to resources occurs across all staff • Establish follow-up protocols based on patients' identified social health needs and priorities • Co-locate services or provide resources directly where possible
3. PRIMARY DRIVER: SOCIAL HEALTH TEAM	
Secondary Drivers	**Change Ideas**
3.1 Ensure adequate staffing and equipment	• Review front desk registration, behavioral health, social work, care coordination and case management services to understand spectrum of existing support and avoid duplication. • Define staff and supervisory roles, responsibilities, and time allocations through job descriptions and evaluation plans

	• Designate team members to provide screening, referrals, and navigation and maintain community resource inventory • Define target caseloads/patient throughput and align with staff capacity • Develop systems and partnerships to support recruitment and retention of staff • Secure administrative resources (i.e., computers, telephones, office space, etc.) to support staff and private patient engagement
3.2 Train providers and staff to support screening, referrals, and navigation	• Provide team members initial and ongoing training on core competencies • Observe and track adoption of new workflows and protocols • Designate time and pathways for team to share questions, feedback, challenges, and successes
3.3 Optimize clinic environment to address patients' social health	• Train all staff on the importance of addressing patients' social health as a standard part of quality care • Incorporate social health messaging in waiting areas, exam rooms, websites and/or phone directories • Routinely assess patient and staff experience with screening, referral, and navigation services • Integrate social health into existing routine communications between team members (i.e., huddles, staff meetings, electronic communications via medical record system, etc.)
4. PRIMARY DRIVER: DATA AND HEALTH INFORMATION TECHNOLOGY	
Secondary Drivers	**Change Ideas**
4.1 Employ a social health information system	• Identify and configure social health information system (e.g., Health Leads Reach™ or a combination of paper, electronic medical record, and local 211 resource database) to support case, resource, and workforce management • Embed triggers, alerts, or automated reminders for screening, referrals, documentation, and follow-up. • Configure reports to support continuous monitoring and improvement
4.2 Document and report screening, referrals, navigation, and connections	• Train users to competency on using social health information system, including data review and analysis • Monitor ongoing use of social health information system through data review and analysis • Periodically assess demographic data to adapt to changes in patient population
4.3 Integrate social health data with clinical systems	• Ensure capability of data transfer between social health information system and medical record system • Include social health needs and goals in care plans and, if applicable, discharge planning • Establish or improve protocols for updating providers on changes in social health
5. PRIMARY DRIVER: COMMUNITY PARTNERSHIPS	
Secondary Drivers	**Change Ideas**
5.1 Establish linkages with community resource providers	• Identify key providers of community-based resources • Assess internal capacity to participate in community partnerships and availability of resources to offer partners • Execute formal agreements with community resource providers as needed to support patient resource connections

5.2 Maintain up-to-date community resource inventory	• Build or buy community resource inventory, based on defined areas of focus, that addresses eligibility and accessibility of resources for patient population • Build trusted contacts and specific referral protocols with key organizations for patient groups facing unique barriers • Routinely assess community resource inventory to identify gaps and better meet patients' social health needs
5.3 Collaborate to identify strengths, gaps and priorities	• Routinely share data about social health and resource connections with community resource providers • Routinely assess experience of community partners with referrals coming from your agency • Refine strategies for connecting patients with community resources in collaboration with community partners
6. PRIMARY DRIVER: LEADERSHIP ENGAGEMENT	
Secondary Drivers	**Change Ideas**
6.1 Ensure strategic and financial commitment to social health	• Provide visible and sustained leadership to make patients' social health a strategic priority • Identify clinical and non-clinical champions to promote an organizational culture in which patients' social health is discussed and prioritized at all levels • Build the organization's values on social health into staff hiring and training processes • Secure sustainable resources for staffing, technology, and management required for effort to be successful
6.2 Maintain systems for patient leadership and decision making	• Solicit feedback and gather valuable insights directly from patients about experience with social health intervention • Establish and engage patient advisory board in meaningful decisions about social health intervention design and improvements • Allocate resources to sustain management of and payment to patient advisory board