



KEY MESSAGES WORKSHEET

<p>What is the reason for change?</p> <p>- Why are we doing this and why now?</p>	<p>Why are we doing this?</p> <ul style="list-style-type: none">- Improved patient care<ul style="list-style-type: none">o Know what's needed for better patient careo Greater impact on people's health longer-termo Increases complianceo Increases engagement with care- Already doing it in fractured way – this brings process and infrastructure and tools to it- Increased joy at work<ul style="list-style-type: none">o More time for doing medical care- Saves money- Sheds light on patient's whole story, holistically view- Can help address social drivers of health- Ties to SRCH mission of social justice- Providers are gateways to health. SDOH are part of the scope of practice of primary care. It is the standard of care in family medicine (WHO definition of health- "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity") <p>Why now?</p> <ul style="list-style-type: none">- Medical field is having an evolution of understanding, acknowledging the importance of SDOH- Public awareness of health inequities is growing. It needs to be part of how we respond- There is a cultural shift within health care. Sutter, Kaiser and St. Joseph Health are all investing in Aunt Bertha or other SDOH referral tools- Status quo is NOT ok. What we're doing currently is not working- It is part of our current strategic plan- There may be financial incentives coming. We need to be ready- Social justice is more important than ever. As a country, social inequities are becoming more extreme. There is a national shift to social justice stances and SRCH has an opportunity to make a statement.- There are new laws within health care to provide housing, clothes, food, etc. (ER and hospital)- We are launching Relevant and are tuned into data- We need the PRAPARE data to inform our practices, programs, staff needs and how we grow
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<p>Why should others care if this project succeeds?</p> <ul style="list-style-type: none">- Address the “what’s in it for me?”- What happens if we don’t achieve the goal?	<p>MA</p> <ul style="list-style-type: none">- Right thing to do- Our patients are our family, friends and community- we are all connected- Our joy increases- Opportunity for professional development- learn health coaching skills- Empowering- we can DO something for patients <p>Providers</p> <ul style="list-style-type: none">- Part of good care- Joy at work! Less burnout, morally right- Patient outcomes improve- would people be healthier if they came to their medical appointment and saw a social worker instead? (VIDEO idea!)- More engaged patients, build patient self-efficacy, build larger support systems for patients <p>Leadership/Board</p> <ul style="list-style-type: none">- Save money, patients healthier- Understand complexity of patients- risk adjustment and alternative payment methodology- Reduce no-show rate- Build relationships, trust and rapport with patients <p>What happens if we don’t achieve?</p> <ul style="list-style-type: none">- Marginalized people continue to die inequitably- Status quo is NOT acceptable- Moral injury to providers not being able to provide what impacts patients the most <p>Ideal</p> <ul style="list-style-type: none">- Have patient navigators- Cultural shift to focus on health. Santa Rosa Community Health dropped “clinics” from name. Become a true “center” for health.- Connect to resiliency collaborative, identify patients to participate, connect the dots to resiliency
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<p>What is the plan?</p> <ul style="list-style-type: none">- Where are we going?- When are we going?- How are we planning to get there?	<p>Where are we going?</p> <ul style="list-style-type: none">- SDOH Charter Purpose “exists to improve patient health by addressing social determinants and create a sustainable system to assess and support patients to overcome barriers”- Goal is to implement the PRAPARE Screening tool for every patient on an annual basis- Ideal- have patient navigators or additional supports implement the tool<ul style="list-style-type: none">o Care Coordination Team- would like to have more Care Coordinators (like Vero) embedded at siteso Care Coordination is proposing that IOPCM be clinic-basedo Volunteers with stipends to help implement? <p>When are we going?</p> <ul style="list-style-type: none">- Timelines in Charter- Ideal by the beginning of 2020 <p>How are we planning to get there?</p> <ul style="list-style-type: none">- Pilots this fall to test workflows- Training ambassadors for each site (pilots and training on parallel tracks)- Training- tell stories of successes<ul style="list-style-type: none">o 5 Whole Person Care Housing Vouchers are going through- tell these stories
<p>Elevator Speech Talking Points</p>	<ul style="list-style-type: none">- Health is much more than health care. Although important, health care only accounts for about 20% of a person’s overall health. Other factors, such as a person’s housing situation, access to food and other services, social support network, etc.- called the Social Determinants of Health- have a much bigger impact on health.- These Social Determinants of Health can cause chronic stress. The stress response releases cortisol and other hormones into the body, which has negative physical impacts over time. So, SDOH are not just associated with health outcomes, but they directly impact health.- SRCH has an SDOH Workgroup. We are working to create a sustainable system to assess and support patients to overcome social factors that impact their health.- To be able to know what barriers our patients have, we are working to implement a Screening Tool for every patient on an annual basis. This Screening Tool is called PRAPARE.- [Add specific points based on stakeholder group]