Serve the People Community Health Center will increase referrals for food insecurity from 0% baseline to 25% as of February 1, 2020.

### Measures for Success

- # of patients identified as food insecure
- # of food insecure patients provided with a referral
- # of food insecure patients who utilized the referral
- # of patients who skipped or refused to answer food insecurity question
- Avg. # of PRAPARE SDH factors per food insecure patient
Changes

Tested Changes

- **Social Needs Screening**
  - **Mini Social Needs Screening Resource Vetting**
    - One time mini test run
    - 5 Diabetic patients
    - One Provider
    - Modify goal based on results

- **Resource Vetting**
  - Assess 3 external directories
  - Vet 5 internal org’s per PRAPARE category
  - 1 person dedicated

- **Social Needs Screening**
- **Resource Vetting**
  - Assess 2 external directories
  - Vet 2 internal org’s per PRAPARE category
  - 2 people dedicated

Implemented Changes

- **Social Needs Screening**
- **Resource Vetting**
  - 10 patients with scheduled appt.
  - 2 providers
  - Screen twice a week for one month
  - 2 screeners

- **Resource Vetting**
  - Assess 2 external directories
  - Vet 2 internal org’s per PRAPARE category
  - 2 people dedicated
"I am honored to be part of this group, that our voices are heard."

"I’ve met many people who have diabetes and have problems controlling their health due to these social factors we’re discussing. These things must be addressed. For us to be here shaping how you all address these needs is something I am grateful for."

"I think it is through these efforts, like this group, like group visits, that patients can trust the clinic, feel comfortable and motivated to improve their health."
Strategies for Success

1. State Assessments
2. Mini PDSA’ing
3. Patient Advisory Group
4. Concrete Milestones
Key Tools & Resources

- The A3 assessment is a problem solving and continuous-improvement approach
- This helped elucidate our current condition and root causes
- Provides a visual, easy to process display of progress

- Mini PDSA’s
- Provides concrete, manageable systems of change
- Simple & scalable = happy team
- Provides effective insight in response to the unknown

- A comprehensive Patient Handbook allowed for clear expectations, goals and productive discussions.
- Patient involvement was a win-win
Next Steps

**Spreading**
- Spreading A3 & Mini-PDSA’s to Quality Improvement Program
- Patient Advisory Group for clinically relevant projects/initiatives
- Spreading Population Health focus to Hypertension patients down the road

**Sustaining**
- Hiring a Project coordinator
- Other Funding Sources
- Staff changes
Current Challenges or Barriers

1. Staff Availability