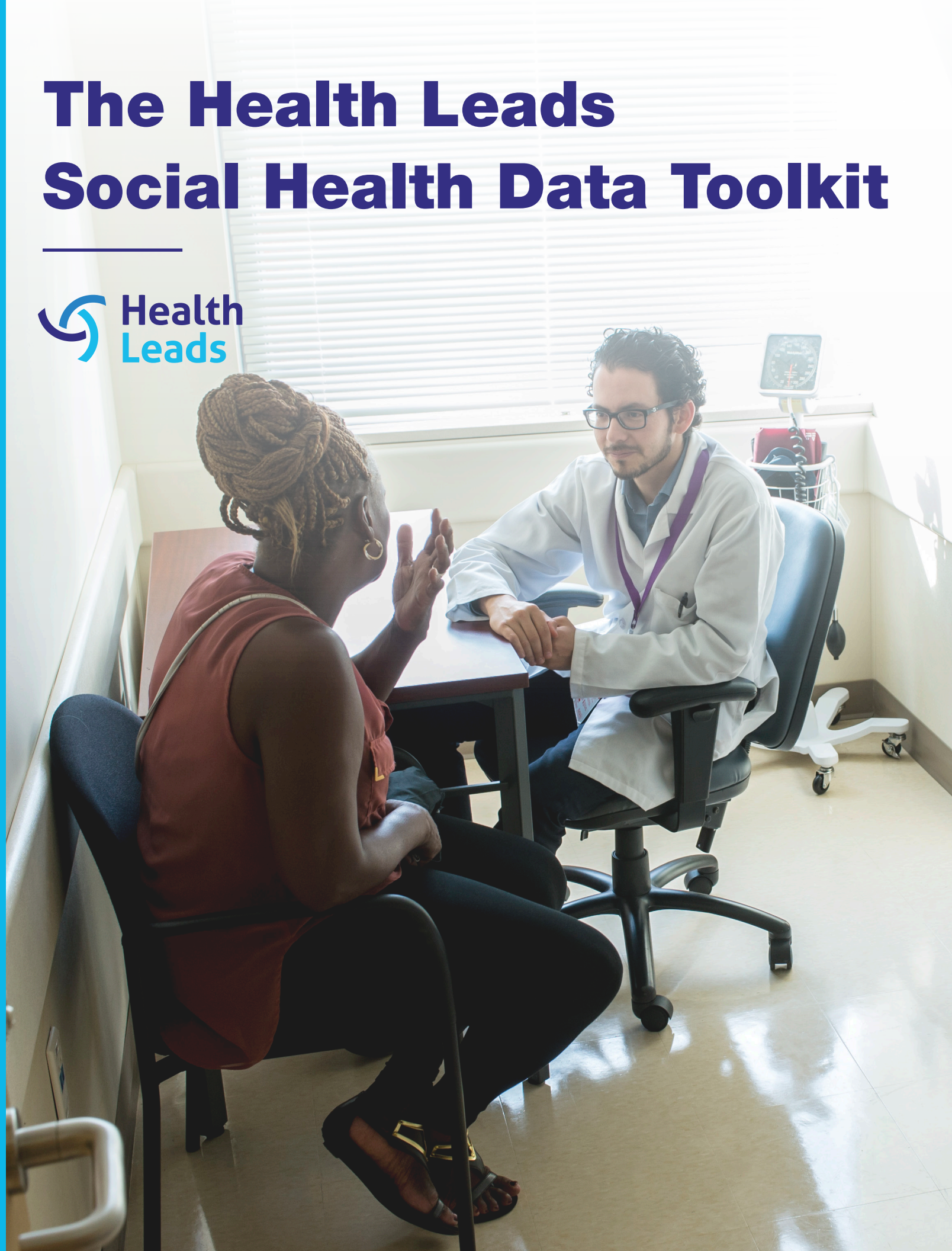


# The Health Leads Social Health Data Toolkit

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## Background

Health Leads has worked with health systems and their community partners to integrate standard essential resource needs screening and navigation services into clinical workflows for more than 20 years. We strongly believe that collecting and analyzing process and outcome data specific to essential resource screening and navigation programs are critical to integrating social health into care delivery and ensuring the best possible outcomes for patients.

Grounded in insights and learnings from Health Leads' traditional model, The Health Leads Social Health Data Toolkit is designed for a range of healthcare teams seeking to effectively collect and apply social health program data. It is best suited for manager or director-level staff who oversee efforts to address social health and is relevant for practices at all phases of implementation and applies to all populations served. To help you harness the potential of data, the Toolkit offers the following guidance and practical tools:

- Social Health Model Overview, outlining the six key steps to implementing a social needs program;
- Screening Funnels, including key process metrics at each step in the screening workflow and tips for tackling common challenges in screening;
- [Screening Data Tracking Workbook](#) with detailed instructions on how to:
  1. Identify and source your screening process metrics
  2. Build run charts using your screening data
  3. Set targets based on your screening and/or navigation
  4. Project the number of people who will need navigation support based on your screening rate.
  5. Monitor where your social needs program is running well and where it may need improvement, allowing you to dig deeper and test new strategies
- Navigation Overview, including key process measures to help you understand the impact of your program and guidance for defining success

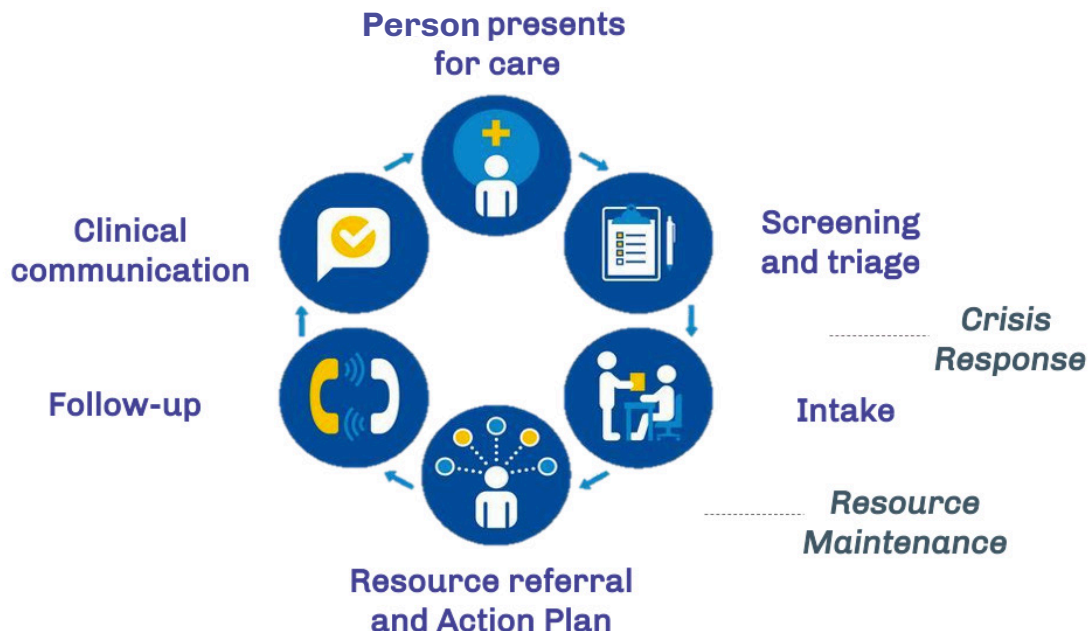
### Glossary

- **Program Scope:** defines which essential needs your program will address, for which people and at what level
- **Social/essential needs:** essential resource needs like housing, food, transportation, or social supports
- **Social health intervention:** an effort to systematically identify unmet social needs among all or a sub-group of people and connect these individuals to resources in their community
- **Social/essential need domain:** a category of social need, for example, food security or housing
- **Screen:** a questionnaire or assessment of an individual's social need(s)
- **Navigation:** supporting a patient to find a resource to address their social need(s)
- **Successful resource connection:** Individual successfully accesses a resource to address their social need(s)
- **Outcome measures:** assess how the system impacts individuals and their health and wellbeing. Outcome measures can also measure the impacts on other stakeholders such as payers, employees, or the community
- **Process measures:** assess whether the parts/steps in the system are performing as planned
- **Positive screen:** when a social need has been identified through screening
- **Screening Funnel:** a set of process metrics that follow an essential resource screening workflow

## Social Needs Model Overview

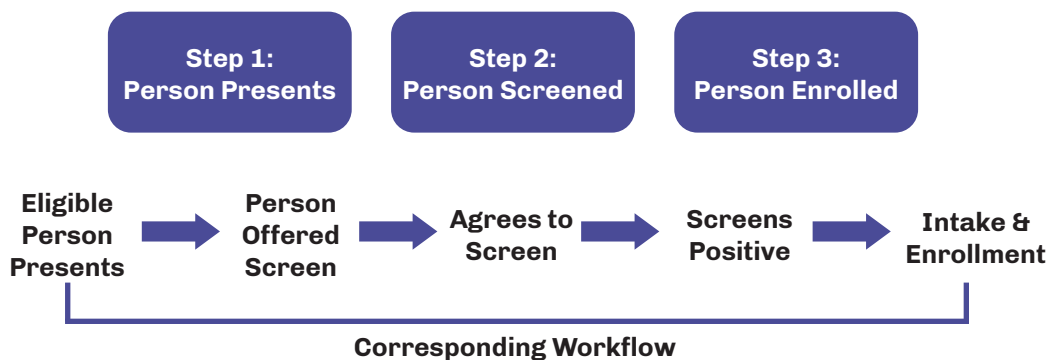
A variety of models and programs focus on addressing non-medical social needs. Health Leads' traditional model, which is commonly found in primary care settings, encompasses six key steps to implementation: **Person Presents, Person Screened, Person Enrolled, Resource Referral Made, Follow-up, Case Closure**.

### Traditional Social Needs Intervention Model

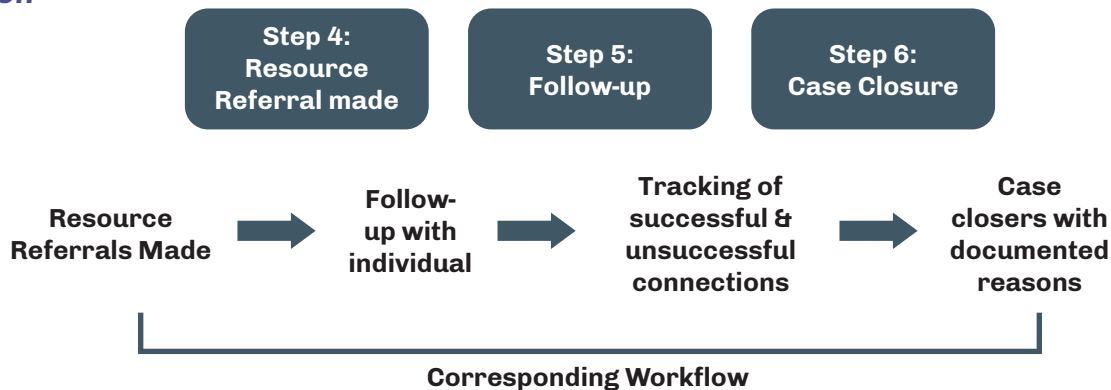


For the purpose of integration and improvement, it is helpful to split these six key steps into two phases - **Screening** and **Navigation** - which have their own unique workflows.

### Screening



### Navigation



## Screening Funnels

Health Leads has developed a set of process metrics, referred to as the “screening funnel,” that allows you to examine how people are progressing through each step of the screening workflow. Each step in your screening workflow is critical to the overall success of your social needs intervention and informs which individuals do or do not receive support accessing essential resources. By collecting and analyzing data, your program can identify where people may be “falling through the cracks” and make adjustments to better serve them.

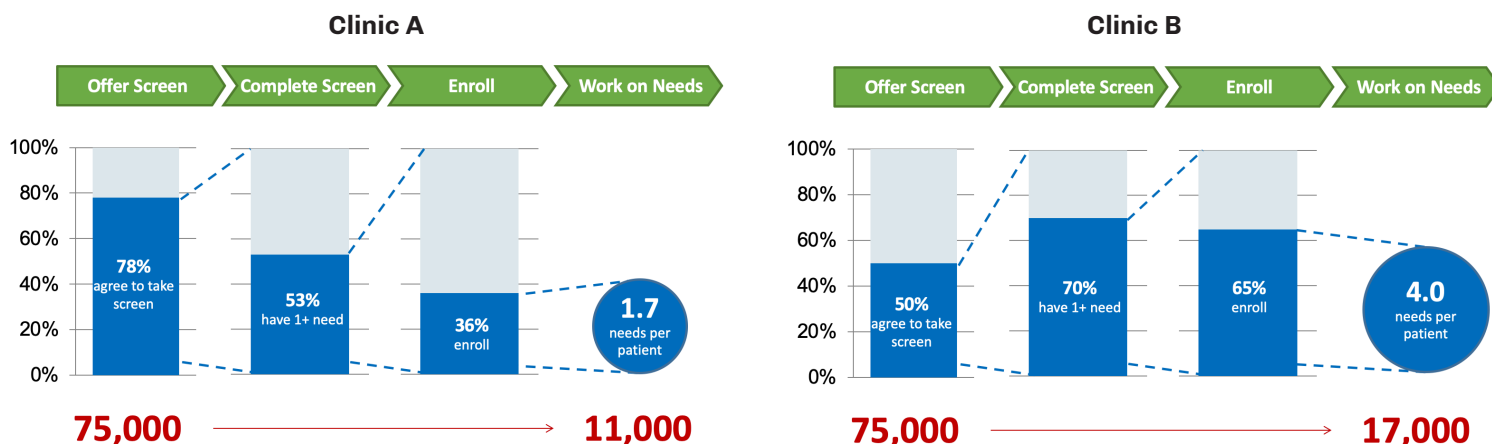
The screening funnel consists of the following process metrics that typically reflect the essential needs workflow:

- # of People Eligible for essential needs screening, also referred to as your base target population
  - To keep an accurate count of unique screens, count returning and new people separately
  - For detailed information on how to screen clients see our [screening toolkit](#)
- # of People Offered a screen for social needs
- # of People Identified at least one social need
- # of People who received navigation/ enrolled in social needs program

**Disaggregating these data by race, ethnicity, and language can help you better understand inequities in program access and success among the people you serve**

### I. Understanding the Utility of the Screening Funnel

A positive screen is simply a critical first step. From there, further assessment is required to design an intervention that can best help meet the individual's preferences and strengths. As a basic principle, not everyone who is screened will identify a need and not everyone who identifies a need will require or want referrals or navigation support. The goal of the assessment process is to understand the person's goals and priorities to create an action plan and provide appropriate referrals.



Comparing differences between Clinic A and Clinic B illustrates the importance of breaking your screening workflow into discrete steps and calculating the percentage of people that move through each step. As you can see, both clinics start with the same number of people (75,000), but differences in the number of people who agree to screen, screen positive, and enroll make a big difference in the number of individuals that ultimately receive navigation or services. This is illustrated in 11,000 people with 1.7 needs vs. 17,000 people with 4 needs. This final number could have big implications in your capacity and resource planning.

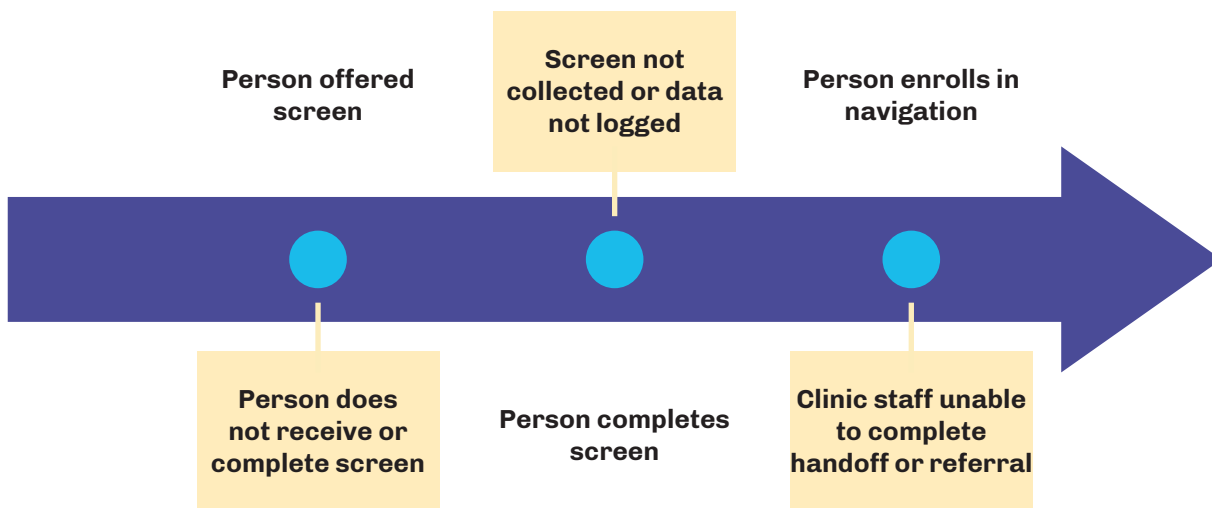
When someone is screened for social needs they typically follow four steps:

1. **They are eligible to be screened:** Based on your goals and population of focus, eligibility criteria may be all people who have yet to be screened, people located at one clinic, or a set of individuals with complex needs.
2. **They agree to screen:** It is not uncommon to experience a drop off at this point. Our findings have shown a drop off rate ranging from 10-90%.
3. **They screen positively (essential resource need identified):** Be aware that individuals may not indicate if they are experiencing a social need. This may be related to several factors including, discomfort disclosing, literacy and/or cultural barriers. If you have questions about how to build an effective screening tool, see our [Screening Toolkit](#).
4. **They enroll in your program or request support/ navigation:** Note that in some cases individuals may have social needs but may not desire support.

We have found that by calculating the percentage of people making it through each of these steps, we are able to more accurately plan for capacity and resource needs. In addition, by breaking up screening into these steps, we can pinpoint targets for each step and easily identify bottlenecks or trouble spots throughout the client's journey from eligibility to navigation. The tools found in the accompanying **Screening Data Tracking Work Book** will help you identify where you will track these metrics, provide you with a table to input the data, provide a run chart to keep your eye on weekly changes, and calculate weekly targets so that you can guide your team to work toward your annual screening and volume targets.

For more information about how a screening funnel can bring insights to your work, check out our [WIC Case Study](#) about connecting patients in New York City to food and nutrition benefits.

## II. Common Challenges in your Screening Funnel



Each step in the screening funnel can experience breakdowns or bottlenecks that can hinder progress towards your goal of screening and/or providing navigation to your population of focus. Here is a summary of common breakdowns and bottlenecks for each step of the workflow. Again, the best way to find and address these is by tracking your screening funnel data and gathering qualitative feedback from the individuals served to understand what is causing these trends.



## Common Breakdowns and Bottlenecks in Social Need Program Workflows

1. **Eligible Individuals:** Clinics often encounter issues capturing and calculating the actual number of individuals who are eligible to be screened. **Tip: Clearly define the population to screen and have systems in place to properly identify them.** Breakdowns commonly occur when the workflow does not capture the population of focus. **Tip: Consider targeting an appointment type or day(s) of the week to screen which will allow you to build a more predictable workflow.**
2. **Offer the screen:** It is very common, especially during integration, for the staff responsible for offering the screen to forget or neglect to hand it out or record it appropriately. **Tip: Color-code or number the screening tools and schedule regular huddles with the staff to problem-solve.**
3. **Agree to Screen:** Communication about the purpose of the screening program has a big impact on the number of patients who agree to screen. **Tip: Develop a few different scripts based on the culture of your population of focus and test a few versions while tracking your Agree to Screen numbers.** See the [Screening Toolkit](#) and [Empathic Inquiry](#) for further guidance.
4. **Screen positive:** This number should reflect the actual number of people (who have been screened) that have social needs. **Tip: Gather feedback from individuals within your target population to ensure that the way your screening questions are structured will elicit accurate responses.** For more information on how to develop a screening tool that reflects your population of focus see the [Screening Toolkit](#).
5. **Enrollment/ Accept Navigation support:** Drop offs often occur here, as more people will identify social needs than will elect to be connected to navigation support. We've found the most common reason is the program failed to accurately and effectively introduce navigation support to those with identified essential resource needs. **Tip: Ensure your program staff have an understanding of the social health program, provide them a clear script, and assign them to ask people if they want navigation support.** It is useful to ask people about their readiness to get navigation support. Test out a few different approaches, track your data weekly, and see what improves your volume. See the [Workforce Training Guide](#) for further guidance.

See the next section for tips on using the Run Chart to identify and address breakdowns and bottlenecks.



# Screening Data Tracking Workbook Guide

The following information and examples are intended to guide you through using the [Screening Data Tracking Workbook](#) to track social health programmatic data and analyze and use the results over time for program improvement.

## I. Identify and Source Your Screening Process Metrics

**Step 1 Identify Measures and Data Sources:** Start by listing the steps of their workflow where data is captured to get a clear understanding of what is being measured. Using the **Data Documentation tab** in the Screening Data Tracking Workbook the clinic can capture learnings from each metric. This should be updated as workflows change or if record keeping technologies change.

### Screening Data Tracking Workbook: Data Documentation Example

A	B	C	D	E
<b>Overview:</b> Use this sheet to document where within your workflows the data needed to fill out your screening funnel is captured. Example below demonstrates how to align a clinical workflow (B) with the screening funnel (A) and identifies where data can be captured (C) and other				
Screening Funnel	WorkFlows Steps and Metrics	Where is this captured?	Reporting Requirement?	Open Questions/ Learning Questions
<b>Is the patient eligible?</b>	<b>Registration Staff Identify Patient</b>			
	# Do they Qualify (Medi/Medi, geographic zone): YES/ NO	EMR Flag	Y	
	<b>PA rules in/ out</b>			
	screen? YES/ NO	EMR		
	<b>CHW checks for prior screening</b>			
	# Not screened in prior 12 months (required for no screen in past 12 months). Universal screening, always attempt the screen.	EMR		
<b>Offer to Screen</b>	<b>Were they offered the screen (did CHW remember to offer it)</b>	EMR Flag		
<b>Agree to Screen</b>	<b>CHW provides overview + consent forms</b>			
	#Consent to be screened			Need to identify how to capture.
<b>Total Screened</b>	<b>CHW offers screen</b>		Y	
	#Screened in the ER	Reach		
	#Screened in the Room? (post Admit)	Reach		
<b>Screened Positive</b>	<b>Patient Completes Screen</b>		Y	
	# Total Positive	Reach		
	# Total Negative	Reach		
	# Total High Risk	Reach		
	#Total Low Risk (RRR)	Reach		
<b>Screens for IPV</b>	<b>Referred to Clinical Staff</b>			
	#Positive for IPV	Reach		each hospital has a
				need to create discrete protocol for staff, need to determine bps at each hospital, Do we have permission to exclude IPV resources, by patient request. can remove resources without removing need.
<b>Patients Enrolled</b>	<b>Low Risk: RRR</b>			
	# Total Recieve RRR	Reach		
	<b>Hi Risk: Initial RRR+ Enrolls</b>			
	# Total fully enrolled	Reach		
<b>Patients Receive Navigation</b>				
	# Total Success (Resolved)	Reach		
	#Total unresolved	Reach		
	Red Flag Referrals	Reach		
	emergency homelessness	Reach		need to build a protocol + comm. plan + def of success
	substance abuse	Reach		need to build a protocol + comm. plan + def of success
	mental health	Reach		need to build a protocol + comm. plan + def of success



**Step 2 Input Program Data:** Once the program is clear on what they are measuring, they can begin to input their weekly screening rates in the **Data Input tab** within the Workbook. This data will become the data source for the Run Charts and the Planning Tools within the Workbook.

### Screening Data Tracking Workbook: Data Input

Data Input					
Week of:	#Eligible for	#Screens	#Agree to	#Positive	#Enrolled
10-Feb	240	96	76	35	25
17-Feb	241	97	77	34	24
24-Feb	242	98	78	32	23
2-Mar	300	99	79	46	22
9-Mar	200	96	78	57	21
16-Mar	250	93	67	56	26
23-Mar	240	90	65	45	24
30-Mar	241	89	47	34	25
6-Apr	242	67	67	64	26
13-Apr	300	96	58	55	23
20-Apr	200	97	67	45	22
27-Apr	250	98	98	66	27
4-May	240	99	67	55	26
11-May	240	96	56	33	28
18-May					
25-May					
1-Jun					
8-Jun					
15-Jun					
22-Jun					
29-Jun					
6-Jul					
13-Jul					
20-Jul					
<b>Total</b>	<b>3426</b>	<b>1311</b>	<b>980</b>	<b>657</b>	<b>342</b>

Calculations							
% Offered	Median %	% Screened	Median %	% Screened	Median %	% Enrolled	Median %
40.0%	39.6%	31.7%	27.8%	46%	68%	71.4%	48.4%
40.2%	39.6%	32.0%	27.8%	44%	68%	70.6%	48.4%
40.5%	39.6%	32.2%	27.8%	41%	68%	71.9%	48.4%
33.0%	39.6%	26.3%	27.8%	58%	68%	47.8%	48.4%
48.0%	39.6%	39.0%	27.8%	73%	68%	36.8%	48.4%
37.2%	39.6%	26.8%	27.8%	84%	68%	46.4%	48.4%
37.5%	39.6%	27.1%	27.8%	69%	68%	53.3%	48.4%
36.9%	39.6%	19.5%	27.8%	72%	68%	73.5%	48.4%
27.7%	39.6%	27.7%	27.8%	96%	68%	40.6%	48.4%
32.0%	39.6%	19.3%	27.8%	95%	68%	41.8%	48.4%
48.5%	39.6%	33.5%	27.8%	67%	68%	48.9%	48.4%
39.2%	39.6%	39.2%	27.8%	67%	68%	40.9%	48.4%
41.3%	39.6%	27.9%	27.8%	82%	68%	47.3%	48.4%
40.0%	39.6%	23.3%	27.8%	59%	68%	84.8%	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
-	39.6%	-	27.8%	-	68%	-	48.4%
<b>38.27%</b>		<b>28.60%</b>		<b>67.04%</b>		<b>52.05%</b>	



## II. Use Run Charts to Visualize Program Data

Now that weekly screening data are being tracked, a program can begin to see their progress using the Run Charts.

### Screening Data Tracking Workbook: Run Chart

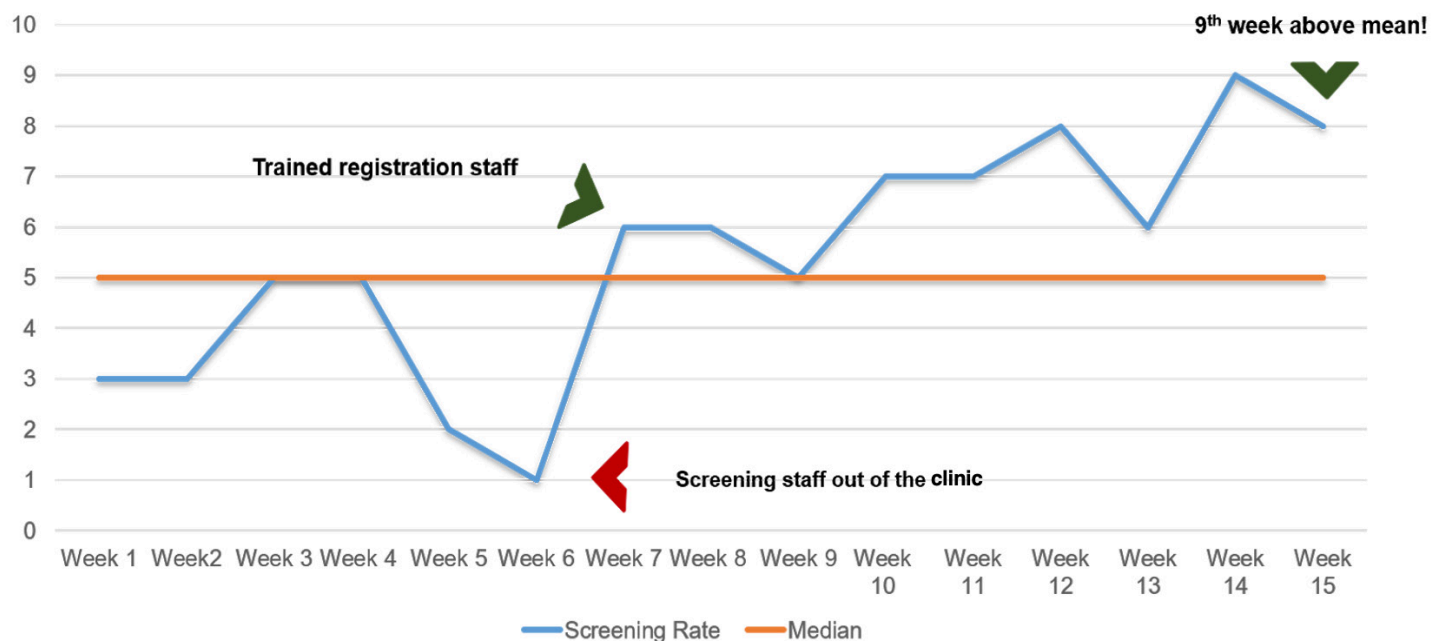


Run charts are graphs of data over time. They can help improvement teams plan and adjust processes by depicting how well or poorly a process is performing. They also help staff determine when changes are truly improvements by displaying a pattern of data that you can observe as process changes are made. If you are unfamiliar with run charts, see [The Institute for Healthcare Improvement's Run Chart Tool](#).

The run charts in this tool will give you insight into the weekly fluctuations in your offer screening, screen positive, and enrollment rates. Tracking these changes can be useful if you are:

1. Integrating the essential needs workflow for the first time
2. Working toward a volume target and suspect bottleneck or breakdowns
3. Implementing changes to your workflow and want to determine which changes improve your volume

### Percent of Patients Offered Screen



A Run Chart can help determine if a change has resulted in an improvement. We can say that there has been a shift in the data when six or more consecutive points either all above or all below the median.<sup>1</sup> Values that fall on the median do not add to nor break a shift - just skip values that fall on the median and continue counting. With those rules of a run chart in mind, we can use Run Charts for each step in the Screening Funnel to see when there are dips in volume or shifts in the data that demonstrate that a change we've employed is working. In the example above, the red arrow shows us where there was a notable dip resulting from staffing changes. We can also see when the team implemented a change (during the 7th week) of training the registration staff to administer the screening tool. As we can see in weeks 8 through 15, this change resulted in an increased screening volume, over the course of 9 weeks. Based on the rules of the run chart, this team can safely conclude that their change resulted in an improvement. Given the success of the training, they may consider sharing it with other teams to determine if they have similar results.

<sup>1</sup>Adapted from "Lloyd & Provost (2011): The Health Care Data Guide – Learning from Data for Improvement"



### III. Using Program Data to Make Screening Volume Projections

As the previous example illustrated, the **Run Chart tab** in the Screening Data Tracking Workbook can help you identify bottlenecks and positive changes in your Screening Funnel rates. However, the Run Chart will not help you to identify your weekly targets or help you predict your volume -- that is where the **Projection Tables** tab comes in handy. Let's explore how this tool is used in the clinic setting.

**Example Use Case - ABC Clinic:** ABC Clinic is establishing a new social health program and would like to screen as many patients as possible per year. The leadership wants to understand how much staff capacity this will take to execute successfully. The clinic has not set an annual Screening or Enrollment Target, but they know that they serve roughly 12,000 patients each year. They also predict that about half of their patients (6,000) have unmet resource needs and can use this estimate to help them set a target. To note, they will need to have several weeks of data (8-10), to more accurately set their screening target.

1. ABC Clinic has been capturing their program's process metrics and can now start to make predictions based on the data calculated in their Screening Funnel (in the **Prediction Tables tab**). The **Year to Date Screening Funnel** summarizes the data from the Data Input tab to their average performance on the key process metrics included in the Screening Funnel. This is based on 8-10 weeks of data captured in the tools above.

Year to Date Screening Funnel				
Eligible Clients	% Eligible Patients Offered Screen	% Clients who Agree to Screen Offer	% Clients who Screened Positive	% Clients Who screened Positive & Enrolled
3426	38%	29%	67%	52%
Weekly Average Actuals				
Eligible Clients	# Patients Offered Screen	# Agree to Screen Offer	# Screened Positive	# Enrolled
245	94	70	47	24

2. ABC Clinic knows they have an annual screening target of 12,000, which they enter into the orange table below.

Annual and Weekly Target Projections Based on Screening Target				
Projected Eligible Clients	Your Annual Screening Target	Projected Agree to Screen	Projected Positive Screen	Projected Enrolled Clients
	12,000			
Weekly Targets				
Weekly Average Actuals				
Difference between Weekly Average Actuals and Weekly Targets				

3. The Orange Table will automatically populate projected annual and weekly screening targets.

Annual and Weekly Target Projections Based on Screening Target				
Projected Eligible Clients	Your Annual Screening Target	Projected Agree to Screen	Projected Positive Screen	Projected Enrolled Clients
31,359	12,000	3,433	2,301	1,198
Weekly Targets				
603	231	66	44	23
Weekly Average Actuals				
245	94	70	47	24
Difference between Weekly Average Actuals and Weekly Targets				
-358	-137	4	3	1

4. Notice that the weekly targets are very high, as are the differences between the targets and actuals. Remember that these are calculated based on the current Screening Funnel count and average weekly actuals, so these numbers will change and become more accurate as the team progresses and gathers more weekly data. In this example, ABC Clinic can see that to reach their annual screening target of 12,000 people screened, they would need to screen 300 individuals a week. Whether or not this is a feasible goal depends on their workflows and staff capacity to conduct that many screens.

#### IV. Using Programmatic Data to Make Enrollment Projections

Now ABC Clinic can use the Purple Table (Enrollment Target) to understand their enrollment data. First, they should input their Enrollment Target, which they've estimated to be 6,000 patients with an essential resource need. This is an estimate based on their goal of serving as many patients as possible AND their hypothesis that about half of their 12,000 patients will have a social need.

Annual and Weekly Target Projections Based on Screening Target				
Projected Eligible Clients	Projected Annual Screening Target	Projected Agree to Screen	Projected Positive Screen	Your Annual Enrollment Target
				500
Weekly Targets				
Weekly Average Actuals				
Difference between Weekly Average Actuals and Weekly Targets				

The Purple Table will automatically populate projected targets.

Annual and Weekly Target Projections Based on Screening Target				
Projected Eligible Clients	Projected Annual Screening Target	Projected Agree to Screen	Projected Positive Screen	Your Annual Enrollment Target
13,089	5,009	1,433	961	500
Weekly Targets				
252	96	28	18	10
Weekly Average Actuals				
245	94	70	47	24
Difference between Weekly Average Actuals and Weekly Targets				
-7	-3	42	28	15

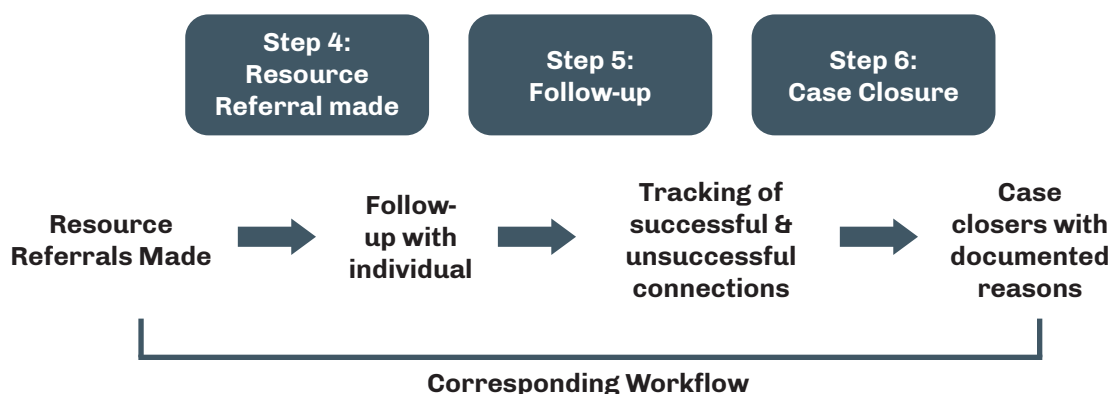
As you can see, based on their current Screening Funnel data, their target of 6,000 enrolled patients is not realistic because it would require that they screen 44,026 patients annually which is well beyond their actual annual volume. These numbers are calculated based on their actual screening funnel percentages seen in the Blue table (shown above). These projections will change as their data changes, but with 8-10 weeks of screening completed, this data is a good indicator that their enrollment target may be too high. Understanding these trends can help with capacity planning for your social needs program, as well as to identify program trends and opportunities for improvement.

ABC Clinic can see that their screening funnel rate reflects some of their predictions (46% of patients screened identified at least 1 need), but they are also not close to meeting their enrollment goals. If they want to improve the accuracy of their positive screening rate, they may look deeper into their Screening offered and Agreed to Screen rates to understand what factors may be influencing these rates to be lower than anticipated. It may be that they need to adjust the scope of their program or provide additional training to their program staff.

## Navigation Overview

Tracking key process measures in your Navigation workflow can provide insight into how successful your program is at connecting patients with community resources and where adjustments may be needed.

### I. Navigation Workflow



Many of the resources and information below are most useful for teams that have an established resource database. If your team has not yet built or used a resource database, we recommend starting with our [101 Social Needs Workshop series](#).

If needs are identified through screening and a person wants assistance in addressing those needs, it is important to connect and navigate people to the appropriate community resources. Tracking referral outcomes can help answer questions like the following:

- Are individuals accessing the essential resources they need?
- What kinds of resource needs are harder or easier to meet?
- What programmatic processes are working, and which ones are not?
- What resource referral relationships need more attention?

### II. Defining Success

How you define success for your social needs program can vary based on a number of factors, such as the availability of the essential resource or the individual's desired level of support. The table below shows several of the likely outcomes from attempting a resource connection. Tracking the outcomes associated with each attempted resource connection can help you to:

1. Demonstrate impact
2. Set clear expectations with individuals served and tailor navigation to resource needs
3. Set a clear signal when to close a case and move to other work



## Potential Resource Navigation Outcomes

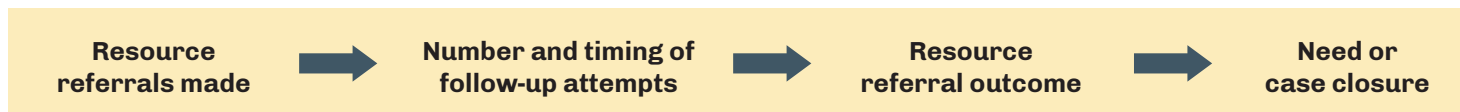
Failure	Waitlist	Equipped	Successful
<p>Individual hit a roadblock and was unable to resolve their need</p> <p>Individual did not meet eligibility requirements (ex: income too high)</p> <p>No resources exist to meet individual's need</p>	<p>Individual placed on a waiting list for two months or longer</p>	<p>Need not yet met, but the individual is actively working on solving the need</p> <p>AND</p> <p>Feels equipped to proceed without further assistance</p>	<p>Individual confirmed successful resolution of need (food is secured)</p>

Not all resources are likely to result in a successful connection, often because of waitlists or other constraints. When these constraints are known and predictable, we recommend tailoring the goals for your workforce and expectations of your clients accordingly. For example, Section 8 Housing is a Federal benefit with a known 8+ year waitlist. Given that most clients will not receive navigation support for 8 years, it is very unlikely that they will obtain a Section 8 voucher. In those circumstances you may want to instruct your workforce to provide information about how to join the Section- 8 waitlist and advise your clients that it is likely they will not obtain this resource. You staff and clients can then shift their attention to other resource needs that are more likely to result in successful resource connections.

### III. Collecting and Using Navigation Data

Some software systems used in clinical settings have the capability to capture essential resource data, while others do not. Given the wide ranging functionality of different social needs and resource management technology platforms, it is likely that you will need to augment one or all of them to capture the set of navigation measures we recommend.

As described above, the navigation workflow can be broken down into the following steps:



We recommend collecting the data associated with each of these steps, including:

1. Needs open (needs that screened positive and those the individual requested support with)
2. Number of follow-up attempts
3. Timing between follow-up attempts
4. The outcome of the Referral\*: (see above on Defining Success)
  - Successful (individual obtained desired/ needed resource)
  - Unsuccessful (individual was unable to obtain resource)
  - Equipped (the individual has the information they need, but hasn't yet obtained the resource)
  - Disconnected (no longer in contact with the individual)
5. Resources
  - Which resources led to successful resource connections
  - What need types this resource can address

To illustrate how one team captured these data points, see the table below:

Food Need Closure		Referral Outcome			
		Failure	Waitlist	Equipped	Success
Food benefits (WIC and SNAP)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food pantry/Fresh fruits and vegetables		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Free hot meals (soup kitchen)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baby formula		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MatterBoxes (FRC)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

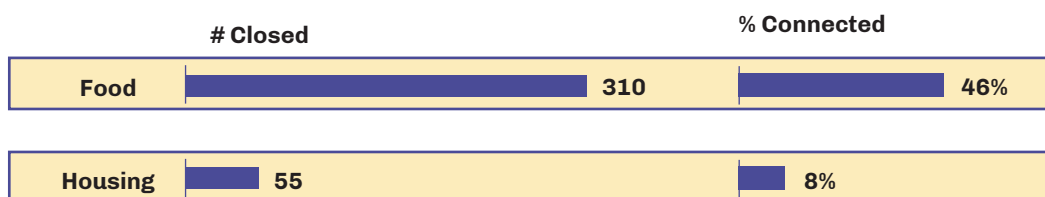
  

Outcome	What resources were the family connected to?
Failure	<hr/>
Waitlist	<hr/>
Equipped	<hr/>
Success	<hr/>

#### IV. Interpreting your Navigation Data

Collecting navigation data will help you understand the impact your program is having on addressing the essential resource needs of your population served and will help you identify opportunities to more effectively address barriers to resources.

If we look at the example below on food and housing data, we can learn a few things just from a couple of data points. First, we see that food needs are more likely to be closed. This doesn't mean housing needs aren't critical, but it does tell us that addressing food needs gets to a much broader set of people.



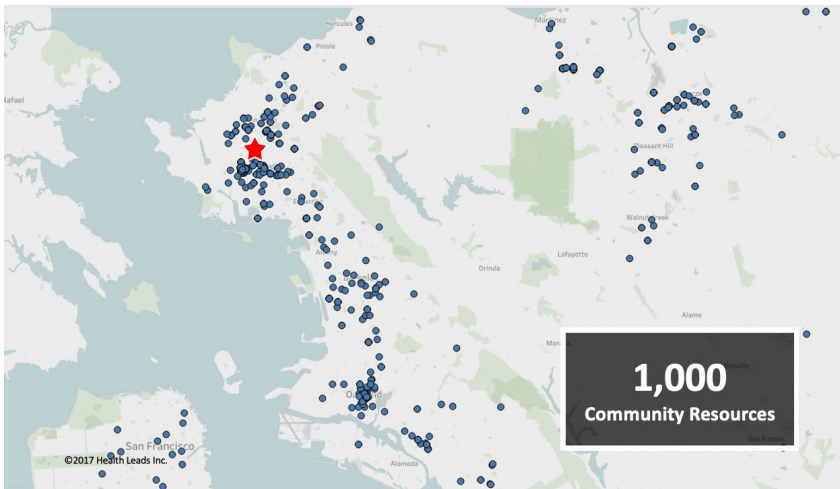
We can also see that while almost half of individuals served were able to connect to the food resources we referred to, only 8% were successful in connecting to the housing resources. In the case of housing, this is an easy one to figure out: housing resources are incredibly scarce and the resources that do exist just do not align with patient housing needs.

On the other hand, if we saw those low numbers for a need category like Medicaid, this data would be a cue that something is going wrong in the referral process, since we know that people who are eligible should be successful in addressing their need. If this happened we would begin talking to individuals and reviewing case notes, and perhaps we'd learn that the Medicaid office is not accessible by public transportation, or that we are referring people who are way above the income eligibility cut-off. These issues can be addressed by updating the eligibility information in your resource database or improving your intake questions to identify potential future barriers.

## V. Population-Level Data

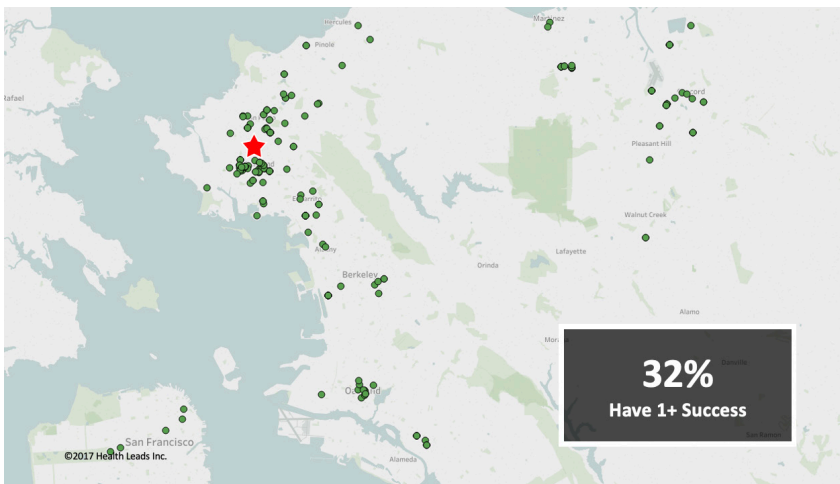
Using your data at the population level to better understand the resource landscape can support your team to improve the efficiency and effectiveness of your program. Looking at your data at the population level can help you consider how your team may refine the resources listed in your directory. At the individual level, obtaining client feedback can help you dive deeper into what's going on behind the data. Taken together, actions to refine your resource list may include:

1. Noting which resources most often result in individuals served obtaining resources
2. Identifying areas where there is a lot of need for resources but few exist in the community
3. Understanding shifts in the resource landscape over time



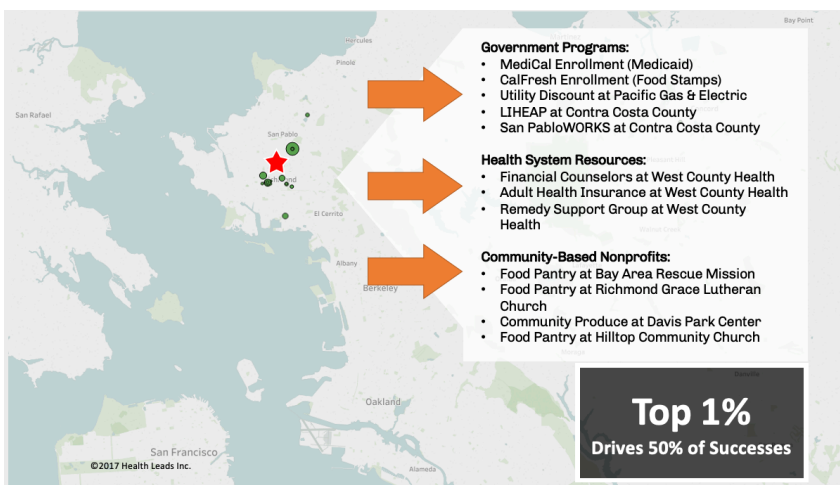
### Example 1:

By tracking which resources were referred to (illustration1), we see there are approximately 1,000 community resources in our resource database.



### Example 2:

When that referral information (which resource) is combined with the outcome (definition of success): Successful, Unsuccessful, Equipped, Disconnected, we can see that only 32% of those resource referrals resulted in a successful connection.



### Example 3:

In fact, in this third illustration, that 1% of resources (100) resulted in 50% of the successful resource connections. This does not mean that you should remove the resources with less connection rates as they may serve smaller populations. By looking at population data, it allows you to narrow down areas you need to invest in more community partnerships.



## Conclusion

The adoption of social health interventions by health systems and their community partners is one of the most important but complex advances in supporting whole-person health in recent years. In order for these programs and interventions to succeed and be sustained, clinical teams must recognize and overcome their complexities and challenges. Consistently tracking process and outcome measures related to your social needs program is critical for understanding how well your program addresses the essential resource needs of the populations you serve. Combined with qualitative feedback from community members served, it will help you identify opportunities to more effectively address barriers to resources. We hope that this toolkit provides you some guidance and knowledge on how to more effectively collect and use social need program data.

We always welcome feedback on our tools and resources. Please reach out to [info@healthleadsusa.org](mailto:info@healthleadsusa.org) with questions or recommendations.

## ABOUT THE NETWORK

The Health Leads Network is a community of healthcare practitioners and caregivers who are taking action to address essential needs within our organizations. Network members work in a wide range of health system roles and settings — but share a commitment both to drive improvement initiatives on the ground, and to advance health equity in their communities.

The Network was created to bring action-oriented practitioners together to collaborate, share and learn from each other. We translate critical front-line experience into tangible tools, guidance and learning opportunities — all designed to support members in advancing the integration of essential needs into community-led health initiatives.

Learn more at [healthleadsusa.org/network](https://healthleadsusa.org/network) — or email [network@healthleadsusa.org](mailto:network@healthleadsusa.org) for additional information.

