MDPQC Action Plan Template
for Implementing Universal SDOH Screening

Identifying pregnant and postpartum patients with health-related social needs is a critical aspect to getting them connected with community services to address Social Drivers of Health (SDOH). As accreditation standards and federal regulations have increasingly prioritized health care disparities and patient's health-related social needs, we hope to support Maryland birthing hospitals in meeting these criteria for SDOH measures and health equity requirements. Use this tool to help get started on your journey to implement universal SDOH screening at your facility, or refine the current processes you have in place for identifying health-related social needs among pregnant and postpartum patients.

Core Team Members

	Team Member Name	Responsibilities
Nurse Champion		
Physician Lead		
Department Staff Members		

Action Plan

Outline a goal to address SDOH among pregnant people, postpartum people and their newborns. Describe the actions you will take to achieve this goal, the resources required, how you will measure your success and how you will monitor your impact.

1. **Goals:** List out your **SMART** goal(s). (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime-Bound)

2. **Action Steps:** List the action steps needed to achieve your goal(s) and include estimated completion dates for each step.

3. **Resources and Key Stakeholders:** List the resources needed to accomplish action steps, including key staff or stakeholders.

4. **Metrics:** What will you monitor? What data will you use to track progress and how often?

5. **Measureable Outcomes/Impact:** Considering long term outcomes, how will you evaluate the impact and sustainability of your actions?

Developing a Strategy to Implement Universal SDOH Screening

What initiatives or activities currently exist in your hospital's labor & delivery/mother-baby/NICU units that address social drivers of health? Answer the following questions about your current programs to develop a plan to implement universal SDOH screening among pregnant or postpartum patients experiencing substance use and/or mental health conditions in your facility.

Is your facility/health system currently screening for social drivers?

Select all that apply:

- ☐ Yes, hospital/health system wide
- ☐ Yes, in labor and delivery unit
- ☐ Yes, in mother/baby unit
- ☐ Yes, in NICU/special care nursery unit
- ☐ Yes, in all inpatient units
- ☐ No
- ☐ Other _____

If you answered yes, please answer the following:

Describe where you are currently screening:

Who is administering these screenings?

Who is providing resources to those who screen positive and accept resources?

How do you provide resources?

How often can a patient be screened?

Is your current screening program tied to a grant or other payment incentive? ☐ Yes ☐ No

If yes, please explain

If you are currently screening for social drivers, which social drivers are patients screened for?

Select all that apply:

- ☐ Food insecurity*
- ☐ Housing instability*
- ☐ Utility Difficulties*
- ☐ Transportation Needs*
- ☐ Interpersonal Safety*
- ☐ Financial strain
- ☐ Employment
- ☐ Loneliness/Social Isolation
- ☐ Education
- ☐ Physical activity
- ☐ Substance use
- ☐ Mental health
- ☐ Disabilities
- ☐ Child Care
- ☐ Other _____
- ☐ Other _____

Which screening tool(s)** are you using?

*Required by CMS

**For those combining questions from multiple sources to create a screening tool; For those using pediatric tool and adult screening tool

Do you have any staff currently addressing social drivers outside of formal in-patient screening?

Select all that apply:

- ☐ Yes, but at patient or provider request only
- ☐ Yes, for those who require discharge planning
- ☐ Yes, for those who are a high-risk pregnancy
- ☐ Yes, for those who are at risk for readmission
- ☐ Yes, if there is suspected abuse or neglect
- ☐ Yes, but only targeting specific patients or units (e.g. uninsured patients or patients in mother and baby, etc.)
- ☐ No
- ☐ Other _____

If you selected yes to any of the above, which staff/departments lead these efforts?

Screening Workflow

Taking into consideration what you are currently doing to address social drivers, outline a screening workflow to map out what occurs during your admission process from triage to labor & delivery to mother-baby and/or NICU. This is an opportunity to try a new approach or fine tune your current approach to improve screening acceptance, screening administration, data collection and resource navigation. **Keep in mind**, perfecting a screening workflow takes time, so be prepared to alter your plans if they are not effective.

Screening for social drivers requires deciding when and how you should screen patients, what to screen for, and how to provide resources to those in need.

Answer the following questions by selecting the options you plan to utilize in your screening process.

When will the screening be initiated?	Who will conduct the screening?	How will resources be provided to patients who screen positive and accept resources?
Select all that apply: ☐ Registration ☐ Bedside anytime during stay ☐ Bedside at a designated time ☐ After discharge is scheduled ☐ Pre-registration (i.e., via patient portal for scheduled or anticipated inpatient stays, "e.g., labor and delivery, scheduled inductions) ☐ Post-discharge ☐ Other _____ ☐ Other _____	Select all that apply: ☐ Registration staff ☐ Medical Assistants ☐ Nurses ☐ Providers ☐ OB Navigators ☐ Nurse Midwives ☐ Social Workers ☐ Case Managers ☐ Community Health Workers ☐ Patient self-administered (via paper or electronically) ☐ Other _____ ☐ Other _____	Select all that apply: ☐ Printed list of general resources provided in discharge summary ☐ Printed list of tailored resources based on patient needs provided in discharge summary ☐ Resources mailed to address on file after hospital stay ☐ Handoff to hospital staff equipped to provide resource navigation and follow up (CHWs, Case Management, etc.) ☐ Electronic referrals made via a closed-loop referral system ☐ Inpatient visits from local resource representatives to provide information ☐ Other _____ ☐ Other _____

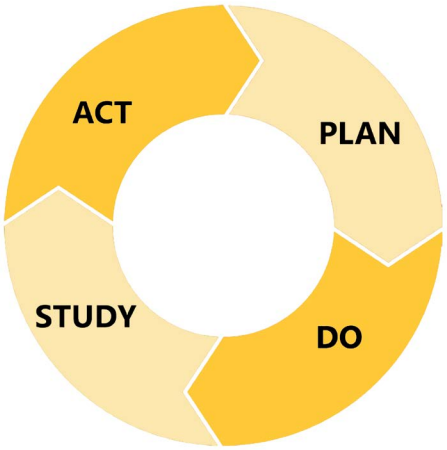
Who will provide information about/connection to community resources?	Which social drivers will patients be screened for?	Where in your facility will you screen?
Select all that apply: ☐ Registration staff ☐ Medical Assistants ☐ Nurses ☐ Providers ☐ OB Navigators ☐ Nurse Midwives ☐ Social Workers ☐ Case Managers ☐ Community Health Workers ☐ Other _____ ☐ Other _____	Select all that apply: ☐ Food insecurity* ☐ Housing instability* ☐ Utility Difficulties* ☐ Transportation Needs* ☐ Interpersonal Safety* ☐ Financial strain ☐ Employment ☐ Loneliness/Social Isolation ☐ Education ☐ Physical activity ☐ Substance use ☐ Mental health ☐ Disabilities ☐ Child Care ☐ Other _____ ☐ Other _____ Which screening tool(s)** will you use? *Required by CMS **For those combining questions from multiple sources to create a screening tool; For those using pediatric tool and adult screening tool	Select all that apply: ☐ All units, all inpatients 18+ ☐ All units, all inpatients 0+ ☐ Pediatric units, all patients ☐ Specific units, all patients 18+ (list units) ☐ Specific units, all patients 0+ (list units) ☐ Specific pediatric units, all patients (list units) ☐ Other _____

Process Map

Using the information provided above, sketch out your screening workflow using a process map. It can serve as an overview to help you visualize where social driver screening is initiated, what happens when a patient screens positive for social drivers as well as when they do not. Be sure to include steps from the point in which a patient is offered a screening to when a patient receives resources.

PDSA Worksheet

Once you've designed your screening workflow, use this chart to begin testing your processes by conducting PDSA (Plan Do Study Act) cycles. These are short, actionable tests that don't have to take a long time and will help refine your SDoH screening processes.



3 Fundamental Questions for Improvement

1. What are we trying to accomplish (AIM)?

2. How will we know that a change is an improvement (MEASURE)?

3. What changes can we makes that will lead to improvement (CHANGE)?

PLAN

What is your first (or next) test of change?	Test population?	Due Date?

List the tasks needed to set up test of change:	Who is responsible?	Due Date?

Predict what will happen when test is carried out (If we do X, we expect Y):	Measure to determine whether prediction succeeds (e.g., what data will be collected during this time?):

DO

Describe what happened when you conducted the test (e.g., what was done, what were the measure results, what were the observations).

STUDY

Describe how the measured results and observation compared with predictions (e.g., what happened that you didn't expect? Both positive and negative).

ACT

Describe the steps (e.g., modify the idea and retest [Adapt], spread the idea [Adopt], test a new idea [Abandon this idea]).

This program is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $966,300 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.