American Hospital Association™

Advancing Health in America

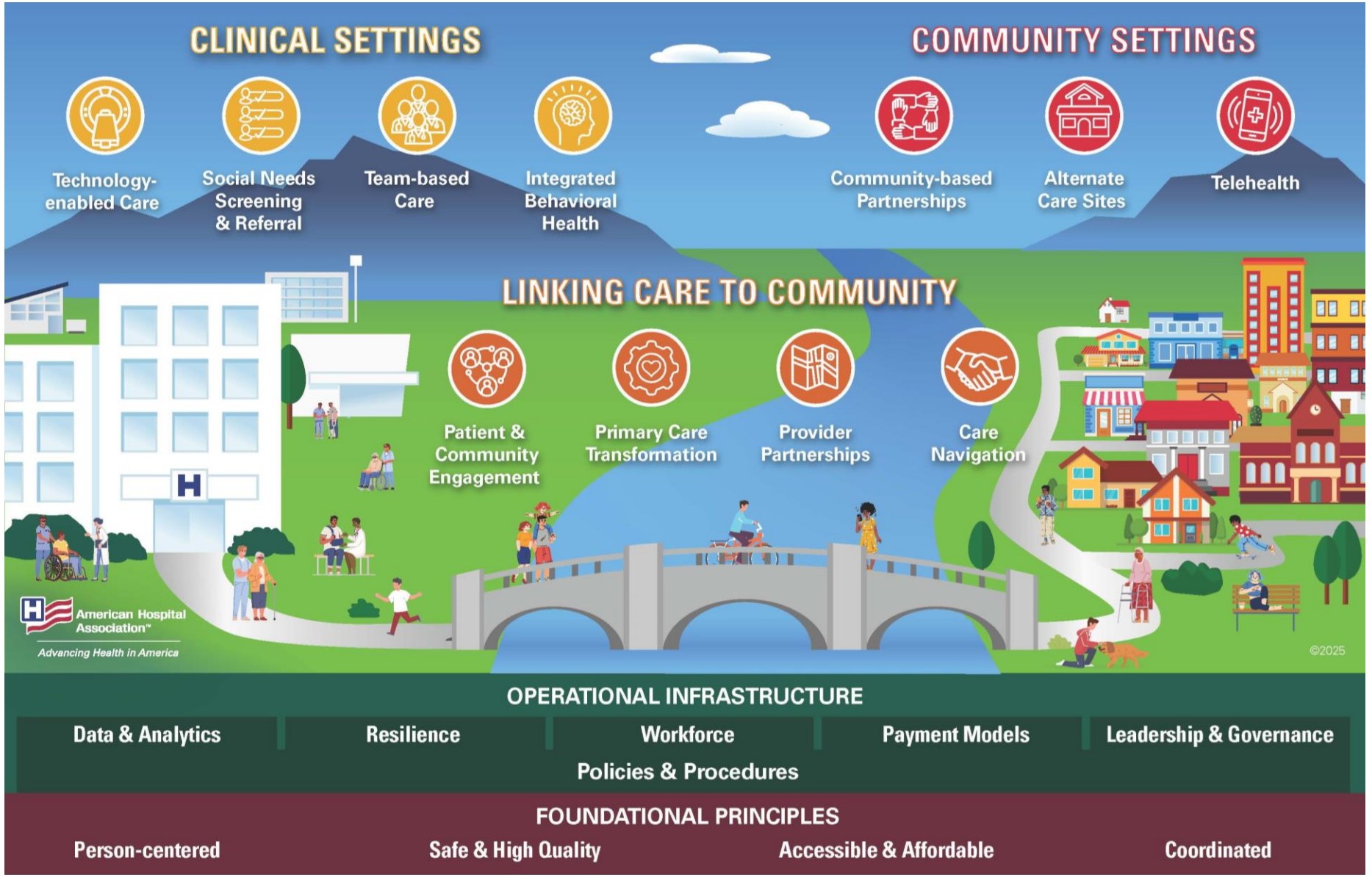
Providing Whole-Person Care by Addressing Patients' Social and Economic Well-being

Care Delivery Transformation Framework Webinar Series

June 26, 2025

Lyon Software

Care Delivery Transformation Framework



AHA offers curated resources in each care delivery transformation topic.

Learn more about the Care Delivery Transformation Framework at www.aha.org/CDT.

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Engage with the Care Delivery Transformation Framework

Explore

Find the most recent and relevant resources around each care delivery transformation topic.

Discuss

Talk with your team about how to advance your hospital's care delivery transformation strategies.

Share Your Story

Tell us how your hospital is transforming care delivery.

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Clinical Settings

Technology-enabled Care

Technological advances can be applied to care delivery to improve patient care and ensure that people are getting the right care at the right time, ultimately improving outcomes.

Social Needs Screening & Referral

Screening for and addressing patients' health-related social needs is an important step for providing holistic care.

Team-based Care

Developing a culture and structure for interdisciplinary team-based care allows health care organizations to meet the physical, mental and social needs of their patients, especially for those with complex care needs.

Integrated Behavioral Health

Integrating behavioral health professionals into the care team contributes to more holistic patient care.

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JUNE 26, 2025

Providing Whole-Person Care by Addressing Patients' Social Well-Being

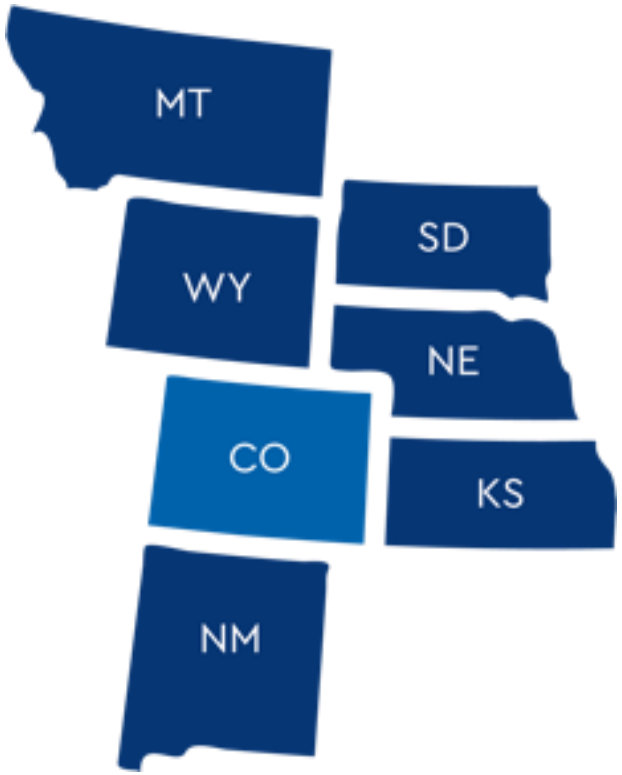
Susan Goldenstein, MNM
Director, Community Impact

Julie Beaubian, BSW
Manager, Community Health Navigation & Resource Connect

Sana Yousuf, MPH
Senior Software Engineer, Community Health Analytics

Children's Hospital Colorado
Here, it's different.

Bringing care closer to home



Partnering across the region

Our miraculous care doesn't just touch lives in Colorado. Through the power of partnership, we support and deliver outstanding care for children across the region. Our growing network of community hospital partners allows us to work as one seamless team to provide exceptional pediatric care close to home.

We've also worked with providers around the region to expand the reach of our telehealth programs. Using specialized equipment, our specialists can conference with patients with complex needs, monitor their condition and order tests from hundreds of miles away — saving parents the trip.

We see more, treat more, and heal more kids than any other hospital in our region

- We are **Colorado's only licensed specialty hospital exclusively for children**.
- We care for patients from all 50 states and at least 29 countries.
- We are the **only level 1 pediatric trauma center in our region**.
- Our level 4 neonatal intensive care unit offers the smallest patients the highest level of acute care.

Regional outreach

- 1,287 clinics
- 13 specialties
- 16 cities
- 2 states

Telehealth

- 84,000+ visits
- 49 specialties
- 44 states

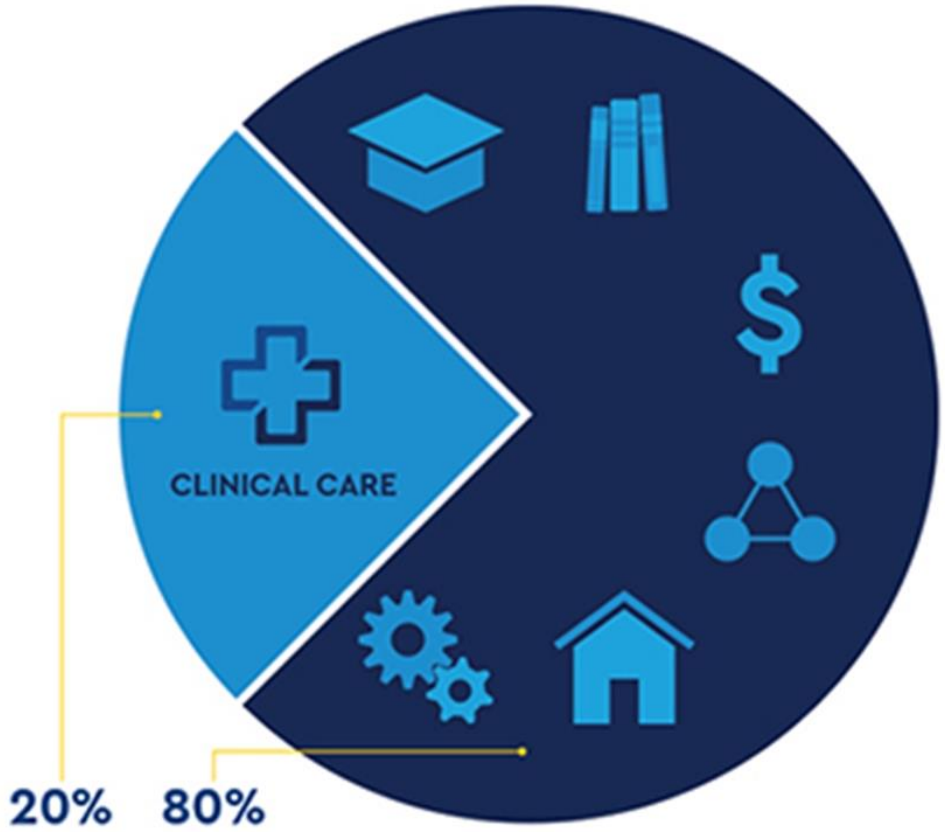
Children's Hospital Colorado Locations

1. Children's Hospital Colorado Anschutz Medical Campus, Aurora
2. Children's Hospital Colorado North Campus, Broomfield
3. Children's Colorado Therapy Care, Broomfield
4. Children's Colorado Outpatient and Urgent Care, Wheat Ridge
5. Children's Colorado Outpatient Care at Uptown, Denver
6. Children's Hospital Colorado South Campus, Highlands Ranch
7. Children's Colorado Therapy Care, Highlands Ranch
8. Children's Colorado Orthopedic Care, Centennial
9. Children's Colorado Outpatient and Urgent Care, Southeast Aurora
10. Children's Colorado Health Pavilion, Aurora - Children's Colorado KidStreet
11. Children's Hospital Colorado, Colorado Springs
12. Children's Colorado Outpatient Care at Briargate, Colorado Springs
13. Children's Colorado Therapy Care on Telstar, Colorado Springs
14. Memorial Hospital Central, pediatric expertise provided by Children's Colorado
15. Children's Colorado Outpatient Care, Grand Junction

Please refer to childrenscolorado.org/locations for the latest location information including hours of operation and services available.


Children's Hospital Colorado
Child Health Clinic
welcome home
WE'LL GUIDE YOU ON THE PATH TO FAMILY HEALTH
Children's Colorado
Health Pavilion
860

Social Drivers of Health



Has anything changed since the last time you filled out this screener? If nothing has changed you do not need to answer the rest of the questions.	**YES**	**NO**
1. Do you need help finding a doctor or clinic for yourself?	**YES**	**NO**
2. Do you have any concerns or problems that make it hard for you to keep your child's health appointments or manage your child's health care? Please circle all that apply: job, transportation, childcare, insurance, money, relationship difficulties, work or school stress, chronic illness, or legal problems	**YES**	**NO**
3. In the last 12 months, did you ever feel stressed about making ends meet? Please circle all that apply: rent/mortgage, formula, diapers, childcare, gas/transportation, paying bills, other _____	**YES**	**NO**
4. In the last 12 months, did you ever worry that your food would run out before you had money to buy more?	**YES**	**NO**
5. In the last 12 months, did your food ever not last and you didn't have money to get more?	**YES**	**NO**
6. Are you worried about your benefits right now? For example, have your benefits been denied, reduced, or eliminated or do you need help renewing your benefits? Please cirlce all that apply: Medicaid/CHP Food Stamps (SNAP) Temporary Assistance for Needy Families (TANF) WIC Child Care Assistance Program (CCAP) Unemployment Insurance Social Security Disability (SSI/SSDI) Other: _____	**YES**	**NO**
7. Do you have concerns about your child's education needs? (IEP, 504 plan, suspensions)	**YES**	**NO**
8. Do have concerns about your housing or becoming homeless?	**YES**	**NO**

Historical Evolution

- 2016-Pilot tested the psychosocial screener in our largest primary care setting.
- 2017-Hired a team of Community Health Workers and implemented the screener across our primary care clinics.
- 2019-Opened the Health Pavilion and Resource Connect.

What is Resource Connect?

- Suite of community partners within the Children's Colorado Health Pavilion that connects patients and families with community-based services to meet non-medical health needs, such as housing and food.
- Resource Connect anchors the CHCO strategy for community health.
- An integrated cross-system support model.

How Families Are Referred to Resource Connect

1. Clinic visit

Family comes in for a clinic visit.

Example: Family comes to the Health Pavilion for a clinical visit.

2. Screener

Family completes a universal psychosocial screener, which includes 8 resource needs questions.

Example: Family completes a psychological screener and screens positive for food and benefits.

3. Referral

Families who screen positive for a resource need meet with a community health worker who works with the family to understand their needs and can refer them to Resource Connect.

Example: Family meets with a community health navigator who refers family to Resource Connect.

4. Addressing needs

Once families complete their clinic visit, they can go to the 4th floor to visit Resource Connect and connect with the appropriate partner.

Example: Family goes to Resource Connect after visit to meet in-person with Eligibility Technician who processes a Medicaid and SNAP application for family. Family then goes to the Healthy Roots Food Clinic to pick up food from a menu of items of their choice and that meets their family's taste and nutritional needs.

5. Follow-up

Once a family completes their visit at Resource Connect, they can return for follow-up assistance.

Example: Family is eligible to return to Resource Connect to meet with any partner and to fulfill their food as medicine prescription up to 12 times in a year.

Resource Connect Partners

- Public Benefits Eligibility Technician
- Housing Navigation
- Medical Legal Partnership
- WIC
- Energy Outreach Colorado
- Healthy Roots Food Clinic
- Adams County Workforce
- A Precious Child (diapers, wipes, school supplies, etc.)
- Injury Prevention / Safety Store (car seats, cribs)

BUILDING THE PROCESS

STANDARDIZED WORKFLOW AND DATA CAPTURE

1) GETTING THE REFERRAL

2) TRIAGE TO PARTNER(S)

3) PARTNER OUTREACH

4) DOCUMENTATION

5) DEFINING SUCCESS

6) MAINTENANCE

A Process Rooted in Collaboration: RC Partners and Epic Analysts

Meet Partners Where They Are At with Interventions and Driving Successful Outcomes

What are we offering patients and families?

Identify eligible programs

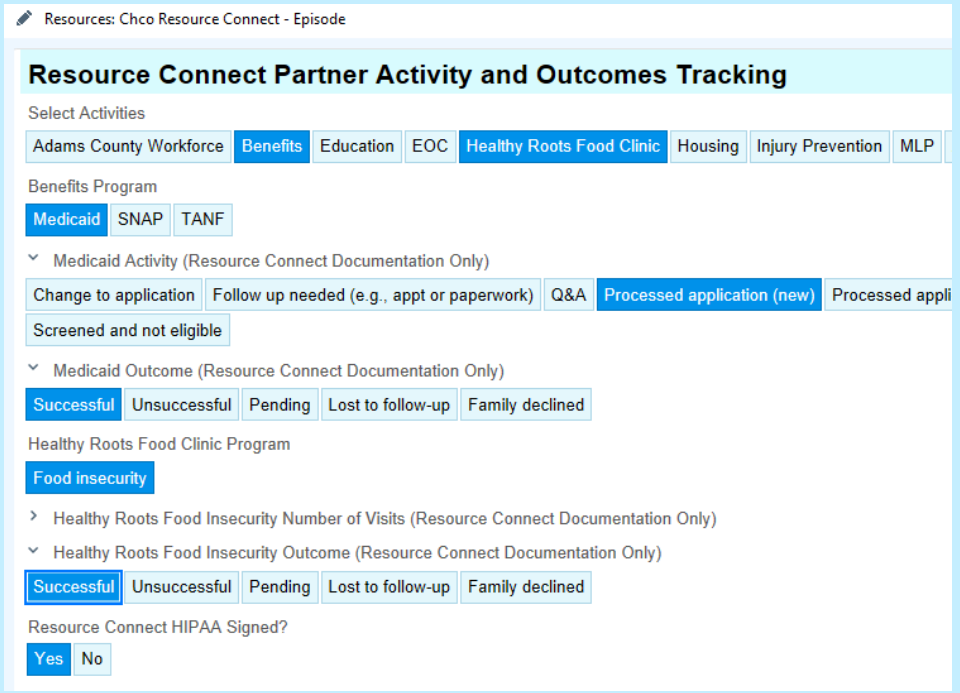
How will partners address needs?

Create a common set of interventions

*What is the **impact?***

Collaborate with partners to develop common definitions

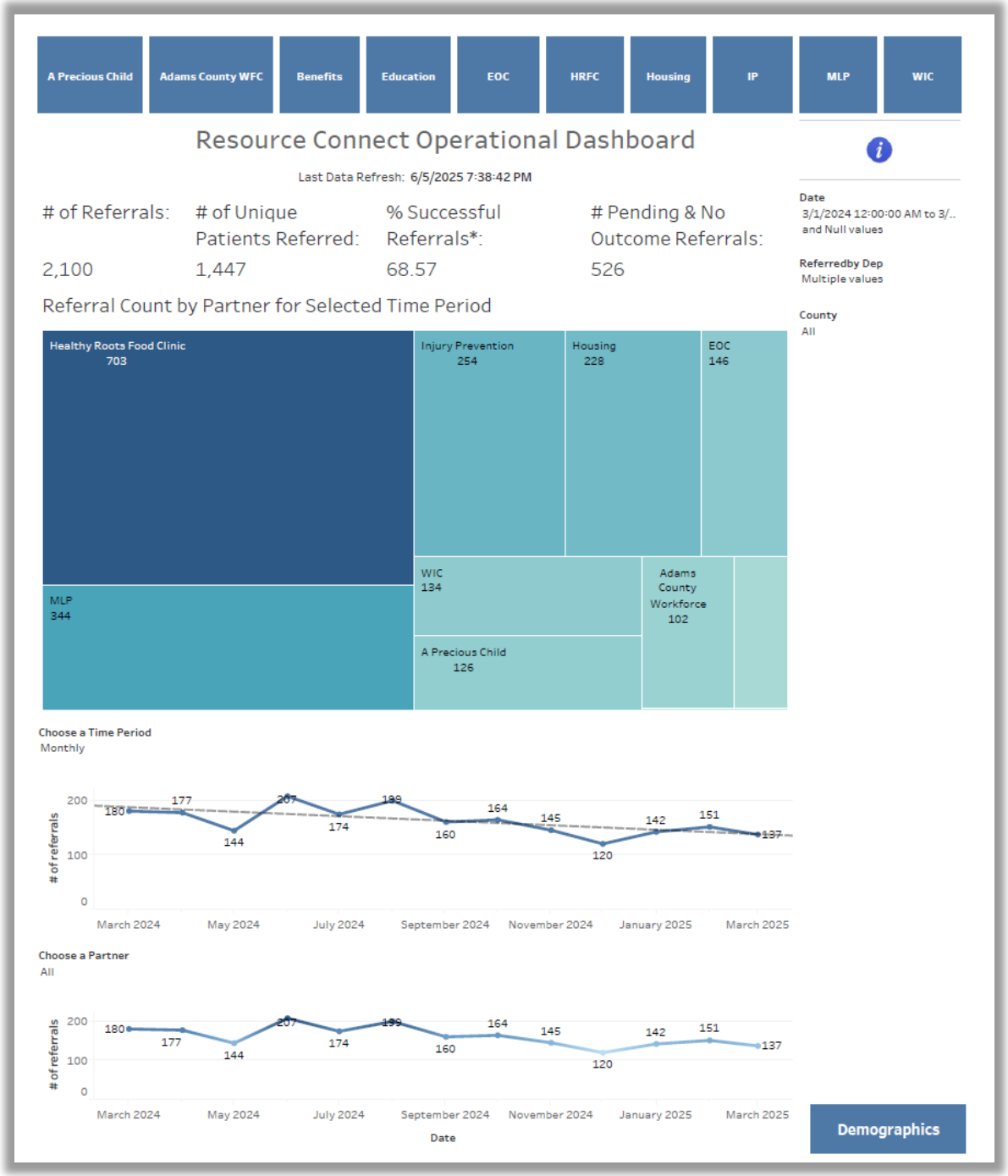
Design Documentation Tools With Our Epic Analysts



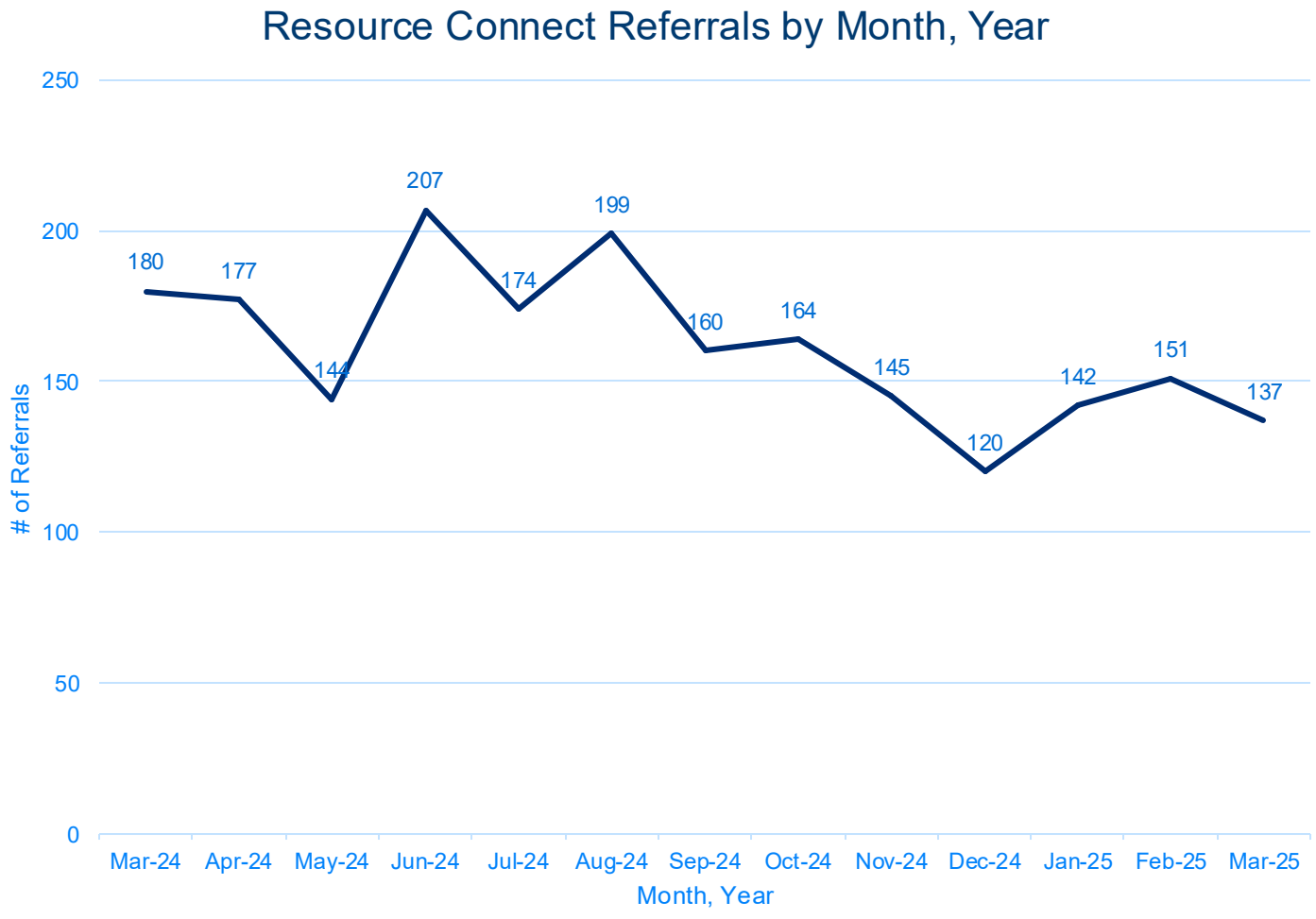
Building the Analytics

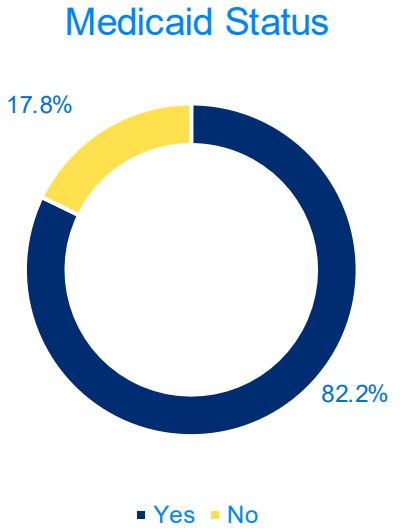
RE-AIM Evaluation Framework

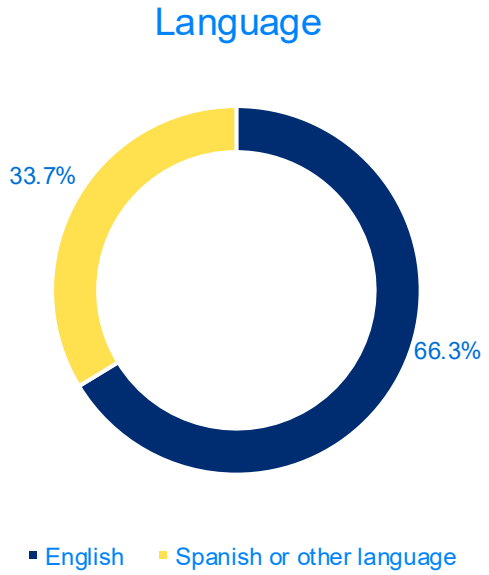
- **R**each
- **E**fficacy
- **A**doption
- **I**mplementation
- **M**aintenance

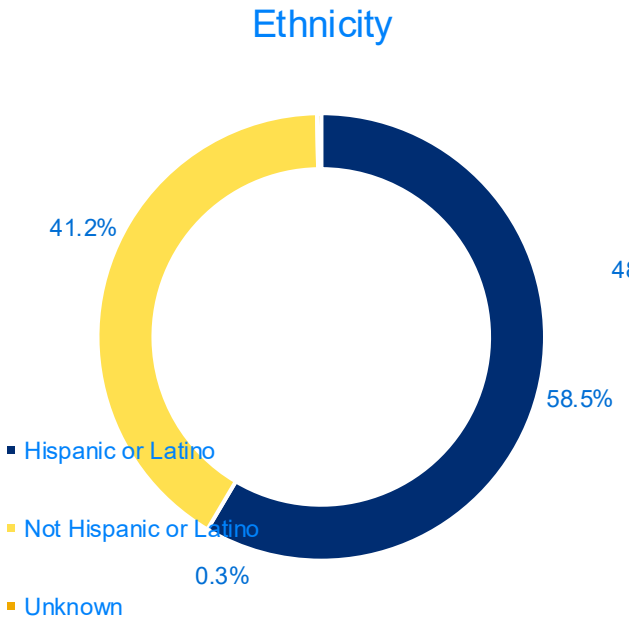


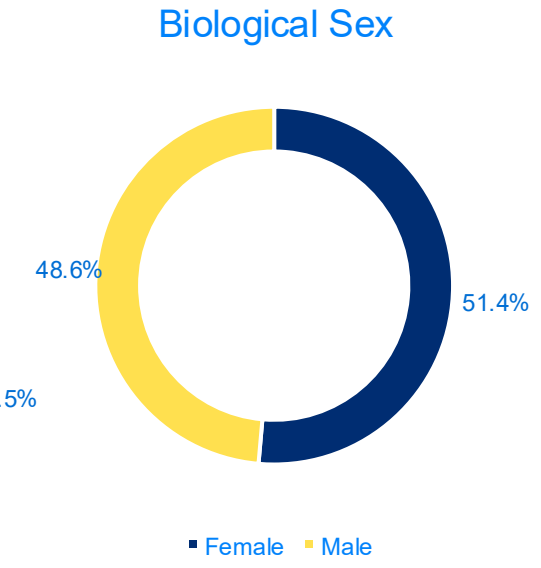
Measuring Impact



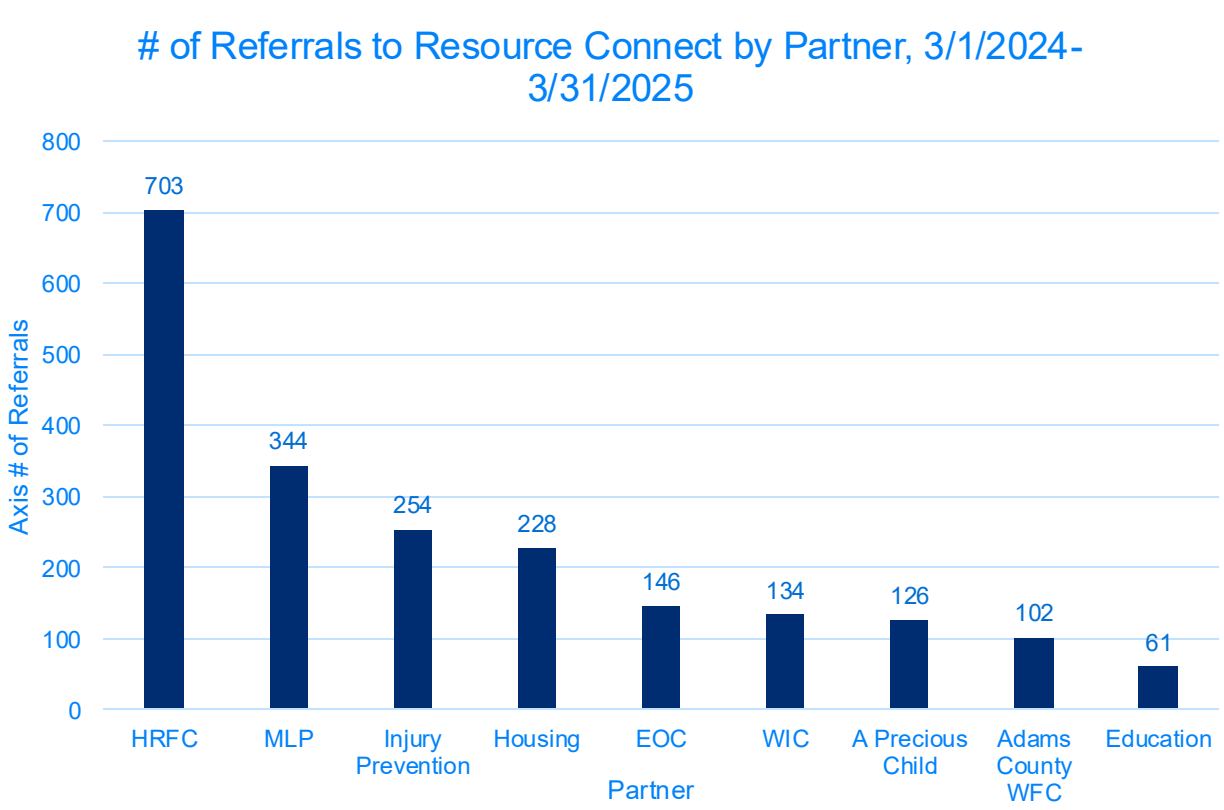


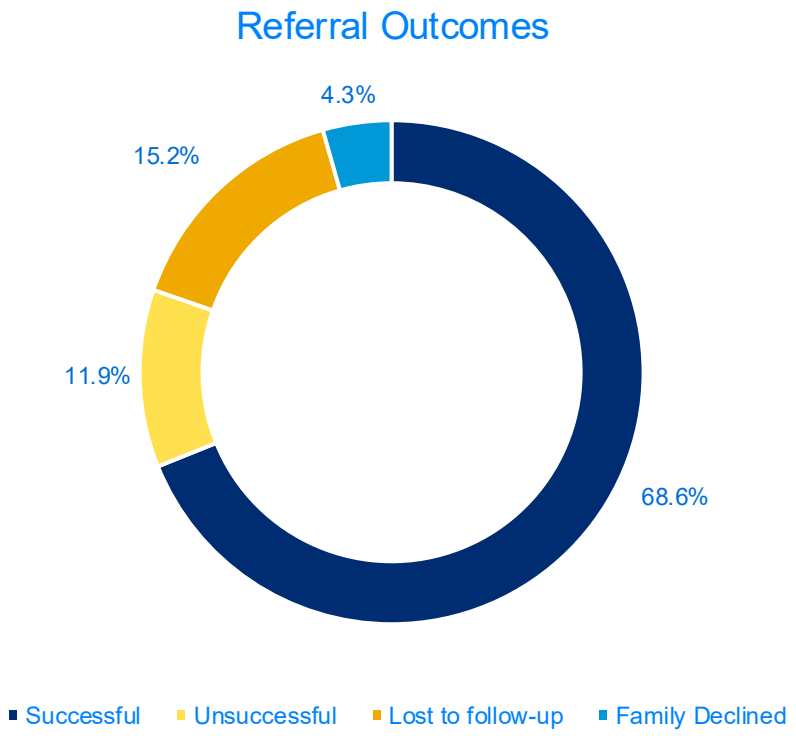






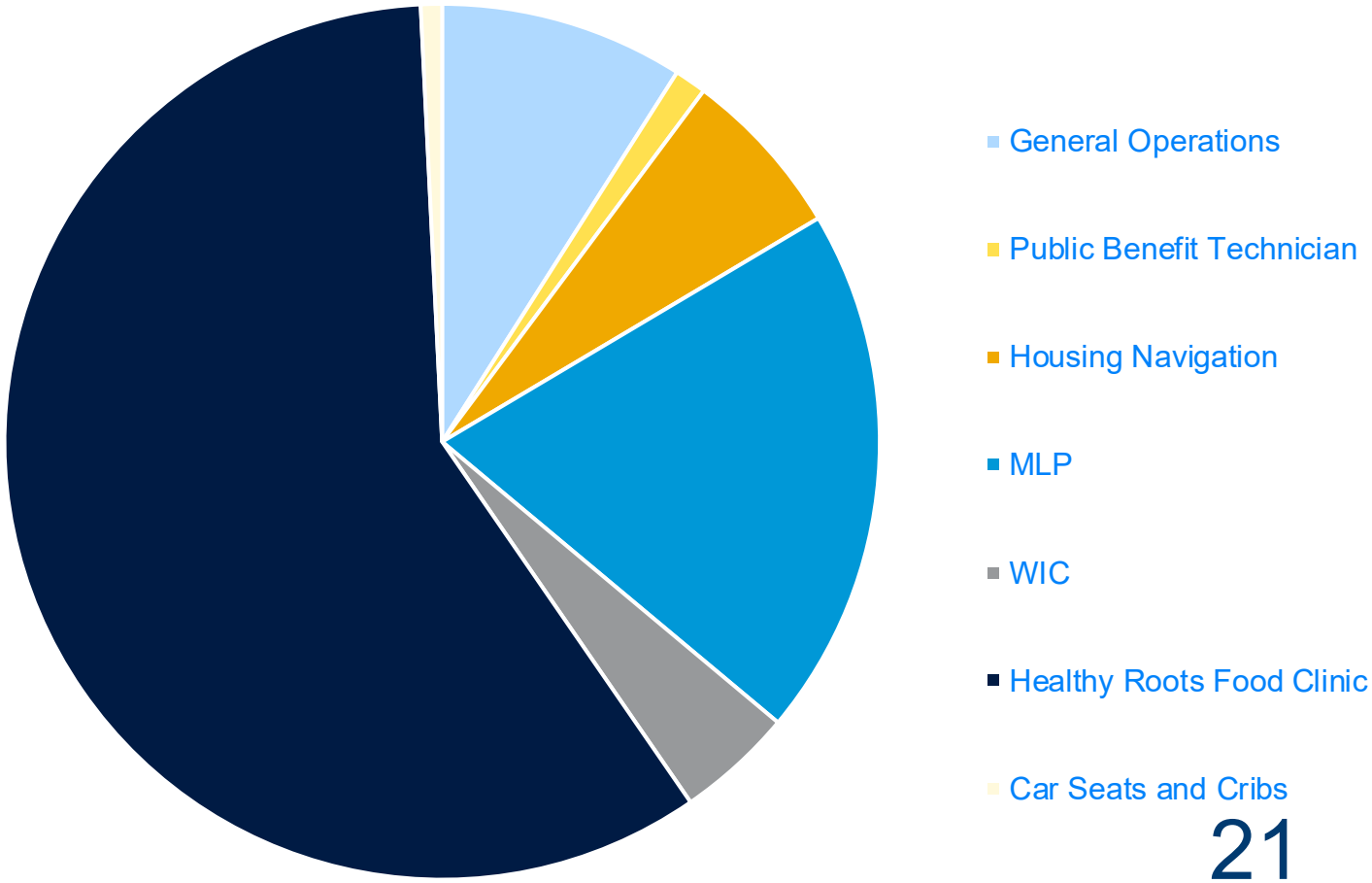
Measuring Impact





Resource Connect Funding

Annual Budget: $1.3M



RESOURCE CONNECT ROADMAP

WHERE WE'VE BEEN AND WHERE WE'RE HEADED

From the Outset: Pivot!

Within 6 months of opening, Resource Connect made a significant pivot to respond to immediate food needs during the pandemic.

2019-2020

Examining the Impact & Sustainability

With a new hybrid model and expanded partnerships, we examined our outcomes and opportunities for improvement. We also successfully advocating fork CHW reimbursement.

2021-2023

System Integration

As our division grows, we look to adapt our model for the broader health system. We successfully integrated Healthy Roots Food Clinic into a true clinic in Epic.

2024

Reimbursement & Scale

We continue to research the impact of our interventions while preparing for reimbursement for navigation services in 2026 and building systems to support reimbursement for the food clinic and other areas. We are preparing to launch an internal SDoH Council to help scale social supports across our system

2025 and beyond

Questions?

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Senior Software Engineer, Community Health Analytics
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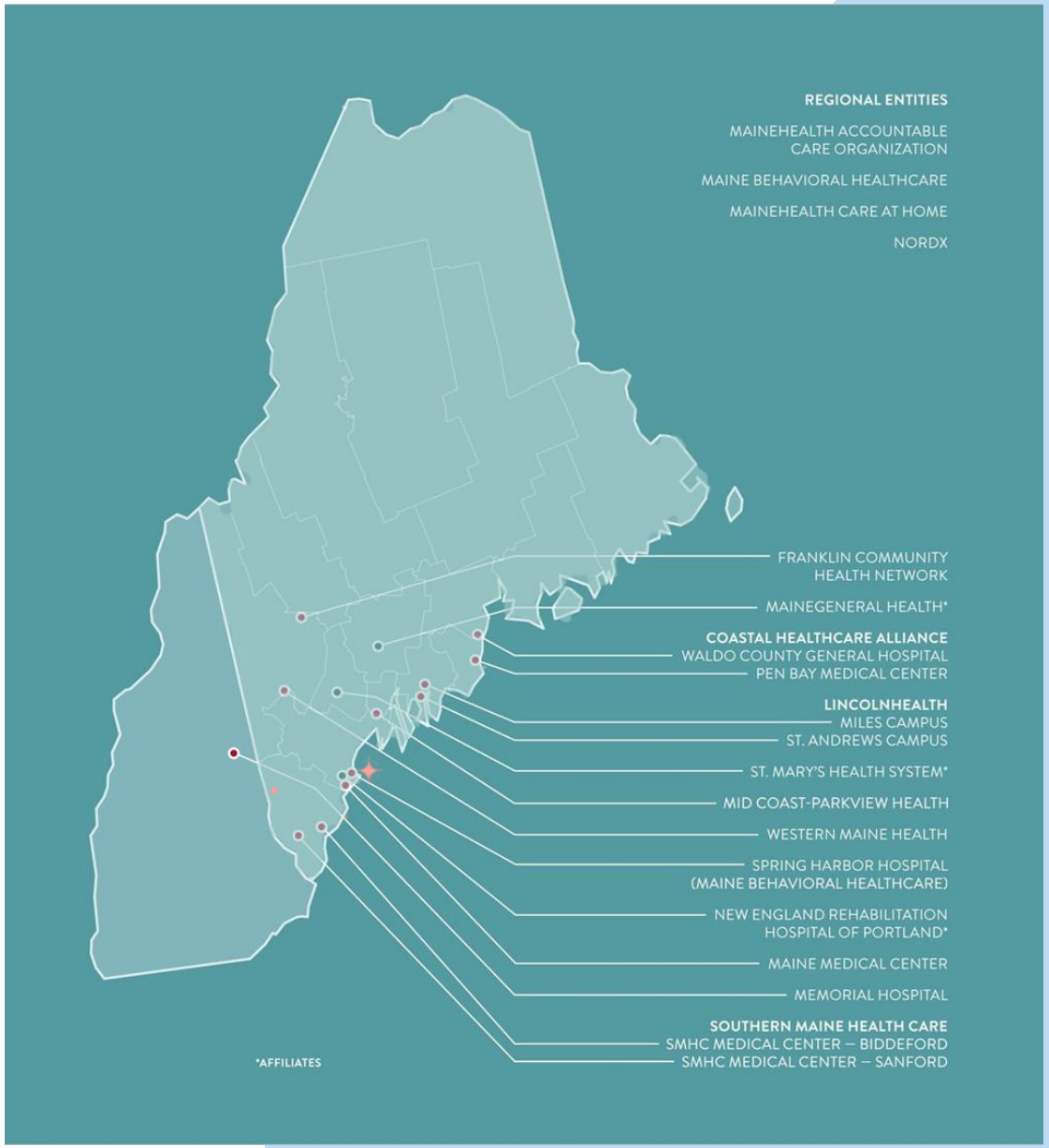
Social Drivers of Health

Bridging the Gap Between
Healthcare, Public Health
and
Social Services

MaineHealth

The Most Rural State In United States

10 hospital system with more than 250 practice locations. With approximately 25,000 employees, it is a leader in research and clinical education and training, and provides preventive care, diagnosis, and treatment to **1.1 million residents** in Maine and New Hampshire.



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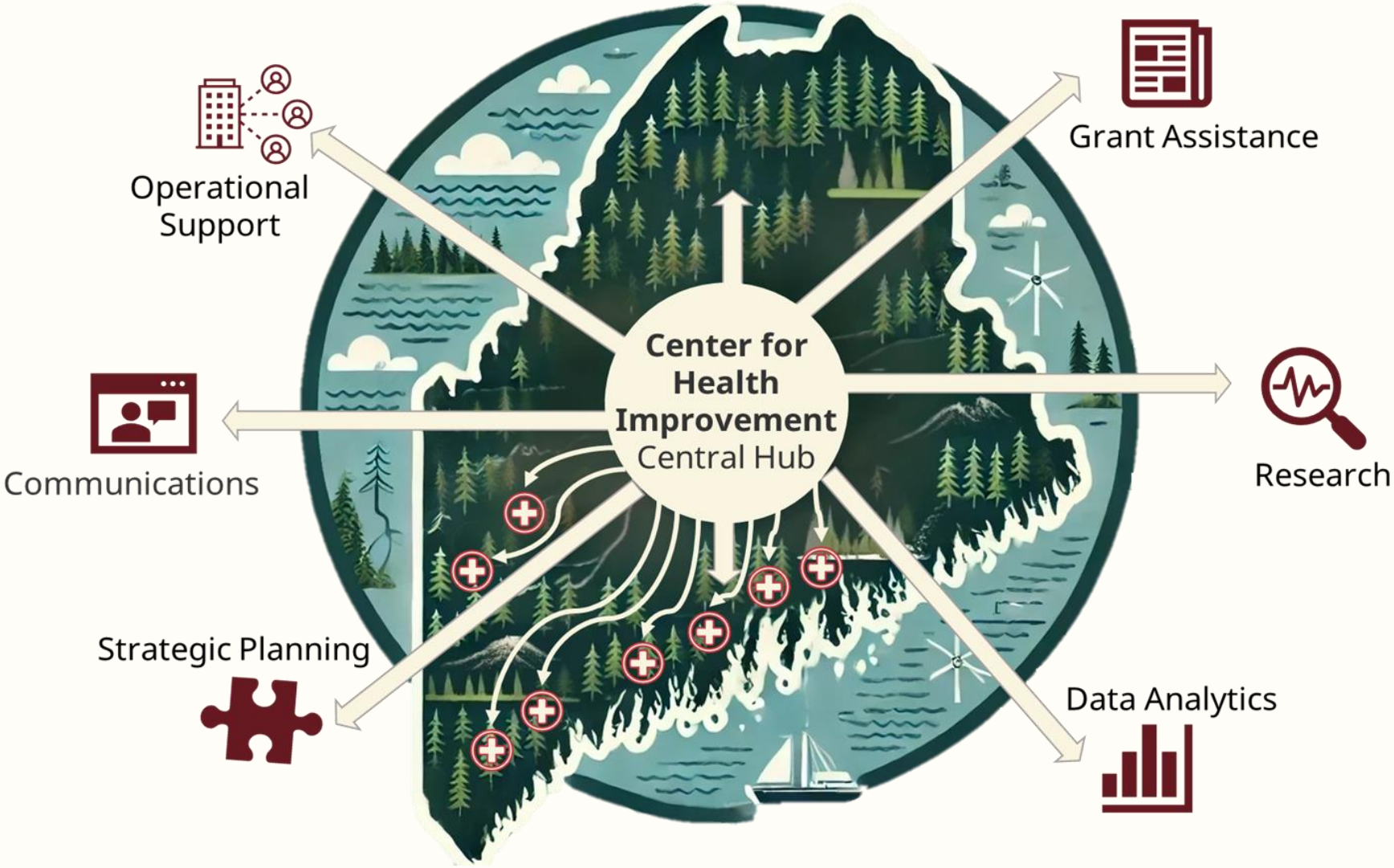
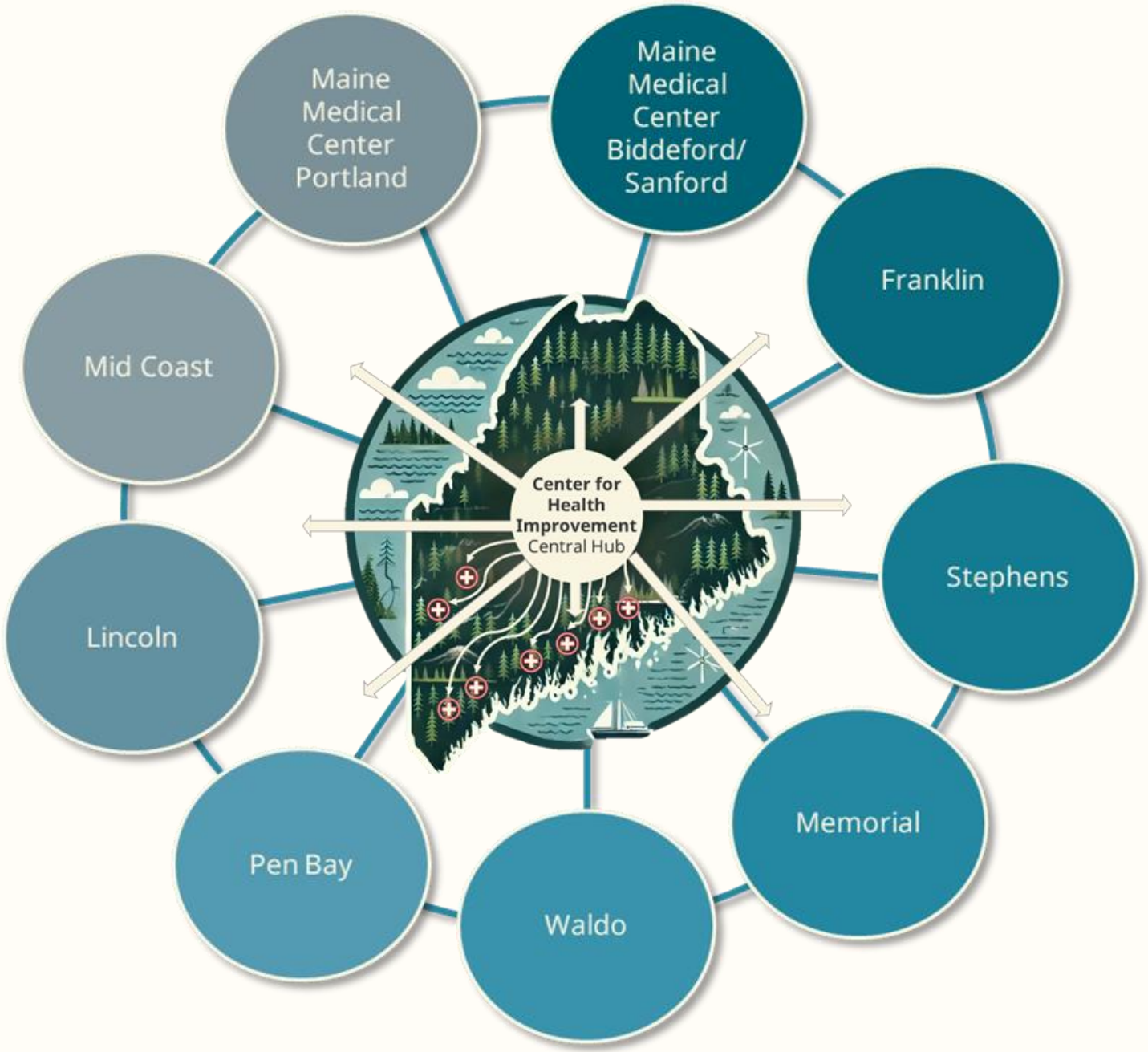
Central HUB

The Center for Health Improvement's hub acts as a central resource by:

- Providing vital resources to the community spokes; and
- Fostering collaboration with statewide and federal government agencies as well as with statewide and national organizations, including clinical and public health professional associations.





Spokes

The spokes are community health teams within local community hospital systems that drive local partnerships with community-based organizations, government agencies, and clinicians.

All but one of these are located in rural areas.

Our SDoH Goals

By Partnering with Others:

PATIENT LEVEL

Improve patients' health-related social needs

SYSTEM LEVEL

Address underlying Social Drivers of Health

Our Path to Impact

MaineHealth

Hub and Spokes Model

WORKING TOGETHER

Trauma Informed Care

CARING TOGETHER

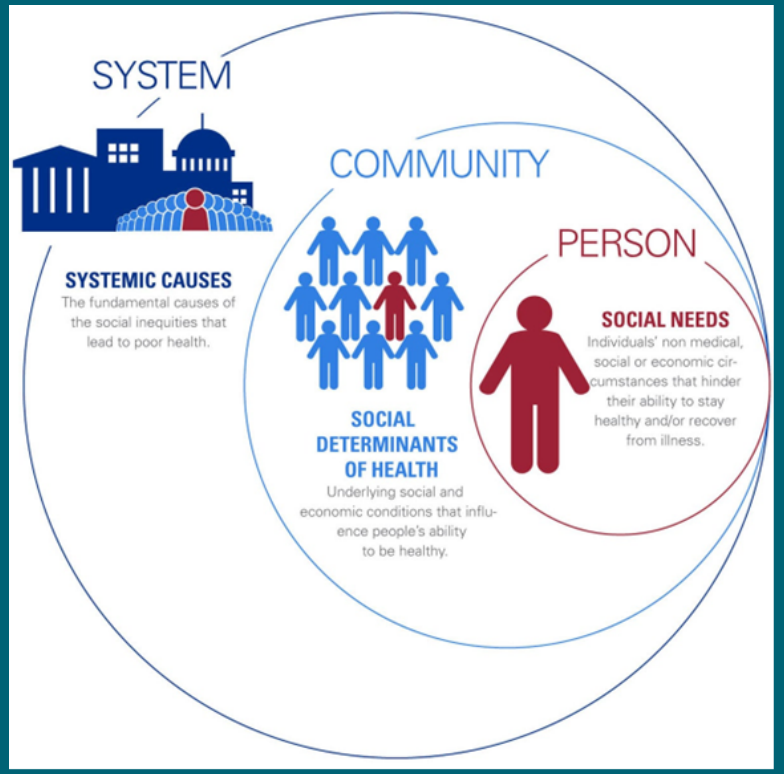
Data Sharing and Community Insights

SHARING TOGETHER

Caring Together

MaineHealth

Interprofessional Representative Teams



MaineHealth Internal Collaboration

Southern Region
- **MMC**
  - Sally Prokey, Clinical Informatics Manager
  - Mary McNulty, Care Management Sr Director
  - Jennifer Boone, Care Management Manager
- **SMHC**
  - Cathy Waterman, Care Management Manager
  - Kathleen Sheehan-Tartre, Nursing Director

Mountain Region
- Mary Beth DiFilippo, CNO
- **Memorial**
  - Molly Greenwood, Manager

Coastal Region
- **LincolnHealth**
  - Norma Dawson, Manager
- **Mid Coast**
  - Melissa Fochesato, Director

MBH SHH
- Gina DiDonato, Chief Nursing Officer
- Karl Buckley, Director

MaineHealth Corporate Leadership:
- Michelle Duval, Chief Information Officer

Community Health Improvement
- Dora Anne Mills, Chief Health Improvement Officer
- Naomi Schucker, Assistant Vice President
- Eisha Khan, Manager
- **Access To Care**
  - Kimberly Beaudoin, Director
  - Benjamin Davis, Director
  - Ryan Bouchard, PAL Sr Manager
- **FindHelp**
  - Ellen Freedman, Manager

Information Technology
- Julie Trimmer, IS Director
- Jim Moulton, Systems Architect
- Andrew Reed, Business Intel Developer

Quality and Saftey
- Natasha Barlett, Regional Accrd & Reg Affrs Sr Director
- Kimberly Nemic, Quality Reporting Manager

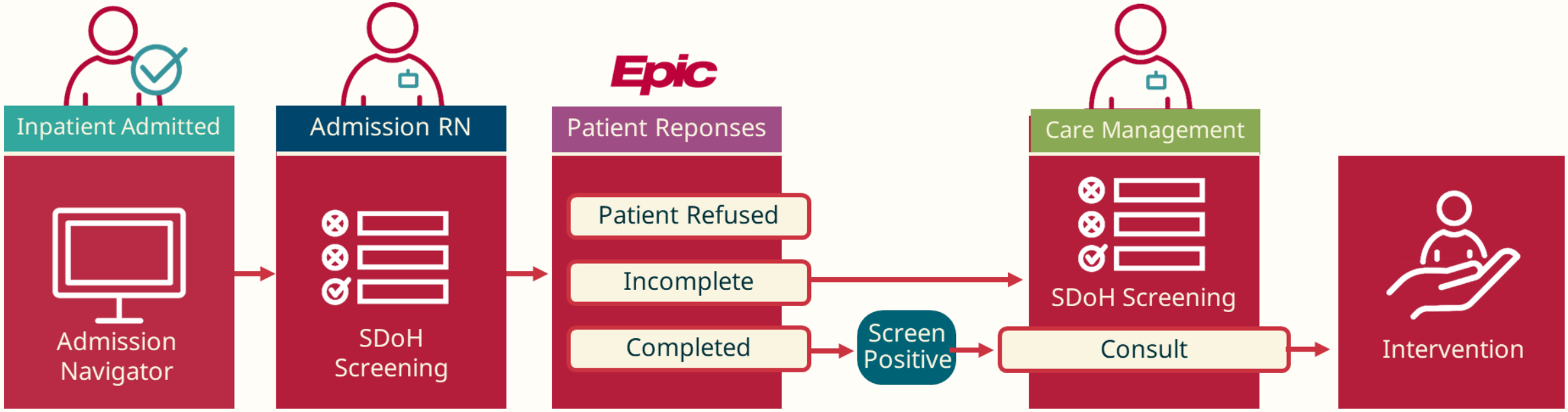
Communications
- Marteen Santerre, Patient Engagement Director
- Rebecca Stevens, Patient Engagement Manager

MaineHealth External Collaboration

Community Based Organization (CBO) SDoH Convening Every 6 weeks to review SDoH Data and Priority Areas. Have engaged over **150 participants**, representing CBOs and statewide partners.

Screening & Intervention

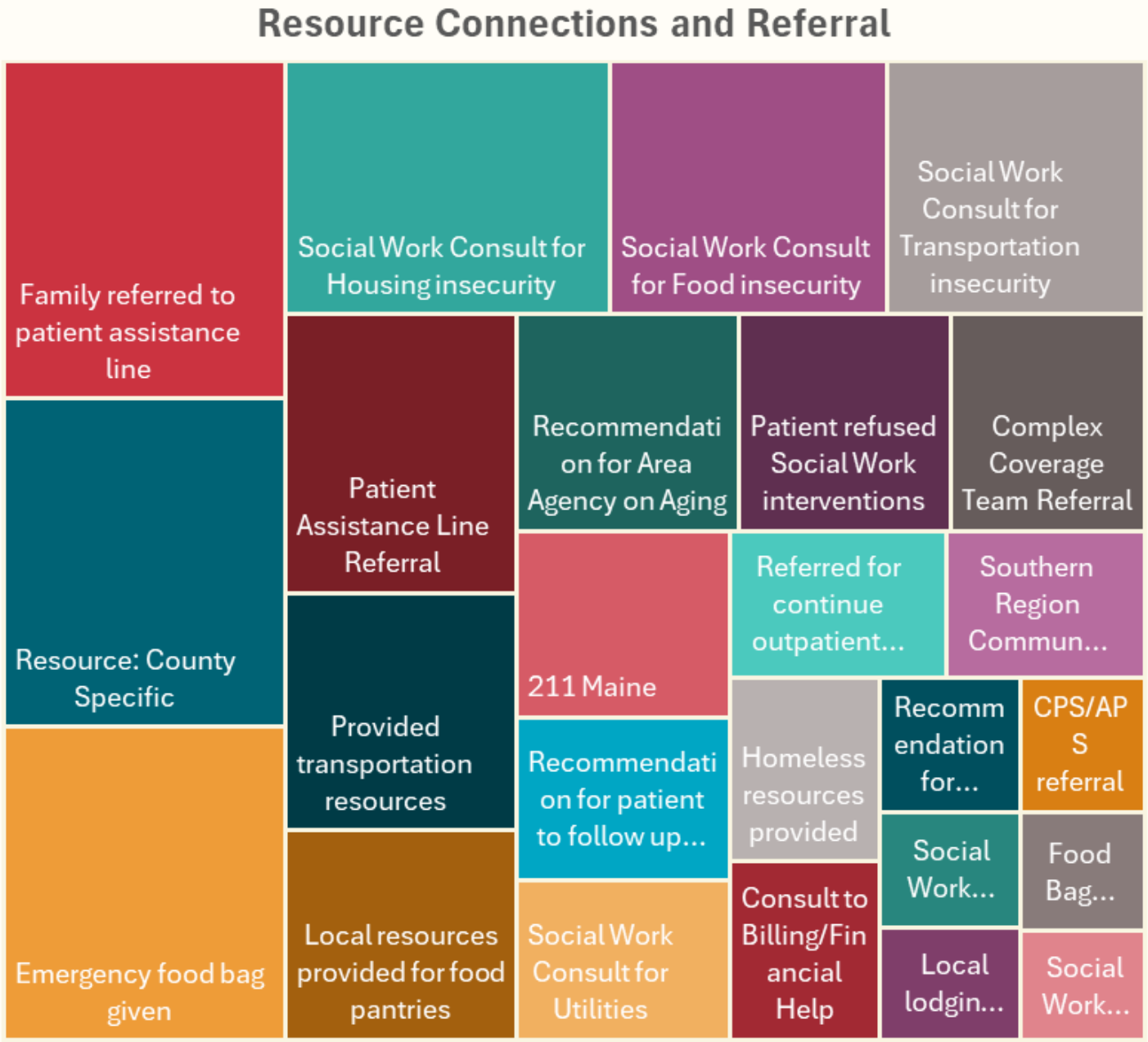
Every positive SDoH screening gets an automatic social work consult that connects the patient with community-based resources,



Resource Connections & Referrals

Close to 10,000 patients connected to resources in CY24

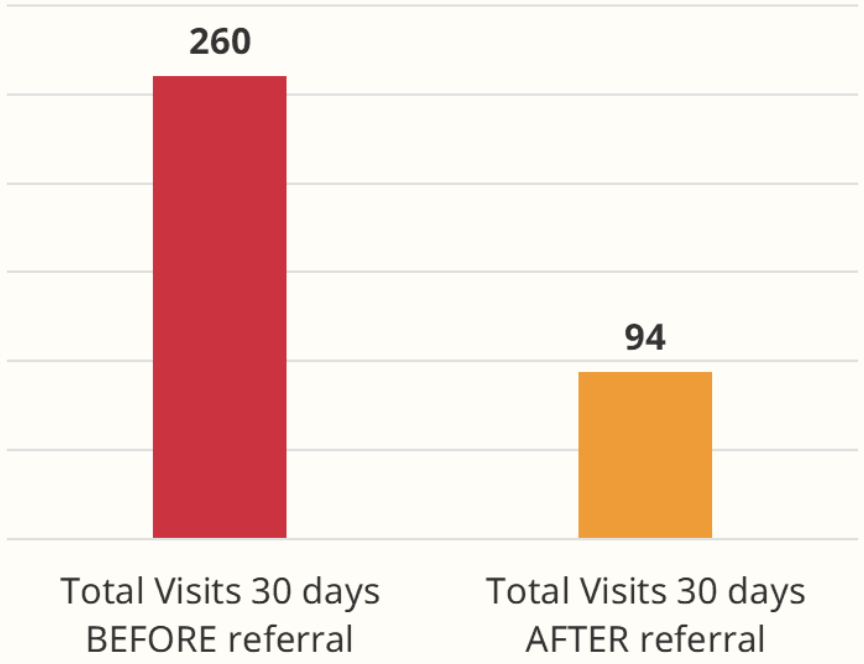
- Emergency food bags
- FindHelp
- Patient Assistance Line
- Community Health Workers



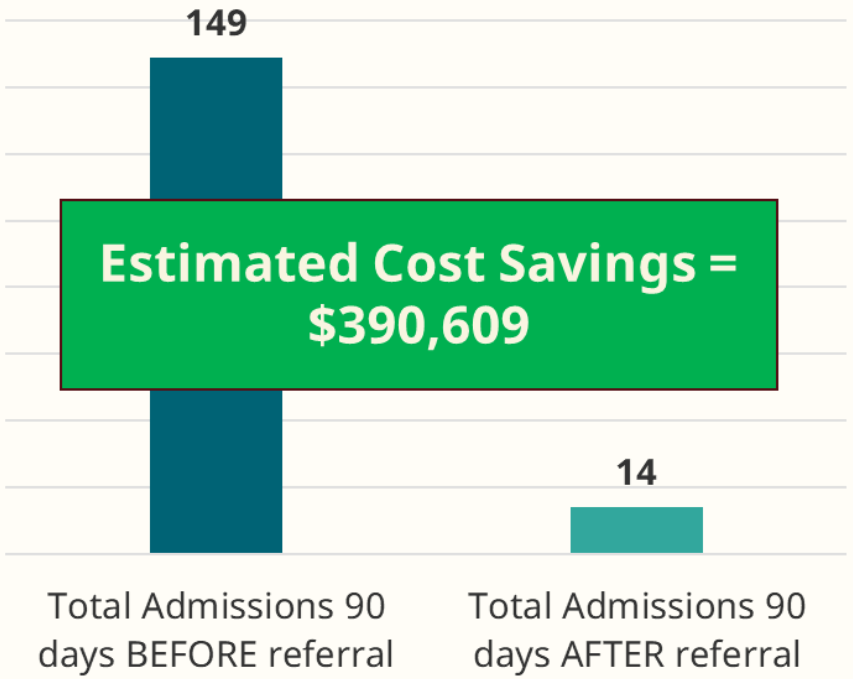
ED and Inpatient Utilization Declined After Enrolling in Franklin & PenBay/Waldo Community Health Worker Programs

Total of 644 Patients enrolled in CHW program in FY24 (10/1/23-9/30/24)

Change in ED Visits Among 176 patients with One or More Visits 30 days before being referred to CHW program



Change in Unplanned Admissions Among 62 patients with One or More Admissions 90 days before being referred to CHW program



Sharing Together

MaineHealth

SDOH: All Domains
System Profile

Total Encounters
51,822

Total Screened
80%

Positive Screening
16%

No PCP
16% (9%)

Avg 1 Yr ED Visit
3.2 (1.8)

30 Day Readmit
18% (14%)

Avg LOS
8 (5.8)

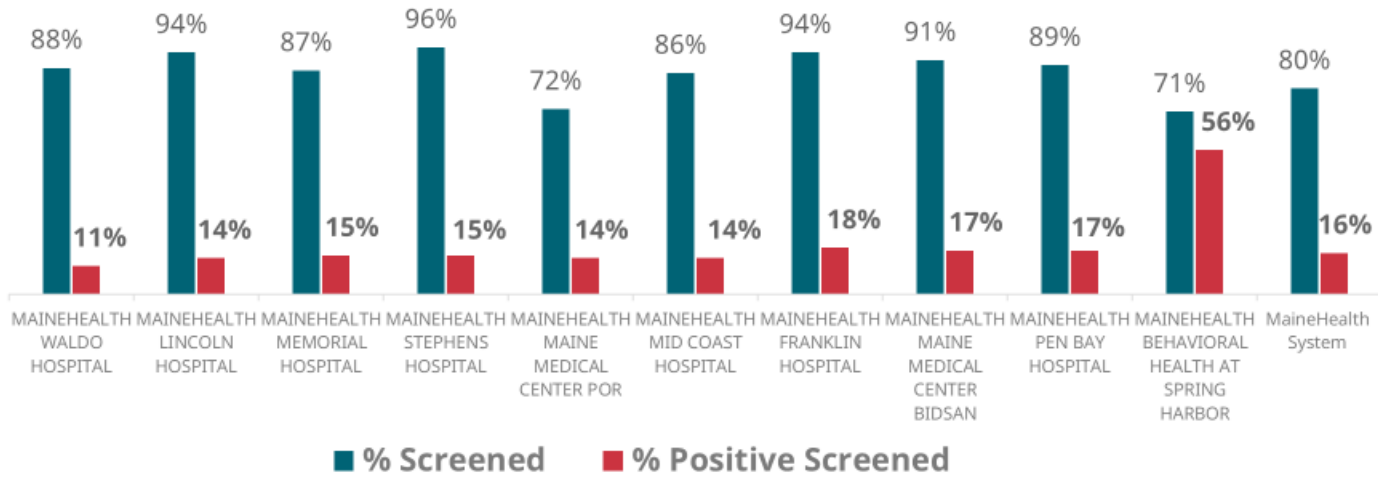
SDOH Adult (18+) Inpatient All Domains Trend CY2024

At Risk Populations *Positive Rate*	56% Psych Hospital	38% Insurance Medicaid	37% Black or African American	34% Non-English Speaker	26% Age Group 31 - 50	17% PenBay, BidSan, Franklin

Positive Rate Trend By Month

16% Jan	17% Feb	16% March	15% April	15% May	14% June	15% July	15% Aug	15% Sept	17% Oct	15% Nov	15% Dec

CY2024 Screening & Positive Screening Rate



Top Admit Dx

- Sepsis (A41.9)
- Suicidal ideations (R45.851)
- Acute respiratory failure with hypoxia (CMS-HCC) (J96.01)
- Pneumonia (J18.9)
- Major depressive disorder (F33.2)

PATIENT CENTERED · RESPECT · INTEGRITY · EXCELLENCE · OWNERSHIP · INNOVATION

1 in 6 adults

have one or more health related social needs

Food Insecurity, Housing Instability, Transportation Inaccessibility, Utilities Insecurity, and/or Intimate Partner Violence

Positive for Social Driver of Health

Positive screening for 1 or more SDOH domains is 2x higher for Non-English Speakers,

compared to patients who speak English.

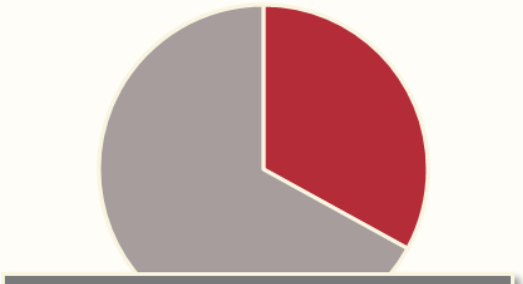
Rate of housing instability and food insecurity is 3x higher among Non-English Speakers,

compared to patients who speak English.

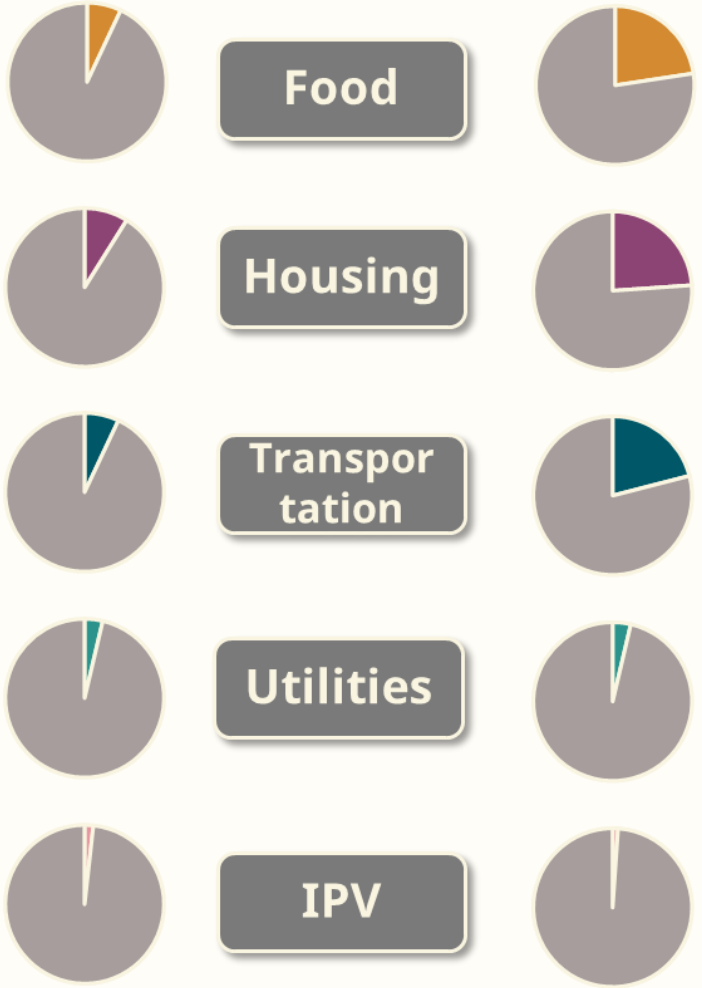
Time Frame: CY2024

Overall Positive for 1 or more SDOH

English Speakers



Non-English Speakers



Impact on Healthcare?

3.5x	1.3x	1.5x	1.8x
Psych Hospital Positive Screening Rate	30 Day Readmission Rate	Average Length of Stay	Average 1 Year ED Visit

SDoH Community Convenings

Virtual and in-person gathering every 6 weeks to:

1. Share Data
2. Bring in community and subject matter expert perspective
3. Collective Action - from Social to Political Drivers of Health

Early Wins & Lessons Learned

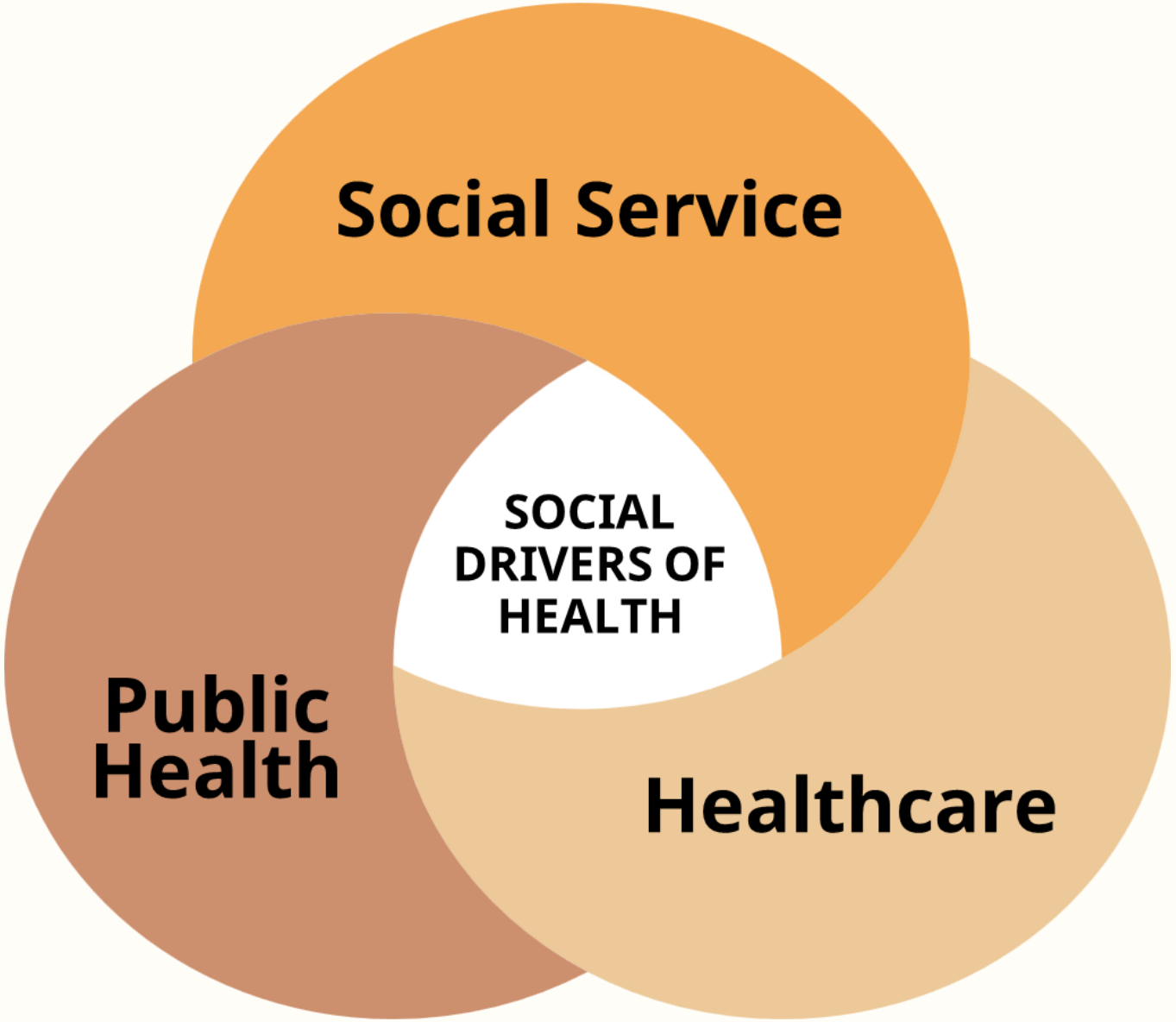
MaineHealth

Early Wins…

ONE	Team and Leadership **buy-in** by focusing on the **WHY** behind Screening and Intervention
TWO	Implementation and Data Collection – **Measuring screening rate and resource impact**
THREE	Community conversation as a tool for improving **Partnership and Trust**
FOUR	Using data, storytelling and partnerships to **move upstream** and **influence policies**

Three System Approach

For Addressing Social Drivers of Health



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Thank you!

Please consider filling out this feedback form.

Next Care Delivery Transformation webinar:
August 21 at 11am CT