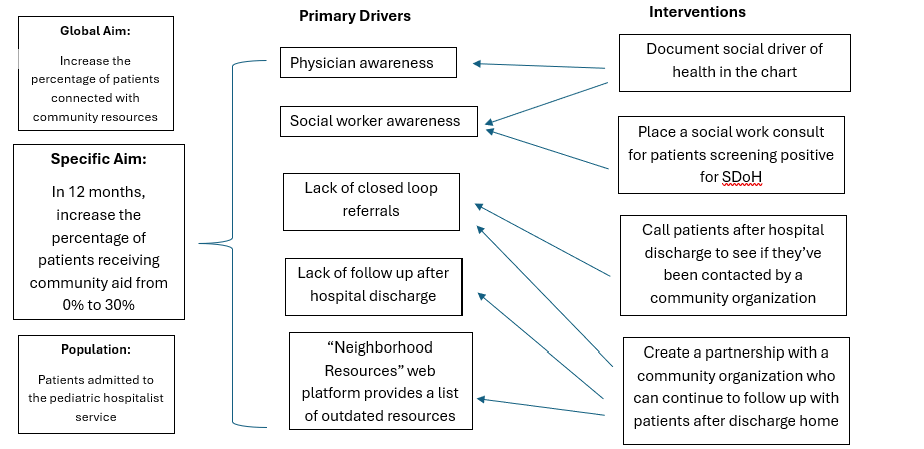
Figure 1: Key Driver Diagram:



Process Measures: Percentage of patients screening positive for SDoH who are contacted by a community organization, Number of referrals

Outcome Measure: Percentage of patients screening positive for SDoH who receive community aid (tangible food, housing, money for rent or utilities, transportation) within 30 days of hospital discharge

Balancing Measure: Family comfort with screening, documentation, and referral on a 5-point Likert scale

PDSA Cycle #1 Intervention:
Physician Education and Research Assistant (RA) texts the physician to document a positive SDoH screen and enter a social work consultation

PDSA Cycle #2 Intervention:
RA enters order for social work consultation

PDSA Cycle #3 Intervention:
Local community partner (CP) identified who could contact our patients after discharge and connect patients with community resources. Social workers refer patients to the CP instead of using "Neighborhood Resources." RAs call families 72 hours after discharge and refer patients to our CP.