IMPROVING HEALTH EQUITY THROUGH SOCIAL DETERMINANTS OF HEALTH

Goal #1 – Increase members screened for unmet food needs.

Goal #2 – Increase members who received a corresponding intervention within one month of screening positive for unmet food needs.

Goal #3 – Increase members screened for unmet housing needs.

Goal #4 – Increase members who received a corresponding intervention within one month of screening positive for unmet housing needs.

Goal #5 – Increase members screened for unmet transportation needs.

Goal #6 – Increase members who received a corresponding intervention within one month of screening positive for unmet transportation needs.

- **Year One**

  - Evaluate the impact on health outcomes of unmet food, housing, and transportation needs on the Medicaid population.
  - Create screening tools to assess members' unmet food, housing, and transportation needs.
  - Research community resources to address unmet food, housing, and transportation needs within the Medicaid population and create resource materials for providers to use to educate/refer members.
  - Create a reporting template with the data fields necessary to assess members' unmet food, housing, and transportation needs, as well as the corresponding interventions received.
  - Conduct education and training of network providers regarding the impact of social determinants of health on the Medicaid population.
  - Create and disseminate protocol for network providers to use.

- **Year Two**

  - Measure baseline for members screened for unmet food needs.
  - Measure baseline for members screened for unmet housing needs.
  - Measure baseline for members screened for unmet transportation needs.
  - Measure baseline for members who received a corresponding intervention within one month of screening positive for unmet food needs.
  - Measure baseline for members who received a corresponding intervention within one month of screening positive for unmet housing needs.
  - Measure baseline for members who received a corresponding intervention within one month of screening positive for unmet transportation needs.
  - Continuous education and training of network providers regarding the impact of social determinants of health on the Medicaid population.

- Review member community resource materials, modify as needed.
- Create continuous quality improvement plan, including information identifying project impacts, reporting modifications needed, lessons learned, opportunities to scale project to a broader population, and key challenges.