internal referrals to Indigenous Services and Cultural Care Coordination. As the implementation continues, scaling up screening efforts has presented the largest challenge due to constraints of current workflow and lack of stakeholder agreement.
Conclusion: This case study explores the evolving landscape of SDoH screening at Indian Health Board, highlighting the role of cultural health in healthcare outcomes. By fostering dialogue and collaboration across stakeholders, we aim to advance both clinical practice and community health through culturally informed SDoH interventions.

Creating actionable surveillance to identify opportunities for CVD prevention for those with unmet social needs

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Background: The burden of undiagnosed and uncontrolled hypertension and other cardiovascular diseases (CVDs) is known to be higher in the communities served by Community Health Centers (CHCs). A multitude of lifestyle and environmental factors may contribute to patients social needs risk, which influences CVD outcomes. Due to barriers in the collection and documentation of patient social needs data in clinical settings, there are limitations in analyzing social and cardiovascular risk concurrently using electronic health record (EHR) data.
Objective: The project aims to establish a partnership-based infrastructure across public health and community health centers that is available to equip frontline care providers and communities to monitor, understand and respond to patterns of cardiovascular diseases (CVD) and risk associated with key social drivers of health (SDOH).
Methods: AllianceChicago (AC), a health-center controlled network, convened a workgroup of clinical, informatics and public health experts to design an extension of the MENDS common data model to incorporate social needs data. Through a series of design sessions, they produced a list of priority considerations and aims for the first iteration of the extended data model.
Results: The MENDS data model was expanded using three tables: Problem List, Social History, Patient Survey, and Social Vulnerability Index (SVI). These social risk tables include screening tool results, semi-structured data and relevant diagnosis codes. An added table utilized the CDC SVI data set with patient location using DeGAUSS methodology to estimate location-based social risk. Querying this data model, AC generated dashboards to demonstrate the relationship of individual and location-based social risk data with hypertension control.
Conclusion: This pilot demonstrated the ability to modify existing data models for analysis of SDOH using patient-level EMR data for public health surveillance, population health, and clinical care optimization. Opportunities to streamline model implementation are being assessed to scale this partnership for future analyses.

Implementing a social needs screening and community health worker referral program for obstetric patients

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Background: Health systems have expanded their focus on health equity in recent years to address the health and social needs of pregnant and postpartum patients.
Objective: To describe the implementation of a novel program, which included standardized screening of health-related social needs (HRSNs) and referral to community health workers (CHWs).
Methods: This was a retrospective cohort study of patients who had: 1) prenatal care, 2) delivered at our institution, and 3) completed a standardized HRSN screener between June 2022 and March 2024. Patients who were screened and self-reported at least one HRSN were eligible to be referred to a CHW by their clinician during routine clinical encounters. We used descriptive statistics to summarize the reach and effectiveness of the HRSN screening and CHW referral program.
Results: There were 3275 obstetric patients screened for HRSNs during the specified timeframe. Of those screened, 489 (14.9%) reported at least one HRSN with the most prevalent HRSNs identified as food security ($n = 204$, 6.2%), housing security ($n = 160$, 4.9%), child or adult care ($n = 150$, 4.6%), housing quality ($n = 120$, 3.66%), and healthcare transportation ($n = 120$, 3.7%). There were 382 (78.1%) patients referred to a CHW, with 303 (89.1%) consenting to HRSN navigation. Overall, 197 patients were connected to at least one social service (65.0%). Of those connected to a social service, 189 (95.9%) reported that their HRSN was improved or fully resolved.
Conclusion: This novel standardized screening and referral program was effective in connecting pregnant and postpartum patients to social services. Future research should evaluate the gap between patients who self-reported HRSNs and those who were successfully connected to a CHW to improve the program's reach. In addition, the impact of HRSN resolution on key obstetric outcomes should be explored.

Psychometric testing of Spanish SINCERE (SINCERE-Sp)

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