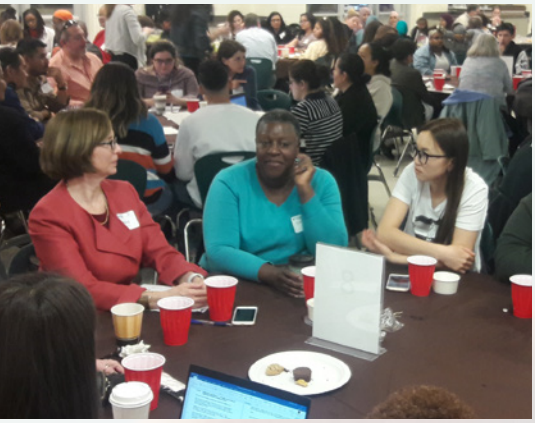
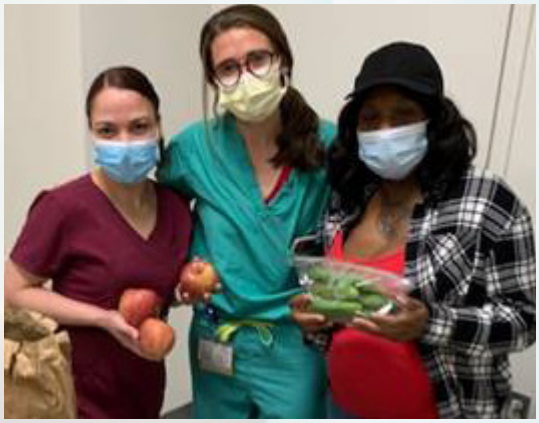
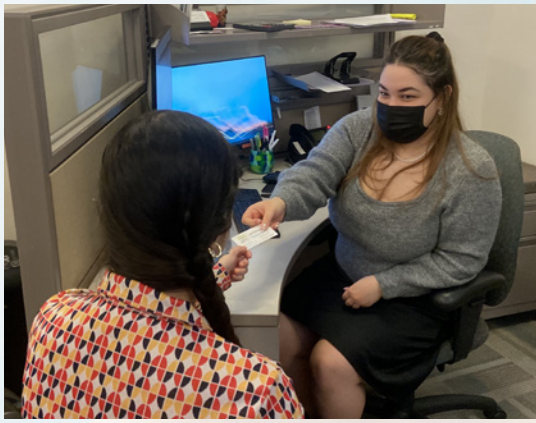
Linking Social Factors to Health in Arlington County (LINK)

Community Report 2019-2023







With Support from Northern Virginia Health Foundation

Background

In 2018, the Northern Virginia Health Foundation (NVHF) issued a Request for Proposals, inviting area organizations to address the root causes of health disparities, commonly known as the 'Social Determinants of Health' (SDOH). Recognizing that upstream factors—adequate housing, food security, safe environments, education and advancement opportunities, a living wage, social connection and influence on policies to improve one's own destiny—have a greater impact on health than do medical care or health behaviors, NVHF chose to invest its capital in policies, systems and environmental change interventions that promise to yield enduring outcomes. The Foundation required applicants to join forces with other organizations and demonstrate their capacity to forge authentic public/private partnerships (comprised of nonprofit community organizations, nonprofit healthcare providers and government agencies), understanding that such diversity in perspective, function, and resources is essential to realizing NVHF's vision: Equity for all Northern Virginians, with a special focus on lifting up low-income residents regardless of race/ethnicity, language spoken or country-of-origin.

Informed by and coinciding with other efforts in the county and beyond[1] and reinforced through longstanding partnerships and common cause, Arlington Free Clinic (AFC), Arlington County Department of Human Services (DHS) and VHC Health, formerly Virginia Hospital Center (VHC), seized this funding opportunity to propose an ambitious plan. Together, we envisioned a 'Healthy Arlington for All' through broad engagement and bold action. We named this initiative LINK—Linking Social Factors to Health in Arlington County—to draw attention to our focus on uniting to identify and connect our patients to resources and to address the upstream conditions disproportionately favoring some and hindering others.

Despite the complexity of SDOH-focused interventions and the extended timeframe to effect community and population health improvements, NVHF determined we were 'up-to-the-challenge' and notified our consortia of grant award in December 2018. Little did any of us know of the impending pandemic. COVID-19 tested our individual and collective capacity to commit to the LINK workplan, given our respective roles in the community and the need for us to devote finite human and other resources to emerging and fluctuating priorities. It also reinforced some of our underlying assumptions about Arlington County's assets and drawbacks at meeting the basic needs of our most vulnerable residents while revealing new and urgent issues requiring our immediate attention. This once-per-century public health emergency ultimately strengthened our resolve and encouraged us to continue this important work as we observed the positive changes—at the individual-, institutional- and county-levels—from our efforts. NVHF's leadership, steadfast support and thought partnership were key not only to sustaining and expanding our efforts throughout this journey, but also to compelling us to 'think big,' widen our network and achieve even loftier outcomes than originally imagined.

Now entering our 5th year of operations, LINK partners and collaborating community stakeholders, pleased with our progress and achievements-to-date, invite you to join us as we continue this vital work.

afc arlington freeclinic

Arlington Free Clinic (AFC) provides comprehensive free healthcare to low-income uninsured adult Arlington County residents through the generosity of volunteers for nearly 30 years.

VHC HEALTH™

VHC Health (VHC) is Arlington County's singular nonprofit hospital. Its two clinics–VHC Pediatrics and VHC Outpatient Clinic–provide a medical home to underserved, uninsured and underinsured children, youth, families and adults.

ARLINGTON VIRGINIA

Arlington County Department of Human Services Public Health Division (DHS) works to improve community conditions to promote health and operates a Maternity Clinic providing pregnancy testing and prenatal services to the county's low-income, uninsured women.

Northern Virginia Health Foundation

Northern Virginia Health Foundation's (NVHF) vision is: Equity for all Northern Virginians, with a special focus on lifting up low-income residents regardless of race/ethnicity, language spoke or country of origin.

1 SDOH screening/assessment imperatives advanced by the U.S. Centers for Medicare and Medicaid Services (Accountable Health Communities Model-CMS Innovations); the Institute of Medicine (recommended social & behavioral domains and measures for Electronic Health Records-National Academies SDOH); the Centers for Disease Control and Prevention (Health Impact in 5 Years based on health impact pyramid-Health Impact Pyramid); and the National Association of Community Health Centers (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences toolkit-PRAPARE); Health Leads (SDOH Screening-Social Needs Screening Toolkit); Virginia Commonwealth University's Center on Society and Health's release of its "Uneven Opportunities" report; Arlington County's Destination 2027 spearheaded by the Department of Human Services; Bridges Out of Poverty initiative organized by the Arlington Community Foundation in partnership with Arlington County DHS.

In the Beginning—The Plan

LINK 1.0 set out to establish the infrastructure to collect, share, analyze and report on data that would help us understand the SDOH landscape and lay the groundwork for informed, prioritized action. Key components of this foundational effort entailed:

- Enlisting George Mason University (GMU) Center for Health Policy Research and Ethic's quantitative and qualitative researchers to help guide our foundational data collection activities and support SDOH data analysis.
- Identifying and standardizing the key SDOH factors to assess and track across all LINK partner clinical sites.
- Acquiring/building the SDOH data collection tools (e.g., Electronic Health Record [EHR] system).
- Developing clinic-specific workflows and schedules for each LINK partner to screen for and track patient SDOH data.
- Creating a system and agreements to protect and share de-identified, aggregated patient SDOH data amongst LINK partners and to streamline reporting to other county residents, leaders and decision-makers.
- Maintaining regular communications amongst LINK partners to ensure adherence to the workplan and institute timely 'course-corrections' if project milestones are missed.
- Advocating for policy, systems and/or environmental change strategies to address the root causes of health disparities to improve population health.
- Engaging patients and community leaders to affirm findings and devote resources to take meaningful action and commit to continuous quality improvement.

LINK Timeline

2018

- NVHF (Northern Virginia Health Foundation) issues RFP for planning grant
- LINK partners collaborated on concept paper
- Planning meetings to design project and proposal
- LINK 1.0 grant awarded (to AFC, DHS, VHC-Pediatrics, VHC-Outpatient Clinic)

2019—LINK 1.0

- Enlisted help of GMU health policy research team
- Developed/finalized SDOH data collection tool
- Developed workflows (for data collection and patient support)
- Created systems to protect and share patient data (SDOH among LINK partners)
- Began data collection/screened 1,737 patients (in first year)
- Identified 3 most prevalent barriers to health—food, housing, and transportation
- Hosted community meeting (with patients and community leaders to confirm problems and explore solutions)

2020—LINK 2.0

- Second year of funding/data collection continued
- Pandemic began
- Data showed impact of pandemic on food, housing, and communication
- Added digital equity question to survey instrument
- (LINK partners) Secured/distributed > $600,000 in grocery gift cards (to meet emergency needs for food)
- Worked with community partners to address digital equity issues
- Focus group of LINK partner frontline staff to improve support to patients

2021—LINK 3.0

- Third year of funding/data collection continued
- (LINK partners) joined Arlington County Food Security Task Force
- (LINK) presentation to Virginia Health Catalyst annual meeting
- Raised awareness of digital equity problems

2022—LINK 4.0

- Fourth year of funding/data collection continued
- Opening of Tele-Connect Space at Arlington Public Library
- County-wide food security strategic plan released.
- Worked with VHC to integrate SDOH into EHR
- Participated in Arlington's Guarantee pilot program.
- Formalized education/awareness for clinic staff/volunteers

2023—LINK 5.0 Begins!

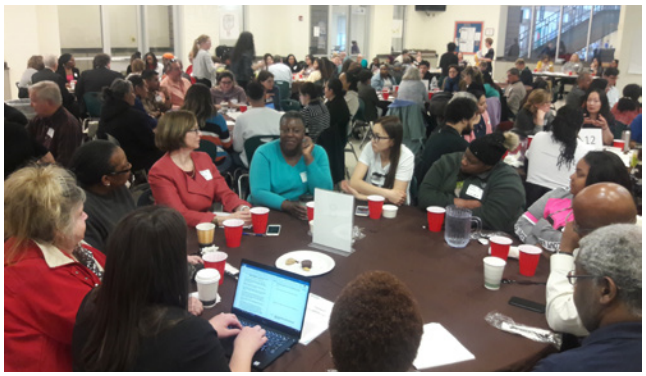
LINK 1.0 Accomplishments

1. Developed and adopted a tool and implementation protocol for collecting data on SDOH barriers-to-health from LINK partners' respective patient communities.

- Examined several nationally recognized instruments and adopted/adapted 10 questions we deemed most pertinent to our client populations. Reviewed data-collection policies and procedures, including:
  - Securing patient privacy and protected health information;
  - Translating to Spanish, Amharic, and Mongolian and testing literacy levels;
  - Acquiring the necessary hardware (e.g., tablets and laptops);
  - Training frontline staff to administer the survey and enter the data;
  - Instituting a process for addressing patients' urgent SDOH needs; and
  - Establishing a system for sharing de-identified data with LINK partners.
- Launched data collection across LINK partners' four clinical sites, screening a total of 1,126 unduplicated patients.

2. Identified three barriers-to-health from the collected data with logical and realistic upstream solutions and shared with community members for confirmation.

- Food, transportation and housing challenges clearly emerged as the leading conditions that impede our patients' overall health and quality-of-life.
- Convened a 3-hour meeting—with the support of Community Progress Network, GMU researchers and 38 volunteers—to facilitate candid roundtable discussions between 70 of our patients and 44 community leaders.



LINK Community Meeting 2019
80 low-income Arlington County residents from zip code 22204 gathered with local municipal leaders and other decision-makers for a dinner meeting to share their SDOH concerns and inform action.

SDOH Questionnaire

1. Are you worried that in the next 12 months you may not have stable housing?
2. In the last 12 months, has the electric, gas, oil or water company threatened to shut off your services in your home?
3. Within the last 12 months, did you worry that your food would run out before you got money to buy more?
4. Do you have trouble finding or paying for a ride (or any form of transportation)?
5. In the past 12 months, have you been hit, slapped, kicked or otherwise hurt by someone?
6. In the last 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
7. Do you often feel that you lack companionship?
8. Think about the place you live. Do you have problems with any of the following?: a) heat; b) lead; c) mold; d) oven; e) pests; f) smoke; g) water; h) none of the above
9. In the past year, have you or your family members been unable to get any of the following when it was really needed?: a) childcare; b) clothing; c) food; d) medicine or healthcare; e) utilities; f) other; g) none of the above
10. Are any of your needs urgent?

Question added in Year 2 in response to Pandemic needs:

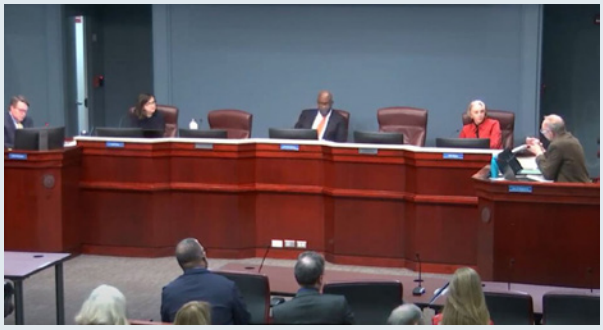
11. Think about how you use technology. Do you have problems with any of the following? a) having reliable internet; b) having or owning a computer, tablet or smartphone; c) having a private space to use a computer, tablet, or smartphone; d) knowing how to use a computer, tablet, or smartphone; e) do not have any problems.

3. Gathered community stakeholders–nonprofit organizations and county agencies with the responsibility, capacity and motivation to address upstream factors–to revisit the chief needs and to assess and prioritize action based on severity/urgency and ease-of-resolution.

This event catalyzed follow-up meetings with municipal leadership to identify potential solutions to transportation and housing challenges.

LINK's Synergy with Arlington's Equity Resolution

LINK's community meeting immediately followed passage of Arlington County's equity resolution aligned with its Destination 2027 objectives. Moving forward, policies, programs, procedures and budgets will be assessed using this basic inquiry framework: Who benefits? Who is burdened? Who is missing? How do you know?



The Plan Unfolds– and Shifts

NVHF knew from the outset that this work would demand a multi-year investment from all LINK partners and renewed our grant to continue our collective efforts. LINK 2.0's ambitious plan for Year 2 included:

- Ensuring sustainability of data collection/analysis systems for continued measurement of SDOH and referral processes–including boosting staff at LINK clinical sites to enter data and navigate patients to community resources and modifying EHR systems to integrate the SDOH screening tool.
- Planning, implementing and evaluating the effectiveness of solutions to leading identified community conditions deemed barriers to good health (i.e., housing, transportation, food scarcity).
- Promoting understanding of SDOH's relevance to facilitate its use in overall healthcare decision-making by creating and delivering educational content to train LINK clinic personnel and volunteers (primary care providers, case managers, frontline staff) to regard SDOH as integral to providing whole-person care and to incorporate screening and referrals into the care-delivery process.

LINK 2.0 Accomplishments

Although LINK activities were both jolted and accentuated by the pandemic (beginning March 2020), we achieved the following outcomes:

1. Continued collecting SDOH data at LINK clinical sites, screening a total of 1,737 unduplicated patients.

- Food access, stable housing and transportation support remained top-tier necessities, with technology/connectivity and lack of companionship emerging as significant barriers-to-health–not an unexpected revelation during the early lockdowns given: a) the reliance on hardware/software/broadband and tech literacy to access education, healthcare and other services; and b) the increased social isolation from friends and family during the time of heightened needs and uncertainty.
- Added an 11th question to our SDOH screening tool to elicit patients' needs in accessing technology equipment, WIFI and technical assistance in how to use it.

2. Addressed community SDOH conditions exacerbated by the pandemic, with special emphasis on increasing food access and connection to essential services via technology.

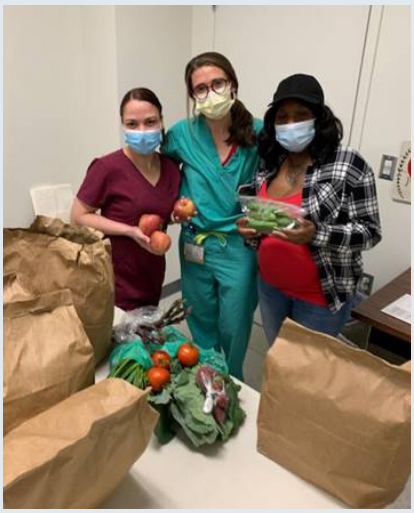
- Partnered on innovative solutions to streamline food access when incomes of hourly wage-earners took a significant 'hit' and using public transportation to grocery shop/visit food pantries became increasingly challenging.
- Responding to digital inequity as a heightened SDOH barrier-to-health during the pandemic, we met with Arlington County Department of Technology Services' leadership to discuss the need for reliable and affordable/free broadband access and lay the groundwork for systemic solutions.

3. Increased exposure to and understanding about SDOH's role in overall health among personnel throughout the respective LINK organizations.

- LINK partners organized and facilitated a focus group of front-line staff to elicit ideas of the most effective and efficient ways to work with patients to identify their needs and connect them to community resources.
- Each partner delivered presentations to our respective staff/volunteers on the impact of SDOH on the health of the patients we serve.
- Collaboratively developed basic educational materials that served as a template for customized communications with donors and community leaders and for presentations to other state and local safety-net organizations.

Unprecedented Opportunity to Increase Food Security in Arlington County

Informed by LINK's SDOH data, LINK partners solicited and secured funding from Arlington County Board ($400K) and joined Aspire! Afterschool Learning, Offender Aid & Restoration and BU-GATA to utilize funding from Arlington Community Foundation ($200K) to purchase and distribute $200/month in grocery gift cards to 500 low-income families over 6 months. AFC subsequently applied for and received an additional $65K from foundations—including NVHF—and private donors to expand our reach.



Gift card eligibility criteria:

1) Arlington resident;
2) Income <200% of the federal poverty level (FPL);
3) Self-reported food insecurity + at least one of the following conditions:
   - Limited community mobility due to health conditions or care-giving responsibilities
   - <100% of the FPL
   - Special circumstances making it difficult to obtain food at local distribution sites
   - Fear that accepting public assistance benefits would lead to being deemed a 'public charge' or other negative consequences.

This coordinated effort not only reduced hunger during the height of the pandemic, it precipitated enduring systems changes to benefit the community well into the future—creation and filling of a county-level Food Security Coordinator position and acceptance of alternative forms of identification to qualify for Arlington Food Assistance Center (AFAC) benefits. AFAC continued offering grocery delivery services to eligible county residents (including LINK partner patients) even after the grocery card program ended.

Settling Into an Evolving Landscape

As pandemic conditions waxed and waned the ensuing few years, LINK's sustained attention to its baseline objectives and calls-to-action remained steady—reflecting a tenacity and acknowledgement that upstream interventions do not take hold and achieve results quickly. LINK principals continued meeting virtually (albeit with less frequency due to some staffing changes and redirection of personnel to disaster response activities) and made progress in addressing documented SDOH needs in the community.

Objectives continued to focus on:

- Improving long-term sustainability and impact of SDOH data collection and sharing;
- Promoting awareness/understanding of SDOH relevance and importance to health and well-being;
- Advocating/planning/implementing up to 3 solutions to identified community issues that are barriers to good health (food, transportation, digital equity/ communications, housing); and
- Fostering dialogue to connect low-income residents with community leaders to express SDOH needs and solutions.

LINK 3.0 & 4.0 Accomplishments

1. Data collection continued in earnest and expanded. The work of LINK partners caught the attention of VHC hospital leadership who invited the partners into a series of conversations leading to the integration and system-wide use of a SDOH data collection instrument embedded in Epic, the EHR system used by AFC and by both VHC partners. DHS, in the planning stages of securing an EHR, participated in the planning meetings. VHC's adoption of this instrument dedicates hospital resources to ensure SDOH screenings are conducted and tracked throughout the VHC hospital system and that patients are connected to resources necessary for good health.

- SDOH data collection extended beyond LINK partner organizations, with Arlington County's Food Security Task Force enlisting Urban Institute to develop a countywide food security needs assessment. LINK partners provided input on the accessibility of the survey and helped to streamline and simplify questions, offered alternate administration methods and prompted its translation to multiple languages for access by those with limited literacy and/or English proficiency.

- VHC provided AFC user licenses to Epic, the EHR system used at the hospital. This investment is indicative of the longstanding collaboration between these two healthcare organizations and fosters streamlined data sharing to support case management, care coordination and improved patient health outcomes.

2. Awareness of SDOH's importance grew as LINK partners developed and delivered trainings for its respective staff and volunteers, communicated to its Boards and donors and participated in presentations to local and statewide governmental and nonprofit entities.

3. Advocacy and action on upstream solutions centered on: a) digital equity (promoting affordable broadband, adequately connected smartphones/ computers, knowledge/skills to perform basic computer-related tasks, promoting Arlington Public Library's new Teleconnect Space which provides private space, internet connection, and support for the community); b) housing (participating in Arlington's Guarantee pilot providing $500/month for 18 months to low-income county households with children); and c) food security (participating in the development of a county-wide strategic plan as an active member of Arlington's Food Security Coalition).

'Aha Moments' and Other Lessons Learned

- This undertaking requires a champion, leadership support, committed partners, persistence, flexibility and dedicated resources (both human and financial) to stay on-track toward meeting ambitious and complex objectives.
  - NVHF's essential role, not only as a funder but as a bold and visionary leader, cannot be overstated. Their wide lens, deep familiarity with the issues and stakeholders, openness to changing course when necessitated by the pandemic (and other environmental shifts) and ability to facilitate connections enabled this project to thrive and gain traction in the community. Their ongoing support has allowed us to showcase LINK as a successful, evolving and worthy initiative.
  - LINK had the benefit of diverse partners, each with a different perspective, scope and size. While AFC could pivot quickly to changing conditions—especially during the pandemic—VHC and the County DHS required legal and other approvals to explore and adopt agency-wide changes. By contrast, VHC had both the will and the capital to integrate the SDOH screening tool into its new EHR system, ensure its hospital-wide adoption and share this resource with AFC to streamline data-sharing and care coordination. DHS, despite hurdles to use a new EHR system, continued collecting and sharing SDOH data (hopefully spurring action toward acquiring a new EHR) and exerted its governmental position to elevate LINK's work as advancing realization of Destination 2027's vision.
- Adopting policy and systems changes to integrate SDOH screening and referral processes at different clinical organizations is not a 'one-size-fits-all' proposition.
  - The county, the free clinic and the hospital each had to examine its resources and workflows, modify existing/deploy new health record systems, train personnel, and adopt ongoing data collection and analysis into its already demanding healthcare operations.
  - Training staff and volunteers at all organizational levels is essential to the integration of lasting structural change. Shining light on the impact of SDOH on overall health and providing local examples of successes in addressing it are essential components of personnel onboarding and follow-up trainings.

"Before we implemented the SDOH screening tool, intake personnel said they always 'could tell' what patients needed and when they were in distress. After 2 weeks of survey administration, they changed their minds, observing patients become emotional when completing the survey and revealing conditions the staff did not anticipate."

– AFC Administrator

  - As recognition of the rationale and imperative to adopt SDOH screening and closed-loop referrals to resources gain traction among other Northern Virginia health and human services organizations, key stakeholders should be mindful of its complexity from the outset.
- As our work progressed, the importance of maintaining GMU or other health policy researchers' expert guidance became increasingly evident. The research team added considerable value by helping to develop the SDOH screening tool, protect private patient information, analyze and describe both quantitative and qualitative data and set us on a path to identifying our community's most pressing SDOH needs. Ongoing engagement of health policy and data experts would benefit the entire community, as they help us manage and interpret our data.

- The pandemic brought into sharp relief the inequities experienced by LINK consortium clients and exposed additional ones. The public health emergency demanded immediate and continual operational adjustments while it presented opportunities to broaden existing and forge new community collaborations (e.g., vaccine and testing clinics with the county) and to consider novel and creative solutions to new and longstanding challenges (e.g., grocery home deliveries, elevation of technology access to a higher priority).

Arlington Public Libraries' Tele-Connect Space at its Columbia Pike Branch addresses the need for private space for telehealth visits, job interviews, etc. This initiative was catalyzed by conversations early in the pandemic on how the library may help remove barriers to essential services.

- Connecting patients to resources to address identified SDOH needs and conducting follow-up monitoring and outcome assessments are critical but challenging endeavors.
  - LINK partners who used dedicated staff navigators had more success with initiating and tracking referrals than those that relied on healthcare providers who often were neither familiar with available community resources nor the process for connecting their patient to them (let alone having sufficient time to do so) at the point-of-care.
  - Patient needs often exceeded resource availability, especially in areas such as housing and childcare.
- The SDOH screening tool questions reveal more than just the direct answers. As patients respond to the prompts, a cascade of needs flows and exposes myriad challenges that we otherwise would not have anticipated. Social isolation emerged as an unexpected finding in this primarily immigrant population. Not surprisingly, the pandemic exacerbated the loneliness in our patient community.

Summary of Impact-to-Date

Reflecting on the last several years, LINK partners feel confident that we are on the right-track. We know this work has been impactful because:

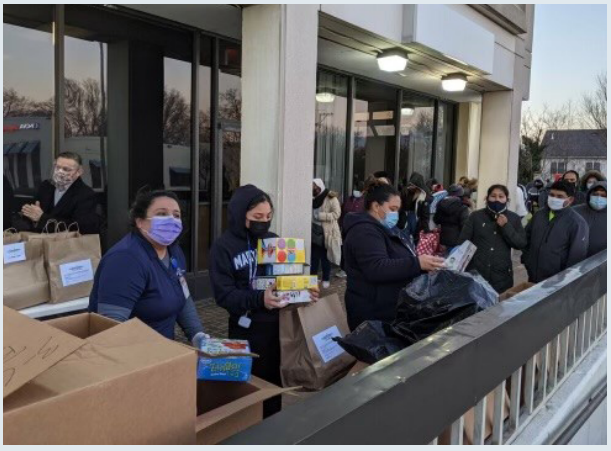
- **Responsiveness to emerging needs**—LINK partners' SDOH data and frontline exposure helped us build the case for just-in-time interventions to advocate for and deploy personnel to address needs exacerbated by the pandemic. Activities included establishing free 'walk-up' COVID-19 testing sites to accommodate residents without cars and supporting the operations of accessible vaccine clinics; providing transportation vouchers for VHC clinic patients needing rides to critical medical appointments (e.g., hemodialysis, cancer treatment); and acquiring nearly $700K in funding for grocery gift cards and coordinating their distribution to residents experiencing food insecurity; elevating the 'digital divide' as a high-need area and taking action to integrate telehealth in our respective operations, promote low-cost broadband access initiatives, offer technical assistance to clients and publicize the county's Teleconnect program.
- **Piqued awareness**—Nonprofit Boards and other community groups request presentations on SDOH and local community conditions, having been exposed to initiatives to address upstream factors impacting the health of their program beneficiaries and the preliminary outcomes of these efforts. Valued for our contributions, spheres-of-influence and record of success in 'upstream' interventions, we are regularly approached to advocate for affordable childcare, dedicated rental housing for low-income families, increased availability of accessible behavioral health services and operationalized food security policies (to name a few).

LINK partners responded to one such request with a presentation, 'Leveraging Social Determinants of Health Data to Meet Community Needs,' at the October 2021 VA Health Catalyst Summit.

Virginia Health Catalyst
The Intersection of Overall Health and Oral Health

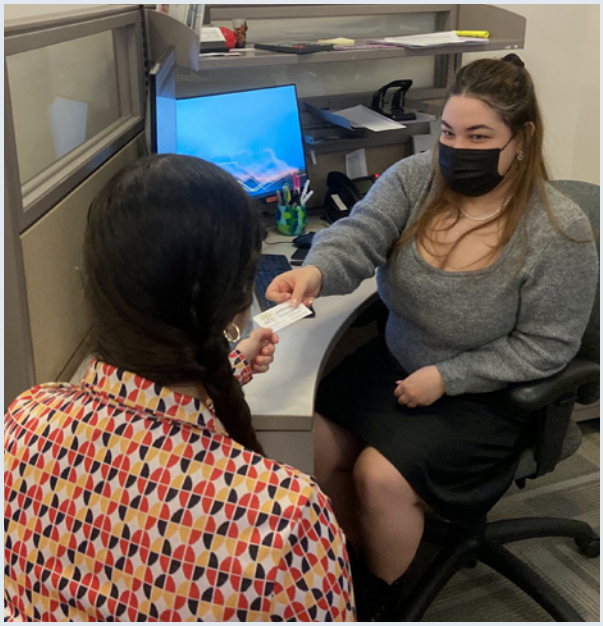
Meet some of the hundreds of families whose loads we were able to make just a little bit lighter thanks to the important grocery card initiative:

18-year-old high school student who lives with her brother. He pays only half the rent and is rarely home. • Day laborer on dialysis. • Single mom with 19-year-old son with special needs who is in a wheelchair. • Patient in active treatment for breast cancer whose husband's work hours were reduced by half. • Single, older woman with dementia and psychosis whose sister and niece care for her. • Young father whose wife died of cancer. He cares for and supports their two children on reduced wages. • 74-year-old two-time breast cancer survivor who is still working and supports herself on $7,200 per year. • Day laborer who lives in his car. Available work has been greatly reduced during the pandemic. • 67-year-old woman with breast cancer and metastasis. Her only support comes from her son who is unable to find consistent employment.



- **Healthcare sector behavior-change**—Physicians and other health professionals in LINK's 'orbit' are increasingly referring patients for non-medical supports/social services that influence health.

At AFC, patients referred for "needs beyond the exam room" meet with the staff Community Resource Navigator for formal needs assessment and connection to local social services.



- **We help set and have a seat at the table**—LINK partner expertise and visibility throughout the county has garnered considerable attention and influence. We credit this work and its growing circle of partners to the following enduring changes to improve SDOH prospects in Northern VA:
  - Arlington County established a Food Security Coordinator position, catalyzed in part by LINK data, with LINK representatives participating in the bimonthly Food Security Task Force and Coalition meetings. This Task Force catalyzed the countywide food security survey, resulted in Arlington Food Assistance Center offering home delivery of groceries for home-bound residents and led to Arlington County's adoption of a long-term food security plan.
  - Our advocacy for providing digital literacy education and expanding internet access to low-income Arlington communities—through communications with leadership of Arlington County's Public Library system, Department of Technology Services and Destination 2027—precipitated free broadband pilot projects at subsidized apartment complexes and attracted the attention of county decision-makers who are exploring strategies to make broadband connections affordable to all. Arlington Public Library's new Teleconnect Space provides free use of computers, printers, internet access, and technology support for residents who now have a private space for telehealth appointments, job interviews, and counseling sessions.
  - Arlington County Public Health Division has demonstrated a high-level commitment to addressing SDOH by way of its recent adoption of race-centered vision, mission and values statements and targeted expansion of community outreach to low-income clients.
  - When VHC Health decided to integrate SDOH screening for all patients into its EHR system, LINK partners were invited to be part of the planning team. The experiences that we had gained by developing and implementing this initiative on a smaller scale allowed us to provide leadership around patient privacy, data collection workflows, and, most importantly, use of the data to efficiently and appropriately refer patients for these essential services.

Where Next?

LINK's Year 5 agenda is brimming with action planning and implementation, much of which is well underway.

Robust Data Collection and Sharing

- Fully integrate new Epic-based SDOH data collection tool into LINK partner workflows and work to implement data sharing and analysis between partner sites.
- Support DHS' continued data collection/data sharing during the planned transition to a new EHR.

Streamlined Patient Referrals to Resources

- Support growth and adoption of UniteUs—a national SDOH referral platform used by VHC—in their efforts to provide a local/regional network of community-based services while continuing to provide direct referrals through onsite community resource navigators.
- Refine system for performing and evaluating closed-loop referrals and supporting a 'no-wrong-door' approach (identifying patient needs and navigating them to community SDOH resources for which they are eligible).

Spreading the Word (and Deed)

- Champion efforts to improve community conditions through memberships on task forces and coalitions and by advocating to county decision-makers on topics including food security, affordable childcare, county-wide broadband connections, and availability of housing for very low-income residents.
- Integrate orientation to importance of SDOH and referral processes into the onboarding of staff and volunteer health professionals and clinical personnel.
- Embrace opportunities to share our experiences and the impact of our work with others.

Join Us

- **Stay informed.** Increase your knowledge of SDOH and the efforts and activities of local government to bring about systemic changes to improve community conditions for all.

  Learn more about Arlington County's commitment to Equity: www.arlingtonva.us/Government/Topics/Equity

- **Spread the word.** Despite being one of the wealthiest counties in the country, there are thousands of Arlington residents who struggle to afford stable housing, sufficient food, and essential healthcare. Don't let this be a secret! Take notice and take action—participate in community events to bring attention to these specific conditions; choose a project to contribute your time, effort, expertise; help a neighbor by connecting them to resources or joining them to share your experiences with Arlington County elected officials.

  Prospective clients should contact Arlington County Department of Human Services at: 703-228-1300. Prospective volunteers can find opportunities to serve their community on Volunteer Arlington's website: volunteer.leadercenter.org.

- **Let your voice be heard.** Arlington County elected officials hear most often from residents who have the knowledge and ability to advocate for issues that affect them directly. Those most affected by adverse community conditions often do not have the language fluency, flexibility, transportation, or understanding of the process to successfully advocate for themselves and their families. Your voice can make a difference!
- **Help strengthen Arlington's safety net of services.** Find out how to volunteer and/or donating regularly to the organizations that provide vital services to our neighbors.

  There are many worthy safety-net organizations in Arlington. Learn more about supporting the nonprofit LINK partners:

  Arlington Free Clinic: www.arlingtonfreeclinic.org/get-involved/donate/

  VHC Health Foundation: vhcfoundation.com/give/