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Enhancing Social Determinants of Health Education in Home Health Care Including Social Determinants of Health in Assessments and Care Plans for Home Health Clinicians

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Emilia Mbanwite

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Walden University
2025

Executive Summary: Staff Education Project

Enhancing Social Determinants of Health Education in Home Health Care Including Social Determinants of Health in Assessments and Care Plans for Home Health Clinicians

by

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Executive Summary Submitted in Partial Fulfillment

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Doctor of Nursing Practice

Walden University

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Summary

This staff education-focused doctor of nursing practice (DNP) project addressed the critical practice problem of one southern health care facility staff's knowledge on the integration of social determinants of health (SDOH) into home health care plans. Despite SDOH screening, clinicians lacked standardized training to effectively assess and intervene on factors such as housing, transportation, and food insecurity, contributing to preventable hospitalizations, particularly in vulnerable populations. The practice-focused question addressed whether an evidence-based education module could improve home health nurses' knowledge and application of SDOH in assessments and care plans. The project's purpose was to develop, implement, and evaluate this training to enhance clinician competency and patient outcomes. Analytical strategies included pre- and postimplementation tests ($N = 41$ clinicians) analyzed by statistical comparisons (t tests and chi-square tests). Findings demonstrated significant improvements: The accurate definition of SDOH rose from 35% to 92%, confidence in assessments increased from 28% to 82%, and SDOH documentation improved from 13% to 67%. Key products included standardized SDOH assessment tools, training modules, and referral pathways. Recommendations emphasized integrating the module into employee onboarding, embedding SDOH tools within electronic health records and establishing an interdisciplinary committee to ensure sustainability. Implications for nursing practice included more equitable, patient-centered care. At the same time, social change is supported by addressing systemic barriers to health equity by fostering attention to SDOH with potential to reduce disparities through structured clinician education.

Background

SDOH are the nonmedical factors that shape a person's health outcomes and quality of life. These include the conditions in which people are born, grow, live, work, and age, as well as the broader systems and policies that influence those conditions (Hovey et al., 2021). Many health care organizations have begun integrating SDOH assessments into clinical workflows and including social workers on care teams. However, these efforts remain in early stages and have not yielded significant reductions in health disparities (Hovey et al., 2021). Current practices in graduate medical education and home health care lack standardized training for clinicians on how to assess and intervene on SDOH, leading to inconsistent care plans and poor health outcomes, particularly for vulnerable populations (Hassan et al., 2023). Without structured education, home health clinicians may overlook critical social factors that influence medication adherence and chronic disease management, contributing to higher readmission rates and suboptimal patient outcomes (Wilder et al., 2021). Hovey et al. (2021) stated the challenge lies in moving beyond identifying SDOH to actively addressing environmental factors such as housing, education, and transportation through interdisciplinary collaboration.

This DNP project addressed one southern health care facility's clinicians' lack of knowledge on the proper identification of their patients' SDOH and incorporating them into patient care plans. The purpose of this DNP project was to develop, implement, and evaluate an evidence-based education module for home health clinicians to improve their ability to assess and address SDOH in patient care plans. The practice question that guided this project was the following: For home health clinicians, how does enhanced

education and training on SDOH, compared to standard training protocols, improve the effectiveness of SDOH assessment and clinical interventions prior to patient discharge from home health services?

Evidence Supporting the Project

The evidence synthesis comprised 26 peer-reviewed articles, with three at Level 1, five at Level II, nine at Level III, and nine at Level IV, as categorized by the Johns Hopkins Research Appraisal tool. Additionally, the strength of the evidence comprised high-quality studies, including 16 systematic reviews and moderate-quality improvement research articles. These studies provided credible findings supporting the project gap and the need for change, as well as supporting the content for the education module to train the clinicians. Research demonstrated that unmet social needs such as housing instability, food insecurity, and lack of transportation significantly reduce medication adherence and worsen chronic disease management (Forber-Pratt et al., 2023; Wilder et al., 2021). The social barriers often force patients to prioritize immediate survival needs over long-term health maintenance, resulting in delayed care, missed medications, and fragmented treatment plans that can lead to preventable hospital readmissions (Hovey et al., 2021).

Need for Clinician Training

Analyses highlighted persistent gaps in SDOH training for health care providers, particularly in home health settings where social risk factors such as housing instability, food insecurity, and transportation barriers directly shape care planning and patient outcomes (Hassan et al., 2023). Despite growing recognition of the importance of SDOH, many clinicians report limited exposure to formal education on how to assess, document, and intervene on these factors, resulting in fragmented care and missed opportunities for

upstream intervention (Hovey et al., 2021) despite evidence suggesting that structured SDOH education improves clinician confidence and intervention strategies (Holt-Lunstad, 2022).

Effectiveness of Educational Interventions

Systematic reviews indicated that training programs incorporating case-based learning and standardized tools enhance SDOH integration into clinical practice (organizational data, quality improvement reports). The synthesis of the nine sources in this field generally centers on the common theme of how enhanced education, systematic assessments, and tailored interventions related to SDOH can improve patient outcomes, health care delivery, and reduce health disparities. Cai et al. (2023), Hassan et al. (2023), and Janssen et al. (2023) all focused on the impact of education and training on SDOH. Cai et al. discussed the importance of an increased ability to assess patients' social contexts and incorporate them into health care through practical experiences gained during home care visits, while Hassan et al. expanded on this by showing how enhanced education equips clinicians with the skills necessary to identify social needs, conduct more systematic assessments, and tailor care plans to address medical and social factors. Janssen et al. reinforced the idea that training programs on SDOH lead to better identification of these social factors during patient assessments.

Staff Education Project Development

Participants

Forty-eight clinicians at the project site, including nurses, therapists, and other health care professionals who conduct home visits, were invited to participate in the DNP project. Convenience sampling was used to recruit participants because it involved

recruiting participants from a readily available population (Stratton, 2021). Forty-one participants (85.4%) of the 48 invited completed the project by viewing the education module and returning both the pre- and postsurveys.

Procedures for Developing and Implementing the Project

With the assistance of the project site stakeholder engagement, the project started with a needs assessment and gap analysis based on site leadership's expressed concerns of increased hospitalizations due to unmet SDOH of their patient population. Stakeholder engagement involved meetings to introduce the project, assign roles, and evaluate organizational readiness, which indicated moderate confidence in implementing change. Educational tools were created, including SDOH assessment guides and training modules focused on identifying key SDOH; integrating them into care plans; and improving clinicians' cultural competence, communication, and documentation skills. Implementation of the project started with recruiting eligible participants via email from a staff distribution email list obtained from the site's leadership. Staff education sessions were held virtually and through self-study, with tools distributed electronically and in physical form. Data collection involved pre- and posttraining surveys to measure the potential difference in staff knowledge of SDOH and integration into patient care plans. Analysis of results included statistical tests to assess the effectiveness of the educational sessions for increasing staff knowledge. Findings were shared via reports, presentations, and emails, emphasizing the impact of SDOH on patient outcomes and the importance of timely, comprehensive assessments.

Data Collection and Analysis of Evidence

Staff self-reported knowledge levels were collected via a pretest and posttest approach. Participants' test answers collected were recorded on an Excel spreadsheet and prepared for analysis.

Results

Synthesis of Findings

Following the implementation of the training, the postsurvey results reflected remarkable improvements in staff knowledge and confidence. Average correct responses (see Table 1) to content questions increased from 47.24% to 94.76%, while those feeling "very confident" in applying the SDOH tool increased from 19.51% to 73.81%. Notably, three areas showed the greatest learning gains: understanding food insecurity as a clinical risk (31.71% to 85.71%), recognizing transportation challenges as access barriers (39.02% to 92.86%), and knowing how to document SDOH to inform holistic care planning (48.78% to 97.62%).

Table 1

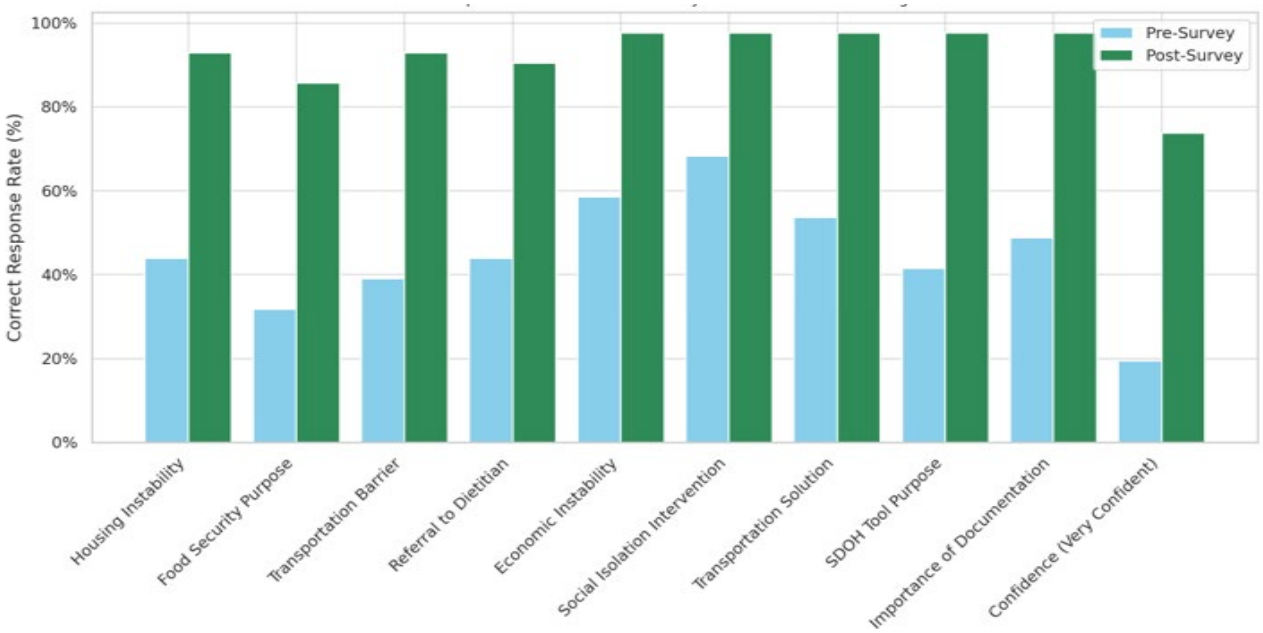
Pre- and Posttest Correct Response Percentages by Question Topic

Survey question	Presurvey %	Postsurvey %
Housing instability	43.9	92.86
Food security purpose	31.71	85.71
Transportation barrier	39.02	92.86
Referral to dietitian	43.9	90.48
Economic instability	58.54	97.62
Social isolation intervention	68.29	97.62
Transportation solution	53.66	97.62
SDOH tool purpose	41.46	97.62
Importance of documentation	48.78	97.62
Confidence (very confident)	19.51	73.81

These outcomes underscore the training's success in equipping staff with the insights and assurance needed to address patients' social needs more effectively. See Figure 1 for a graph depiction of the substantial improvement in knowledge and confidence following implementation.

Figure 1

Comparison of Pre- and Posttest Results on Staff Knowledge and Confidence Levels



Impact on the Organization

The SDOH training led to several impactful changes across the agency, notably strengthening clinical decision making by equipping staff with the knowledge to better identify key social risk factors such as food insecurity and housing instability. Staff confidence increased, fostering greater ownership of care coordination and improving interdisciplinary collaboration. Through increased staff knowledge and confidence, the site intends to include the education content in future training for enhanced care planning

through more effective use of the SDOH tool, enabling patient-centered, holistic interventions.

Limitations and Their Impact

The project had several limitations that may have influenced the outcome. Although the survey included 41 respondents, a strong number for a single agency, the sample size limits the generalizability of results and may not reflect variability across different shifts or satellite locations. Confidence levels reported in the postsurvey were self-assessed and subjective, which may not accurately represent actual competence or changes in clinical behavior. Future evaluations would benefit from incorporating objective measures such as observational audits or chart reviews. Additionally, the postsurvey was administered immediately after the training, providing no insight into long-term knowledge retention or application; a follow-up evaluation at 3 to 6 months would offer a more comprehensive assessment of impact. Lastly, the virtual format of the training may have posed participation challenges for staff who are less comfortable with digital platforms, potentially affecting engagement and learning outcomes.

Importance Beyond the Local Site

This project holds significance beyond the local agency because it aligns with national efforts led by the Centers for Medicare & Medicaid Services and the Centers for Disease Control and Prevention to integrate SDOH into clinical practice to promote health equity. The project provides a replicable model for other home health agencies seeking to implement structured SDOH assessments and staff education initiatives. Additionally, the project supports workforce development by equipping clinicians with practical skills to identify and address nonclinical factors that influence patient outcomes.

On a broader scale, early intervention through SDOH screening in home health care has the potential to reduce health care costs and improve population health by mitigating preventable social risk factors.

Conclusions

The staff education initiative on SDOH, as measured by pre- and postsurvey results, had a meaningful impact on the organization by significantly increasing clinicians' knowledge and confidence in identifying and addressing social factors that influence health outcomes. This improvement reflects a stronger foundation for delivering comprehensive, patient-centered care and sets the stage for more effective integration of SDOH practices across clinical workflows. To build on this success, the organization should consider implementing the SDOH Assessment Tool as a standard part of patient evaluations and embedding related interventions into care planning. Further recommendations include ongoing clinician education to reinforce learning, engaging interdisciplinary teams to support SDOH efforts, and establishing long-term evaluation methods to monitor knowledge retention and practice integration over time.

For nursing practice, this project reinforces the role of nurses as leaders in addressing social and environmental contributors to health. The project empowers nurses to advocate for their patients more effectively and align care delivery with individual needs beyond clinical symptoms. On a broader level, the initiative supports positive social change by promoting equitable care practices and ensuring that diverse patient populations receive culturally responsive and socially informed health care. This directly advances principles of diversity, equity, and inclusion within the organization and the communities it serves.

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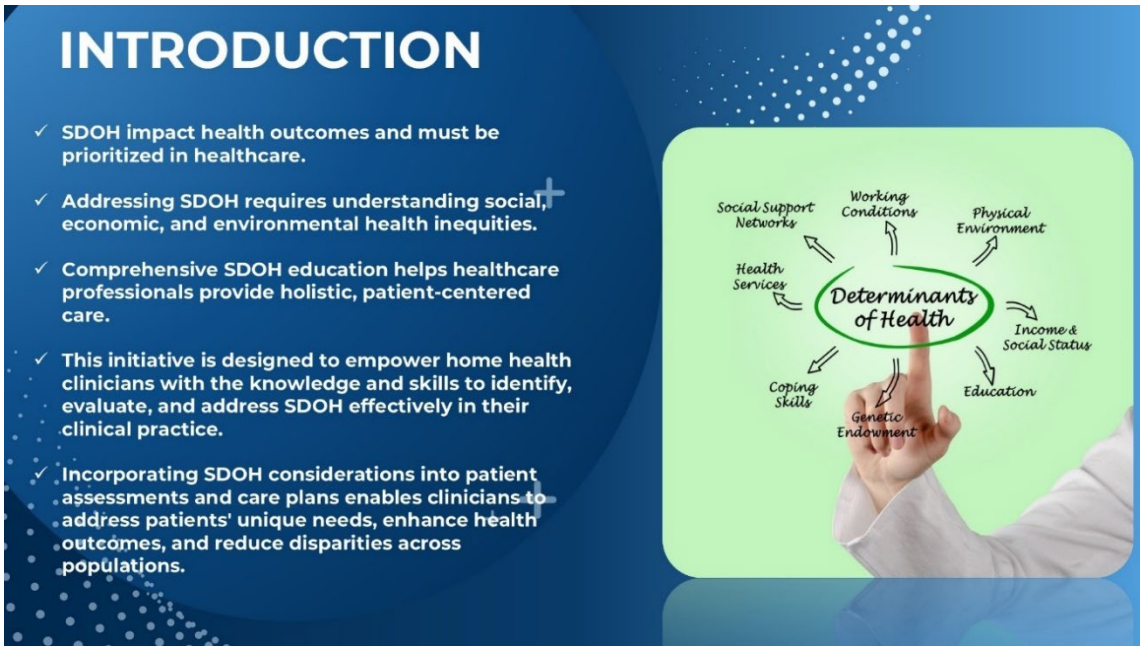
Appendix A: PowerPoint Presentation




Learning Objectives
✓ Identify SDOH domains:
Clinicians will be able to recognize and define the key social determinants of health (SDOH) domains that impact patient outcomes.
✓ Assess SDOH needs:
Clinicians will be able to effectively assess patients' SDOH needs using a standardized assessment tool.
✓ Develop targeted interventions:
Clinicians will be able to develop and implement interventions to address patients' social determinants of health (SDOH) needs.


Learning Objectives
✓ Document SDOH information:
Clinicians will be able to accurately and consistently document SDOH information in patient records.
✓ Integrate SDOH into care planning:
Clinicians will be able to integrate SDOH considerations into patient care planning.


THE NEED FOR
SDOH INTEGRATION
Key Social Factors Impacting Health
✓ Transportation – Lack of access limits medical visits, medication adherence, and healthy food options.
✓ Bill Payments – Financial stress correlates with chronic conditions (e.g., hypertension, depression).
✓ Food Security – 1 in 10 U.S. households face hunger, worsening diabetes and obesity rates.
✓ Housing Maintenance – Poor conditions (e.g., mold, lead) drive asthma and pediatric ER visits.

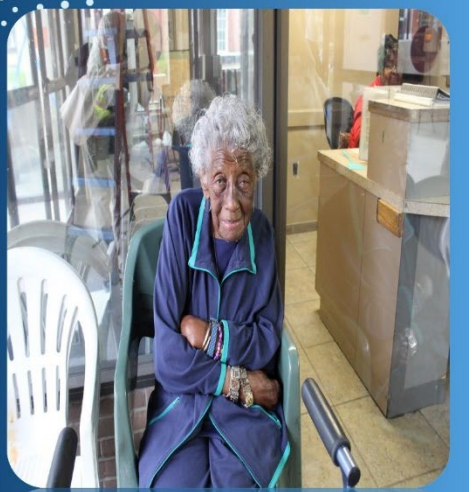

THE NEED FOR
SDOH INTEGRATION
✓ Education – Lower education levels link to higher mortality rates.
✓ Income – Low-income populations live 10+ years fewer than high-income peers.
✓ The issue is substantiated by evidence consistent with current healthcare trends.
✓ In home healthcare, addressing and incorporating social determinants of health (SDOH) into patient care plans is vital for enhancing patient outcomes.
✓ The omission of Social Determinants of Health (SDOH) in patient care plans and failure to address these elements adequately can significantly impact patients' budgets.

Overview of SDOH Assessment & Care Plan Tool

- The Social Determinants of Health (SDOH) Assessment & Care Plan Tool helps clinicians systematically identify and address non-clinical factors affecting patient health.
- Tool covers: Housing Stability, Food Security, Transportation, Economic Stability, and Social Support.
- Each domain includes both assessment criteria and corresponding interventions.
- The tool is used during patient assessments, care planning, and discharge preparation.
- Blank spaces allow for individualized notes and care customization.
- Completed by clinician with date and signature to ensure accountability.

1. Housing Stability

Assess	Assess if patient lives in stable housing or experiences frequent moves or homelessness.
Document	Document any housing-related risks: overcrowding, unsafe conditions, or temporary shelters.
Intervene by	Intervene by referring to social services, connecting with community housing programs, or educating patients on their housing rights.
Consider	Consider collaboration with legal aid or housing assistance organizations.
Improve	Addressing housing can improve patient compliance and reduce hospital readmissions.
Note	Note individual concerns in the blank fields for personalized care plans.



2. Food Security

- Determine if patient has regular access to nutritious food or shows signs of food insecurity.
- Identify patients dependent on food assistance programs such as SNAP or food banks.
- Refer to local food programs or dietitians for counseling and nutrition planning.
- Educate patients on budgeting for food and healthy meal planning.
- Food insecurity can impact medication adherence and recovery outcomes.
- Tailor recommendations based on cultural and dietary needs.

3. Transportation

- ✓ Assess if the patient has access to reliable transportation for appointments or daily needs.
- ✓ Identify challenges like cost, lack of services, or dependence on others.
- ✓ Intervene by referring to transport programs, arranging rides, or providing info on public transit.
- ✓ Transportation barriers can lead to missed visits and poor health outcomes.
- ✓ Explore local transit vouchers or volunteer services for seniors.
- ✓ Document specific patient barriers in the additional notes section.

4. Economic Stability

- Evaluate the patient's employment status and income security.
- Identify signs of financial strain: inability to pay bills, utilities, or medical expenses.
- Connect patients with financial counselors, employment programs, or benefits enrollment.
- Discuss budgeting strategies to support treatment compliance.
- Financial stress can lead to anxiety and nonadherence to treatment plans.
- Use notes section to track referrals and progress.

5. Social Support

- Assess presence or absence of a support network (family, friends, community).
- Identify isolation or over-reliance on informal caregivers.
- Refer patients to support groups or encourage community engagement.
- Coordinate with family or caregiver teams to ensure continuity of care.
- Social support plays a critical role in mental and physical health recovery.
- Customize recommendations for cultural or religious support resources.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Appendix B: Assessment and Intervention Tool

Social Determinants of Health (SDOH) Assessment and Intervention Tool

Patient Information:

Name: _____

Date of Birth: _____

Date of Assessment: _____

Clinician Name: _____

Clinician Title: _____

Date: _____

Instructions:

- Review each section and indicate the relevant factors affecting the patient. Use additional notes to provide context or details as necessary.
- Discuss findings with the patient to ensure accuracy and gather additional insights.
- Develop a care plan with interventions tailored to address identified SDOH factors.

This tool serves as a structured framework for home health clinicians to assess various SDOH factors impacting patient health and well-being. By systematically documenting findings and planning interventions, clinicians can enhance care coordination and improve patient outcomes by addressing holistic healthcare needs.

1. Housing Stability:

- **Assessment:**
  - ☐ What is your current living situation? (rent, own, homeless, etc.)
  - ☐ Do you have concerns about your housing stability? (yes/no)
  - ☐ Are you facing eviction or housing insecurity? (yes/no)
  - ☐ Do you have working utilities (electricity, water, heat)? (yes/no)
  - ☐ Is your housing safe and stable? (yes/no)
  - ☐ _____
  - ☐ _____
  - ☐ _____
- **Intervention:**
  - ☐ Referral to social services for housing assistance
  - ☐ Collaboration with community resources for housing support
  - ☐ Education on housing rights and resources
  - ☐ _____
  - ☐ _____
  - ☐ _____

2. Food Security:

- **Assessment:**
  - ☐ Do you have difficulty accessing food or groceries? (yes/no)
  - ☐ Have you had to skip meals or reduce food intake due to financial constraints? (yes/no)
  - ☐ Do you receive food assistance (e.g., SNAP, food bank)? (yes/no)
  - ☐ How often do you worry about running out of food? (scale: never, sometimes, often)
  - ☐ Do you have access to fresh fruits and vegetables? (yes/no)
  - ☐ _____
  - ☐ _____
  - ☐ _____
- **Intervention:**
  - ☐ Referral to food banks or nutrition assistance programs
  - ☐ Education on budgeting and meal planning
  - ☐ Collaboration with a dietitian for dietary counseling
  - ☐ _____
  - ☐ _____
  - ☐ _____

3. Transportation:

- **Assessment:**
  - ☐ Do you have reliable transportation to medical appointments? (yes/no)
  - ☐ Do transportation costs limit your access to healthcare or essentials? (yes/no)
  - ☐ Are there transportation services you'd like to know about? (yes/no)
  - ☐ How do you typically get to medical appointments? (drive, public transportation, walk, etc.)
  - ☐ Do you need assistance with transportation costs? (yes/no)
  - ☐ _____
  - ☐ _____
  - ☐ _____
- **Intervention:**
  - ☐ Referral to transportation services or programs
  - ☐ Assistance with arranging transportation for medical appointments
  - ☐ Education on public transportation options
  - ☐ _____
  - ☐ _____
  - ☐ _____

4. Economic Stability:

- **Assessment:**
  - ☐ Do financial concerns affect your ability to pay bills or access healthcare? (yes/no)
  - ☐ Are you eligible for financial assistance programs? (yes/no)
  - ☐ Do you need help navigating financial resources? (yes/no)
  - ☐ How do you manage your finances? (open-ended)
  - ☐ Do you have concerns about paying for medications or treatments? (yes/no)
  - ☐ _____
  - ☐ _____
  - ☐ _____
- **Intervention:**
  - ☐ Referral to financial counseling or employment services
  - ☐ Assistance with accessing benefits (e.g., Medicaid, SNAP)
  - ☐ Education in financial management and budgeting
  - ☐ _____
  - ☐ _____
  - ☐ _____

5. Social Support:

- **Assessment:**
  - ☐ Who do you live with, and do they provide emotional support? (open-ended)
  - ☐ Do you feel isolated or lonely? (yes/no)
  - ☐ Are there community resources you'd like to connect with for social support? (yes/no)
  - ☐ How often do you interact with friends or family? (scale: daily, weekly, rarely)
  - ☐ Do you have a support system for emotional needs? (yes/no)
  - ☐ _____
  - ☐ _____
  - ☐ _____
- **Intervention:**
  - ☐ Referral to social support groups or community activities
  - ☐ Coordination with family or caregivers for additional support
  - ☐ Education on building social connections and support networks
  - ☐ _____
  - ☐ _____
  - ☐ _____

_____

Additional Notes:

- **Summary of Findings:**
  - **a.** _____
  - **b.** _____
  - **c.** _____
  - **d.** _____
- **Care Plan Recommendations:**
  - **a.** _____
  - **b.** _____
  - **c.** _____
  - **d.** _____

Clinician Signature: _____

Date: _____

Appendix C: Handout for Staff Education

Key Insights from Research

Clinician Training and Patient-Centered Care

- Training clinicians to understand and assess SDOH leads to a more holistic, patient-centered approach to care.
- Continuous education and research are essential to bridge knowledge gaps and improve care delivery.

Structured Education and Training

- Education on SDOH helps clinicians identify social barriers to care (e.g., mobility issues, social isolation, stress).
- Training improves assessment skills, multidisciplinary collaboration, and the ability to create personalized care plans.

Racial and Ethnic Disparities

- Racial discrimination and disruptive life events (e.g., bankruptcy, sudden moves) disproportionately affect marginalized groups.
- Building trust, improving communication, and implementing equitable clinical pathways are essential to address disparities.

Patient Empowerment and Community Collaboration

- Patients should be active participants in their care, not passive recipients.
- Tailored interventions that recognize patients' social agency and cultural contexts are more effective.
- Community partnerships and interdisciplinary collaboration strengthen SDOH-informed interventions.

Policy and Structural Changes

- Broader policy changes are needed to integrate SDOH into healthcare delivery.
- Multidisciplinary collaboration among healthcare clinicians, policymakers, and community organizations is key to addressing social factors like poverty, employment, and housing.

What are Social Determinants of Health (SDOH)?

SDOH are the conditions in which people are born, grow, live, work, and age. These factors include housing, food security, transportation, access to healthcare, and social support networks. SDOH significantly influence health outcomes and contribute to health disparities.

Recommendations for Homecare Clinicians:

Enhance Your SDOH Competency

- Participate in structured SDOH training programs.
- Stay updated on research and best practices for addressing SDOH.

Adopt a Holistic Approach

- Assess and document SDOH during patient visits.
- Consider social and environmental factors when creating care plans.

Advocate for Systemic Change

- Support the integration of SDOH into EHR systems and healthcare policies.
- Collaborate with community organizations to address local social needs.

Build Trust and Improve Communication

- Foster open, empathetic communication with patients, especially those from marginalized groups.
- Address racial and ethnic disparities through equitable care practices.

Empower Patients

- Involve patients in care planning and decision-making.
- Recognize and leverage patients' social resources and agency.

ENHANCING SDOH EDUCATION IN HOME HEALTH CARE

Appendix D: Survey Questionnaires

Pre_Survey SDOH

PRE SDOH STAFF EDUCATION SURVEY

Which of the following best defines housing instability?

- ○ Homeownership
- ○ Living in a quiet neighborhood
- ○ Frequent moves or risk of eviction
- ○ Owning more than one property

What is the primary reason to assess food security in patients?

- ○ To recommend expensive diet plans
- ○ To understand nutritional preferences
- ○ To identify barriers to adequate nutrition
- ○ To limit patient intake

What does "transportation barrier" most likely refer to?

- ○ A toll road
- ○ Poor road conditions
- ○ Lack of reliable transportation
- ○ High gas prices

Who is most likely to benefit from a referral to a dietitian?

- ○ Patients who skip meals due to food insecurity
- ○ Patients with strong financial stability
- ○ Patients with private chefs
- ○ Patients without dietary concerns

Which of the following best describes economic instability?

- ◯ Owning stocks
- ◯ Living in a high-income area
- ◯ Irregular or low income and unemployment
- ◯ Retiring early

Which is an appropriate intervention for socially isolated patients?

- ◯ Encourage home confinement
- ◯ Refer to social support groups or community centers
- ◯ Increase medication dosage
- ◯ Limit phone access

What should you do if a patient reports lacking transportation to appointments?

- ◯ Ignore the concern
- ◯ Suggest rescheduling frequently
- ◯ Refer to transportation assistance programs
- ◯ Recommend driving lessons

What kind of tool is the SDOH Assessment & Care Plan?

- ◯ Diagnostic imaging guide
- ◯ Clinical procedure manual
- ◯ Standardized tool for identifying and addressing social needs
- ◯ A financial report

Why is documenting SDOH in careplans important?

- ◯ It satisfies patient curiosity
- ◯ It increases billing rates
- ◯ It informs comprehensive, patient-centered care
- ◯ It is a legal requirement only

Before completing this training, how confident are you in using the SDOH Assessment Tool in your clinical practice?

- ◯ Not confident at all
- ◯ Slightly confident
- ◯ Moderately confident
- ◯ Very confident

Post-Survey SDOH

POST SDOH STAFF EDUCATION SURVEY

Which of the following best defines housing instability?

- ◯ Homeownership
- ◯ Living in a quiet neighborhood
- ◯ Frequent moves or risk of eviction
- ◯ Owning more than one property

What is the primary reason to assess food security in patients?

- ◯ To recommend expensive diet plans
- ◯ To understand nutritional preferences
- ◯ To identify barriers to adequate nutrition
- ◯ To limit patient intake

What does "transportation barrier" most likely refer to?

- ◯ A toll road
- ◯ Poor road conditions
- ◯ Lack of reliable transportation
- ◯ High gas prices

Who is most likely to benefit from a referral to a dietitian?

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- ◯ Patients with strong financial stability
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- ◯ It increases billing rates
- ◯ It informs comprehensive, patient-centered care
- ◯ It is a legal requirement only

After completing this training, how confident are you in using the SDOH Assessment Tool in your clinical practice?

- ◯ Not confident at all
- ◯ Slightly confident
- ◯ Moderately confident
- ◯ Very confident

Submit

Appendix E: Recruitment Email

Subject: Invitation to Participate in Virtual Staff Education Project on Social Determinants of Health (SDOH)

Dear [Intended Participant],

My name is Emilia Mbanwite, MSN, RN, a Doctor of Nursing Practice (DNP) student at Walden University. I am inviting you to participate in a staff education project at Carmel Health Care Services, PLLC, aimed at enhancing our clinical understanding and integration of Social Determinants of Health (SDOH) into patient assessments and care planning.

This education initiative is designed to support clinicians in identifying and addressing social barriers to care, ultimately enhancing patient outcomes and agency performance.

Virtual Training Schedule:

- Day 1: July 7th, 2025, at 1:00 PM
- Day 2: July 8th, 2025, at 10:00 AM
- Day 3: July 9th, 2025, at 3:00 PM

These sessions will be conducted virtually, and for those unable to attend live, a self-study training package will be made available. The self-study option will include the same materials and objectives.

Participation Requirements:

- Completion of a pre-education survey via Zoho Survey
- Participation in the virtual training or completion of the self-study package
- Completion of a post-education survey via Zoho Survey
- Surveys will be sent via email or phone and must be completed anonymously online through Zoho Survey between July 1st and July 14th, 2025.

Benefits of Participation:

- Acquire knowledge and tools better to address patients' social and environmental health needs
- Enhance patient care outcomes and improve quality indicators
- Contribute to interprofessional collaboration and care planning
- Support agency goals for quality improvement, compliance, and patient satisfaction

Participation is entirely voluntary, but your involvement will be a valuable contribution to improving care delivery within our organization.

To sign up or request the self-study package, please contact:

Emilia Mbanwite, MSN, RN
DNP Student – Walden University
emilia.mbanwite@waldenu.edu
469-636-4483

Thank you in advance for your support and participation.

Warm regards,
Emilia Mbanwite
DNP Student – Walden University