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Executive Leadership System Improvement Program Proposal for Capturing At-Risk Patients in a Primary Care Setting

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Walden University

College of Nursing

This is to certify that the doctoral study by

Winter Wilson

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University
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Executive Summary: Executive Leadership System Improvement

Program Proposal for Capturing At-Risk Patients in a Primary Care Setting

by

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Executive Summary Submitted in Fulfillment of
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Summary

This Doctor of Nursing Practice (DNP) project is an executive leadership systems implementation proposal focused on standardizing the identification and referral of patients with unmet social determinants of health (SDOH) in a primary care setting. The practice problem addressed is the inconsistent identification and inadequate management of social needs. The guiding practice-focused question asks whether implementing a standardized social needs screening tool, compared with current non-standardized practices, increases the timely identification and referral of adult primary care patients to social work services and reduces avoidable emergency department utilization. To address this question, the project proposes integrating a validated screening tool into the electronic health record, supported by standardized workflows, automated referral processes, and structured staff training.

Outcome measures will include emergency department utilization, patient experience, staff satisfaction, and equity indicators. Major products include an embedded screening template, automated electronic health record (EHR) flags and referral orders, standardized workflows, training modules, and performance dashboards. Key recommendations include piloting the model, expanding social work capacity as demand increases. This project strengthens nursing practice in population health, and advances positive social change by ensuring fair, needs-based access to supportive services, thereby promoting diversity, equity, and inclusion.

Background

The primary care aspect is uniquely positioned to address SDOH due to its longitudinal relationships with patients and its central role in prevention, chronic disease management, and care coordination. Current practice within the organization relies mainly on provider discretion and ad hoc inquiries to identify social needs. The approach produces inconsistent documentation, variable referrals, and inequitable access to social services. As a result, the patients with significant non-medical barriers often cycle through the health system without receiving timely support, leading to avoidable emergency department (ED) visits, poor adherence to the treatment plans, and worsening health outcomes. Leadership has identified the trends as incompatible with the organization's strategic priorities for equity, patient experience, and value-based performance.

If the project is not implemented, the organization will likely continue to experience high cost utilization among socially vulnerable patients, persistent gaps in care coordination, and a limited ability to demonstrate progress on equity metrics increasingly emphasized by payers and accrediting bodies. In addition, failure to address SDOH undermines the nursing profession's ethical mandate to promote justice, beneficence, and patient-centered care.

Original quality reports show that fewer than 10% of the primary care patients received a social work referral in the last year, despite frequent documentation of missed appointments, medication nonadherence, and repeated ED visits for conditions that can be managed in the outpatient setting. Utilization analyses show a disproportionate share

of ED encounters among the patients who self-report food insecurity, housing instability, or trauma-related barriers (Wagner et al., 2023). Patient experience surveys further show dissatisfaction related to the unmet non-medical needs and difficulties in navigating community resources.

Community assessments document rising rates of food insecurity, housing instability, and economic hardship, factors that are closely associated with poor health outcomes and increased healthcare utilization. Public health reports show a higher prevalence of chronic conditions and preventive hospitalizations in neighborhoods characterized by concentrated disadvantages. The data underscores the necessity of a proactive, standardized approach within primary care to note needs early and connect patients to appropriate resources.

A comprehensive literature review was done using Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and the Cochrane Library. Search terms included social determinants of health, Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), Primary care screening, referral, and emergency department utilization. The inclusion criteria were peer-reviewed, full text articles in English published within the last five years. Out of 49 articles initially identified through database searches, duplicates were removed, and 22 studies met the inclusion criteria after title/abstract screening and full-text review. The final evidence set was weighed toward higher levels of evidence. Of the 22 included sources, nine were Level I studies, including systematic reviews, umbrella reviews, and scoping reviews that examined standardized SDOH screening, integration strategies, and health outcomes.

Four studies were Level III, consisting of implementation studies, logic model analyses, and reports focused on applied system change. Five studies were Level V–VI, primarily qualitative analyses, theoretical works, and practice guides. The remaining four sources represented mixed or moderate-quality designs.

Overall, the body of evidence was predominantly high-level and consistently supported the use of standardized screening, referral workflows, and reduced emergency department utilization. Evidence consistently demonstrates that standardized SDOH screening, when paired with referral pathways and follow-up initiatives, identifies unmet needs, increases linkage to community resources, and is associated with reductions in available ED visits and hospitalizations. National initiatives and practice guidelines endorse tools like PRAPARE and Accountable Health Communities Health-Related Social Needs (AHC HRSN) as feasible, validated instruments for clinical settings. The literature emphasizes that screening alone is insufficient; success requires workflow integration, staff training, community partnerships, and performance measurement.

The expected outcomes include higher screening and referral rates, improved referral completion, reduced ED utilization among the high-risk patients, enhanced patient trust, and meaningful reductions in disparities, which benefit the organization, the nursing profession, and the population served. For nursing, the project strengthens leadership in population health, reinforces evidence-based practice, and advances ethical commitments to equity. For patients, it promotes timely access to resources that address upstream determinants of health.

Project Development

Successful implementation needs coordinated action across multiple stakeholder groups. First, primary care providers need to integrate screening into clinical encounters, initiate referrals, and reinforce care plans to ensure effective patient care. The nurses and medical assistants will administer screening tools, provide patient education, and ensure accurate EHR (Electronic Health Records) documentation. The social workers will manage referrals, conduct assessments, connect patients to resources, and document the outcomes. Clinical administrators will help oversee logistics, staffing, budgeting, and policy alignment. Information technologists (IT) to build the EHR templates, automate flags and orders, and develop reporting dashboards (Kreuter et al., 2021). Patients and community partners will provide feedback on the acceptability of the services and facilitate access to them. Engagement will occur via executive sponsorship, workflow code design workshops, training sessions, pilot feedback meetings, and quarterly performance reviews. The proposed program aligns directly with the organization's mission to deliver equitable, patient-centered, high-quality care and its vision to improve community well-being through integrated services. By embedding SDOH screening into routine workflows, the initiative operationalizes the organizational values of compassion, integrity, and excellence (Yan et al., 2022). Standardization promotes fairness and transparency in care delivery, while coordinated referrals show commitment to holistic, whole-person care.

The project aligns with The Joint Commission and Centers for Medicare and

Medicaid Services (CMS) expectations related to patient-centered care, population health management, and SDOH integration. Compliance will be ensured via standardization documentation, role-based access controls, data governance policies, and routine audits (Karran et al., 2023). Performance metrics will support accreditation readiness and value based reimbursement reporting.

The strengths include strong leadership commitment to equity and quality, established interdisciplinary collaboration among providers, nurses, and social workers, and a robust EHR infrastructure capable of supporting tool integration and reporting. Some of the weaknesses include limited time during visits, variable staff familiarity with SDOH, and potential documentation burden during initial rollout. Some opportunities include national emphasis on population health and value-based care, availability of validated tools, potential quality incentives, and opportunities to strengthen community partnerships. Threats include risk of social work capacity constraints as demand increases, patient reluctance to disclose sensitive information, and financial limitations related to staffing and technology. Benefits include improved identification of need, enhanced care coordination, reduced ED utilization, improved patient experience, and stronger presence on equity and quality metrics. Risks will be mitigated via phased implementation, targeted training, leadership sponsorship, and capacity planning.

Technology requirements include the integration of EHRs with PRAPARE or AHC HRSN templates, automated flags for identified needs, standardized referral orders, and reporting dashboards (Whitman et al., 2022). No external supply chain dependencies are anticipated beyond the software configuration and potential licensing requirements. Data security and interoperability will be addressed via existing IT governance structures.

A structured training program will prepare staff to implement the model effectively. Training will cover tool administration, training-informed and culturally responsive communication, referral workflows, documentation standards, and privacy requirements. Competency will be assessed via post-training evaluations, chart audits, and direct observation (Rudisill et al., 2023). Ongoing education will be provided to help address workflow refinements and sustain adherence. The collection of sensitive social data necessitates strict adherence to the Health Insurance Portability and Accountability Act (HIPAA) and regional privacy policies. Role-based access, secure storage, and explicit consent language will be employed. No union barriers are anticipated in this case; policy updates will be reviewed by the compliance and human resources departments.

The implementation of standardized SDOH screening in primary care using PRAPARE or AHC–HRSN will occur in structured phases aligned with organizational workflows and leadership oversight. The first goal is to integrate the screening tool into the EHR. During Weeks 1 through 6, the IT department and EHR analysts will build screening templates and enable auto-flagging functionality, with the primary deliverable being live PRAPARE or AHC–HRSN fields within the EHR system. Concurrent with system integration, staff training on screening and workflows will be conducted between Weeks 2 and 8.

The second goal is to increase identification and referral of patients with unmet social needs. Screening completion is targeted to reach 90 percent within 3 to 5 months, as measured by EHR audit reports. Automated referral pathways will be established by

the social work lead and IT team to increase referral rates by over 50% within the same timeframe.

The third goal is to reduce emergency department utilization among high-risk patients. Patients identified through screening as having one or more unmet social needs or prior high ED use will be tracked. Under the implementation plan summary, this will be undertaken in the following phases: Phase 1 will involve finalizing tool selection, building the EHR, engaging stakeholders, training staff, and collecting baseline data. Phase 2: piloting in one clinic, monitoring process measures, and collection of feedback. Phase 3: analysis of piloting data, refining workflows, and addressing barriers. Phase 4: scaling across sites, implementation of dashboards, and conducting Continuous Quality Improvement (CQI) cycles.

The line-item budget for the project includes costs associated with training, technology development, staffing support, evaluation, and project oversight. Training materials, including guides and printouts, are estimated at \$300. Staff training is calculated based on 20 employees receiving one hour of training at \$45 per hour, totaling \$900. EHR template building by information technology staff is budgeted at \$1,500. Social work capacity support is allocated to \$3,500 for additional hours for existing staff to manage increased referrals, with no additional full-time equivalent positions needed. This cost reflects a temporary allocation of additional hours for existing social work staff to accommodate the increased referral volume generated by the screening program. Evaluation tools, including audit tools and surveyors, are estimated at \$400. The DNP student will provide project oversight. The total projected cost for the project is \$4,000.

The return on investment (ROI) analysis is based on several assumptions (see

Table 1). Reducing avoidable emergency department visits is estimated to save between \$1,000 and \$1,500 per visit. The target outcome is a 10% reduction in ED visits among high-risk patients. If baseline emergency department visits are 100 per year, the projected savings are \$12,000. The ROI is calculated using the formula: cost savings minus project cost, divided by project cost. Using the values provided, 12,000 minus 6,600 divided by 6,600 equals 0.818. Therefore, the return on investment is 82%.

Table 1

Logic Model

Inputs	Activities	Outputs	Shortterm outcomes, i.e., 0 to 3 months	Intermedi ate outcomes, i.e., 3 to 12 months	Longterm outcome s, i.e., over 12 months	Assumpti ons	External factors
It includes leadership commitment. EHRs technical support PRAPARE/A HC-HRSN tool Trained social workers The training modules Community resource directly Evaluation tools	Integrate screening into the EHRs Training of the staff Implementation of the automated EHR flags and referral orders Establishme nt of referral workflows Community MOUs Doing a pilot and collecting data.	Staff are trained New patients are well screened EHRs flags Referral s to the social work Referral completi on rates Staff feedbac k	Increased detection of unmet social needs Increased referrals to the social work Increased staff confidence Patient acceptabil ity.	Increasing social work engageme nt Increasing followthrough on the referrals Improvem ent of care coordinati on Better adherence to the care plans	Decreas ed avoidabl e ED visits Improve d disease control Increase d patient satisfacti on Reduced dispariti es Cost savings	Patients disclose Resources available Staff adopt the workflow s	Commun ity resource capacity Policy

Results

The evaluation plan includes both formative and summative components to assess implementation progress, workflow adoption, and outcome achievement. Formative evaluation will occur throughout the implementation period to monitor readiness, competence, and adherence to the process. Staff readiness will be assessed during Weeks 1 to 2 using a pre-trial survey administered through a survey tool.

The summative evaluation will assess whether the project's outcomes and targets are achieved. Screening completion will be measured through monthly EHR audits by calculating the number of visits with completed PRAPARE or AHC HRSN screening, divided by the total number of eligible visits, and then multiplied by 100. The target for screening completion is over 90%. Screening completion will be measured through structured EHR audits, which involve identifying eligible patient encounters and determining whether all required screening fields were completed using the standardized tool.

Social work referrals will be evaluated using EHR referral reports, with a target of increasing referrals by 50%. Referral completion will be measured using social work documentation to determine follow-through rates, with a target of over 50%. Emergency department utilization reduction will be evaluated by comparing pre- and postimplementation EHR data on ED encounters among patients identified as high risk through PRAPARE or AHC HRSN screening who received referrals or care navigation, with a target reduction greater than 15 percent.

Data will be extracted from the EHRs and patient surveys. Pre- and post-comparisons will be done using descriptive statistics, with stratified analyses to assess the impact across demographic groups. Findings will be reviewed monthly during the pilot and quarterly post scale. The success criteria will be equal to or greater than 90% of the eligible patients screened within 12 months. Statistically and clinically meaningful improvement in patient experience. A reduction in avoidable ED utilization among high-risk patients (i.e., greater than or equal to 15%). The program strengthens value-based performance, advances nursing leadership in population health, and operationalizes equity by ensuring access to identification and support for vulnerable patients. By addressing the upstream determinants of health, the initiative contributes to sustainable, positive social change.

Conclusions

The executive leadership system implementation proposal demonstrates how a standardized SDOH screening and referral model can advance organizational performance, strengthen nursing practice, and promote proactive social change grounded in diversity, equity, and inclusion. By embedding evidence-based tools into routine primary care workflows and supporting implementation with governance, training, and performance monitoring, the project translates population health principles into sustainable operational practice. Organizational implementations where implementations of the model is expected to improve value-based care outcomes via reduced avoidable emergency department utilization, enhanced patient experience, and stronger performance on quality and equity metrics. Standardized documentation and dashboard

reporting will support data-driven executive decision-making and accreditation readiness, while accepted cost advancements and quality incentives will result in financial sustainability.

The project reinforces nurses/ leadership in population health, care coordination, and advocacy. Nurses will play a significant role in administering screenings, initiating referrals, and ensuring continuity of care, hence promoting evidence-based practice, ethical accountability, and interprofessional collaboration. The model advances the nursing profession's mandate to deliver effective, patient-centered care. By statistically identifying patients affected by food insecurity, housing instability, transportation barriers, and financial hardship, the program directly addresses structural drivers of health disparities. Standardized screening ensures fair and transparent access to supportive services, while culturally responsive and trauma-informed practices foster inclusion and build trust among patients. The project exemplifies executive nursing leadership by integrating evidence, technology, and collaborative governance to achieve measurable improvements in outcomes, strengthen professional practice, and advance equity-driven healthcare delivery.

References

Kreuter, M. W., Thompson, T., McQueen, A., & Garg, R. (2021). Addressing social needs in healthcare settings: Evidence, challenges, and opportunities for public health.

Annual Review of Public Health, 42(1), 329–344.

<https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-090419-102204?crawler=true&mimetype=application/pdf>

- Rudisill, A. C., Eicken, M. G., Gupta, D., Macaуда, M., Self, S., Kennedy, A. B., Thomas, D., Kao, E., Jeanty, M., & Hartley, J. (2023). Patient and care team perspectives on social determinants of health screening in primary care: A qualitative study. *JAMA Network Open*, 6(11), e2345444.
<https://doi.org/10.1001/jamanetworkopen.2023.45444>
- Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). Addressing social determinants of health: Examples of successful evidence-based strategies and current federal efforts. *Office of Health Policy*, 1, 1–30.
<https://aspe.hhs.gov/sites/default/files/documents/6ba4bbb2e9c9551355a6926f023f1585/SDOH-Evidence-Review.pdf>
- Wagner, C. M., Jensen, G. A., Lopes, C. T., McMullan Moreno, E. A., Deboer, E., & Dunn Lopez, K. (2023). Removing the roadblocks to promoting health equity: finding the social determinants of health addressed in standardized nursing classifications. *Journal of the American Medical Informatics Association*, 30(11), 1868-1877.
- Yan, A. F., Chen, Z., Wang, Y., Campbell, J. A., Xue, Q. L., Williams, M. Y., Weinhardt, L. S., & Egede, L. E. (2022). A systematic review of the effectiveness of social needs screening and interventions in clinical settings on utilization, cost, and clinical outcomes. *Health Equity*, 6(1), 454–475.
<https://doi.org/10.1089/heq.2022.0010>