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Caring for Vulnerable Populations: Addressing Social Needs

March 27, 2019

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HealthTeamWorks Team

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Using WebEx Chat

Minimize & Maximize chat panel

Chat

Choose **All Participants** to make entries visible to all attendees

Host
Presenter
Host & Presenter
All Attendees
All Panelists
HealthTeamWorks Training and Edu...
All Participants

Send to: All Participants

Type Chat Message Here

Select a participant in the Send to menu first, type chat message, and send...

Send

Click Send

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WebEx Annotation Tools

"Squiggly line" icon must be blue/active to use annotation bar. Click to activate

Text

Pointer

Draw Line

Draw Shape

Pen or Pencil Tool

Change Color

Erase

- Click on the tool that you would like to use to activate it.
- To deactivate tool, click on it again.

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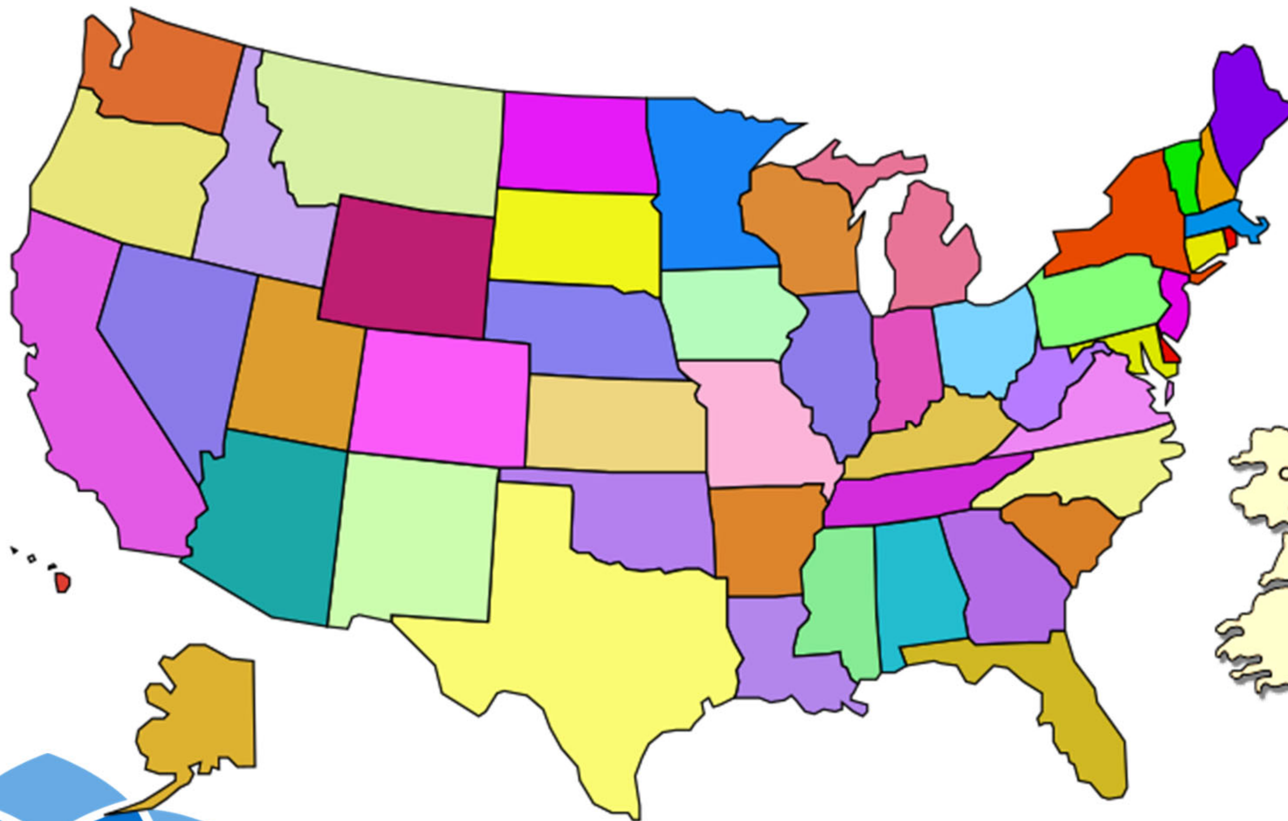
Where are you?



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Objectives for Today

- Discuss the evidence-based research that supports the efficacy of addressing social needs
- Identify evidence-based tools to screen for social needs
- Discuss successful strategies to implement a process for screening and addressing social needs

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Today's Panel

Megan Swenson LPC, LAC
Manager of Integrated Care and Care Coordination - Jefferson Center for Mental Health

Eliana Shooster, B.A. (Public Health)
Healthcare Coordinator
Jefferson Plaza Family Health Home

Leslie Ruprecht MA, BSN, RN, HWNC-BC, HNB-BC
Clinical Care Coordination Manager
Boulder Community Health

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Jefferson Plaza Family Health Home

Primary Care integrated with Community Mental Health Center

Patient Panel Size: 5,035

Providers: 4

Ancillary: 1 BHP, 1 health coach, 1 dental hygienist

Care Coordinators: 2

EHR:

- Primary Care – Centricity
- Behavioral Health - Avatar

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Boulder Community Health

Large health system:
- 5 Family Practice
- 5 Internal Medicine

Patient Panel Size: 60,684
- Clinic panel varies (2,074 – 10,769)

Providers: 60 (MD, DO, NP, PA)

Ancillary: Behavioral Health (7 LCSW), PharmD (1), CDE (1)

Care Managers: 11 RNCM, 3 Care Coordinator 1 (non-licensed)

EHR: Greenway

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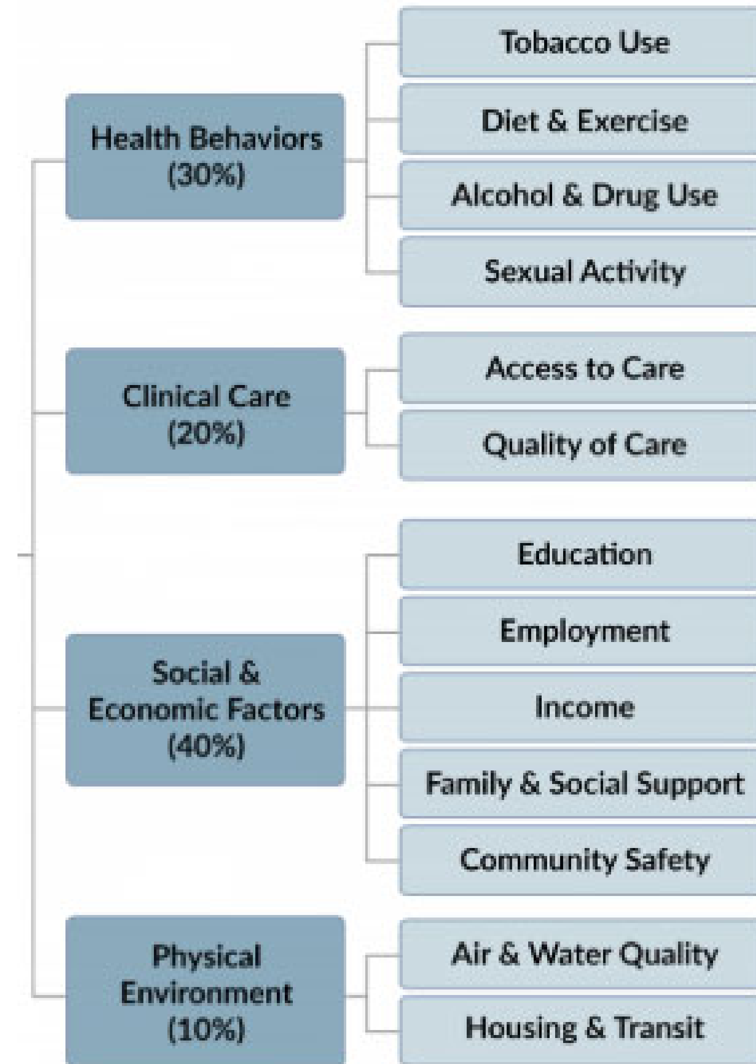
Health Outcomes

- 20% influenced by clinical care
- 80% related to factors that take place outside of the clinic



RWJF County Health Rankings model

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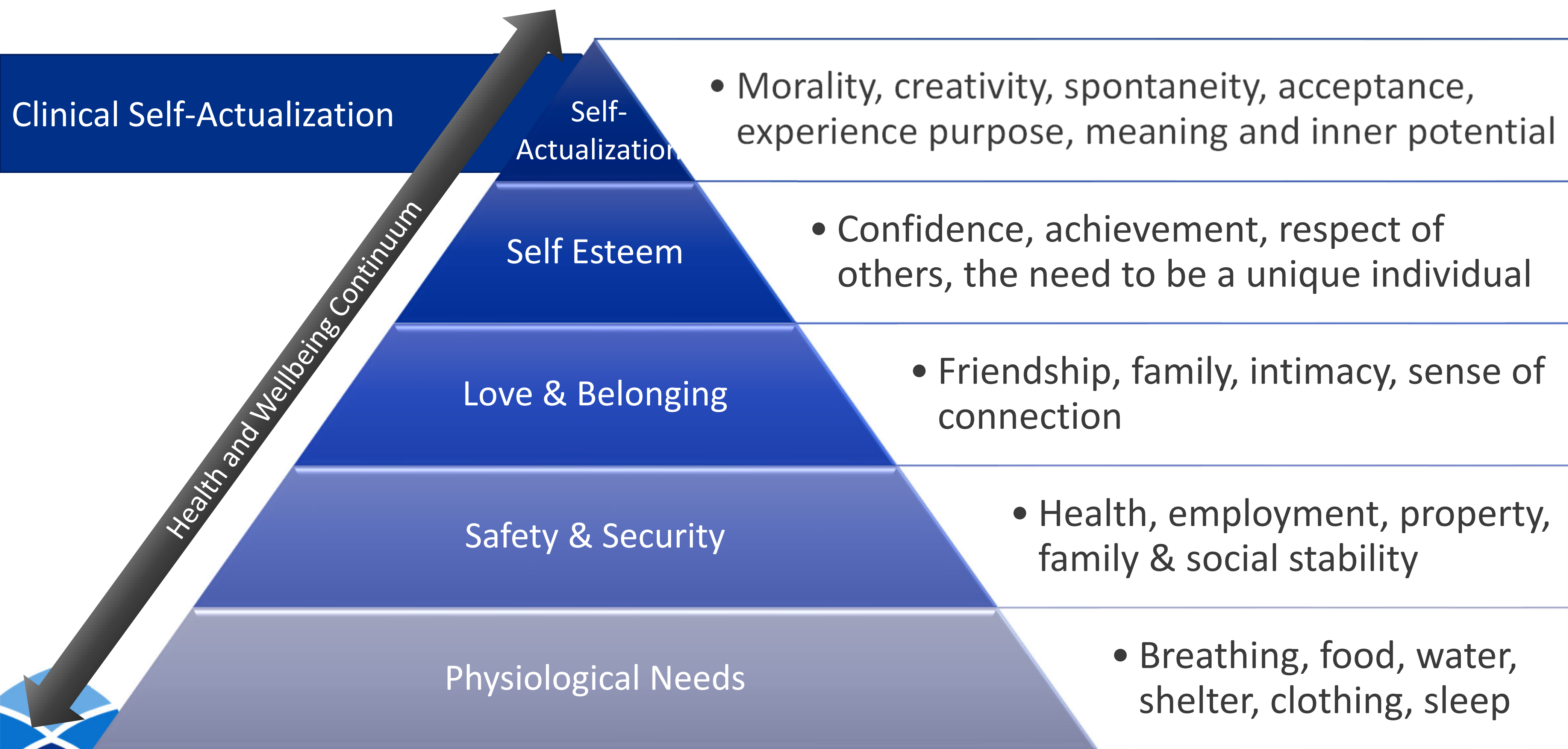

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Question for the chat…

What screening tool does your practice use?

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Evidence Based Tools

- Accountable Health Communities Screening Tool (CMS)
- EveryONE Project Toolkit (AAFP)
- PRAPARE (The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences)

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Social Determination Assessment

Screen in/out question

Social Determination Assessment
In the past 12 months have you had any issues with: having enough food, paying critical bills, housing, accessing care or personal safety?
In the last 12 months, did you ever eat less than you felt you should because there was not enough food?
In the last 12 months, has your utility company shut off your service for not paying your bills?
Are you worried that in the next 2 months, you may not have stable housing?
Do problems getting child care make it difficult for you to work or study? (Answer no if you have no children)
In the last 12 months, have you needed to see a doctor but could not because of cost or transportation?
Was this due to Cost , Transportation, or Both?
Do you ever need help reading hospital materials?
Are you afraid you might be hurt in your apartment or building?
Would you like to receive assistance with any of these needs?
Are any of your needs Urgent? (For Example I do not have food or housing for tonight)

If yes, front desk or medical assistant give 2-1-1 card to patient.

You will be contacted within a week by a Care Coordinator to assist you with your needs.

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Jefferson Plaza Family Health Home Screening

CC:
Widget:
ROI:

Patient Initials: _______________ **MCPN ID:** ___________________

Referral Made ___________________ **JCMH ID:** ___________________

Staff Initials: _________________

Date: _____________________

Research shows that integrating mental health, substance use, and primary care services produces the best outcomes and proves the most effective approach for caring for people with multiple health care needs.

To help us better serve your family, please answer the following questions:

1. What has been your family's biggest stressor(s) since the last medical appointment?
   - Lack of food/clothing
   - Housing
   - Child care
   - Employment
   - Legal issues
   - Relationship concerns
   - Parenting
   - Safety at home or in the community
   - Changes in mood or behavior (of any family member)
   - Assistant program (WIC, CCAP, TANF, food stamps…)
   - School difficulties
   - Health concerns
   - Drug and/or alcohol use
   - Other: ___________________________

2. How much are any of these events still bothering your family?
   - Not at all
   - A little
   - Most of the time
   - All the time

3. Even with these struggles, what strengths do you notice in your family?

4. Any additional information you would like to share?

The Eight Dimensions of Wellness:

Please select a number under each wellness dimension to represent your level of functioning since your last medical appt.

1. **Emotional-** Coping effectively with life and creating satisfying relationships.
   Example: I feel safe and supported in my relationships.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

2. **Environmental-** Good health by occupying pleasant, stimulating environments that support well-being.
   Example: I feel safe in my neighborhood and community.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

3. **Financial-** Satisfaction with current and future financial situations.
   Example: I am able to make my own financial decisions. I am able to pay for groceries and rent. I am able to pay for "surprises" such as car repairs or emergencies.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

4. **Intellectual-** Recognizing creative abilities and finding ways to expand knowledge and skills.
   Example: I know my strengths and am supported in my education and learning.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

5. **Occupational-** Personal satisfaction and enrichment from one's work or school.
   Example: I have job stability. My job meets my financial needs.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

6. **Physical-** Recognizing the need for physical activity, healthy foods, and sleep.
   Example: I have good energy. My body is safe. I usually get at eight hours of sleep.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

7. **Social-** Developing a sense of connection, belonging, and a well-developed support system.
   Example: I have family and friends I can talk with in time of need. I have healthy relationships.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

8. **Spiritual-** Expanding a sense of purpose and meaning in life.
   Example: Meditate or pray every day and/or spend time with nature. I feel supported by my church and/or spiritual leaders.

   1_____2_____3_____4_____5_____6_____7_____8_____9_____10

Question for the chat…

How does your practice administer the screening questions?

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When to Complete Social Needs Screening

- Check-In
- Rooming
- Patient Portal
- Home Visit

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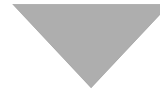
Addressing Social Needs

Identify Community Resources



Establish Collaborative Relationships

Bi-Directional Information Sharing

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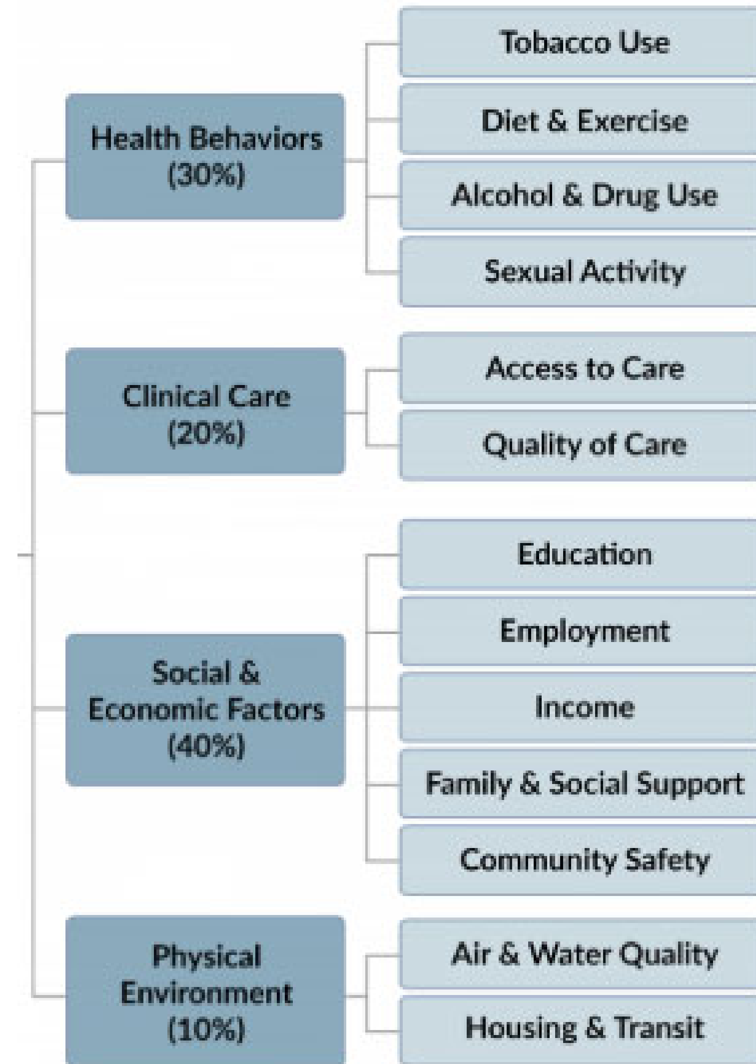

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Getting Started

- Start small
- Assess population data
- PFAC input & assistance
- Care team input

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Resources

- The Accountable Health Communities Health-Related Social Needs Screening Tool https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
- AAFP EveryONE Project Toolkit https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools.html
- PRAPARE - http://www.nachc.org/research-and-data/prapare/

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References

- RWJF County Health Rankings model http://www.countyhealthrankings.org/county-health-rankings-model

Upcoming Events

Roundtable Discussion: Care Management – Who Should Do the Work?

May 15, 2019
11:00 a.m. MST/12:00 p.m. CST

Expert Panel: Reinventing Physician Leadership in a Value-Based Environment

June 12, 2019
11:00 a.m. MST/12:00 p.m. CST

https://www.healthteamworks.org/center/events

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