Care Needs Screening and Social Determinants of Health
Ambulatory care site training
Fred McCalla
Fiona McCaughan
Leah Zallman
Agenda

• **What** is care needs screening and social determinants of health?
• **Why** are they important?
• **How** are we doing this?
What are social determinants of health and why are they important?

• “The **social determinants of health** are the conditions in which people are born, grow, live, work and age” (WHO Definition)
  - Unaffordable housing, inadequate housing (infestations), food insecurity, lack of utilities, education, employment, experience of violence, legal needs, . . .
• **Care needs** are needs for supports in the home that are not already met
• Social and environmental factors account for **70%** of what it takes to stay **healthy**—while only **10%** are attributable to direct medical care.
  – addressing these **IMPROVES health**
Why screen for and address social determinants of health and care needs?

- Revere recent screen: 50% of patients are food insecure
- We didn’t know until we asked!
Commitments

• Recognizing importance of these factors and our mission, we have committed to doing better through some of the funding streams that allow CHA to thrive (e.g. MassHealth ACO, also MMCE formerly known as ‘the waiver’)
OUR CURRENT SYSTEM          THE SYSTEM WE WANT

WHAT WE WANT TO DO

Reactive

Proactive
What are we talking about here?
Cambridge HA Offers Neighborhood Network ConnecTions

CONNECT

CONNECT - C (Care Needs) ONCE

CONNECT - S (Social Determinants of Health) YEARLY
At CHA, we want to help you be healthy and find the support you need. Many community resources are free. You don’t need to answer these questions, but answering them will help us take better care of you. Thank you! (Check “✓” one answer for each question below.)

**What is your housing situation today?**
- ☐ I do not have housing — I am staying with others, living in a hotel, in a shelter, outside, in a car, in an abandoned building, or in a public place.
- ☐ I have housing today, but I am worried about losing housing in the future.
- ☐ I have housing.

**Within the past year...**

- ☐ I worried that my food would run out before I got money to buy more.
  - ☐ Often true
  - ☐ Sometimes true
  - ☐ Never true

- ☐ The food I bought didn’t last and I didn’t have money to get more.
  - ☐ Often true
  - ☐ Sometimes true
  - ☐ Never true

- ☐ The electric, gas or oil company threatened to (or did) shut off services in my home.
  - ☐ Already shut off
  - ☐ Yes
  - ☐ No

- ☐ I skipped medications to save money.
  - ☐ Yes
  - ☐ No

- ☐ I had trouble getting transportation to medical appointments
  - ☐ Yes
  - ☐ No

- ☐ I am unemployed and looking for work
  - ☐ Yes
  - ☐ No

**Can we refer you to free or low cost community programs (like food pantries) by sharing your name, phone and address so they can reach you?**
- ☐ Yes
- ☐ No

**Would you like help connecting to resources? Please circle “✓” what you need.**
- ☐ I do not want to answer these questions.
At CHA, we want to help you be healthy. You do not need to answer these questions, but answering them will help us take better care of you. Thank you!

Do you need help with any of the following, beyond what you already get? (check “✓” all that apply)

- Getting medical or diagnostic equipment (such as wheelchair, oxygen, walker, commode, shower chair, CPAP, braces, dressings).
- Getting services for eyesight problems (for example, finding low cost eye services or equipment like glasses or if you are blind, job training or getting government services).
- Getting services for hearing problems (for example, low cost hearing aides or if you are deaf, daily living support, interpreter services and case management).
- Dressing, feeding yourself, preparing meals, walking independently, going to the bathroom by yourself, or doing your own hygiene.
- (If you have a disability or are older) Cleaning and maintaining your home, managing money, preparing meals, shopping for food and necessities, taking your medications, or calling or connecting with people.

Check “✓” one answer for each question below:

Do you have any adults living with you who can help take care of you if you need it?
- Yes
- No

In general, how would you rate your health?
- Excellent
- Very Good
- Good
- Fair
- Poor
Referral and Navigation System

CONNECT (4 languages)

CONNECT S (yearly) positive screen
- Referral to Project Bread (if food insecure + and agrees to referral)
- Referral to PRC (if wants help)
- TIP SHEET in AVS (everyone)

CONNECT C (once) positive screen
- RN in-basket message
- Project Bread calls pt; provides info on food resources, screens for WIC/SNAP
- PRC actively reaches out to patient
- Patient navigates (refers pt to PRC if needs help)
- RN reviews and addresses needs, uses tip sheet and CCM team as resources

Patient navigates (refers pt to PRC if needs help)

Project Bread calls pt; provides info on food resources, screens for WIC/SNAP
- PRC actively reaches out to patient
- Patient navigates (refers pt to PRC if needs help)
- RN reviews and addresses needs, uses tip sheet and CCM team as resources
Resource Guide - Chelsea, Revere & Winthrop

Start with CHA! Patient Resource Coordinators (PRC) are here to help you with heat, electricity, food, housing, getting rides and more. If you have questions or need help, call your CHA Primary Care Center and ask for the Patient Resource Coordinator.

Need Heat/Electricity?
If you are eligible for MassHealth, TANF, WIC, SSI, SNAP or EAEDC, you can save money on your heat/electricity. Contact Community Action Programs Inter-City (CAPIC) Energy Services at 617-884-6130 (x125) to set up an appointment.

Need Food?
- Call the Project Bread FoodSource Hotline: 1-800-645-8333 or TTY (hearing impaired) 1-800-377-1292. They can also help you apply for SNAP/food stamps.
- If you’re pregnant, or have a child under five, you may be able to get food support from WIC, call 617-575-5330.

Need a Ride?
Call for free or low-cost rides:
- Ask your PRC or primary care provider for a referral to the MassHealth Transportation Program.
- CHA Medical Access: 617-522-3159, call several days before your appointment.
- MBTA The Ride: First time users must call Eligibility Center at 617-337-2727. For existing users to book a ride, call Greater Lynn Senior Services (GLSS) at 888-319-7433.
- If elderly/disabled, you can apply for a reduced fare MBTA Transportation Access (TAP) Pass. Talk to your PRC to apply.

Need Housing?
If you are a family with dependent child(ren):
- Go to Chelsea DTA/DHCD at 80 Everett Ave. (across from Market Basket) and ask for the Housing Coordinator. They can help you with an application for shelter services or Emergency Assistance. If denied, get a written notice to appeal and contact Housing Families: 781-322-9119 or Greater Boston Legal Services: 800-323-3205.

If you are a youth or young adult:
- Age 17-24: Call Bridge over Troubled Waters’ Runaway and Homeless Youth at 617-423-9575.

Need to Keep Housing?
Are you worried about becoming homeless, paying your rent, or being evicted? Are you in an abusive relationship? Have you had a change in household income (death of spouse, job loss)? Call CAPIC: 617-884-6130 (x104)
- For free eviction legal help, call Housing Families’ Legal Services team at 781-322-9119. Just A Start Legal Services at 617-918-7516, or Greater Boston Legal Partnership at 800-323-3205.

If you are experiencing domestic violence:
- Call SAFElink at 877-785-2020 or HarborCOV at: 617-884-9909 for help finding shelter and supportive services.

Need Employment Support?
Call Career Source (Chelsea) 617-884-4333.

Need Prescription Medication Support?
If you can’t afford your prescription medication, let your medical provider know and consider using CHA’s Pharmacy.
*The timing of entering the answers is critical as they must be entered prior to the patient leaving the MD*

---

**Patient**
- Patient arrives at visit
- Fill out assessment by hand

**Front Desk**
- Begin check in process & hand the patient a pre-printed language-specific assessment (paper) to fill out

**MA**
- Review schedule day before using DAR. If HM says due or due soon, add 'SDOH' to DAR
  - Room Patient
  - Enter patient answers for assessment (Connect C & Connect S)
  - BPA suggests/adds smartset with appropriate orders for referral to PRC, Referral to Nursing Ed, and patient education, MA Signs orders and designates PCP for cosign

**MD**
- BPA suggests visit diagnosis to be added to encounter based on SDOH screening
- Add visit diagnosis
- Review reference sheet with patient if appropriate

*When adding the diagnosis, the diagnosis should populate just the visit diagnosis*
Who do we screen?

• **Phase 1: Paper workflow**
  – MassHealth ACO patients (“ACPP” insurance flag)= Tufts Together with CHA
  – All ages, languages

• **Phase 2: Expanded workflow (piloting MyChart, tablets in year 1)**
  – Expand beyond ACPP patients
Timeline

1st group
- Union Square
- East Cambridge
- Revere

2nd group
- Everett
- Cambridge Family Health - North.

3rd group
- Broadway
- Cambridge Pediatrics
- Zinberg

4th group
- Primary Care - Somerville
- Primary Care - Cambridge
- HIP
These are sensitive topics . . .

• Don’t force or pressure patients to complete
  – Invite: We want to help you be healthy and find the support you need. Answering these questions will help us take better care of you.

• If patient takes offense:
  – Emphasize we are not singling out individuals - We aim to do this with everyone
  – Reinforce the patients’ agency - Pt can choose to not complete the form
  – State goal - We are doing this to take better care of our patients
Care Needs Screeners on Staffnet
What does it look like in EPIC?

1. The ACO flag will be present in the patient header to identify those patients.

2. The HM topic for Care Needs will not be there. It was moved to PREVIEW by mistake—sorry about that! We will only show the HM topic for SDOH.

3. The Associate diagnosis window will open automatically when the MA signs the smartset and there won’t be a hard stop to associate the diagnosis.
THANK YOU!!!

Fred McCalla  wmccalla@challiance.org
Fiona McCaughan fmccaughan@challiance.org
Leah Zallman lzallman@challiance.org

(or feel free to page Leah 1002 or Fiona with urgent questions!)