ROCKY MOUNTAIN
HEALTH PLANS®

WESTERN COLORADO ACCOUNTABLE HEALTH COMMUNITIES MODEL

Toolkit for Primary Care Practices

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Introduction

Mission and Values of the Accountable Health Communities Model

Mission

As deployed by Rocky Mountain Health Plans and its regional partners, the mission of the Accountable Health Communities Model (AHCM) is to develop a more effective network to support the social, emotional, and physical health of Western Coloradoans.

AHCM acknowledges that a comprehensive definition of health includes complete social, emotional, and physical well-being. Health is dependent on physical environment, social and economic factors, clinical care, and health behaviors. Improving health at a population level requires impacting both individuals and communities. There are many current efforts that address aspects of individual and community health, but these efforts are not always coordinated. In addition, gaps in services are not prioritized or communicated broadly enough to enact change.

One goal of the AHCM program is to gain a better, ongoing understanding of how social determinants impact individuals' abilities to engage in the healthcare system and care for their health and wellbeing. One of AHCM's central aims is to gather current, relevant data on social determinants of health impacting patients, families and communities. There are many gaps we are hoping to fill through AHCM efforts, and previous studies have highlighted the pervasiveness of many problems associated with social determinants of health. For example:

- The percentage of working Coloradans struggling with high housing costs increased by 27 percent from 2005 and 2014, suggesting that high costs of housing and limited incomes present barriers to working class members of the state (**Rusch, 2016**).
- One in four women has experienced domestic violence in her lifetime (**CDC, 2000**).
- One in ten Coloradans struggle with hunger and not always having enough money to buy adequate food, and many people who are eligible for benefits like SNAP and WIC are not enrolled (**Colorado Blueprint to End Hunger, 2018**).

By understanding the needs of individuals and families within our community, we can help ensure programs are put in place to **optimize social determinants of good health**. Good health means consistent access to:

- Safe and stable housing
- Adequate, nutritious food
- Economic and job opportunities
- Health care services
- Quality education and job training
- Transportation options
- Communication and information technology
- Recreation activities and culture
- Public safety

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Values

Rocky Mountain Health Plans' AHCM program is guided by a strong set of values:

- We, individuals and communities, have a right to achieve our greatest potential of health.
- There is room for improvement in the systems that support health. We have a responsibility and an opportunity to improve those systems.
- Healthcare and systems of health are local.
- Collaboration is built on trust, and trust is built on relationships. We will be intentional and patient with the time-consuming process of relationship-building.
- We have an opportunity and responsibility to foster more leaders in our communities.
- We value funding the social determinants that impact individual and community positive health outcomes and well-being.
- We seek continuous learning and improvement.
- We work to identify the value proposition of our efforts and aim to be transparent in discussing and communicating both tangible/non-tangible and short-term/long-term benefits.
- Achieving needed change will require risk taking and being nimble, adaptable, and bold.

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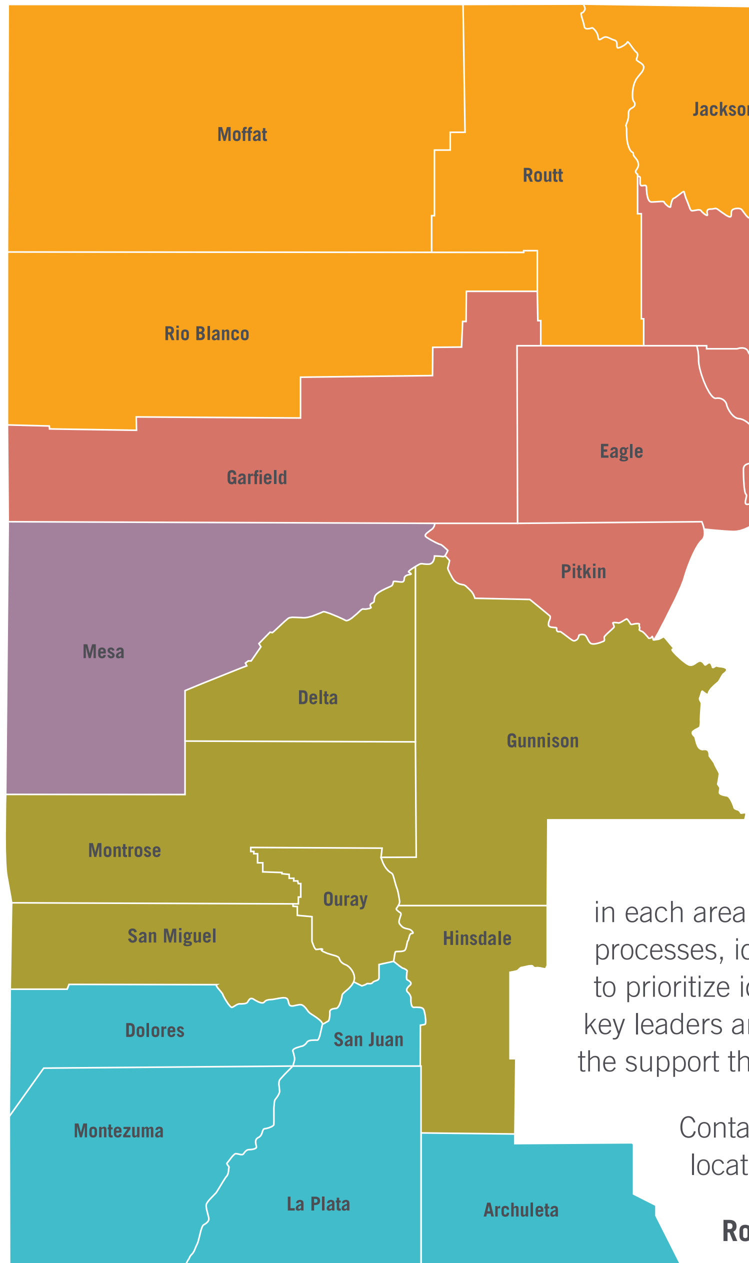
AHCM Organization in Western Colorado



General Community Infrastructure

Participating primary care, behavioral health, and hospital partners will screen patients of all ages for social needs including transportation, utilities, housing, food, interpersonal violence, and social isolation. In connection with the Community Resource Network (CRN) — a division of Quality Health Networks (QHN) that focuses on information exchange with social service organizations — patients will be connected to community organizations that target their unmet social needs. Patients with at least one unmet social needs and two or more ER visits in the last year will also be invited to engage with an internal or external community navigation resource.

Strong relationships with the existing community infrastructure have enabled Rocky Mountain Health Plans (RMHP) to partner with community leads in each of the five regions of the Western Slope to help coordinate AHCM efforts. Community leads in each area will be responsible for coordinating local advisory processes, identifying gaps in resources, and developing the process to prioritize identified gaps. In addition, a region-wide consortium of key leaders and state partners will ensure that each community has the support that they require to meet patients' social needs.

Contact information for each region's community lead is located at the end of this toolkit.

Role of Your Practice in AHCM

Determine WHY social needs screening is important for your patients:

- Social needs screening attempts to change perceptions that "whole health" does not begin at the doctor's office but is heavily influenced by what happens outside the clinic walls. Take the time to develop a practice-level approach to explaining to staff and patients why it is important to uncover patients' social needs.
- Administer the AHCM social needs screening: Beginning in 2018, participating practices, with the support of RMHP, will administer an evidence-based **social needs screening** to most Medicare and Medicaid enrollees.
- **Gain access to a community resource inventory for referrals:** Practices who participate will receive access to a community resource inventory through 2-1-1 that can generate referrals to assist clients with their identified social needs.
- **Expand access to community-based navigation support for high-needs patients:** Patients with high needs and an identified social need (who have had two or more ER visits in the last year) will have access to community-based navigation support.

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Role of Community-Based Organizations in AHCM

- **Receive referrals:** Many community based organizations (CBOs) already provide services to individuals who meet the navigation criteria (two or more ER visits and at least one social need). Better coordination and collaboration between clinical and non-clinical providers may result in improvements in services for these clients.
- **Track data:** CMS is interested in capturing data on the outcomes and costs of the CBO interventions.
- **Participate in the advisory committee:** In the advisory committee, CBOs will have an opportunity to partner with clinical / medical settings to identify gaps in the community service continuum, prioritize community needs, and develop a plan to address some of those community needs.

Role of Regional Community Leads in AHCM

- **Review and update community resources:** Community leads will review the complete list of resources and identify organizations not currently listed who provide AHCM-related services. They will support 2-1-1 in connecting with those organizations or will ask those organizations to contact 2-1-1.
- **Monitor ongoing concerns:** If a community lead hears or identifies concerns about the resources being provided, they will request specifics about the concern and then immediately notify the 2-1-1 Director and the RMHP AHCM Director in order to remedy the issue as quickly as possible.

Role of RMHP Practice Transformation in AHCM

- **Support process development & implementation:** As a participant in AHCM, your practice can request support from a Quality Improvement Advisor (QIA) from RMHP's Practice Transformation Team. The QIA will help you develop processes and workflows that will help your practice implement this new screening process or adjust your current processes. RMHP understands that implementing a comprehensive screening tool in practice is time intensive and may require changes to established workflows. QIAs will meet with the practice up to eight times during the planning and implementation process of the AHCM screening tool.

<table>
<tr><th>RMHP QIA Support Timeline</th><th>Meeting Type</th></tr>
<tr><td>AHCM onboarding meeting</td><td rowspan="2">In-person meeting</td></tr>
<tr><td>Planning meeting prior to first PDSA cycle deployment</td></tr>
<tr><td>2-week PDSA review, PDSA cycle #2 developed</td><td rowspan="2">Telephone meeting</td></tr>
<tr><td>4-week PDSA review, PDSA cycle #3 developed</td></tr>
<tr><td>2-month check in meeting</td><td rowspan="3">In-person meeting</td></tr>
<tr><td>3-month data review</td></tr>
<tr><td>6-month meeting</td></tr>
</table>

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AHCM and Practice Transformation

Practice transformation aims to help primary and specialty care practices meet the Quadruple Aim of healthcare reform: enhanced patient experience, improved population health, reduced cost of care, and improved experience for health care providers and staff (**Bodenheimer & Sinsky, 2014**). The work of practice transformation requires significant amounts of change in the way providers and staff provide care, including workflows, team development, task distribution, and reimbursement methods.

RMHP's Practice Transformation Team is proud to partner with AHCM to support practices in this important initiative. Developing processes to screen for social determinants of health and provide supportive resources to patients and their families aligns well with the work of practice transformation initiatives such as the Comprehensive Primary Care Plus (CPC+) initiative and the State Innovation Model (SIM) program.

Program	Where AHCM Fits
Comprehensive Primary Care Plus (CPC+)	**Function 3:** Comprehensiveness and Care Coordination • Track 2: Systematically assess patients' psychosocial needs using evidence-based tools (the AHCM screening tool is one of the tools that can be used for CPC+)w • Track 2: Conduct an inventory of resources and supports to meet patients' psychosocial needs (AHCM will partner with 2-1-1 to create a resource directory for use by practices)
State Innovation Model (SIM)	**Milestone 7:** Practice screens for behavioral health and substance use disorders and links primary care to behavioral health and social services • Practice performs an assessment of community resources, with Regional Health Connector support when possible, to assist patients/families with social needs (such as food, housing, transportation)

This toolkit will guide you through many of the necessary questions that need to be asked and answered in order to develop and implement a screening process that adequately fills the needs of the practice, as well as the patients you serve. In upcoming sections, this resource provides practical tips for identifying patients for screening, administering the screening, and following up on screening results.

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Identifying Patients for Screening

Selecting Patients for Screening

The purpose of any screening tool is to encourage routine and systematic surveillance of factors that influence patients' clinical health outcomes and engagement in the healthcare system. Human biases and preconceived ideas often leave us vulnerable to missing out on valuable information about our patients or jumping to unfounded conclusions. Rather than relying solely on intuition or prior experience, positive responses on an evidence-based screening tool flag clinicians and staff members to ask for more information to determine appropriate next steps. It is important to keep in mind that interpretation of a patient's response on a screening tool must take into account more thorough information gathered through conversation and follow-up questions, as opposed to being considered a diagnostic tool used in isolation.

As a clinical delivery site partnering with the AHCM program, your practice will be helping to contribute to the goal of screening approximately 100,000 Western Coloradans and 200,000 total Coloradans each year with this social needs screening tool. Using evidence based screening tools that minimize human bias regarding vulnerable populations, you will become part of the solution to problems such as the more than 69,000 people on the Western Slope who experience food insecurity (**Community Commons, 2017**).

To accommodate for the wide variation in clinic systems, your practice can choose from three ways in which to identify patients to screen for social determinants of health using the AHCM screening tool. Whichever option you choose, your practice should thoughtfully consider the best way to integrate this within the clinic workflow and weigh anticipated costs and benefits of each approach.

Pediatric Considerations

Screening for social determinants of health is important for patients of all ages, including children and adolescents. One factor that may vary is who completes the screening tool for pediatric patients.

For children under the age of 12, a parent or guardian completes the tool on the child's behalf and answers based upon the family experience. This also pertains to the questions about personal safety and violence; parents answer on behalf of their children according to their knowledge of the child's experience.

Children over the age of 12 can usually complete the screening tool themselves.

Additional consideration should be given to how your practice will develop and implement policies related to privacy and documentation. We recommend following similar policies to those that your practice has developed to accommodate sensitive information such as screening parents for depression in the context of a pediatric visit.

** TIP: Keep looking for green boxes throughout this toolkit for more pediatric-related considerations.*

Option A: Screen All Patients

Your practice can choose to administer the screening to all practice patients. In order to do this, it is important to consider the best timing of when to administer this screening tool. Generally, patients may be less likely to complete additional paperwork during an acute visit for a significant health problem, compared to an annual wellness visit or a follow-up appointment. If a patient is in for an acute visit, their record could be flagged to remind a screening tool to be administered at the next well visit. There are several pros and cons associated with this approach of screening all patients, regardless of payer type.

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Pros	Cons
Normalizes the routine nature of asking questions about social needs within primary care	May require changes in staffing and task distribution to accommodate significant time dedicated to AHCM screening and connection with community resources
Provides the clinic with significant opportunity to increase comfort with the process of screening for social needs and connecting patients with community resources	Requires more strategy in the use of physical space in the office to administer and discuss screening results with patients
Workflow remains consistent across payer type for all patients	

Option B: Screen a Subgroup of Patients Based on Payer Type

As an alternative to screening all patients, you could choose to identify and screen all patients with Medicaid or Medicare coverage. The same recommendations mentioned above about the need to choose the timing of screening carefully apply to this option, as well. Pros and cons are listed below.

Pros	Cons
Reduces the burden of time for the practice to spend on AHCM screening and connection with community resources	Leaves a gap in the rest of the clinic's population that does not get screened
Limits the physical space difficulties needed to administer the screening and discuss results with patients, compared to screening all patients	Requires additional step in the workflow of checking for payer type before administering the tool
	May inadvertently reinforce biases about patients with these forms of insurance coverage and lead to questions from patients about method of selection for screening

Option C: Screen a Subgroup of Patients Based on Visit Type

Another option is to screen patients based on visit type, choosing to expand visit types as you become more comfortable with the screening process for patients. An example of this would be screening all patients who are in for an annual wellness exam, physical, or well-child check.

Pros	Cons
Reduces the burden of time for the practice to spend on AHCM screening and connection with community resources	Leaves a gap in the rest of the clinic's population that does not get screened
Limits the physical space difficulties needed to administer the screening and discuss results with patients, compared to screening all patients	Requires additional step in the workflow of checking for visit type before administering the tool

Setting the Frequency for Re-Screening

In order to ensure patients' needs are tracked over time and follow-up remains a priority, we recommend annual screening for patients. This mirrors other screenings that primary care practices conduct, such as those to detect symptoms of depression and substance use disorders. Our experience has shown that this method generally works well in practices' workflow and requires the least mental energy to calculate between screenings.

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Administering the Screening

Introducing the Screening

It will be important for all staff within the practice to understand why administering this screening tool is important to the patients they serve in the practice. Patients need to hear from their care team that taking the time to complete the screening is important and that answering honestly can enable them to be connected to available community resources. Developing a script that allows staff members to explain how answering these questions can potentially improve the care they receive from their medical home may be beneficial. This script could either be verbally said if the tool is handed to the patient in the office or included in a written format if the patient accesses the tool him/herself.

Sample Script

"Our goal is to connect you to the community resources you need to be healthy. This health care provider participates in the Accountable Health Communities (AHC) program funded by the Centers for Medicare and Medicaid Services. By answering these questions, we can help connect you to services and programs in your community. Your information will be kept confidential, and will only be shared with others on your care team. The information that you provide will not impact your Medicare or Medicaid eligibility status. You should answer the questions in your own way. This screener is optional. You can choose not to answer any of the questions, and there are no right or wrong answers."

It is not necessary to read this script word for word if you are administering the screening verbally to a patient, but we recommend including main points in whatever introductory language feels natural for your clinic culture. This introduction is the same as what is included in the online portal and could also be included at the top of a paper version that patients could read to themselves.

Pediatric Considerations

When introducing the screening to parents who will be answering on their child's behalf, it is important to clarify whether they are answering questions for their entire family or a particular child. It is also important to encourage parents that their responses will not be viewed in a punitive fashion, and honest responses are essential for identifying applicable resources the practice can share with the family.

Integrating Screening into the Workflow

Once your practice has decided who you plan to screen, the next step is to consider how the assessment fits into the patient visit workflow. Practices have the option of sending the screening for the patient to complete prior to the visit, offering it at check-in, or administering it when the patient has been led back to an exam room. Practices can administer the screening verbally, on paper, or electronically using various methods. It will be important to test this workflow to maximize the number of patients who are screened and subsequently connected with identified community resources.

Developing a Process Map

As you are planning how to integrate this into your clinic's workflow, the following process map is designed to help you track key steps you'll need to include.

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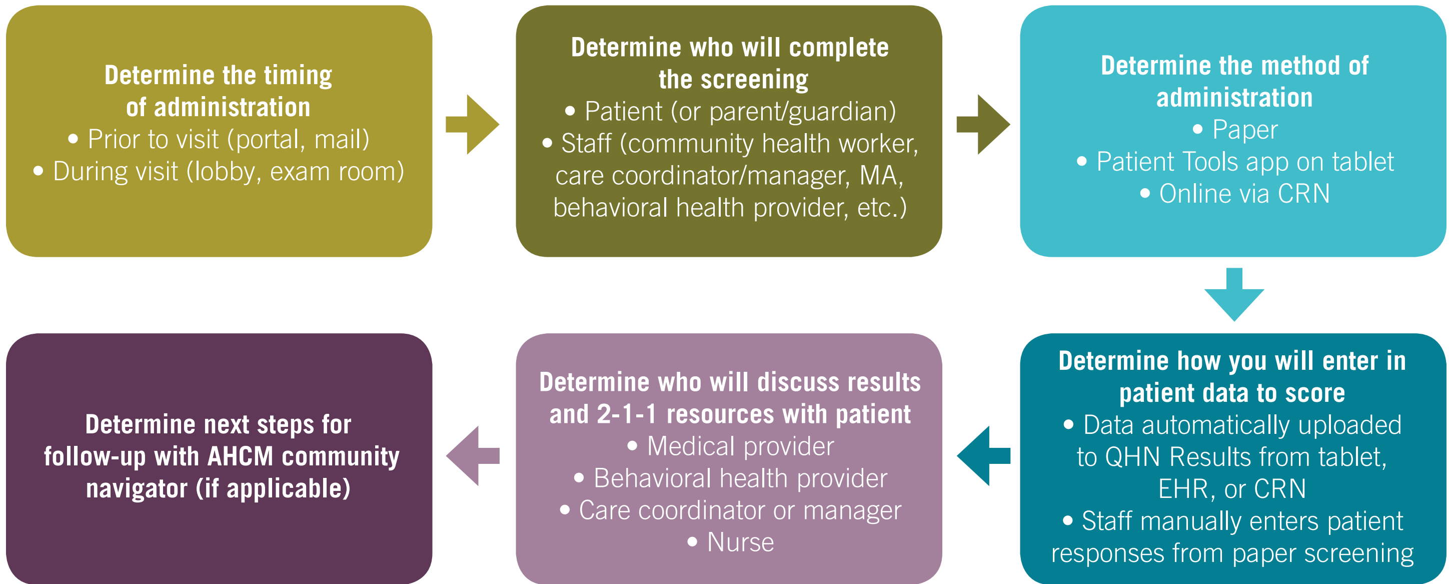
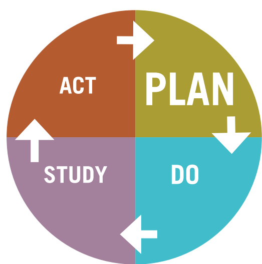


Testing the Process with a PDSA

Next, use a **Plan-Do-Study-Act (PDSA)** cycle test and implement the workflow you have developed based on answering the process map questions. Keep in mind that the goal of a PDSA cycle is to conduct rapid-cycle tests on a small scale, learn what you can, and then refine the process and conduct another PDSA cycle.



Plan Phase

The plan is developed by discussing the outlined on the above process map. Attempt to set an aim statement using the **SMART** format — **S**pecific, **M**easurable, **A**chievable, **R**elevant, and **T**ime-sensitive — to help you outline your test of implementation. Important questions to consider include:

- Who is the specific target population?
- What is our test period?
- What is our measurement of success?
- How many patients do we expect to screen during the test period?

Pediatric Considerations

When planning to implement the AHCM screener, you may need to consider privacy of the patients in the pediatric population. For example, this could affect when the screener is completed during the visit if the practice wants to give privacy to the child or adolescent to answer. In addition, you may choose to have the parents answer the screener on behalf of the family and may need to discuss information they want to keep private from their children if they are identified as having a social need. Be cognizant of additional space needed to address privacy concerns.

In addition to the process map, you may consider answering the following questions:

What is the practice's current workflow for pre-appointment forms?
Can this screening tool be easily added to the current process?
Does the practice feel the screening needs explanation before administering?

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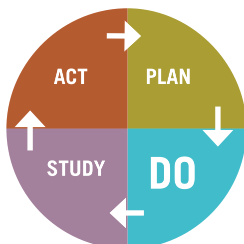
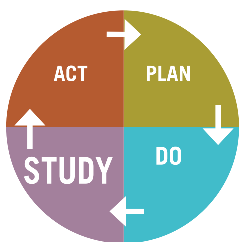
How often do patients come prepared with pre-visit paperwork now?
What are the processes that will be put into place to minimize risk of positive screening responses that may be submitted before the appointment (through e-mail or patient portal)?
How does the practice currently administer screening tools (PAM, PHQ, etc.)?
Can this screener be completed in the waiting room, or is it best suited after the patient is roomed?
Who has the capacity to enter the patient's answers DURING the patient visit?
What patient needs will be addressed at the time of the visit, and what will be part of a follow-up plan?
If a patient cannot complete the screener on his/her own, who can administer the screener verbally?
How much time will implementing this process take each staff member involved (front desk, MA, clinician, care manager, etc.)?



Do Phase

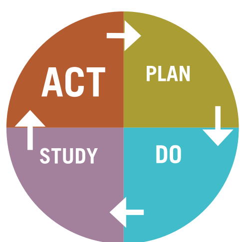
Once you have developed a solid plan, it is time to execute the plan by implementing the change on a small scale. When you begin the process, if you need to tweak the plan: do so, note it, and move forward in your testing. When you are ready to start, make sure to communicate your start date with the staff that may be affected by the process. Start collecting qualitative and quantitative data; consider taking notes of observations regarding patient responses, impediments in current workflow, and unforeseen barriers. Track completed screenings, patient refusals, and if screened using pre-visit method, how many patients brought completed screenings to their visit.



Study Phase

During the study phase, devote time to conduct an assessment of how the implementation went on your test patients during the testing period. Remember to compile both quantitative and qualitative data to review. Based on the information gathered, the team should be able to decide on the next step.

- Did the practice successfully meet its screening goals?
- Did the workflow developed run smoothly, or were there
- Unforeseen barriers that need to be addressed in the next test?



Act Phase

This is the phase in which you decide the practice's next steps. Based on the data you collected, the experience of the implementation, and the goals you have set forth for screening, decide whether to implement the screening across a larger patient population, spread the screening to other providers/care teams, adapt the change and run another test, or abandon the process and go back to the drawing board. Once you have decided to implement the workflow throughout the practice, a policy and procedure should be developed to formally document the workflow for ease of training future employees.

Screening Tool

The **AHCM screening tool** consists of questions that ask patients about their emergency department utilization, current living situation, access to food, access to reliable transportation, and interpersonal violence. There is also a small section that requests background information on demographics.

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ACCOUNTABLE HEALTH COMMUNITIES MODEL SCREENING TOOL

Information

1. **Complete the following statement: I am answering this survey about...**
   - ☐ Myself
   - ☐ My Child
   - ☐ Another adult for whom I provide care
   - ☐ Other (please describe your relationship to this person) ____________________

2. **How many times have you received care in an emergency room (ER) over the last 12 months?** (If you are in the ER now, please count your current visit. Please do not count urgent care visits.)
   - ☐ 0 times
   - ☐ 1 time
   - ☐ 2 or more times

3. **Do you live in any of the following locations?**
   - ☐ I live in an **Assisted Living Facility** (this is a long-term care option that provides personal care support services such as meals, bathing, dressing, or medications)
   - ☐ I live in a **Nursing Home** (this is a long-term care option that provides 24-hour a day medical care that would not be possible in other housing)
   - ☐ I live in a **Rehabilitation Center** or **Skilled Nursing Facility** (these are centers that help a person heal after illness or injury by providing treatments like physical, occupational, or speech therapy)
   - ☐ I live in an **In-Patient Recovery Program** for a drug or alcohol problem
   - ☐ I live in a **Psychiatric Facility** (this is a health care facility providing treatment to those with behavioral or emotional illnesses)
   - ☐ I live in a **Correctional Facility** (such as a jail, prison, detention center, or penitentiary)
   - ☐ **None of the above**

Living Situation

4. **What is your living situation today?**
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but I am worried about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

5. **Think about the place you live. Do you have problems with any of the following?** Choose all that apply.
   - ☐ Pests, such as bugs, ants, or mice
   - ☐ Smoke detectors missing or not working
   - ☐ Oven or stove not working
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

6. **Within the past 12 months, you worried that your food would run out before you got money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

7. **Within the past 12 months, the food you bought just didn't last and you didn't have any money to get more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

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Transportation

8. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting to things needed for daily living?

☐ Often true ☐ Sometimes true ☐ Never true

Utilities

9. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Often true ☐ Sometimes true ☐ Never true

Safety

Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions:

10. How often does anyone, including family and friends, physically hurt you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

11. How often does anyone, including family and friends, insult or talk down to you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

12. How often does anyone, including family and friends, threaten you with harm?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

13. How often does anyone, including family and friends, scream or curse at you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

Family and Community Support

14. How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

Background

Now we would like to know a little more about you.

15. What is your sex?

☐ Male ☐ Female

16. Are you of Hispanic, Latino/a, or of Spanish origin? Choose all that apply.

☐ No, not of Hispanic, Latino, or Spanish origin

☐ Yes, Mexican, Mexican American, Chicano

☐ Yes, Puerto Rican

☐ Yes, Cuban

☐ Yes, another Hispanic, Latino, or Spanish origin

17. Which one or more of the following would you say is your race? Choose all that apply.

☐ American Indian / Alaska Native ☐ Asian

☐ Black or African American ☐ White

☐ Native Hawaiian / Other Pacific Islander ☐ Other (specify) ______________________

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18. What is the highest grade or year of school you completed?

- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1 through 8 (Elementary)
- ☐ Grades 9 through 11 (some High school)
- ☐ Grade 12 or GED (High school graduate, diploma, or alternative credential)
- ☐ College 1 year to 3 years (some College, Associate's degree, trade, vocational, or technical school)
- ☐ College 4 years or more (College graduate)

19. How many people do you currently live with?

Please count yourself, your spouse / partner, your children, and any other dependents. If you live alone, put 1.

☐☐ number of people

20. What is your annual household income from all sources?

Please include your income as well as the income for everyone you counted above in your household.

- ☐ Less than $10,000
- ☐ $10,000 to less than $15,000
- ☐ $15,000 to less than $20,000
- ☐ $20,000 to less than $25,000
- ☐ $25,000 to less than $35,000
- ☐ $35,000 to less than $50,000
- ☐ $50,000 to less than $75,000
- ☐ $75,000 or more

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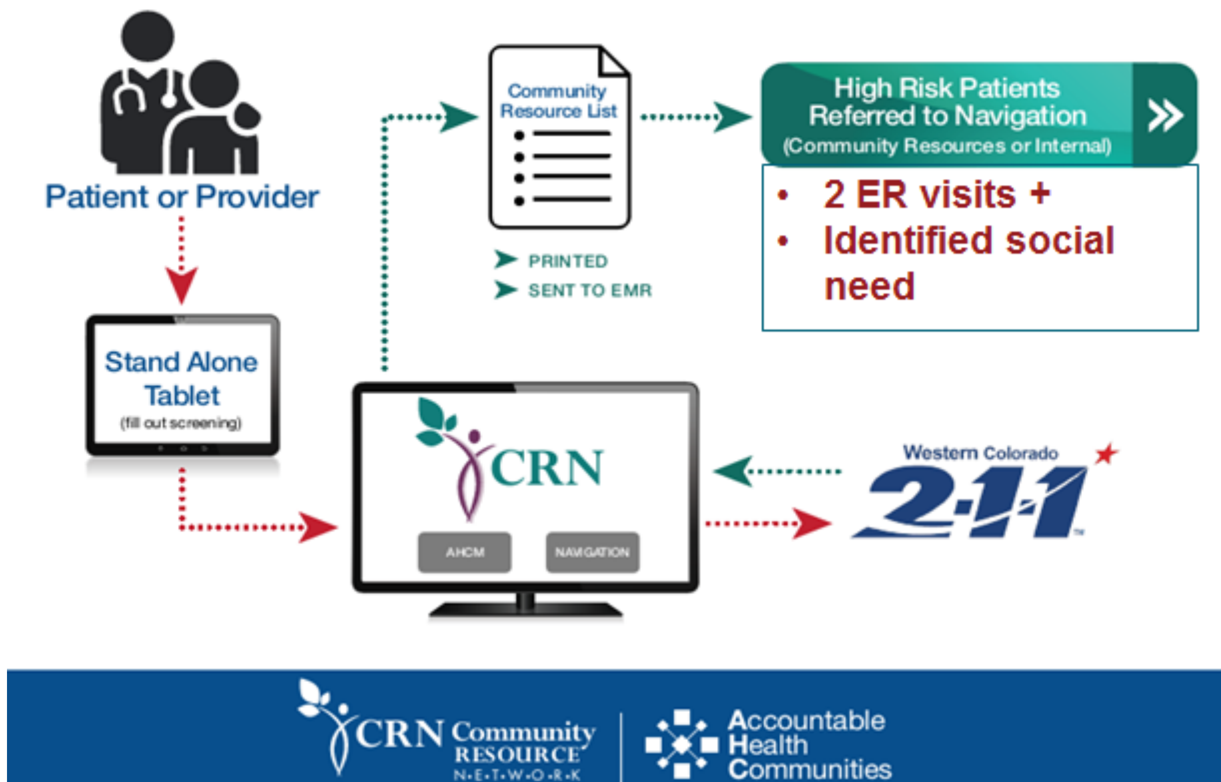
Accessing the Screening Tool

Your practice has several options regarding how to administer the screening tool to patients:

- Print paper copies of the tool and collect them from patients upon completion
- Administer the screening via tablet
- Administer screening using a kiosk set up in a private area

Each of these options will influence the general workflow in the practice. Paper screening will require practice staff to ask patients who qualify for navigation support for consent to be contacted. In addition, paper screenings will need to be entered into the CRN manually during the visit in order for the resources to be identified and printed prior to the end of the visit.

In the electronic formats of administration, the AHCM screener will automatically ask the follow up question regarding consent to be contacted via navigation. In addition, electronic screening will allow streamlined connection to the CRN tool and resources can be printed to a designated printer in the clinic.



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Scoring the Screening & Discussing Results with Patients

Assigning Staff Duties

One question for your practice to consider is: will you have the same person administer the screening tool, enter data into the online platform, and discuss results and provide a list of resources to the patient? If front desk staff are involved in administering and entering screening data, they likely will not be the person who provides the tailored community resource information to the patient. However, if the screening is given by a clinical staff member like a medical assistant (MA), care manager or coordinator, or behavioral health provider, these tasks could either be (a) performed by the same person, or (b) handed off to another member of the team.

Some questions to determine who will discuss results of the social needs screening and deliver a list of community-based resources include:

- Who can be trained to confidently and compassionately discuss sensitive topics such as violence and food insecurity with patients and their family members?
- Who will be able to look for unmet needs and strengths throughout the conversation with patients?
- Who is already trusted by patients in your practice to share sensitive information?
- What self-care and reflective processing opportunities will be started/ continued in the practice to support staff from feeling overwhelmed by patients' responses to these sensitive questions?

Scoring the Screening and Next Steps

Identified Need on Screening Tool	ER Visits in Last 12 months	Next Steps
No	No	No further action needed
Yes	0–1	Primary Care team member provides patient with list of resources from 2-1-1. Best practice includes following up at the next visit to assess for success of referral given and any continuing needs.
Yes	2+	Primary care team member provides patient with list of resources from 2-1-1 and asks for permission to connect patient with AHCM community navigator. Best practice includes following up at the next visit to assess for success or referral given and any continuing needs.

Pediatric Considerations

For parents who screen positive, it is important to ask if they feel comfortable having a follow-up conversation with or without their children present. Some parents may wish to refrain from speaking openly about social, financial, or safety issues in front of their children, and your practice should develop procedures for supporting parents who request additional privacy discussing these sensitive topics.

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Facilitating Conversations with Patients

Discussing results with patients who screen positive for one or more social needs can be a bit challenging. Developing a common language that seeks to reduce the stigma associated with social and emotional needs can begin by expressing the shared values that health starts in our homes, schools and communities. In the Robert Wood Johnson Foundation (2010) publication, **A New Way to Talk about the Social Determinants of Health**, using terms like "social determinants of health" or "social needs" did not help participants better understand these concepts and their importance. Instead, consider using phrasing that normalizes the challenges many people face and focuses on solutions while acknowledging the notion of personal responsibility such as:

- Health starts — long before illness — in our homes, schools and jobs.
- All Americans should have the opportunity to make choices that allow them to live a long and healthy life.
- Your community and workplace should not be hazardous to your physical or emotional health.
- Addressing social barriers you are facing can improve your opportunities for better health choices.

When staff members are discussing results of the screening tool with patients, there are several goals to keep in mind:

- Empower the patient to understand that social determinants are an important aspect to overall health.
- Maintain the relationship between the patient and the care team as an essential element of providing comprehensive care.
- Provide a brief summary of the social needs identified by this screening tool.
- Inquire about patients' priorities regarding social needs and most pressing specific concerns when multiple needs have been identified.
- Provide a list of resources with options for assistance with the patients' social needs.
- Create a brief plan for follow-up with specific, measurable, attainable goals.

Another important factor to consider is the need to conduct a strengths-based assessment (**Flacks & Boynton-Jarrett, 2018**). Rather than solely discussing unmet needs in checklist-style monotony, empower staff to ask about more than the problems their patients face. Use the discussion to ask questions like, "How did you get by with the trouble paying utility bills last winter?" and "What helps you manage all that stress?" Look for opportunities to highlight resourcefulness, not just need. It is also essential to recognize the resiliency inherent in strong social connections in extended family, neighborhoods, and faith communities; inquire about others in patients' support system who help work together to meet needs as they arise.

We recognize that this process of screening for social needs presents both opportunities and barriers to the clinical workflow in primary care. One potential barrier may arise when some patients show hesitation to complete additional paperwork during or before a medical visit. Some patients may also not initially understand the reasoning why their primary care office collects this kind of information or may find the questions intrusive or embarrassing. The AHCM screening tool is designed to be concise with initial questions that can lead to more detailed conversations about specific needs, ruling out false positives, and allowing staff to address in-the-moment discomfort for patients and responding with a solution-oriented approach. In the sections below, we anticipate some of the most common questions patients may ask staff members.

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"Why Are You Asking Me about These Things?"

Some key talking points include:

- There is plenty of research data and real-world life experience that shows that practical considerations like housing, transportation and the quality of social relationships impact the ways in which patients engage with the healthcare system and manage their health. These types of things tend to make it harder to focus on things like taking medication, keeping medical appointments, and buying nutritious foods.
- Providers and staff sometimes think they are able to tell who struggles with these types of needs, but our assumptions aren't always right. Left to our own devices, our biases mean that we might miss out on identifying some ways we can help by connecting with community resources. So while these questions may not identify any unmet needs you have today, this process helps us identify ways we can help other patients, so it's important to screen everyone.
- We want to make sure our patients are aware of social resources that are available and assist them in connecting with community organizations that can help you and your family stay healthy. This is important so we can do our best to keep our communities healthy and strong.
- Not all of the questions on this screening tool pertain to the amount of money you make and your financial security, so it's applicable to everyone, regardless of socioeconomic status.

Some phrasing to stay away from includes:

- Pinpointing the patient as part of a specific population (e.g. Medicaid, Medicare) that may be at higher risk since this increases stigma and the likelihood of a patient taking offense.
- Explaining the primary reason for screening as the practice's participation in a regional program that is designed for research purposes. This is unlikely to enhance patient motivation to complete the screener and detracts from meaningful impact in the patient's present-day life.

"What Happens with the Information You Collect?"

Some key talking points include:

- Data collected from hundreds of thousands of Colorado residents over the next few years will help us identify gaps in community programs so we can address these gaps and make changes appropriately.
- This data is useful beyond a population level. It's designed to actually give us helpful information to share with you as the patient. Once we enter your responses into the system, we'll be able to identify key social needs so that we can connect you with resources that may be helpful.
- Before you leave today, we'll provide you with a list of referrals for community programs that may be a good fit for you.

Some phrasing to stay away from includes:

- A significant emphasis on population-level data — make sure the primary focus stays on the patient and your ability to serve their needs.

Additional Recommendations

- Lean into the times when patients appear initially hesitant. Rather than immediately withdrawing the tool from patients who initially decline to fill it out, ask them what leads them to be hesitant about filling it out at this time. If you can quickly resolve a concern they have or provide reassurance, you can re-administer it at that visit or the next one.

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- If discomfort and resistance to answer the screening questions persists, do not let it become a block that stands in the way of a productive medical visit. Respect the patient's wishes, and ask for permission to revisit the topic at the next appointment.

Documentation in the Electronic Health Record (EHR)

Due to immense variation in clinic teams and EHRs in use, it is near impossible to generalize the process of documentation. However, some top recommendations based upon other screening processes include:

- Ensure clinic-wide consensus about where in the electronic health record the results of the screening and plans for follow-up will be stored.
- Identify a process for flagging patients in need of significant follow-up and directing that to the appropriate person on the team.
- Consider reaching out to RMHP's Clinical Informaticist through the Practice Transformation Team if you are experiencing trouble with tracking data related to screening.

Use of Time and Space within the Clinic

Although there can be immense variation between patients within a given practice, we estimate that this AHCM screening process with follow-up will take an average of 4–5 minutes. Without proper planning, this could pose a burden on some clinics with limited space and few physical exam rooms spread across multiple providers.

Thus, we recommend considering:

- Is there an alternative office space that could be used to briefly meet with patients prior to or following the medical encounter?
- Can patient arrival times be shifted for patients who need to be screened to allow for additional time in the visit and improved clinic flow?
- Could PDSA cycles help identify the smoothest way to integrate the screening into the practice workflow for various types of visits and test the timing of when to give the screening?

Addressing Sensitive Topics

Interpersonal Violence

Despite others studies finding support from patients for screening for interpersonal violence, many healthcare settings have been hesitant to engage in screening (**Kimberg, 2001**). The AHCM project recognizes that in order for patients to strive for good health in all domains of life, personal safety must be a priority. Your practice is already treating patients who have been affected, currently or previously, by interpersonal violence. Without routine screening, however, your providers and care teams tend to treat presenting complaints (e.g. depression, anxiety, PTSD, somatic complaints without medical explanation, physical injuries) without addressing root causes of health problems caused by violence (**Usta & Taleb, 2014**).

One important thing to remember: it is essential that staff members refrain from judgment and asking questions like "Why don't you just leave?" if the person who has identified experiencing violence lives with the perpetrator. Judgment damages the patient-care team relationship and is associated with victim blaming and shaming. There are a variety of reasons why people in violent relationships do not leave, including wanting to stay for their children or pets, having limited resources to support themselves, experiencing complicated emotions for the perpetrator of violence, being isolated from friends and family, having concerns about status and stigma, and receiving threats about increased violence if they do try to leave.

Adding to the complexity of the issue, some violence can be characterized as situational or common couple violence, meaning that there is not a sole perpetrator and a sole victim in the relationship (**Project Safe, 2014**).

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This is different from intimate terrorism and is often seen in couples with poor communication strategies who resort to managing conflict by name calling, shoving, hitting, or damaging property. In the context of healthcare where multiple members of the same family may be treated, this is often important information to know.

If a patient has screened positive for interpersonal violence, a trained clinical staff member should have a confidential conversation with the patient prior to them leaving the office. The purpose of this is threefold: (1) assess for the current level of risk and safety in leaving the office, (2) thank the patient for the bravery and courage displayed in sharing this information with their provider, and (3) collaborate with the patient on plans for follow-up and any resources they are open to considering. This is likely similar to your practice's workflow related to depression and suicide screening. Furthermore, this conversation should include gently asking about whether children have been exposed to violence and whether the situation requires **mandatory reporting**.

We recognize that staff members in your office are likely not experts on how to treat victims of abuse and violence. In the interest of increasing staff competence and comfort with providing support for positive screens, we offer a few recommendations:

- Rely on support from community partners with expertise in this area, including local crisis centers and the **Colorado Coalition Against Domestic Violence**.
- Know the local and regional resources available to patients in your area (domestic violence shelters, groups for individuals who have experienced trauma, agencies available to support pregnant women and children, therapists who have experience in working with victims of violence and trauma, etc.)
- Ensure patients have phone numbers for the **Statewide Crisis Line** (1-844-493-8255) or the **National Domestic Violence Hotline** (1-800-799-7233). If patients have concerns about the perpetrator finding this number, help them think of secure ways to store this number (under a secret name in their phone, hiding the card with the phone number in a secure location, etc.)
- Train key staff members (e.g. behavioral health providers, care managers, nursing staff, providers) creating a basic **safety plan** so they can confidently support patients who desire this assistance. Although this is an **extensive template**, staff members will likely feel more confident in having this conversation if they know a few key areas to address with patients when there is an immediate need.
- Because individuals experiencing interpersonal violence are at heightened risk for suicide, an assessment of suicidal thoughts and behavior is highly recommended. Examples include the last question on the **PHQ-9** or the **Columbia Suicide Severity Rating Scale**. The **National Suicide Prevention Lifeline** has also provided some guidelines for a suicide risk assessment.

Social Isolation

The risks of social isolation extend far beyond feelings of loneliness. Impaired health associated with social isolation can result from raised levels of stress hormones and inflammation, which can increase the risk of heart disease, arthritis, Type 2 diabetes, dementia, and suicide attempts (**Brody, 2017**). Loneliness can stem from a variety of situations related to unsatisfying relationships and friendships, an absence of close relationships with friends or family, being confined to home due to poor health or lack of transportation options, grief and loss, and more.

As with addressing interpersonal violence, refraining from assigning judgment or blame is essential. Listening is important. Let the patient's voice be heard, valued, and respected. It is overly simplistic to just assume that people who are lonely should try to interact more with others, and keep in mind that patients will have varying levels of interest and confidence in changing this experience. The quality of relationships matters more than the number of interactions with others, and there are often complex factors (e.g. underlying depression, anxiety, comorbid health conditions with limitations, etc.) to consider.

We recognize that staff members in your office aside from behavioral health providers may not have substantial

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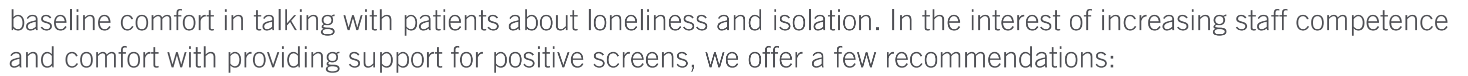

baseline comfort in talking with patients about loneliness and isolation. In the interest of increasing staff competence and comfort with providing support for positive screens, we offer a few recommendations:

- Consider asking patients what they want and need from relationships with others, and use that to drive brainstorming for potential solutions.
- Encourage patients to be creative and open to a variety of solutions (getting a pet, doing volunteer work, taking a class, joining a senior center, joining a recreational sports team, joining an online support group, etc.). List a couple of options but let patients pick something that sounds meaningful.
- Due to the heightened risk of suicide, an assessment of suicidal thoughts and behavior is highly recommended. Examples include the last question on the **PHQ-9** or the **Columbia Suicide Severity Rating Scale**. The **National Suicide Prevention Lifeline** has also provided some guidelines for a suicide risk assessment.

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Managing Data in the Program

Baseline and Monthly Reports

Based upon data you will receive through the AHCM program, develop a registry report with patients whom you have screened using the AHCM tool. As you seek to better understand the psychosocial aspects of your patient population, it may be worthwhile to track patients based on their identified needs. For example, if you have a high number of no-show or late appointments, would it be beneficial to assess how many patients state they have challenges with transportation? Is there a subset of your patient population who has food insecurities?

This ongoing registry shows that you are evaluating more than just chronic illness in your patients. You understand that in **Maslow's hierarchy**, patients may find it challenging to treat their chronic condition if they do not know where their next meal is coming from. Tracking this data can be highly valuable for your practice and has the potential to reduce many of the barriers that arise when patients have significant psychosocial needs.

In addition to practice level reports, participation in the AHCM screening process allows RMHP to collect service area, sub-region, county, and practice and provider level data in the following categories:

- Screening penetration rate: ratio of Medicare and Medicaid patients in AHCM service area who have been administered the AHCM screener
- Monitoring of the resource results generated by the screening process
    - Percent of patients who screen positive for an unmet social need
    - Quantification of resources available to meet social needs of community members
- Monitoring of the navigation process for region, sub-region, county and practice level
    - Number of patients provided with community navigation
    - Percent of patients with navigation needs
    - Number of patients who received navigation services

Choosing to access the screener in an electronic version through the Community Resource Network (CRN) through QHN can enhance the practice's ability to generate practice and provider level data that informs the most common social needs identified in your patient population. This data can then be used to improve relationships with most commonly resourced community affiliates and develop strategies to continue reducing barriers to social health that impact the overall health of the patients you serve.

Coding

One idea includes using ICD-10-CM, CPT, LOINC, and SNOMED CT codes to document work you are doing with administering screening and delivering interventions as part of your participation in the AHCM project. For example, you can use these codes to track when patients report issues with homelessness, food security, utilities, and safety and when your clinical team counsels patients through how to address these needs. Then, you can run a report using these discrete data fields to answer questions such as "How many patients seen in the last 12 months reported they had an unstable living situation?"

Although these codes are not necessarily reimbursable by payers, they can be helpful in tracking internal data for your practice. Plus, they can be used to gather practice-specific data that could be useful when determining which grants to apply for and including that data as background research for the application. More information, including a downloadable Excel spreadsheet with specific codes, can be found on the **Siren Network** website.

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Creating Follow-Up Procedures

Assessing Patient Follow-Through and Engagement

Once patients are given the names of community resources with whom they may be well matched, it is imperative to develop a process to track patient follow-through on engagement with these resources. Patients retain autonomy to determine whether and when to contact a community organization for assistance, but best practice for screening sites includes following up to see the status of the patient's follow through. If the patient reached out but was blocked by a barrier, it would be helpful to reconsider alternative ways of meeting that need or removing that barrier.

Within your practice, develop a workflow to determine who will follow up with patients about this topic. Options could include:

- Tasking a care manager or care coordinator with making phone calls two weeks after the patient has been given a list of resources (and additional opportunities for follow-up at longer intervals if no action has been taken after a shorter period of time)
- Making a flag within the EHR to remind providers or staff to inquire at the next appointment about whether the patient engaged with any resources on the list provided
    - Timing opportunities:
        - During clinical check-in with nurse or medical assistant
        - Co-visit with care manager, care coordinator, or behavioral health provider
        - During the encounter with the medical provider

Although your practice will develop a strategy for what information is important to gather about patient follow-through, we recommend asking questions related to:

- Whether they made initial contact with the community resource
- The outcome of that initial interaction
    - Satisfactory aspects
    - Less than satisfactory aspects
- Specific details about the resources they have received/are receiving and how well that fits with their current needs
- What sort of coordination the patient would prefer between the primary care office and this community resource

Coordination with AHCM Resource Navigator

Patients who screen positive for an identified social need and self-report two or more ER visits in the past 365 days will receive an additional question at the end of the screener. This question states: "You qualified for Community Navigation. Community Navigation is a person in your community who can help you access resources for the needs you identified. If you do not want a Community Navigator to contact you, please select 'do not contact me' below."

For patients who select that they would like to be outreached by a navigator, the navigator will receive an electronic alert from RMHP alerting them that they have a patient in need of their services. That alert will be sent no later than eight hours after the patient's appointment. If a patient selects that they do not want outreach from a navigator, they will still receive the name and phone number of the Navigator so they can follow up later if they choose.

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Appendix A: Key Contact Information

AHCM Community Leads

Name	Role	Location	Email	Phone
Kathryn Jantz	AHCM Director – Rocky Mountain Health Plans (RMHP)	Western Slope	Kathryn.Jantz@rmhp.org	(303) 638-9897
Ken Davis	Community Lead – Northwest Colorado Community Health Partnership	Moffat, Routt, Jackson, Grand, Rio Blanco Counties	kdavis@ncchealthpartnership.org	
Cristina Gair	Community Lead – West Mountain Regional Health Alliance	Garfield, Eagle, Summit, Pitkin Counties	cgair@mountainfamily.org	
Sarah Robinson	Community Lead – Mesa County Public Health	Mesa County	Sarah.Robinson@mesacounty.us	
Adrienne Christy	Community Lead – Tri-County Health Network	Delta, Montrose, San Miguel, Ouray, Gunnison Counties	Coord-ip@tchnetwork.org	
Rusty Connor	Community Lead – SW Area Health Education Center	Dolores, Hinsdale, San Juan, Montezuma, La Plata, Archuleta Counties	Russelyn.connor@swahec.org	
Laura Warner	Community Lead – San Juan Basin Public Health	Dolores, Hinsdale, San Juan, Montezuma, La Plata, Archuleta Counties	lwarner@sjpublichealth.org	
Cindy Wilbur	Community Resource Network (CRN) Director – Quality Health Network (QHN)	Western Slope	cwilbur@qualityhealthnetwork.org	(970) 248-0033
Cynthia Mattingley	RMHP Practice Transformation Team	Western Slope	Cynthia.Mattingley@rmhp.org	

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Appendix B: Additional Resources

Center for the Study of Social Policy (CSSP)	Strengths-based approach to screening families for health-related social needs
Robert Wood Johnson Foundation	A new way to talk about the social determinants of health
Health Affairs	Physicians' broader vision for CMMI's future: Look upstream

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Appendix C: Tablets Compatible with CRN AHCM Screening Tool

For practices that choose to use QHN's Community Resource Network (CRN) screening tool for AHCM, here is a list of tablets that are and are not compatible with the system.

VisionLink-Approved Tablets				
Devices with Android OS Make/Model	**Android OS**	**Browser Supported**	**System Approved**	**Notes**
Samsung/Galaxy Tab 4	Android 4.4 (Kitkat)	Chrome/Firefox	Not Supported	This version is no longer receiving security updates from Android
Samsung/Galaxy S5	Android 4.4.1 (Kitkat)	Chrome/Firefox	Not Supported	This version is no longer receiving security updates from Android
Samsung/Galaxy Tab E Lite	Android 4.4.1 (Kitkat)	Chrome/Firefox	Not Supported	This version is no longer receiving security updates from Android
Samsung/Galaxy Tab A 7'	Android 5.1 (Lollipop)	Chrome/Firefox	Pass/Approved	
Samsung/Galaxy Tab A 8'	Android 5.1 (Lollipop)	Chrome/Firefox	Pass/Approved	
Google Nexus 7	Android 6.0 (Marshmellow)	Chrome/Firefox	Pass/Approved	
Google Nexus 10	Android 6.0 (Marshmellow)	Chrome/Firefox	Pass/Approved	
Samsung/Galaxy Tab A 8.0' (Latest Model)	Android 7.1 (Nougat)	Chrome/Firefox	Pass/Approved	
Samsung Galaxy Tab S	Android 7.1 (Nougat)	Chrome/Firefox	Pass/Approved	
Samsung Galaxy Tab E	Android 7.1 (Nougat)	Chrome/Firefox	Pass/Approved	
Samsung Galaxy Note 8	Android 7.1 (Nougat)	Chrome/Firefox	Pass/Approved	
Samsung Galaxy Book	Android 8.0 (Oreo)	Chrome/Firefox	Pass/Approved	
Devices with Apple OS	**Apple OS**	**Browser Supported**	**System Approved**	**Notes**
iPad Generation 1	iOS 5.1.1	Chrome/Firefox	Not Supported	This version is no longer receiving security updates from Apple
iPad Generation 2	iOS 9.3.5	Chrome/Firefox	Not Supported	This version is no longer receiving security updates from Apple
iPad Generation 3	iOS 9.3.5	Chrome/Firefox	Not Supported	This version is no longer receiving security updates from Apple
iPad Generation 4	iOS 9.3.5	Chrome/Firefox	Not Supported	This version is no longer receiving security updates from Apple
iPad Air	iOS 11.4	Chrome/Firefox	Pass/Approved	
iPad Air 2	iOS 11.4	Chrome/Firefox	Pass/Approved	
iPad	iOS 11.4	Chrome/Firefox	Pass/Approved	

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