SIM Community Health Team

Final

Evaluation Report

Prepared by:

University of Rhode Island

Rhode Island State Evaluation Team

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LIST OF ABBREVIATIONS

Abbreviation	Full Name
AUDIT	Alcohol Use Disorder Identification Test
BH	Behavioral Health
BI	Brief Intervention
BMI	Body Mass Index
BT	Brief Treatment
CAGEAID	Alcohol Use Screening Tool- CAGE is 1st letter of each of 4 items
CTC – RI	Communities That Care – Rhode Island
CHT	Community Health Team
CHW	Community Health Worker
DAST	Drug and Alcohol Screening Test
ED	Emergency Department
GAD	Generalized Anxiety Disorder screener
IRB	Institutional Review Board for human subjects concerns
LCSW	Licensed Clinical Social Worker
LMHC	Licensed Mental Health Counselor
NP	Nurse Practitioner
PCOQ	Patient Centered Outcome Questionnaire
PCP	Primary Care Practice or Practitioner
PHQ	Patient Health Questionnaire
RI	Rhode Island
RFP	Request for Proposals
RN	Registered Nurse
ROI	Return on Investment
RT	Referral for Treatment
RTT	Referral Triage Tool
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
sd	Standard deviation
SDOH	Social Determinant of Health
SIM	State Innovation Model grant
UDS	Uniform Data System
URI	University of Rhode Island

CHT Executive Summary

Coordinated by the Care Transformation Collaborative of Rhode Island (CTC-RI), Community Health Teams (CHTs) have worked in different Rhode Island medical and community settings, using differently integrated team models, to improve qualifying primary care patients' medical, social, behavioral and substance-related care. RI SIM funded CTC-RI to support existing and develop new CHTs, in this project braided with SBIRT– Screening, Brief Intervention, and Referral to Treatment. SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. CHTs are an integral part of the RI SIM health transformation plan to improve health care and health equity for high-risk, high need patients. CTC-RI collaborated with eight different community-based agencies that were funded, staffed, trained and coordinated over two years. CHT staff included medical, behavioral, and community health specialists, that varied across sites. CHT clients were selected to include patients with high medical, social, behavioral, and substance-related needs. This CHT evaluation included a variety of sources of data to determine CHT client levels of risk, need, progress, and care. These combined results demonstrated substantial CHT effort, patient contact, a variety of clinically useful and evaluation screenings, care coordination and care delivered by CHT staff over between nine and twenty-one months. Sources of data were varied including: qualitative case studies; data on patient volume and sessions over time; site-specific data reflecting quality metrics; Screening Brief Intervention Referral and Treatment (SBIRT) Project coordinated evaluation data reflecting substance use screenings and re-screenings from CHT sites; and pre-post data over nine months of CHT care with new CHT intakes across 7 CHTs and 4 partner sites. Taken together, these data demonstrate at least six important points about CHT care.

1) CHT clients were indeed at high risk for a variety of health, social, and behavioral problems. Demographic characteristics attested to this CHT Intake sample's higher age, and higher rates of ethnic, racial, and language diversity compared to the general population rates from the state of Rhode Island. A map of zip codes of CHT intakes demonstrated that most CHTs were located in some of the most populated, urban, and lowest resource areas of the state.
2) SBIRT screenings and 10% random six-month re-screenings at CHT sites demonstrated that the SBIRT model works well in CHT settings and that people who received brief substance use interventions reduced their past 30-day substance use by 30-40%, a finding that was both statistically significant and clinically meaningful.
3) Data from one large site with multiple CHTs demonstrated that in spite of high levels of health and social needs, clients who participated in CHT care met or exceeded most UDS targets for quality medical care.
4) Substantial numbers of health, social, and behavioral screenings were conducted by CHT staff in this Intake sample (N=397).
    a. **Health Risk** - Most (92%) CHT clients were screened at intake for health risk using either of two tools, and of those, 70% met at least moderate risk and 59% met high health risk criteria.
    b. **Social Determinants** - At intake, 84% of CHT clients were also screened for social determinants of health (SDOH) using various screening tools

and 83% of those screened reported at least one social determinant issue, with a median (most common) of two social determinants.

c. **Behavioral Health** - In addition, 83% were screened for depression, with 47% of those scoring above criterion. For anxiety, 59% were screened and of those, 46% scored above criterion. For substance use, 79% were screened and of those, 9% met moderate substance use risk criteria. In response to two life evaluation/wellbeing items, 77% of CHT clients were categorized as either suffering or struggling.

5) CHT clients were seen for an average of 4.7 months (140 days) of CHT care during the evaluation timeframe. Over that time in many CHT clients who completed follow-up screenings through June 30, 2019, several statistically significant and clinically meaningful changes were demonstrated.
   a. **Health Risk** - 33% statistically significant reductions in health risk scores over time;
   b. **Social Determinants** - statistically significant reductions in all social determinants of health, both taken together and separately, for large proportions of CHT clients over time;
   c. **Behavioral Health** - 32-33% reductions in levels of depression and anxiety over time; reductions in substance use over time; statistically significant improvements over time in support, health knowledge and understanding, adherence, health confidence, current and future life evaluation, well-being, and numbers of unhealthy days where the client could not function properly due to either physical or mental health problems. These empirical findings support and underscore the qualitative data from case studies that also tell compelling stories of how individual CHT clients benefited in these ways and in additional ways from CHT care.
6) CHT clients who completed patient experience surveys were generally in strong agreement with items reflecting excellent levels of patient satisfaction with their CHT care.

Taken together, these findings support the substantial value and benefits of CHT care to improve the health and wellbeing of high-risk patients, assisting primary care providers and payers in Rhode Island to improve health equity and underscoring the importance of increased sustainability planning for the future of CHT care. CHTs have improved the integration of medical, behavioral, social and substance-related healthcare in the state of RI, showing substantial improvements in health risk, social determinants of health, behavioral health and wellbeing for these high risk, high need patients. Additional efforts to streamline and align clinical screening and evaluation would benefit clinical care, documentation, and evaluation efforts, across health areas and specifically regarding the social determinants of health and behavioral health. Additional research to clarify cost savings and return-on-investment is warranted. These results also reveal some opportunities for continued improvements in reach, evaluation, and screening capacity that may improve CHT care even more in the future.

INTRODUCTION

Poor access to behavioral healthcare impedes many adults with medical and behavioral health issues from getting timely, effective care and increases their use of medical care. This is challenging for primary care practitioners who often lack staff, training, and resources to attend to the many social and behavioral health problems that present alongside patients' medical problems. Adults with multiple social, behavioral, and medical challenges are over-represented in primary care practices and tend to overutilize medical care, at least partly in response to lack of social and behavioral health services. Nationally, there has been a movement towards better integrated behavioral and primary care, both to better address social and behavioral health needs with evidence-based, effective and accessible treatments and to reduce overutilization of costly medical and emergency care.

The Community Health Team Project is a system change initiative in Rhode Island that aligns with the guiding principles of the RI SIM Operational Plan and Population Health Plan. In support of improved health for all Rhode Islanders, both the RI SIM Operational Plan and Population Health Plan seek to:

1. Make investments that better integrate social, behavioral health and physical health.
2. Change the focus of the health care payment system toward value and less on volume.
3. Increase use of data to provide feedback to policy makers, providers and consumers about quality of care, outcomes, costs/benefits of specific health care interventions.
4. Address the social, behavioral, and environmental determinants that affect the overall health of individuals.
5. Empower consumers to assume greater control and choice over their own health care.
6. Support health care providers who are embarking on practice transformations that emphasize value over volume and providing services in the least restrictive settings possible (such as community based versus hospital interventions).
7. Identify and address disparities in health outcomes across various population groups or communities.

Better integrated physical, social, and behavioral health can be delivered and supported across multiple health-related settings in Rhode Island. Community Health Teams (CHTs) can provide essential screenings, access, and coordination of care across medical and behavioral health settings for many of Rhode Island's high risk individuals. Universal screening for unmet health, behavioral, substance-related, and social needs can become part of the standard of care and can be accessible to all Rhode Islanders. Such integrated care can provide clear and reliable treatment pathways for brief intervention and referrals to various treatment options, including Community Health Teams, resulting in better quality care, more efficient use of health care dollars, as well as increased health equity for all Rhode Islanders.

Community Health Teams (CHTs) are a vital component of the RI SIM Operational Plan. CHTs have the potential to facilitate coordinated and integrated care (using screenings, dashboards, and other tools) while attending to the whole person (i.e.,

physical, social, behavioral and environmental health needs). Currently in Rhode Island, there are several different models for CHTs, with variability in their location within the state, organizational structure, affiliation with healthcare providers and/or carriers, organizational support, and services provided. Current Rhode Island CHTs all focus on servicing individuals with high risks and/or high medical costs.

In order to maximize improvements in Rhode Island population health, address and improve our social and environmental health determinants, and make progress towards increasing health equities in our state, RI SIM prioritized additional CHT services to be focused on those patients with greatest clinical needs. The Care Transformation Collaborative of Rhode Island (CTC-RI) is a "statewide multi-payer, multi-stakeholder, public-private partnership focused on primary care and health system transformation" (Yeracaris et al., 2019). Convened in 2008 by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS), CTC-RI manages the state's Patient Centered Medical Home project for adults and children, and recently piloted an Integrated Behavioral Health project as well. CTC-RI, in collaboration with RI SIM, established the following criteria to assist in the identification of individuals with the greatest unmet needs and therefore, the greatest likelihood of benefiting from CHT services:

- Individuals with 3 or more chronic conditions
- Individuals with 2 or more special healthcare needs (i.e., disabilities)
- Individuals with substance use disorder and at least one other co-morbid physical or behavioral health condition
- Individuals who were not accessing primary care regularly
- Individuals who had 3 or more inpatient or emergency department (ED) visits within 6 months

CHT Evaluation Goals

The goal of this evaluation was to assist RI SIM in determining if the following project goals were achieved:

1. Increased availability of behavioral and mental health care for high risk, high cost individuals by aligning CHTs with community health centers, behavioral health treatment centers, primary care practices, among other referral sources
2. Alignment and integration with RI SIM Grant Operational Plan and Population Health Plan
3. Collection of data to track key indicators, including, but not limited to
    a. type and amount of services provided
    b. number of primary care practitioners referring to CHT services
    c. number of high-risk patients served, description of patients served
    d. Between 10/1/2018 and 6/30/2019, change over time in health risk, social determinants of health, behavioral health, quality of life, health literacy, and wellbeing metrics in sample of CHT patients in care for > 2 months from intake to follow-up/discharge. Patient experience following CHT care will also be assessed.
4. Collaborate with Brown University Experts to facilitate evaluation of cost-effectiveness and/or return on investment (ROI) of CHTs

Community Health Team Resources

Resources included the time, talent, technology, equipment, information, money, and other assets available to conduct CHT program activities. The ROI and economic evaluations will require an understanding of all direct and indirect program inputs and costs. The following CHT recommendations were copied from the RFP:

Community Health Team Recommendations:

- CHTs should be multidisciplinary, connected with primary care, and payer agnostic, meaning that any Rhode Islander can receive services they are eligible for regardless of health insurance status or carrier.

- CHTs should focus on primary care practices located in underserved communities that are not currently served by a CHT in the state and that have large high-risk populations.

- At least one CHT staff member must be trained and dedicated to provide SBIRT screening and referral.

- The composition of CHT staff (including staff at SBIRT sites) should meet minimum standards and reflect the needs, language preferences, and/or diversity of the community being served.

The primary resources utilized were on-site staff positions to provide the necessary CHT and SBIRT services. CHT teams included a behavioral health clinician, and at least 2 Community Health Workers (CHWs) who worked collaboratively to assess clients' needs and development a comprehensive care plan. Each team had someone who served as a "team lead" who was responsible for working with referring practices, scheduling intakes and ensuring communication back to the referring practice.

Physical and behavioral health comorbidities are well-documented in *RI's State Health Improvement Plan* (State of Rhode Island, 2017) that includes an extensive focus on depression, chronic disease, severe mental illness, tobacco use, and opioid use disorder. With growing focus on practice transformation and value-based care, addressing the complex care needs of patient populations is increasingly urgent (Humowiecki et al., 2018). Rhode Island has invested in the CHT/SBIRT model to assist PCPs with improving patients' physical, behavioral, and social health needs. CHTs included both new and established teams, five co-located with PCPs with shared medical records, and the remaining three operating separately (off-site) in both community and clinic settings. The CHT teams that were co-located in PCP settings were also required to take on additional clientele from outside their primary setting. In addition to varying by the degree of integration into primary care of the CHT teams, teams vary widely by history, geography, demographics and social needs of populations served, amount of institutional support, and numbers and composition of primary care practices served.

CTC-RI oversaw a network of eight, payer-agnostic CHTs (Yeracaris et al., 2019). In the last quarter of 2018, CHTs were referred patients with following insurance carrier

breakdown from PCPs: commercial (29.3%), Medicare (14.7%), Medicaid (52.5%), Uninsured (3.5%). CHTs were comprised of at least one behavioral health clinician and two community health workers trained in SBIRT. Pharmacist, nutritionist, and legal consultations were available as needed. Formally integrating SBIRT into CHTs increased whole-person care, especially important for vulnerable populations often lost to follow-up. CHTs normalized screening for and treating patients' behavioral health and social needs, ultimately delivering more integrated care responsive to emerging needs (e.g., opioid epidemic, costly healthcare overutilization).

The eight CHTs were operated by five community-based implementation partners in Aquidneck Island, Blackstone Valley, Providence, South County, West Warwick, and Woonsocket (see **Figure 2**). This place-based (i.e., where patients live) approach to CHTs was intentionally aligned with RI Health Equity Zones (Alexander-Scott et al., 2015). By using new intake patient ZIP codes reported by CHTs over six months, **Figure 2** shows the geographical distribution of CHT intakes over a six-month evaluation period (10/1/2019 – 3/31/2019).

CHT Logic Model. A logic model described the sequence of events for bringing about change by synthesizing the main program elements into a picture of how the CHT program was expected to work. CTC-RI created a logic model which identified assumptions concerning conditions for program effectiveness and provided some frame of reference for the CHT evaluation. See Appendix.

EVALUATION

Some evaluation metrics reflect performance and volume of CHT care over time. The following Quarterly Performance Metrics were collected from all 8 CHTs by CTC-RI since July 2018:

- number of referrals, by insurance and by practice
- number of intakes, by insurance and by practice
- total number of patients served (new + existing), by insurance and by practice
- number of face to face meetings
- number of new patients offered CurrentCare
- number of new patients asked about receipt of a flu shot in the past 12 months
- number of new patients who smoke tobacco

Table 1 (below) results demonstrate various CHT value-add activities. Some of these data were also reported in Rajotte et al., 2019. Eight CHTs served 2,952 unique patients, providing 13,519 face-to-face visits between July 1, 2018 - June 30 2019. A total of 971 new patients were referred from primary care practitioners (PCPs) who were not previously established with CHT care. Given that patients seen by CHTs were predominantly high-risk and often disengaged from primary care, screening for influenza vaccination and tobacco use were prioritized. Between October 2018 and June 2019, a total of 1529 CHT patients were screened and informed about influenza vaccine and 2098 CHT patients screened positive for tobacco use. In addition to existing SBIRT services across CHTs, pharmacy, nutrition, and/or medical-legal consultation services were added as features of the CHT network and data reflect limited utilization due to delayed uptake and referral as new workflows were established, limited capacity and

funding for medical-legal case reviews, and other related reasons. CHTs also delivered at least 14 PCP-focused trainings over a longer timeframe to develop referral relationships and foster engagement.

Table 1. Volume of Activity Across Eight CHTs

Measure	Value	Reporting Period
Number of patients served	2952	07/01/2018—6/30/2019
Number of unique face-to-face visits with patients in community	13,519	
Number of new referrals from primary care practices	971	
Number of patients asked if influenza vaccine received within the past year	1529	10/01/2018—6/30/2019
Number of patient referrals to pharmacy and/or nutrition and/or medical-legal consultation services	12	
Number of patients who screened positive for tobacco use	2098	
Number of provider trainings delivered to PCPs about practice transformation, value-based care, and CHT benefits	14	06/01/17—12/31/2018

SBIRT CHT Activities

Another important and valuable aspect of CHT work included SBIRT, which was funded separately by SAMHSA. SBIRT activities were integrated into CHT care, with all CHT staff trained in SBIRT. Rhode Island College provided training in SBIRT processes that will be evaluated as part of the SAMHSA grant. SBIRT was evaluated separately, and braided funding allowed collaboration on some aspects of the SIM evaluation. URI SBIRT collaborators and partners developed an infographic describing the statewide SBIRT outcomes that can be found *here*.

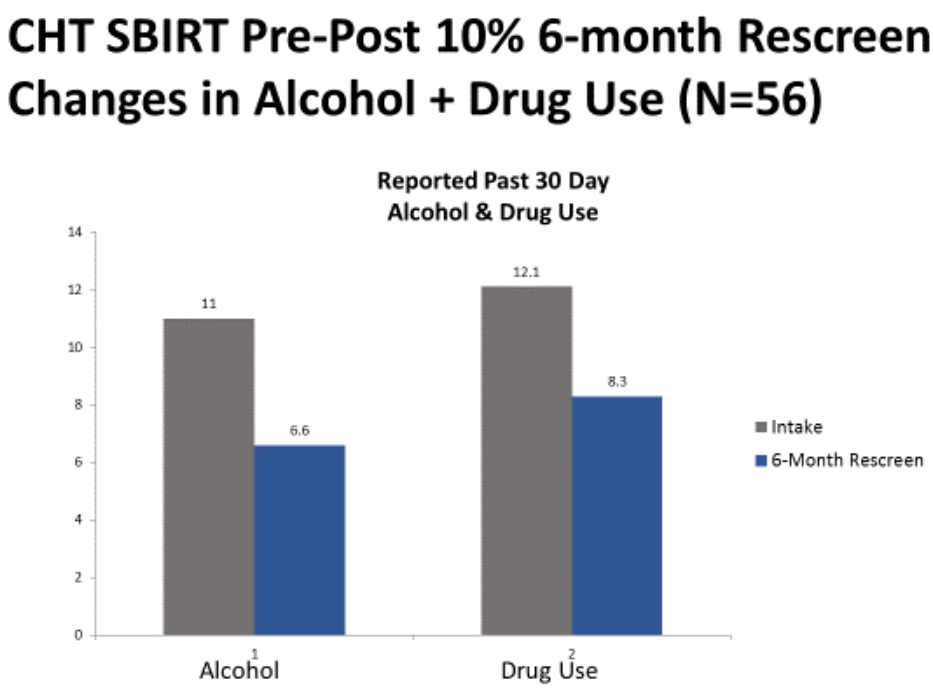
URI SBIRT collaborators also reported the following SBIRT activities specifically at CHT sites through 6/14/19. A total of 2,845 SBIRT screenings for substance use were conducted by CHTs over 21 months through 6/14/19. Earlier 18 month summaries of these data were reported in Rajotte et al., 2019. **Table 2** (below) shows 16.6% of CHT screened patients required brief intervention (BI), 1.5% required brief treatment (BT), and 4% required referral-to-treatment (RT). Per the SBIRT evaluation plan, ten percent of patients who screened positive for risky substance use were randomly selected for six-month re-assessment. Among those in that randomly selected subsample of re-screens (N=56), paired sample t-tests examined past 30-day substance use changes over time. Statistically significant reductions in reported past 30-day alcohol use ($t(55)=3.1$, $p<.01$) and illicit drug use ($t(55)=2.8$, $p<.01$) were found, reflecting declining substance use by CHT screened patients from initial SBIRT screen to six-month rescreen.

Table 2. CHT-Based SBIRT Results

Measure	Value	
Total SBIRT screens performed by CHT staff	2,845	
CHT SBIRT screens by race/ethnicity		
African American/Black	14.4%	
White	81.8%	
Other	4.3%	
Hispanic/Latino	18.6%	
CHT SBIRT screening result type		
Screen-Only	78.1%	
Brief Intervention	16.6%	
Brief Treatment	1.5%	
Referral-to-Treatment	4.0%	
CHT SBIRT Follow-Up Substance Use Results (N=56)	**Baseline Screen Mean (sd)**	**6-month Re-Screen Mean (sd)**
Number of past 30 days where patient used alcohol	11.0 (12.6)	6.6 (10.5)
Number past 30 days where patient used illicit drugs	12.1 (13.6)	8.3 (11.3)
Additional SBIRT data available here.		

Table 2 (above) **and Figure 1** (below) show these declines to be 30-40% in the patient reported amount of alcohol or illicit substances used in the past 30 days. SBIRT screened CHT patients were not required to meet CHT eligibility criteria and therefore, results from this SBIRT evaluation may not generalize to the general population of CHT patients. These results, in combination with the larger SBIRT evaluation results, support the high volume, potential reach, and the effectiveness of the SBIRT model of screening, brief intervention and treatment referral generally. These results specifically also support the utility and efficacy of SBIRT's integration into CHT care.

Figure 1. CHT SBIRT Changes in Substance Use Over Six Months in 10% Rescreened Sample



<u>Medical Quality Measures</u>.

In order to evaluate how well CHTs also help PCPs address the medical needs of their patients, we examined specific medical UDS quality measures in one large available 12-month sample. These data were also reported in Rajotte et al., 2019. **Table 3** (below) compares quality measure rates over 12 months (January 1, 2018 - December 31, 2018) from one partner (Site 1) with four CHTs that were fully integrated into primary care settings with shared medical records across two geographic regions of the state. Generally, one would expect patients selected to be at high risk for medical comorbidities, behavioral health and social issues to perform worse on most or all of the UDS target measures. In contrast, statistically significant, small sized differences were found between CHT patients and entire clinic populations on several measures. CHT patients were actually more likely to meet BMI, tobacco use screening and cessation services, and breast/cervical/colorectal cancer screening quality measure targets compared to the general clinic population. No difference in blood pressure control between samples was observed. Diabetes control was the only indicator where the CHT patients showed significantly worse rates than the general population, potentially reflecting challenges of high-risk patient comorbidities, including BH and SDOH needs (e.g., food insecurity). These Chi-squared tests showed cross-sectional differences between UDS rates of these two independent groups, but cannot show causation and are not adjusted for any of many potentially confounding variables. Nevertheless, these analyses show that most high-risk patients engaged in CHT care in an integrated primary care setting can and do meet or exceed most UDS quality targets.

Table 3. Quality Measure Rates Comparing CHT and Clinic Populations

UDS Measure	CHT Population* *Percent (n/N)*	Clinic Population** *Percent (n/N)*	X^2 (1)
Controlling High Blood Pressure	82.9% (610/736)	80.0% (4,532/5,659)	3.24
Diabetes Care—Poor Control	26.2% (109/416)	20.3% (474/2,339)	7.36++
BMI Assessment	94.8% (1,674/1,766)	88.5% (18,104/20,458)	65.91++++
Tobacco Use—Screening/Cessation	99.7% (1,721/1,726)	98.8% (16,879/17,091)	11.49+++
Breast Cancer Screening	63.4% (244/385)	57.8% (1,963/3,396)	4.46+
Cervical Cancer Screening	77.6% (660/851)	70.5% (6,504/9,220)	19.11++++
Colorectal Cancer Screening	62.4% (457/732)	56.7% (3,847/6,784)	8.77++

+ $p<.05$; ++ $p<.01$; +++ $p<.001$; ++++ $p<.0001$
**CHT population includes patients with face-to-face visit with CHT behavioral health clinician or community health worker in past 12 months*
***Whole population includes all primary care patients (excluding CHT patients) across all locations in past 12 months*

Following up on these results, CTC-RI and Brown University collaborators are working with Site 1 to capture matched patient level cost of care data that can evaluate and compare costs longitudinally before and after CHT care to draw ROI conclusions more clearly, with appropriately matched control and/or comparison groups (Yeracaris et al., 2019).

Nine Month CHT Data Collection

To assess the impact of CHT care on patients directly, the following CHT Monthly Patient Outcomes Metrics were collected using a deidentified number for each new patient who was seen in CHT care for at least 2 months starting on October 1, 2018 through April 1, 2019. These data are complete through June 30, 2019. Clients were followed through June 30, 2019 for 7 CHT Partners (Sites 1-4). Follow-up or discharge occurred over the 9 months of the evaluation timeframe, whichever came first.

The following **Table 4** (below) describes each construct, timeframe, and measurement tool/metric used to evaluate patients over the 9 months (measures available in English, Spanish and Portuguese):

Table 4. Outcome Evaluation Timing and Tools

Construct	Intake	FollowUp or Discharge	Measurement Tool/Metric (Citation)
Demographics	X		Age, Gender, Racial/Ethnic Group, Zip Code, Primary Language=English?
Health Risk	X	X	Referral Triage Tool or Impactability Score
Social Determinants	X	X	RTT or Health Leads or PRAPARE Mapped into comparable SDOH categories
Anxiety	X	X*	GAD2/7 (Lowe et al. 2008)
Depression	X	X*	PHQ2/9 (Kroenke et al., 2010)
Substance Use	X	X*	AUDIT, DAST-10, CAGEAID (Brown et al., 1995; Maisto et al., 2000) with Revised 30-Day FollowUp Versions
Health Literacy	X	X	3 items (Wallston et al., 2014)
Health Knowledge & Understanding	X	X	4 items from Primary Care Outcome Questionnaire (PCOQ - Murphy et al., 2018)
Support	X	X	2 items from PCOQ (Murphy et al., 2018)
Health Confidence	X	X	3 items from PCOQ (Murphy et al., 2018)
Adherence	X	X	2 items from PCOQ (Murphy et al., 2018)
Quality of Life	X	X	3 items from RAND (Moriarty et al., 2003)
Life Evaluation/ Wellbeing	X	X	2 items - Cantril Life Evaluation Index (Deiner et al., 1999; Evers et al., 2014)
Patient Experience		X	6 items
Discharge Status		X	Single item
SDOH Care?		X	Single item
Pt SDOH Progress		X	Single item (if Patient got SDOH Care)
BH Treatment?		X	Single item
Pt BH Progress		X	Single item (if Patient got BH Treatment)

* only assessed at follow-up if positive at intake

Collection of these measures (see Appendices) allowed us to describe CHT patients, their duration of CHT care, their challenges at intake, and changes over time on important metrics that reflect their social, behavioral, and health challenges, as well as their experience in CHT care, and degree of progress over time. These data could provide some empirical support for the effectiveness of CHT care and provide a basis for future randomized effectiveness trials and ROI evaluations, when combined with cost/resource information. We expected some missing data for patients who left CHT care suddenly, were unable to participate in the evaluation (dementia, urgent needs, etc.) or refused to participate in evaluation. For those patients, we still had their duration of care, primary CHW's description of the care and/or treatment they received and how much progress was made.

CHT Qualitative Case Studies. At monthly Best Practice meetings run by CTC-RI, CHT staff met and shared a case study that was de-identified to discuss ideas for how to work with clients facing a wide array of diverse medical, legal, social, and behavioral health issues. As these meetings progressed, presenters increasingly included data points that had been collected at intake and discharge in these case studies, to underscore the value of these data to document and demonstrate some of the changes over time that may have been evident to the CHT clients and staff. Many of the shared case studies are included in the Appendix. They show a richness with storylines, details and context that complements the data included in this report.

CHT Evaluation Pilot Study. Prior to the start of the full evaluation in October 2018 a pilot study was conducted in June 2018 with three participating CHT sites with approximately 5 selected English-speaking CHT clients per site. Most clients were able to complete the survey within 10-20 minutes. However, some client and staff concerns about evaluation item wording, survey length, and time taken from CHT care emerged during this pilot study. These concerns were discussed and we decided to proceed with the evaluation plan.

CHT Data Quality Control & Sharing. CHT Site meetings preceded the launch of the CHT evaluation effort to review and resolve measure, staffing and workflow issues. Finalized measures (in English, Spanish, and Portuguese), CHT Evaluation Instructions and Frequently Asked Questions were developed and kept on a shared drive (Basecamp) where sites could find them (see Appendices). Using an online data entry website, Qualtrics surveys were developed that CHT sites could use to enter either Intake or Follow-up data directly (partial data could be submitted using this site). Sites agreed to send monthly data within 2 weeks of the end of each month to URI. URI compiled all the data from all sources (submitted via spreadsheet, paper, or Qualtrics) for each site and sent them back a spreadsheet in June 2019 with all submitted data included, for review and quality control purposes. Data were checked with sites and corrected as needed to ensure the most accurate data possible. Overall data were shared with both SIM and CTC. Site level data were shared with each partner site. By mistake, two Health Literacy items in both the Spanish and Portuguese translated paper surveys used a set of response options that were reversed compared to the English version of those items, both on paper and in Qualtrics (see Appendices). To avoid data errors resulting from this mistake, Evaluation ID's of individuals who used either Non-English version of this survey were requested from each site (n=7) and each set of data were manually adjusted to fix this error. Correction of this error is recommended prior to using these forms in the future.

CHT Data Analysis. As monthly data accrued for each site, URI built an integrated dataset across sites that enabled us to examine intake descriptive (demographic) and clinical (behavioral health, social determinants of health, health risk) characteristics of CHT participants and finally, after data collection was completed, to examine duration of CHT care and change over time across the full range of dependent measures in participants with complete data (depression, anxiety, substance abuse, health risk, health literacy, health knowledge and understanding, support, health confidence, adherence, quality of life, and wellbeing). We also examined patients' experience of CHT care for those who completed the follow-up patient satisfaction survey.

CHT Intake Data Collection. This program evaluation effort was submitted to the URI IRB to review for appropriate management of human subjects concerns and was approved. Intake data were collected by seven CHTs at four partner sites starting October 1, 2018 and were submitted to URI starting in November 2018. Each month, the previous month's Intake data were submitted until mid-May, when the last batch of Intake data covering through March 31, 2019 were submitted.

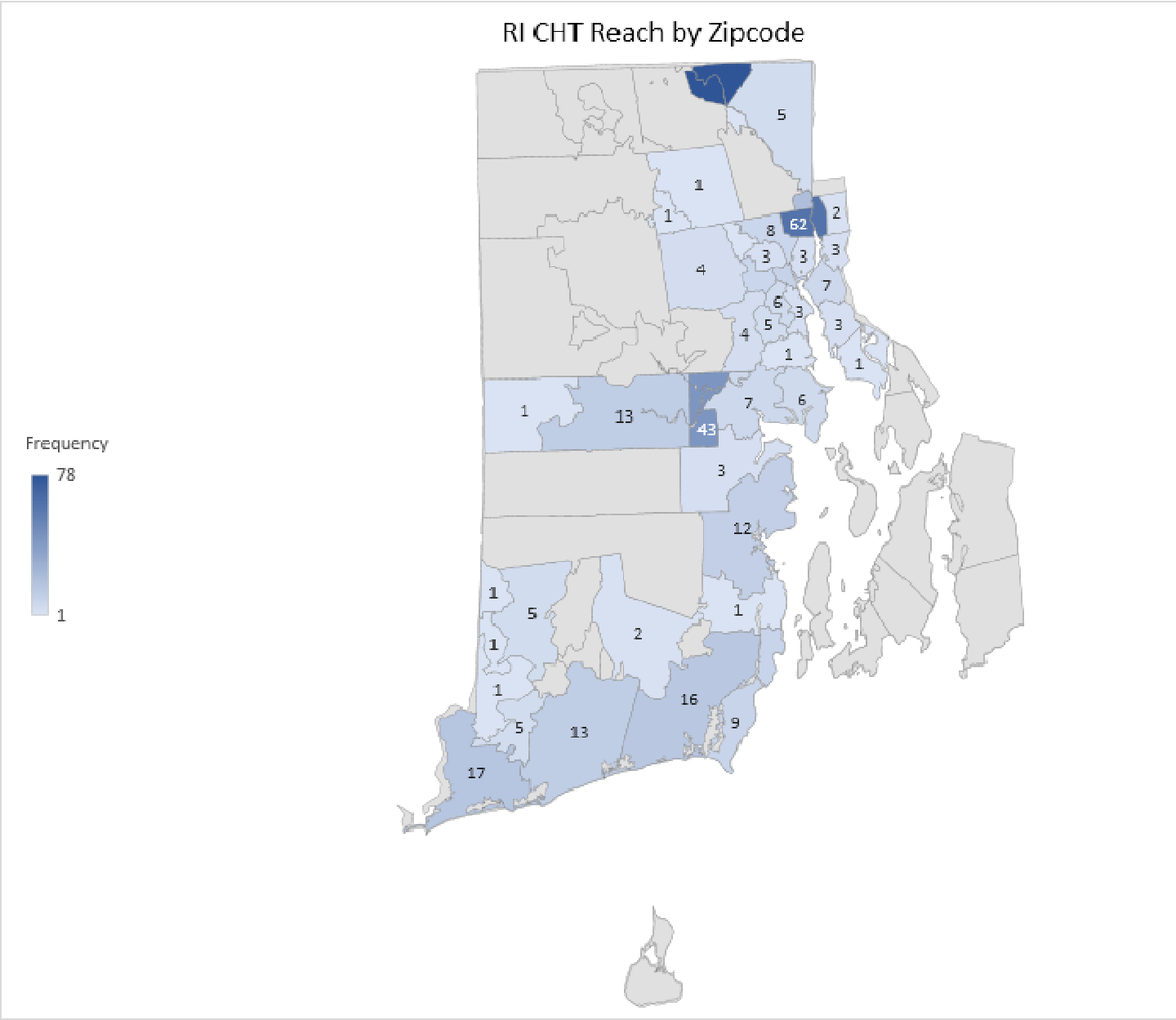
Partial CHT Intake Data Publication. In March 2019 we published some de-identified CHT Intake data (collected over four months, October 1, 2018 – January 31, 2019) in the *Rhode Island Medical Journal*. This plan was also reviewed and approved for human subjects concerns by the URI IRB. We analyzed, wrote and submitted this descriptive publication by Rajotte, Redding, Hunter, & Bassett in April, 2019: http://www.rimed.org/rimedicaljournal/2019/04/2019-04-42-health-rajotte.pdf . Some parts of this paper are included in this report.

Complete Six Month CHT Intake Data. As of June 30, 2019, CHT Site 1 relied on 15 staff members across 4 sites to collect N=169 clients' data, Site 2 relied on 9 staff members at 1 site to collect N=87 clients' data, Site 3 relied on 6 staff members at 1 site to collect N=57 clients' data, and Site 4 relied on 6 staff members at 1 site to collect N=84 clients' data. A total sample size of N=397 was collected over six months of Intake data collection effort. Sites indicated a variety of reasons why some clients could not complete the full evaluation survey, including dementia, end-stage disease, language barriers, client crises, and client refusal. Full evaluation data was available on a subsample N=336. Across sites, Site 1 collected N=168; Site 2 collected N=64; Site 3 collected N=55; and Site 4 collected N=49 with full evaluation data.

The intake data included many RI zip codes (N=397). **Figure 2** shows a Rhode Island map of CHT reach over the past 6 months based on number of unique cases from each zip code. **Figure 2** shows the reach of CHTs over 6 months, with the intake sample size printed within each zip code area.

Figure 2 (below) shows the broad coverage of the state of Rhode Island by the SIM CHT teams together over six months. The three most frequently reported zip codes included: 02895 (Woonsocket) with n=78, 02860 (Pawtucket) with n=62, and 02893 (West Warwick) with n=43. The greatest population density areas and urban centers in and around Providence, Warwick, and Pawtucket were covered. Although the state CHT coverage was good, there were some blank areas evident as well. This map reveals future opportunity for expanded state coverage in the Westernmost and Northwestern sections of the state. It is worth noting that one CHT team that operated in Aquidneck Island, Newport, and Portsmouth areas did not participate in the evaluation data collection, so that entire area was blank, reflecting this lack of data. No CHT was available from Western or Northwestern Rhode Island.

Figure 2. CHT Intakes over 6 Months Across Rhode Island



The CHT Intake Data Demographic characteristics (see **Table 5**) (N=397) are presented below. These data show that CHT patients showed more age, gender, ethnic, racial, and language diversity compared to the demographics of the state of Rhode Island http://www.dlt.ri.gov/lmi/census.htm. This sample included about 10% more females compared to the RI Census (gender split 50/50) and was somewhat older with a mean age of 54 compared to the average RI age (Mean = 39 years), with a higher percentage of ethnic, racial and language diversity, compared to the state-level descriptions of RI adults. The two ethnic categories below: "Two or More – 11/19" and "Refused – 60/68" included many individuals who also self-identified as Hispanic/Latinx.

Table 5. Demographic Characteristics of CHT Patients

Characteristic	Subgroup	n	Valid %	Mean	sd
Age		397		54.1	16.7
Gender					
	Male	148	37.4		
	Female	241	60.9		
	Transgender Female	1	0.3		
	Other	2	0.5		
	Refused	4	1.0		
Hispanic/Latinx					
	Yes	102	25.8		
	No	293	74.2		
	Missing	2			
Racial/Ethnic Group					
	American Indian/Alaskan Native	3	0.8		
	Asian	4	1.0		
	Native Hawaiian/Pacific Islander	9	2.3		
	Black/African American	37	9.3		
	White	256	64.5		
	Two or more groups	19	4.8		
	Refused	68	17.1		
Primary Language was English					
	Yes	314	79.1		
	No	83	20.9		

The CHTs routinely collected screening data as part of CHT care, including Social Determinants of Health (Referral Triage Tool, Health Leads, or PRAPARE), Health Risk assessments (Referral Triage Tool or Impactibility Algorithm), Behavioral Health Screenings for depression (PHQ2/9 – Kroenke et al., 2010; Poots et al., 2014), anxiety (GAD 2/7 – Lowe et al., 2008; Poots et al., 2014), and Substance Use (DAST + AUDIT, or CAGEAID – Brown et al., 1995; Maisto et al., 2000). Such screening and data collection provided important information to inform treatment planning and care and was already integrated into CHT clinical practice (Rajotte et al., 2019). This fact made including these screening tools in the evaluation both feasible and important. **Table 6** shows the Social Determinants of Health (SDOH) Intake Screening Results. Since sites used different tools to screen for SDOH issues, each tool was mapped to common SDOH

domains that were assessed across tools. Sites reported whether each client responded to their set of SDOH assessment items as positive or negative for each domain. Across all assessed (n=342), 83% of CHT clients reported one or more SDOH issue.

Table 6. CHT Social Determinant of Health Screening Results

Social Determinant		n	Valid %	Mean	sd	Median	Mode
Number of SDOH+		342		1.8	1.3	2.0	1.0
	0	58	17.0				
	1	96	28.1				
	2	90	26.3				
	3	57	16.7				
	4	32	9.4				
	5	6	1.7				
	6	3	0.8				
Housing							
	Yes	**151**	**45.3**				
	No	182	54.7				
	Missing	64					
Transportation							
	Yes	**128**	**39.9**				
	No	193	60.1				
	Missing	76					
Food							
	Yes	**126**	**39.0**				
	No	197	61.0				
	Missing	74					
Finance/Utilities							
	Yes	**128**	**41.2**				
	No	183	58.8				
	Missing	86					
Interpersonal Violence							
	Yes	**47**	**16.3**				
	No	241	83.7				
	Missing	109					
Caregiver Support							
	Yes	**43**	**18.7**				
	No	187	81.3				
	Missing	167					

sd - standard deviation

Table 7 shows the CHT Intake Screening Tool Summary Statistics, including the sample size and proportion screened, the Mean, and standard deviation (sd) for each scale.

Table 7. Screening Statistics for CHT Intake Sample (N=397)

Screening Goal	Tool	n	%	Mean	sd
Health Risk	RTT	197	53.7	16.8	5.8
Health Risk	IA	170	46.3	3.9	2.1
Depression		329	82.9		
	PHQ2	253		1.7	2.1
	PHQ9	221		13.2	6.4
Anxiety		234	58.9		
	GAD2	114		2.5	2.2
	GAD7	184		11.0	6.1
Substance Use		314	79.1		
	DAST	163		0.6	1.7
	AUDIT	149		2.8	7.3
	CAGEAID	143		0.0	0.2

sd - standard deviation

Table 7 shows that slightly more than half the CHT sample was screened for health risk using the Referral Triage Tool (RTT) and slightly less than half the sample was screened for health risk using the Impactibility Algorithm (IA). Taken together, about 92% (n=367) of the sample was screened for health risk using either scale at intake. These tools included many comparable items, however, are scored differently. (See Appendix for item-level comparison of Health Risk Assessment tools). **Table 7** also shows that 83% of the sample were screened for Depression using the PHQ2 and/or the PHQ9, 59% of the sample were screened for Anxiety using the GAD2 and/or the GAD7, and 79% of the sample were screened for Substance Use using either the DAST and AUDIT or the CAGEAID. Sites differed on which tools they used for these purposes.

Table 8 (below) shows the proportions of the CHT Intake sample meeting various clinical scoring guidelines across these screening tools.

Table 8. CHT Screening Tool Scoring Guideline Results (N=397)

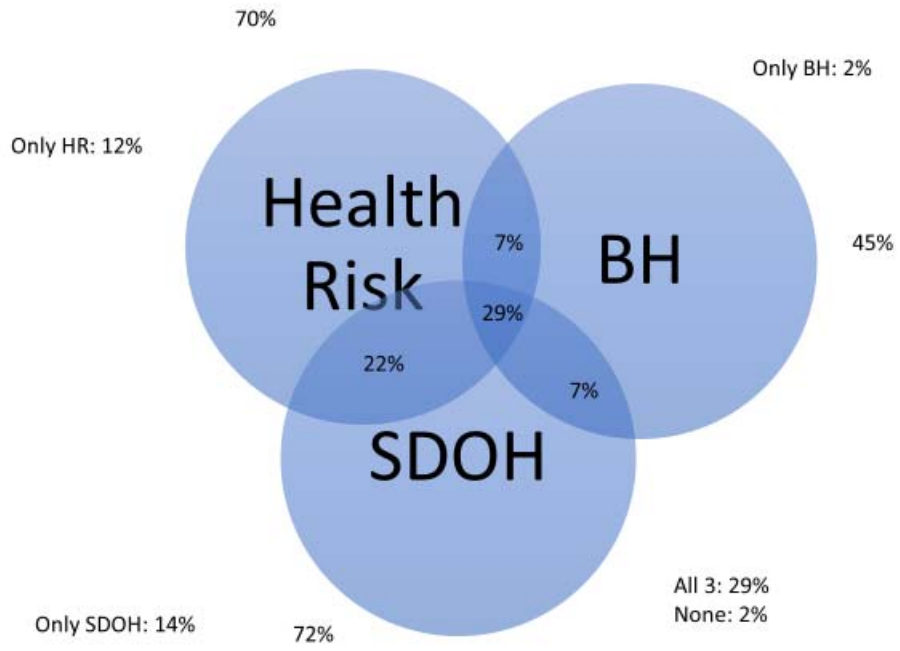
Screening Tool	Criterion Score	# positive	# screened	% positive
Health Risk - RTT	High Risk > 15	130	198	65.7
	Moderate Risk 8-14	61	198	30.8
Health Risk - IA	High Risk >4	87	169	51.5
Depression - PHQ9	At Risk >10	157	226	69.5
Anxiety - GAD7	At Risk >10	109	191	57.1
Substance Use - DAST10				
	Low <=2	158	172	91.9
	Moderate 3-5	5	172	2.9
	High >= 6	9	172	5.2
Substance Use - AUDIT				
	Low <=15	142	158	89.9
	Moderate 16-19	3	158	1.9
	High >= 20	13	158	8.2
Substance Use - CAGEAID				
	Low < 2	143	143	100.0
	High >= 2	0	143	0.0

Table 8 shows that 66% of those screened with the Referral Triage Tool (RTT) scored at high health risk and an additional 30% scored at moderate health risk. Of those screened for health risk using the Impactibility Algorithm, 52% screened at high risk. Taken together, 70% of the sample screened at moderate or high health risk based on either tool at intake. Among those screened for depression, 70% screened as at risk for likely depression with a score greater than ten (Poots et al., 2014). Among those screened for anxiety, 57% screened as at risk for anxiety with a score greater than ten (Poots et al., 2014). Among those screened for substance use with the DAST10 and/or AUDIT, between 9-11% met criteria for Moderate or High levels of Substance Use Risk (Maisto et al., 2000). Among those screened for Substances using the CAGEAID, 100% screened at Low Risk. These results differ slightly from results reported by SBIRT screening results (see Table 2) that found approximately 20% of the screening sample met the same Moderate or High Risk DAST and AUDIT criteria for substance use. This could reflect sample differences. The CHT sample was screened for eligibility, having more medical problems, behavioral health and social determinant of health issues

compared to the SBIRT sample. This could also reflect differences in the relationship between SBIRT screeners and clients compared to the relationship between CHT workers and clients. CHT members establish more long-lasting relationships with their clients than SBIRT screeners, and in addition to evaluating substance use, CHT staff evaluate and develop care plans with CHT clients addressing any other medical, behavioral, and social issues. CHT staff said they thought clients may have misreported their substance use at times in response to questions in order to appear more socially acceptable as well.

Figure 3 below shows crosstabulations of Health Risk, SDOH, and BH screening tools that show how many risks clients were positive for, using moderate-level criteria. Across the whole sample (N=397) with missing data assumed to be negative, 70% were at any Health Risk, 72% showed any SDOH issues, and 45% had any BH issue. By number of risks, 29% of CHT clients were at risk for all 3 categories. Pairwise, 22% of CHT clients had both Health Risk and SDOH issues, 7% had both Health Risk and BH issues, and 7% had both SDOH and BH issues. Smaller percentages of clients showed single risks: 14% had only SDOH issues, 12% had only Health Risk, and just 2% had only BH issues. Just 2% of the sample showed none of these three risks, with all but one of these individuals having missing screening data.

Figure 3. Venn Diagram of CHT Client Intake Numbers of Risks



The final set of 19 CHT Intake Evaluation items included additional constructs to assess Health Literacy, Health Knowledge & Understanding, Support, Health Confidence, Adherence, Quality of Life, and Life Evaluation, Current and Future. Since not all CHT patients were able to complete these measures for a variety of reasons including dementia, being end-stage, language barriers or being in crisis, sample sizes were

reduced, ranging from N=304-339. **Table 9** shows the CHT Intake Results for these evaluation scales.

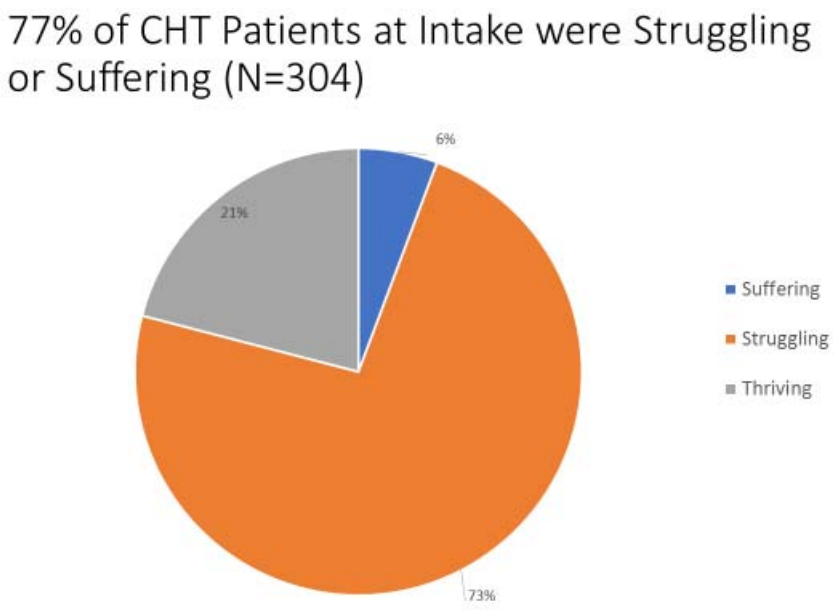
Table 9. CHT Evaluation Scale Results (N=305-339)

Evaluation Goal	Subscale	n	# items	Range	Alpha	Mean	sd
Health Literacy	HL	337	3	3-15	0.77	10.0	3.5
Health Knowledge & Understanding	HKU	337	4	4-20	0.89	15.3	4.5
Support	Supp	331	2	2-10	0.77	6.4	2.7
Health Confidence	HC	332	3	3-15	0.85	9.5	3.1
Adherence	Adh	332	2	2-10	0.70	7.9	1.8
Quality of Life Unhealthy Days	physical	321	1	0-30		17.3	11.3
	mental	321	1	0-30		18.2	11.4
	either	321	1	0-30		16.8	11.4
Life Evaluation	current	325	1	0-10		4.8	2.4
	future	305	1	0-10		8.1	2.5

Alpha is Cronbach's coefficient alpha, a measure of scale internal consistency ranging between 0-1, with higher values reflecting better internal consistency; sd – standard deviation.

For Health Literacy, Health Knowledge & Understanding, Support, and Quality of Life days, higher scores (and means) reflect more problems in this area (see Appendices for items). In contrast, for the Adherence, Health Confidence, and Life evaluation items, higher scores (and means) reflect better life evaluation, both current and future. The two life evaluation items were used to place clients into three wellbeing groups (Evers et al., 2014). These groups are shown below in Figure 3.

Figure 3. CHT Sample Wellbeing Groups Results (N=304)



CHT Follow-Up/Discharge Data. Deidentified Follow-up/Discharge data were collected by 7 CHTs across 4 sites starting in January, 2019 and submitted to URI starting in February 2019 either via the Qualtrics website or by secured email for data entry. Each month, the previous month's Intake and Follow-up data were submitted until July, when the last batches of data covering through June 30, 2019 were submitted. Evaluation IDs were matched as much as possible. Mismatches were shared with each site to correct any data entry or typographical errors. **Table 10** shows the number of staff per site and the amount of Intake and Follow-Up data submitted by site by June 30, 2019, for an overall Follow-Up completion rate of 98%, with minimal site variability (95%-100%).

Table 10. CHT Sample Sizes at Intake & Follow-Up

	# CHT Staff	Intake n	FollowUp n	%
Site 1	15	169	167	98.8%
Site 2	9	87	84	96.6%
Site 3	6	57	57	100.0%
Site 4	6	84	80	95.2%
Total	36	397	388	97.7%

Days in CHT Care was calculated by subtracting the Intake Date from the Follow-Up Date. Days in CHT Care (n=319) ranged from 8-262 days, with a Mean = 139.9 days (sd=54.1). This reflects an average of 4.7 months in CHT care during this evaluation period through June 30, 2019.

Table 11 (below) shows the Follow-Up or Discharge Status for the Follow-Up Evaluations (n=365) that were submitted by June 30, 2019. This shows that about 42% of CHT care was ongoing at the time of the follow-up evaluation. About 16% of CHT care was completed during the evaluation timeframe. About 30% of CHT care initiated since October 1, 2018 was lost to follow-up or had discontinued care. This table also shows that CHWs reported that about 90% of CHT care included addressing Social Determinants of Health issues, while about 49% of CHT care included addressing behavioral health issues. SDOH showed very low rates of care refusal (2%), compared to BH care (11%), which likely reflects the ongoing stigma of accepting the need for BH care. CHWs reported that when CHT clients accepted and received care for SDOH, they rated some or good progress 80% of the time. CHWs reported that when CHT clients accepted and received some BH care, they rated some or good progress 73% of the time.

Table 11. CHT Follow-Up or Discharge Status (N=365)

FollowUp/Discharge Status		n	%
Evaluation Only		153	41.9%
DC/Completed Care		60	16.4%
DC/Lost to FollowUp		64	17.5%
DC/No Longer Interested CHT Care		49	13.4%
DC/Referred Lower Level Care		6	1.6%
DC/Referred Same Level Care		3	0.8%
DC/Referred Higher Level Care		13	3.6%
DC/Moved Out of Area		7	1.9%
DC/ Incarcerated		0	0.0%
DC/ Died		3	0.8%
Other Discharge		7	1.9%
Received SDOH Care?			
	No	31	8.6%
	Refused	8	2.2%
	Yes	321	89.2%
If Yes, SDOH Progress?			
	None	67	20.4%
	Some	141	43.0%
	Good	120	36.6%
Received BH Treatment?			
	No	123	39.7%
	Refused	34	11.0%
	Yes	153	49.4%

If Yes, BH Progress?			
	None	44	26.7%
	Some	73	44.2%
	Good	48	29.1%

Table 12 (below) shows the Follow-Up Changes in SDOH (n=108-162) that were assessed and reported by June 30, 2019. The total number of summed SDOH (n=160) showed a statistically significant decrease of 0.7 from intake to follow-up (t (159) = -7.45, $p < .001$). All SDOH categories separately showed significant changes between intake and follow-up assessment, especially among those who reported the issue at intake and no longer reported the issue at follow-up. For example, we will look more closely at housing. Of the n=67 clients (29 + 38) who reported a housing issue at intake, 57% (n=38) of those no longer had a housing issue at follow-up. And conversely, of the n=95 clients who did not have a housing issue at intake, only 6% (n=6) of those later reported a new housing issue at follow-up.

Table 12. CHT Follow-Up Changes in SDOH (n=108 - 162)

Social Determinant	Intake Mean	Intake sd	FollowUp Mean	FollowUp sd	test statistic
Number of SDOH+	1.7	1.3	1.0	1.1	t (159) = -7.45*
			FollowUp Yes	**FollowUp No**	
Housing					$X^2(1) = 31.7$*
		Intake Yes	29	38	
		Intake No	6	89	
Transportation					$X^2(1) = 42.2$*
		Intake Yes	27	22	
		Intake No	9	100	
Food Insecurity					$X^2(1) = 17.1$*
		Intake Yes	19	33	
		Intake No	10	96	
Finance/Utility					$X^2(1) = 17.0$*
		Intake Yes	20	40	
		Intake No	7	87	
Interpersonal Violence					$X^2(1) = 10.9$*
		Intake Yes	8	20	
		Intake No	8	109	
Caregiver Support					$X^2(1) = 24.7$*

	Intake Yes	12	12
	Intake No	6	78

$^{*}p < .001$

Table 13 (below) shows a clearer summary of these same data. This shows that the same pattern of changes from intake to follow-up is evident across social determinant categories, with substantially greater percentages of CHT clients who had the issue at intake later reporting that that issue was no longer present (range: 45% - 71%). In contrast, small percentages (6%-8.5%) of CHT clients who did not report an issue at intake reported a new SDOH issue at follow-up (see Table 12). **Table 13** (below) shows for each SDOH Category, the proportion of the sample with follow up data (n=108-162) that reported the issue at intake and the proportion of that group that no longer reported that issue at follow up, most likely reflecting CHT care. Each of these shifts was statistically significant, as shown in Table 12. These data show that CHT care demonstrated important statistically and clinically meaningful impacts on reducing SDOH issues in this sample.

Table 13. CHT Simplified Follow-Up Changes in SDOH (n=108 - 162)

All SDOH Categories Showed Significant Changes From Intake to Follow Up (n=108-162)

	% reporting issue at intake	% no longer reporting issue at follow-up
Housing	**41.4%**	56.7%
Finance/ Utilities	**39.0%**	66.7%
Food Insecurity	**32.9%**	63.5%
Transportation	**31.0%**	44.9%
Caregiver Support	**22.2%**	50.0%
Interpersonal Violence	**19.3%**	71.4%

Table 14 (below) shows the matched Follow-Up Screening Data (n=54-169) that were submitted by June 30, 2019. The RTT, IA, PHQ, GAD and CAGEAID screening tools all used the same items at both Intake and Follow-Up and were evaluated using paired sample t-tests. The DAST and AUDIT, however, were asked in the past year at Intake and then, adapted to reflect the past 30-days at follow-up only, thus the two data points at Intake and Follow-Up were not comparable since they assessed different timeframes. For this reason, the Table shows both DAST and AUDIT scales means and sd's, however, no t-test is reported.

Table 14. CHT Follow-Up Changes in Health Risk and Behavioral Health Screening Tools

Screening Goal	Tool	n	Intake Mean	Intake sd	FollowUp Mean	FollowUp sd	t-test
Health Risk	RTT	106	17.7	5.2	11.8	5.2	-10.4*
Health Risk	IA	169	3.9	2.1	4.0	2.3	1.4
Depression	PHQ9	106	13.7	5.8	9.1	6.8	-6.9*
Anxiety	GAD7	71	12.4	5.7	8.3	6.1	-6.4*
Substance Use							
	DAST	59	0.7	1.9	0.2	0.8	
	AUDIT	54	4.1	9.1	0.3	1.9	
	CAGEAID	78	0.03	0.2	0.01	0.1	-1.0

* $p < .001$; Since DAST and AUDIT surveys had noncomparable timeframes from Intake to FollowUp, no t-test is reported.

The RTT data show 33% reductions in health risk from intake to follow-up that were statistically significant, $t(105) = -10.4$, $p < .0001$. **Figure 4** below shows this change. Health risk, assessed using the IA, did not change. CHT staff who used the IA said that IA may not have been reassessed at follow-up since it was simply pulled from the electronic record, thus this finding may reflect that this measure did not actually assess health risk change over time. Depression levels assessed by the PHQ9 and Anxiety levels assessed by the GAD7 did both show statistically and clinically significant 32-33% reductions from Intake to Follow-Up that are shown in **Figure 5** below.

Figure 4. CHT Changes in RTT Health Risk from Intake to Follow-Up

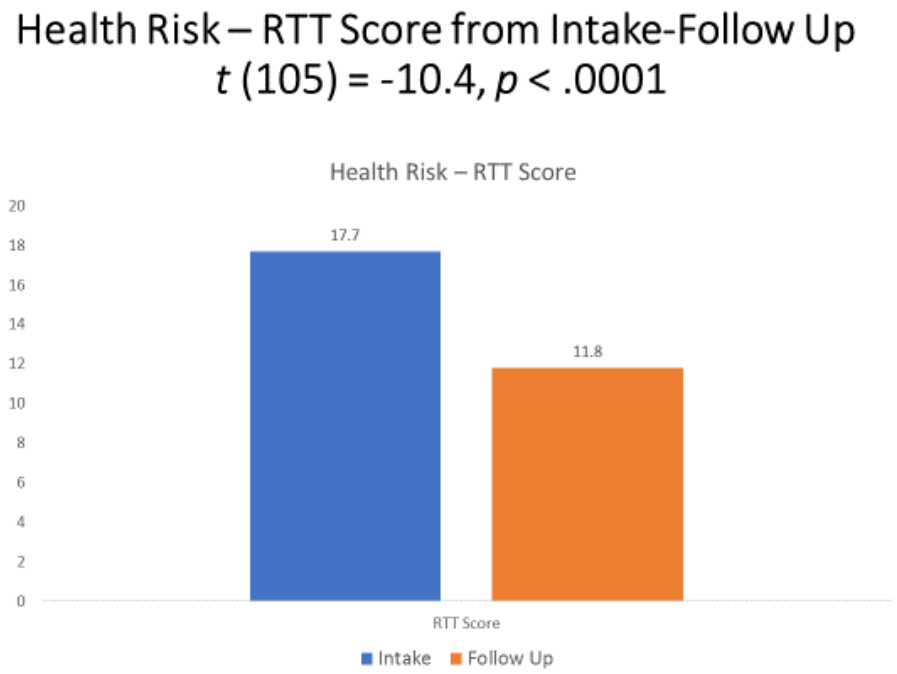


Figure 5. CHT Changes in Depression and Anxiety from Intake to Follow-Up

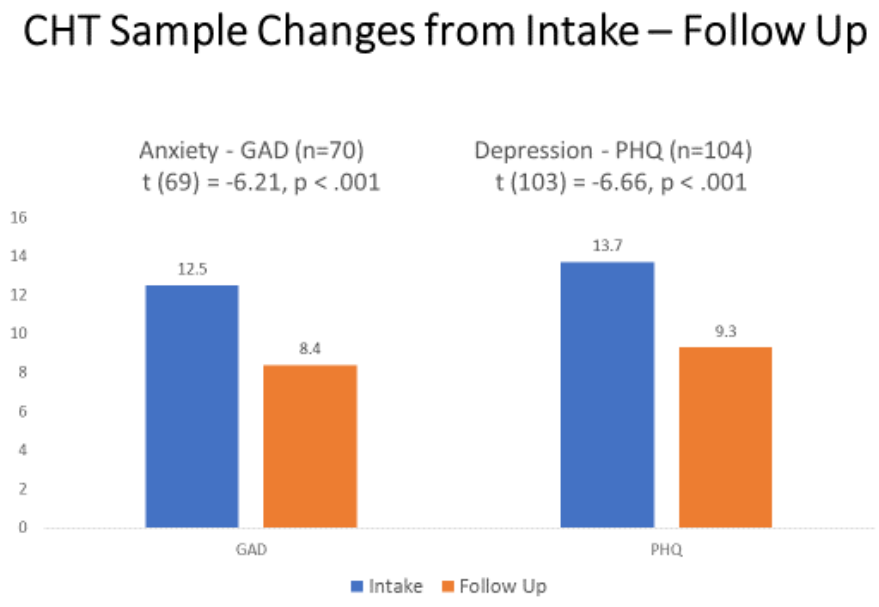


Table 15 (below) shows the Follow-Up Evaluation Data scales (n=135-145) that were submitted by June 30, 2019. All scales used the same items at both Intake and Follow-Up and were compared over time using paired sample t-tests. Health Literacy showed no significant changes from Intake to FollowUp. Health Knowledge and Information, Health Confidence, Support, Adherence, all three Quality of Life Unhealthy Days items, and Current and Future Life Evaluation showed statistically significant improvements from Intake to Follow-Up in these data.

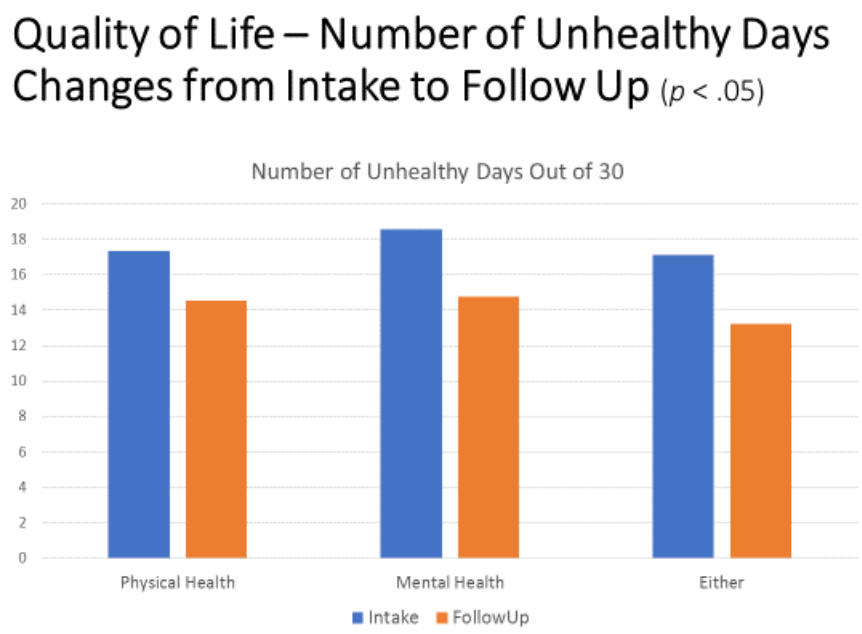
Table 15. CHT Changes in Evaluation Scales from Intake to Follow-Up

Evaluation Goal	n	Intake Mean	Intake sd	FollowUp Mean	FollowUp sd	t-test
Health Literacy	145	9.8	3.5	9.8	3.6	0.17
Health Knowledge + Info.	142	14.9	5.0	8.2	4.5	-10.91***
Health Confidence	141	9.4	3.2	10.2	3.3	2.30*
Support	142	6.4	2.7	4.6	2.7	-5.06***
Adherence	140	8.0	1.8	8.3	1.8	2.20*
Quality Life Days – Physical Health	142	17.2	11.0	14.5	11.5	-2.52*
Quality Life Days - Mental Health	142	18.4	11.4	14.7	10.7	-3.55***
Quality Life Days - Either PH/MH	140	17.0	11.6	13.1	11.7	-3.29***
Life Evaluation Current	145	4.6	2.4	5.4	2.4	3.59***
Life Evaluation Future	135	7.5	2.8	8.3	2.5	2.69**

* $p < .05$, ** $p < .01$, *** $p < .001$

For Health Knowledge & Understanding, Support, and Quality of Life days, the reductions in means over time reflect fewer problems in this area at follow up (see Appendices for items). In contrast, for the Adherence, Health Confidence, and Life evaluation items, higher means at follow up reflect better adherence, health confidence, and current and future life evaluation. **Figure 6** (below) shows the changes in Quality of Life numbers of unhealthy days out of 30 that were found.

Figure 6. CHT Changes in Numbers of Unhealthy Days – Quality of Life from Intake to Follow-Up



Finally, the Patient Experience Surveys submitted as of June 30, 2019 are reported in **Table 16** (below). In general, patients reported very good agreement with the items, with means nearly 5's which reflect strong agreement with each item. A coefficient alpha was run on the 6-item scale with n=126 who answered all 6 items which was 0.89. Alpha is Cronbach's coefficient alpha, a measure of scale internal consistency ranging between 0-1, with higher values reflecting better internal consistency. However, a good amount of redundancy was also evident in these items, and examination of the sample sizes revealed that some items had lower response rates due to too much specificity. For example Item #2 references the Emergency Room, so many patients responded to this item as Not Applicable. Cutting this item did not reduce the scale alpha at all. Thus, this scale could be reduced by half to a 3-item scale* that could capture the same construct with lower response burden, including items 1, 3, and 5, and that 3-item scale (n=141) has an alpha of 0.87.

Table 16. CHT Patient Experience at Follow-Up

CHT Patient Experience Item	n	Mean	sd
1. CHT staff help me understand how to follow through with specialty care.*	147	4.56	0.63
2. CHT staff help me understand when I should or should not go to the Emergency Room.	134	4.55	0.64
3. CHT staff connect me to community resources that help me with my health and wellness.*	156	4.52	0.70
4. CHT staff help me overcome challenges.	157	4.44	0.78
5. CHT staff provide me with emotional support.*	153	4.49	0.76
6. I feel comfortable talking openly and honestly with CHT staff.	158	4.61	0.66

* Item selected for 3-item scale

SUMMARY AND RECOMMENDATIONS

Community Health Teams (CHTs) have worked in different Rhode Island medical and community settings, using differently integrated team models, to improve qualifying primary care patients' medical, social, behavioral and substance-related care. CHT clients were selected to include patients with high medical, social, behavioral, and substance-related needs. This mixed-methods CHT evaluation included a variety of sources of data to determine CHT client levels of risk, need, progress, and care. These combined results demonstrated substantial CHT effort, patient contact, a variety of clinically useful and evaluation screenings, care coordination and care delivered by CHT staff over between nine and twenty-one months. Sources of data were varied including: qualitative case studies; data on patient volume and sessions over time; site-specific data reflecting quality metrics; SBIRT coordinated evaluation data reflecting substance use screenings and re-screenings from CHT sites; and pre-post data over nine months of CHT care with new CHT intakes across 7 CHTs and 4 partner sites. Taken together, these data demonstrate at least six important points about CHT care.

1) CHT clients were indeed at high risk for a variety of health, social, and behavioral problems. Demographic characteristics attested to this CHT Intake sample's higher age, and higher rates of ethnic, racial, and language diversity compared to the general population demographics from the state of Rhode Island. A map of zip codes of CHT intakes (Figure 2) demonstrated that most CHTs were located in some of the most populated, urban, and lowest resource areas of the state.
2) SBIRT screenings and 10% random six-month re-screenings at CHT sites demonstrated that the SBIRT model works well in CHT settings and that people who received brief substance use interventions reduced their past 30-day substance use by 30-40%, a finding that was both statistically significant and clinically meaningful.
3) Data from one large site with multiple CHTs demonstrated that in spite of high levels of health, behavioral, and social needs, clients who participated in CHT care met or exceeded most UDS targets for quality medical care.

4) Substantial numbers of health, social, and behavioral screenings were conducted by CHT staff in this Intake sample (N=397) over six months.
    a. Most (92%) CHT clients were screened at intake for health risk using either of two tools, and of those, 70% met at least moderate risk and 59% met high risk criteria. Clients screened with the RTT met at least moderate health risk criteria 96% of the time and high health risk criteria 64% of the time, compared to the IA, where clients met high risk criteria 51% of the time.
    b. At intake, 84% of CHT clients were screened for social determinants of health using various screening tools and 83% of those screened reported at least one social determinant issue, with a median of two social determinants. Social determinants were mapped from three different screening tools into common domains for this analysis. Alignment of screening tools across sites would enhance evaluation efforts. Choice of a SDOH screening tool that could be integrated into electronic health records (Tumber et al., 2019), integrate z-codes, and show levels of reduction in SDOH issues over time would also enhance future clinical, population health, and evaluation efforts.
    c. In addition, 83% were screened for depression, with 47% of those scoring above criterion. For anxiety, 59% were screened and of those, 46% scored above criterion. For substance use, 79% were screened and of those, 9% met moderate substance use risk criteria. The DAST and AUDIT screened about 10% clients positive for possible substance use compared to the CAGEAID which did not screen anyone positive for possible substance use. Such differences are unlikely to reflect site or sample differences and are most likely to reflect screening tool utility and sensitivity differences. Sites may re-consider the utility of these screening tools in this context.
    d. In response to two life evaluation/wellbeing items, 77% of CHT clients were categorized as either suffering or struggling.
5) CHT clients were seen for an average of 4.7 months of CHT care during the evaluation timeframe. Over that time in many CHT clients who completed follow-up screenings through June 30, 2019, several statistically significant and clinically meaningful changes were demonstrated. We found 33% statistically significant reductions in RTT health risk over time; statistically significant reductions in all social determinants of health categories, both taken together and separately, over time; 32-33% reductions in levels of depression and anxiety over time; reductions in levels of substance use over time; statistically significant improvements in support, health knowledge and understanding, adherence, health confidence, and numbers of unhealthy days where the client could not function properly due to physical health and/or mental health problems. These empirical findings support and underscore the qualitative data from case studies that also tell compelling stories of how individuals benefited in these and additional ways from CHT care.

6) CHT clients who completed patient experience surveys were generally in strong agreement with items reflecting excellent levels of patient satisfaction with their CHT care.

Taken together, these findings support the substantial value and benefits of CHT care to improve the health risk, social determinants of health, behavioral health, and wellbeing of high risk patients, assisting primary care providers and payers in Rhode Island to improve health equity and underscoring the importance of increased sustainability planning for the future of CHT care. CHTs have improved the integration of medical, behavioral, social and substance-related healthcare in the state of Rhode Island, showing substantial improvements in health and wellbeing for these high risk, high need patients. Additional efforts to streamline and align clinical screening and evaluation would benefit clinical care, documentation, and evaluation efforts, across health areas and specifically regarding the social determinants of health and behavioral health. Evidence-based practices and care increasingly rely on such alignment of clinical and evaluation goals, and CHT care, like other types of care, can participate in and benefit from this alignment. Additional research to clarify cost savings and return-on-investment is warranted. These results also reveal some opportunities for continued improvements in reach, evaluation, and screening capacity that may improve CHT care even more in the future.

References Cited

Alexander-Scott, N., Novais, A.P., Hall-Walker, C., Ankoma, A.B., Fulton, J.P. (2017). Rhode Island's health equity zones: Addressing local problems with local solutions. *Journal of Health Disparities Research and Practice* 2017;(9)6: 54-68.

Brown, R.L., Rounds, L.A. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: Criterion validity in primary care practice. *Wisconsin Medical Journal* 1995;*94*(3):135-140.

Diener, E., Suh, E.M., Lucas, R.E., Smith, L. (1999). Subjective well-being: three decades of progress. *Psychological Bulletin 1999; 125*: 276-302.

Evers, K.E., Castle, P.A., Prochaska, J.O., Prochaska, J.M. (2014). Examining relationships between multiple health behaviors, well-being and productivity. *Psychological Reports: Mental & Physical Health* 2014; 114(3): 843-853.

Gregory, C.A., Coleman-Jensen, A. (2017). Food insecurity, chronic disease, and health among working-age adults, ERR-235, U.S. Department of Agriculture, Economic Research Service, July 2017.

Health Resource Services Administration. (2018). Uniform data system—reporting instruction for the 2018 health center data. Retrieved online: https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2018-uds-reporting-manual.pdf

HealthRIght. (2015). U.S. and Rhode Island healthcare system—a brief overview. Providence, RI: Retrieved online at http://www.rilin.state.ri.us/commissions/HLit/commdocs/HRIPB_Overview.pdf

Hernandez-Cancio, et al. (2018). A framework for advancing health equity and value: policy options for reducing health inequities by transforming health care delivery and payment systems. *Health Equity Task Force for Delivery and Payment Transformation*. Retrieved online: https://familiesusa.org/sites/default/files/product_documents/FamiliesUSA_Policy-Options_Report.pdf

Humowiecki, M. et al. (2018). Blueprint for complex care. Camden, NJ: Retrieved online: https://www.nationalcomplex.care/wp-content/uploads/2018/12/Blueprint-for-Complex-Care_FINAL_120318.pdf

Kroenke, K., Spitzer, R., Williams, J., Lowe, B. (2010). The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: A systematic review. *General Hospital Psychiatry* 2010; 32: 345–349.

Lowe, B., Decker, O., Muller, S., Brahler, E., Schellberg, D., Herzog, W., Herzberg, P.Y. (2008). Validation and standardization of the Generalized Anxiety Disorder screener (GAD-7) in the general population. *Medical Care* 2008;46: 266 -274.

Maisto, S., Carey, M., Carey, K., Gordon, C., Gleason, J. (2000). Use of the AUDIT and the DAST-10 to identify alcohol and drug use disorders among adults with a severe and persistent mental illness. *Psychological Assessment* 2000; 12:186-192.

Moriarty, D.G, Zack, M.M., Kobau R. (2003). The Centers for Disease Control and Prevention's Healthy Days Measures – Population Tracking of perceived physical and mental health over time. *Health and Quality of Life Outcomes* 2003*; 1:* 37.

Moriarty, M., Hollinghurst, S., Salisbury, C. (2018). Identification, description, and appraisal of generic PROMs for primary care: A systematic review. *BMC Family Practice* 2018; *19*: 41.

Poots, A.J., Green, S.A., Honeybourne, E., Green, J., Woodcock, T., Barnes, R., Bell, D. (2014). Improving mental health outcomes: Achieving equity through quality improvement. *International Journal for Quality in Health Care* 2014; *26*(2): 198–204.

Rajotte, J., Garneau, D., Sutton, N., Clyne, A. (2016). Community health teams: a healthcare provider's system transformation opportunity. *Rhode Island Medical Journal* 2016; October:57-60.

Rajotte, J., Redding, C.A., Hunter, C.E., Bassett, S.S. (2019). Initial Findings: Rhode Island's Community Health Teams Address Complex Physical, Behavioral, and Social Needs of Patient Populations. *Rhode Island Medical Journal* 2019; April:42-47.

Reiss-Brennan, B., Brunischolz, K.D., Dredge, C. Briot, P., Grazier, K., Wilcox, A., Savitz, L, James, B. Association of integrated team-based care with health care quality, utilization, and cost. *Journal of the American Medical Association* 2016; 316(8):826-834.

Saha Stout, S. et al. (2018). Pathways to population health: an invitation to health care change agents. Retrieved online: http://www.pathways2pophealth.org/files/Pathways-to-Population-Health-Framework-April-2018.pdf

State of RI. (2017). Rhode Island state innovation model test grant—operational plan version 3. Providence, RI: Retrieved online: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SIM/SIM_OpsPlan_May2017.pdf

State of RI. (2017). State health improvement plan—component a: health assessment report. Providence, RI: Retrieved online:

http://www.health.ri.gov/publications/reports/2017StateInnovationModelHealthAssessment.pdf

Substance Abuse and Mental Health Services Administration. (2017). CSAT GPRA client outcome measures for discretionary programs. Retrieved online: https://www.samhsa.gov/sites/default/files/GPRA/csat_gpra_client_outcome_measures_tool_2017.pdf

Tumber, M.B., Bunzli, L., Rosenberg, M. (2019). Addressing the Social Determinants of Health: the Rhode Island State Innovation Model (RI SIM) Experience. *Rhode Island Medical Journal* 2019; June:22-25.

Wallston, K.A., Cawthon, C., McNaughton, C.D., Rothman, R.L., Osborn, C.Y., Kripalani, S. Psychometric properties of the Brief Health Literacy Screen in Clinical Practice. *Journal of General Internal Medicine* 2014 Jan; 29(1): 119-126.

Yeracaris, P., Campbell, S., Coleman, M., Cabral, L., Hurwitz, D. (2019). Care Transformation Collaborative of Rhode Island: Building a Strong Foundation for Comprehensive, High-Quality Affordable Care. *Rhode Island Medical Journal* 2019; June:26-29.

Appendices – CHT Evaluation Logic Model (next page)

CHT Evaluation – Logic Model

Key Components

Open Access | Coordination of Care | Team Based Care | Engaged Leadership | Learning Collaborative | Data Driven | Population Focus | Supplemental Payments | Incentive P4P

Affordable Care A
Evolving Compari
APCD

Situation

Community Health Teams are being funded to focus on high risk patients with multiple chronic conditions and co-morbid behavioral health issues (mental health and substance abuse), and unmet social needs.

South County Healthcare System (SCH), Blackstone Valley Community Health Care (BVCHC), Family Service of Rhode Island (FSRI), East Bay Community Action Program (EBCAP), and Thundermist Health Centers (TMIST) have been identified as the entities to facilitate the pilots. SCH and BVCHC were original pilot sites with activity beginning in Q4 2014, while FSRI, EBCAP, and TMIST are new to the pilot program beginning September 2017.

Priorities

Develop, test and evaluate care management strategies that can be focused on patients identified as high risk/high cost/ high impact in a targeted geographic region.

INPUTS	OUTPUTS	Patient
Funding SIM funding* Health Plan funding*	**Funding** CHT Model*# (3)	**Funding** Patients Served (3)(CHT 18) Cost per patient/cost per vi
Staffing Consolidated Operations (CHT/SBIRT) (6)* Staff (CHWs/SBIRT Screeners/BHCMs/Team Leads)(3)*	**Staffing** Centralized CHT/SBIRT Administration*# Fully Staffed Teams *# (3)	**Staffing** Patients Served (3)(CHT 18)
Practices Referrals from Primary Care*#	**Practices** Case Review *#	**Practices** Care Coordination
CHT Activity • Assessment Tools*# Referral Triage Form (1) Social Determinants of Health (SDOH) (2) Behavioral Health Screens (2) Pyscho-social Assessments (2) • Current Care Enrollment Offered # • Tobacco Cessation Treatment Offered # • GPRA *#	**CHT Activity** Comprehensive Health Assessment *# - Completed Assessment Tools # Psycho-social Assessment Results (2) BH Screen Results (Pre/Post) oSDOH, PHQ 2/9, GAD 2/7, AUDIT/DAST, GPRA (2) - Care Plan # oProblem, Goal, Intervention, Date of Review for Progress - Discharge Summary# Process Measures # - CHT Metric 1, 6, 7,8,9, 12, and 18 (4)	**CHT Activity** Change in Referral Triage Tool score/ items from baseline to follow-up *(Potential 1.0)* Change in SDOH score/items from baseline to follow-up Change in BH screen scores from baseline to follow-up
Technology EHRs / Access Database * HIT Assessment # Care Management Dashboard * APCD *	**Technology** HIT Business Requirements*# Patient Related Hospital Data Utilization Data	**Technology**
Training CHW Certification Program *# RIC SBIRT Relationship *# SAMHSA/SPARS Relationship *# Primary Care Relationships*	**Training** CHW Certification (5)*# SBIRT Training*# GPRA Training*# Primary Care Meet and Greets#	**Training** Patients Served (3)
Experience Patient Experience Assessment (TBD)*# Provider Experience Assessment (TBD)*#	**Experience** Patient Experience with CHTs - Data*# Primary Care Experience with CHTs – Data*#	**Experience** Patient satisfaction with CHT services Patient functional status

KEY:

* :Structure

: Process

(Specified #): References supporting section of RFP Excerpt Document

TBD: To Be Developed

Appendices – CHT Measures

Appendix 1. Comparison of Health Utilization Risk Scores from Impactability Algorithm (IA –Site 1) and Referral Triage Tool (RTT - Other CHTs)

IA	**IA Points**	**RTT Points**	**RTT**
3+ED or IP Visits	3	3 each *(max of 15)*	2+ IP admits in past 6 months OR 2+ ED visits in past 6 months
ED or IP Visits for BH	3		
		3 each *(max of 15)*	IP admit in past 30 days OR 30-day Re-admission in past year
		3 each *(max of 6)*	IP admit/ED visits in next 6 months
		3 each *(max of 6)*	Significant decline in functional status/need for LTC in next 6 months
		3 each *(max of 6)*	Palliative Care in next 12 months (Levine Score >=4)
2+No Shows	2	1 each *(max of 2)*	Inadequate follow-up with PCP OR Not following care plan OR Specialty care without coordination
		2	Disability: significant Physical/Mental/Learning/Disability
Homeless	2	each *(max of 6)*	SDOH/ Psychosocial Risk Factors: Language/literacy Safety Homeless Poor supports Food insecurity Undocumented legal status other
Uninsured	2		
HbA1C>9	1	2 each	Poorly controlled High Risk Chronic Disease CAD CHF Diabetes COPD Chronic Pain End Stage disease
Poorly Controlled Asthma	1	2 each	Poorly controlled High Risk Chronic Disease
Active Addiction	1	1 each *(max of 2)*	Substance Abuse Alcohol Opioid

			Benzodiazepine Other
10+ Active Medications	1	2	8+ active medications
Incomplete Referrals > 6 Months	1	1 each *(max of 2)*	Inadequate follow-up with PCP OR Not following care plan OR Specialty care without coordination
BMI > 35	1	2	Poorly controlled High Risk Chronic Disease
Active Smoker	1	1 each *(max of 2)*	Substance Abuse
		1	Chronic Disease/Co-morbidities not well controlled
		1	Functional Impairments – fall risk, impaired ADLs, impaired ambulation, impaired judgement, difficulty getting to appointments, unable to follow medication regimen
Total Possible Points	19	41	Total Possible Points

Appendix 2, SDOH Tools: Referral Triage Tool, HealthLeads, PRAPARE

Community Health Team Referral and Triage Tool

Date of Referral:

Patient First Name: **Last Name:** **DOB:** **Gender:**

Address: **Address2**: **City**: **State**: **Zip**:

Best Phone Number to Reach Patient: **Home/Cell** :Home

Emergency Contact & Support Person (please list name, phone and relationship):

Practice: (select one): **Nurse Care Manager:**

Primary Care Provider: **Next Visit Date**: **Next Visit Time**:

Health Insurance: (select one): **Health Insurance Member ID**:

Secondary Health Insurance: (select one): **Secondary Insurance ID**:

Pharmacy:

Enrolled in Current Care? ☐ **Interpreter Needed?** ☐ **Is patient aware of referral to CHT?** ☐

Reason for Referral and/ or Desired Outcome:

PLEASE INCLUDE MEDICAL SUMMARY

Higher Risk Drivers (3 Points Each)

0	**Utilization** (medical or psych)**:** (15 Points Max) ☐ IP admit in past 30 days **OR** ☐ 30-day Readmission in past year **OR** ☐ 2+ IP admits in past 6 months **OR** ☐ 2+ ED visits in past 6 months ☐ Health Plan High Risk Report – impactable costs actual or predictive > $25,000
0	**High Risk of**: (6 Points Max) ☐ IP admit/ ED visits in next 6 months ☐ Significant decline in functional status/ need for LTC in next 6 months ☐ Do you think it likely that pt will pass away in next 12 months **or** Palliative Care Referral Made?– (Levine Score or Palliative Care Screening Tool ≥ 4)

0

Moderate Risk Drivers

0	**Poorly Controlled High Risk Chronic Disease** (2 Points Total) CAD☐ CHF☐ Diabetes☐ COPD☐ Chronic Pain☐ End stage disease**:** ☐_____
0	**RX Meds: 8+ active prescriptions OR** recent change in high risk meds (2 Points Total) ☐
0	**Disengagement:** significant, chronic condition(s) and (2 Points Total) ☐inadequate follow-up with PCP, or ☐not following care plan, or ☐specialty care without coordination
0	☐**Disability:** significant Physical/ Mental/ Learning disability impacting reasons for referral (2 Points Total)
0	**Psycho-Social risk factors** which prevent adequate mgmt of high risk diseases (2 Points Each/ 6 pts max) ☐language/literacy ☐safety ☐homeless ☐poor supports ☐food insecurity ☐undocumented legal status ☐other

0	**Substance Abuse:** Actively using, newly sober, motivated to change (2 Points Total) ☐Alcohol ☐Opioid ☐Benzodiazepine ☐Other
0	**Mental Health DX** that is severe, persistent, and uncontrolled: (2 Points Total) ☐Schizophrenia ☐Major Depression ☐Bipolar ☐Debilitating Anxiety ☐Other _____
0	

Fundamental Risk Drivers (1 Points Each)

0	**Chronic Disease/ Co-morbidities** – <u>not well controlled</u>/ not noted above (1 Point)☐
0	**Functional Impairments** – Fall risk, impaired ADLs, impaired ambulation, impaired judgment, difficulty getting to appts, unable to follow med regimen (1 Point Each)☐
0	

>15 = High Risk – Offer CHT to patient

8 - 14 = May meet criteria for CHT due to rising risk

<8 = Discuss referral with CHT before offering to patient

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SOCIAL NEEDS SCREENING TOOLKIT

SOCIAL NEEDS SCREENING TOOLKIT

The First Step in Your Social Needs Intervention

Health care leaders and front-line clinicians have long recognized the connection between unmet basic resource needs – e.g. food, housing, and transportation – and the health of their patients. Indeed, research suggests that more than 70% of health outcomes are attributable to the social and environmental factors that patients face outside of the clinic or hospital.[1]

One of the first steps to addressing social needs is asking your patients about this aspect of their lives. Building on Health Leads' 20 years of experience implementing these programs, as well as recent guidelines from the Institute of Medicine and Centers for Medicare & Medicaid Services, this Social Needs Screening Toolkit shares the latest research on how to screen patients for social needs.

Published first in July 2016, this toolkit will be updated annually. Social needs programs and research are constantly evolving, so we welcome your feedback, ideas, and suggestions of questions to add to our library – please email us at screening-toolkit@healthleadsusa.org.

Health Leads would like to thank our many healthcare partners and advisors who contributed to this toolkit, including: Massachusetts General Hospital, Kaiser Permanente, Boston Medical Center, Johns Hopkins, NYC Health + Hospitals Corporation, Contra Costa Regional Medical Center, Cottage Health, Children's National Medical Center, and our many Workshop and Collaborative participants.

SOCIAL NEED DOMAINS

Pages 3 - 4

KEYS TO A GREAT SCREENING TOOL

Pages 5 - 6

RECOMMENDED SCREENING TOOL

Page 7 - 8

SCREENING QUESTIONS LIBRARY

Pages 9 - 22

Sources

- *University of Wisconsin County Health Rankings*
- *New England Healthcare Institute*

Essential Social Need Domains

Representing the most common social needs impacting the health of patients today, these domains are based on findings from IOM, CMS, and Health Leads' two decades of experience implementing social needs programs. We recommend all healthcare systems include these domains in a screening tool for social determinants of health.

SOCIAL NEED DOMAINS	EXAMPLES
Food Insecurity	Limited or uncertain access to adequate & nutritious food
Housing Instability	Homelessness, unsafe housing quality, inability to pay mortgage/rent, frequent housing disruptions, eviction
Utility Needs	Difficulty paying utility bills, shut off notices, discounted phone
Financial Resource Strain[2]	Public cash benefits, charity emergency funds, financial literacy, medication under-use due to cost, benefit denial
Transportation	Difficulty accessing/affording transportation (medical or public)
Exposure To Violence[3]	Intimate partner violence, elder abuse, community violence

- [2] *Questions about financial resource strain often produce a high false positive rate; review these questions carefully.*
- [3] *These categories will likely require a more highly skilled workforce than other types of social needs*

Optional Social Need Domains

Depending on the goals of the initiative, these optional categories may be included on a social determinants of health screening tool.

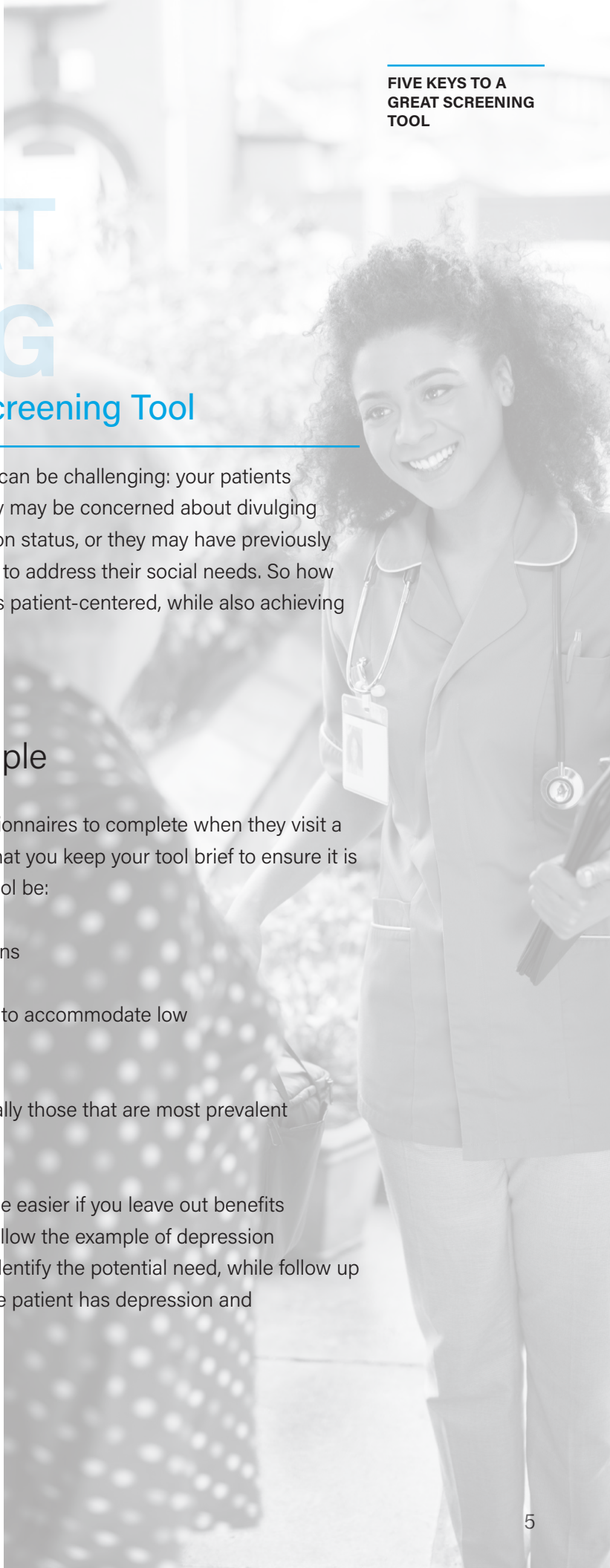
SOCIAL NEED DOMAINS	EXAMPLES
Childcare	Childcare / preschool / after-school programs, prenatal support services, kids clothing and supplies, summer programs
Education	English as a Second Language (ESL/ESOL), high school equivalency (GED), college training programs, health literacy
Employment	Under-employment, unemployment, job training
Health Behaviors[3]	Tobacco use, alcohol and substance use, physical activity, diet
Social Isolation & Supports[3]	Lack of family and/or friend network(s), minimal community contacts, absence of social engagement
Behavioral/ Mental Health[3]	Stress, anxiety, depression, psychological assets, trauma

[3] *These categories will likely require a more highly skilled workforce than other types of social needs*

FIVE KEYS TO A GREAT SCREENING TOOL

Five Keys to a Great Screening Tool

Understanding a patient's social needs can be challenging: your patients may not speak or read English well, they may be concerned about divulging sensitive information such as immigration status, or they may have previously had negative experiences in attempting to address their social needs. So how do you ensure your screening process is patient-centered, while also achieving your population health research goals?



1. Make it short and simple

Patients have so many forms and questionnaires to complete when they visit a doctor these days, so we recommend that you keep your tool brief to ensure it is completed fully. We recommend your tool be:

- ☐ Short, with a maximum of 12 questions
- ☐ Written at a fifth grade reading level to accommodate low literacy populations
- ☐ Translated into other languages, ideally those that are most prevalent in your clinics

Keeping your screening tool brief may be easier if you leave out benefits assessments or full intake questions. Follow the example of depression screening: your initial screening helps identify the potential need, while follow up questions with a clinician diagnose if the patient has depression and how to address it.

2. Choose clinically validated questions at the right level of precision

Identify targeted questions that match the need for your intervention and population. Watch out for broad questions that may generate false positives, narrow questions that do not catch enough patients, or questions that are relevant to specific patient demographics (e.g., pediatric or senior populations).

3. Integrate into clinical workflows

Social needs are part of a much larger patient journey and care plan. To successfully provide whole person care, we must expect providers to have the same understanding of patients' social needs as they do of their clinical needs — and then equip them with the tools to act on what they hear from patients.

4. Ask patients to prioritize

Just because a patient screens positive for social needs doesn't mean they would like help working on those needs. Talk to your patients about their priorities, goals, and strengths to clarify whether there are useful ways for your health system to provide support services.

5. Pilot before scaling

Given that there is no one standardized screening tool used by all health systems today, you may find yourself designing a tool that takes questions from multiple instruments. To confirm your screening tool is truly patient-centered, we recommend running a short evaluation to test the tool with patients before offering the tool to your entire patient population.

Recommended Screening Tool

This is a sample social needs screening tool – please tailor it based on your population, scope, and goals.

Example introductory text: This form is available in other languages. If you do not speak English, call (800) 555-6666 (TTY: (800) 777-8888) to connect to an interpreter who will assist you at no cost.

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		Yes / No
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Are you **afraid you might be hurt** in your apartment building or house?	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	Y N

FOR STAFF USE ONLY:

- Place a patient sticker to the right
- Give this form to the patient with patient packet
- PRINT your name and role below.

Staff Name: _____

Place patient sticker here

Recommended Screening Tool (Spanish)

This is a Spanish version of the sample social needs screening tool – please tailor it based on your population, scope, and goals. This work is licensed under a Creative Commons Attribution-ShareAlike 4.0 International License.

Example introductory text: Este formulario está disponible en otros idiomas. Si no habla inglés, llame al (800) 555-6666 (TTY: (800) 777-8888) para conectarse con un intérprete que le ayudará gratis.

Nombre:_____ Teléfono:_____

Idioma preferido:_____ Mejor momento para llamarle:_____

		Sí / No
	En los últimos 12 meses, **¿comió menos de lo quecreía que necesitaba** porque no le alcanzaba el dinero para la comida?	S N
	En los últimos 12 meses, **¿le cortó una compañía un servicio público** por no pagar sus cuentas?	S N
	¿Le preocupa **quedarse sin vivienda estable** en los próximos dos meses?	S N
	¿Conseguir cuidado de niños le **dificulta trabajar o estudiar?** *(Dejar en blanco si no tiene niños.)*	S N
	En los últimos 12 meses, ¿necesitó ver a un médico **pero no pudo por el costo?**	S N
	En los últimos 12 meses, ¿alguna vez dejó de recibir cuidados de salud porque **no tenía cómo llegar al sitio?**	S N
	¿Alguna vez necesita ayuda para **leer los materiales del hospital?**	S N
	¿Tiene **miedo de lesionarse** en su edificio de apartamentos o casa?	S N
	Si marcó que sí a cualquiera de las casillas anteriores, **¿le gustaría recibir ayuda** con cualquiera de estas necesidades?	S N
	**¿Es urgente alguna de estas necesidades?** Por ejemplo: No tengo qué comer esta noche, no tengo dónde dormir esta noche.	S N

PARA USO EXCLUSIVO DEL PERSONAL/FOR STAFF USE ONLY:

- Place a patient sticker to the right
- Give this form to the patient with patient packet
- PRINT your name and role below.

Place patient sticker here

Staff Name: _____

SCREENING QUESTIONS LIBRARY

Additional Questions for Each Domain

This section provides more detail about the available screening questions in each social need domain. Please use these questions to customize your screening form based on the unique scope, goals, and target population of your social needs program. To help you choose the right question for your screening form, every question is rated on three criteria:

1. Clinically Validated:

Does the question come from a clinically validated instrument?

- Question comes from clinically validated instrument
- Question has not yet been clinically validated

2. Precision:

Are you looking to get a general understanding of social need prevalence in this domain, or a more specific focus?

- Broad question, some patients may incorrectly be flagged as having social needs
- Balanced question
- Narrow question, some patients with social needs may be missed

3. Grade Level:

Is the question readable for low literacy populations?

- 5th Written at a fifth grade level, which most adult populations will understand
- 9th Written at a ninth grade level, some adults may not understand the question

SCREENING QUESTIONS LIBRARY

Checklist: Screening Tool Best Practices

Understanding a patient's social needs can be challenging: your patients may not speak or read English well, they may be concerned about divulging sensitive information such as immigration status, or they may have previously had negative experiences in attempting to address their social needs. The ideal screening process will begin to surface social needs by offering a tool that is easy to complete, questions that are simple for patients to understand, and a screening process that is integrated into clinical workflows with clear next steps upon completion.

Use this best practice checklist to ensure your tool will be effective:

Simple, Effective Questions

✓ Come from clinically validated tools or measures

✓ Written at a fifth grade reading level to be accessible for low literacy populations

✓ Focus on prevalence of need separately from interest in program enrollment

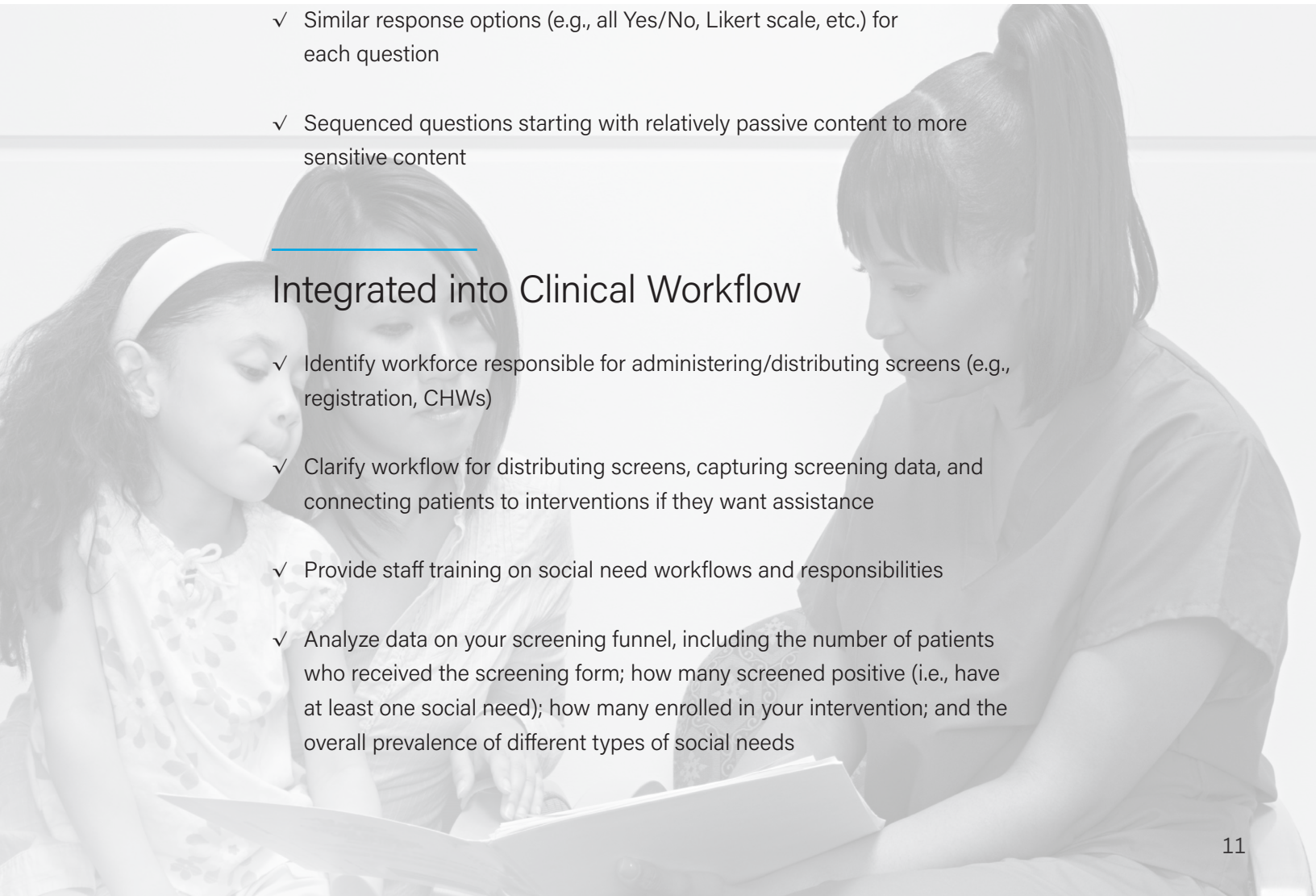
- Prevalence Example: In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
- Interest in Program Enrollment Example: Would you like help getting healthy food for you or your family?

✓ Designed to open a conversation with your target population, while reducing the likelihood of misidentifying patients (balance of broad and specific)

SCREENING TOOL BEST PRACTICES

Easy for Patients to Complete

- ✓ Simple and brief (takes less than five minutes to complete)
- ✓ Contains at least one question from the essential social needs domains
- ✓ Presented in a format that works for your staff and patients (paper or electronic)
- ✓ Available in top three languages in your population and large print sizes if needed
- ✓ Visually appealing, concise, and accessible
- ✓ Similar response options (e.g., all Yes/No, Likert scale, etc.) for each question
- ✓ Sequenced questions starting with relatively passive content to more sensitive content



Integrated into Clinical Workflow

- ✓ Identify workforce responsible for administering/distributing screens (e.g., registration, CHWs)
- ✓ Clarify workflow for distributing screens, capturing screening data, and connecting patients to interventions if they want assistance
- ✓ Provide staff training on social need workflows and responsibilities
- ✓ Analyze data on your screening funnel, including the number of patients who received the screening form; how many screened positive (i.e., have at least one social need); how many enrolled in your intervention; and the overall prevalence of different types of social needs

FOOD INSECURITY

Essential to include on your screening form

Examples: Limited or uncertain access to adequate food

Recommended Screening Question

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

√ Yes, No

Why we recommend this question: This question is from the USDA Household Food Survey and has been widely adopted as a standard question to ask when screening for food insecurity. It is written at a seventh grade reading level, which may be somewhat challenging for low-literacy populations to understand.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
The food that we bought just didn't last, and we didn't have money to get more. Was that often, sometimes, or never true for your household in the last 12 months? (USDA, The Hunger Vital Sign)	✓		5th
Within the past 12 months we worried whether our food would run out before we got money to buy more. (USDA, The Hunger Vital Sign)	✓		8th
We couldn't afford to eat balanced meals. Was that often, sometimes, or never true for you in the last 12 months? (USDA)	✓	▼	4th
In the past year, have you ever used a Food Pantry/Soup Kitchen or received a food donation? *Yes, No* (Children's HealthWatch)	✓		7th

Sources & Additional Options

- *Children's HealthWatch Survey Instrument 2013 (These questions were selected from the two-item Children's HealthWatch Hunger Vital Sign™ screening tool. We recommend that both questions are included together whenever possible.)*
- *IOM Capturing Social and Behavioral Domains and Measures in Electronic Health Records*
- *USDA Household Food Security Survey*

HOUSING INSTABILITY

Essential to include on your screening form

Examples: Homelessness, unsafe housing quality, inability to pay mortgage/rent, frequent housing disruptions, eviction

Recommended Screening Question

Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?

√ Yes, No

Why we recommend this question: This question was written by the Veterans Administration and is a good proxy for immediate housing challenges. It comes from a validated instrument and is written at a tenth grade level, which may be somewhat challenging for low-literacy populations to understand.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping? *Yes, No* (Health Begins)	✓		5th
Do you think you are at risk of becoming homeless? *Yes, No* (WeCare)	✓		5th
Since [current month] of last year, was there a time when you were not able to pay the mortgage or rent on time? *Yes, No* (Children's HealthWatch)	✓		6th
How often in the past 12 months would you say you were worried or stressed about having enough money to pay your rent/mortgage? *Always, Usually, Sometimes, Rarely, Never* (CDC)	✓		10th

Sources & Additional Options

- *Centers for Disease Control and Prevention, 2014 Behavioral Risk Factor Surveillance System*
- *Children's HealthWatch Survey Instrument 2013*
- *HealthBegins Upstream Risks Screening Tool and Guide v2.6*
- *Veterans Affairs Homelessness Screening Tool 2009*

UTILITY NEEDS

Essential to include on your screening form

Examples: Difficulty paying utility bills, shut off notices, access to phone

Recommended Screening Question

In the past year, has the utility company shut off your service for not paying your bills?

√ Yes, No

Why we recommend this question: This question was written by Children's Health Watch and is a good proxy for utilities assistance needs. It comes from a validated instrument and is written at an eighth grade level, which may be somewhat challenging for low-literacy populations to understand.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
Do you have trouble paying your heating bill for the winter? *Yes, No* (WeCare)			5th
In the last 12 months, have you ever used a cooking stove to heat the [house/ apartment]? *Yes, No* (Children's HealthWatch)			4th
Since [name of current month] of last year, were there any days that your home was not heated because you couldn't pay the bills? *Yes, No* (Children's HealthWatch)			7th

Sources & Additional Options

- *Children's HealthWatch Survey Instrument 2013 (These questions were selected from the four-item Children's HealthWatch energy insecurity indicator. We recommend that all four questions are included together whenever possible.)*
- *WeCare Social Needs Screening Tool*

FINANCIAL RESOURCE STRAIN

Essential to include on your screening form

Examples: Inability to afford basic needs, financial literacy, medication under-use due to cost, benefits denial

Recommended Screening Question

In the last 12 months, was there a time when you needed to see a doctor but could not because of cost?

✓ Yes, No

Why we recommend this question: Questions about financial resource strain often produce a high false positive rate, as individuals and families at all incomes experience stress around money. This question provides a more targeted focus on health care access and poverty. The question was written as part of the Behavioral Risk Factor Survey, is clinically validated, and is written at a seventh grade level.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
In the last 12 months, did you skip medications to save money? (Medical Expenditure Panel Survey)			6th
Please indicate how often this describes you: I don't have enough money to pay my bills. *Never, Rarely, Sometimes, Often, Always* (Aldana & Liljenquist)			7th
Sometimes people find that their income does not quite cover their living costs. In the last 12 months, has this happened to you? *Yes, No, Don't Know* (OECD)			5th

Sources & Additional Options

- *Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey 2011*
- *Aldana & Liljenquist, "Validity And Reliability Of A Financial Strain Survey"*
- *Behavioral Risk Factor Survey, CDC, 2012*
- *OECD, Measuring Financial Literacy 2011*

TRANSPORTATION

Essential to include on your screening form

Examples: Difficulty accessing/affording transportation (medical or public)

Recommended Screening Question

In the last six months, have you ever had to go without health care because you didn't have a way to get there?

√ Yes, No

Why we recommend this question: This question was written by Cunningham et al and published in the Medical Care journal, and is a good question to understand the impact of transportation issues on medical care. It comes from a validated instrument and is written at a seventh grade level, which may be somewhat challenging for low-literacy populations to understand.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
Do you put off or neglect going to the doctor because of distance or transportation? (Blazer)	✓		8th
Does lack of money for transportation expenses, such as parking, make it difficult to get to the doctor or dentist? *Very Difficult, Difficult, Easy, Very Easy* (Borders)	✓		11th
Are you regularly able to get a friend or relative to take you to doctor's appointments? *Yes, No* (Borders)	✓		9th

Sources & Additional Options

- *Blazer et al, Health Service Access and Use Among Older Adults 1995*
- *Borders, Transportation Barriers to Health Care 2006*
- *Cunningham et al, The Impact of Competing Subsistence Needs 1999*

EXPOSURE TO VIOLENCE

Essential to include on your screening form

Examples: Intimate partner violence, elder abuse, community violence

Recommended Screening Question

Are you afraid you might be hurt in your apartment building or house?

√ Yes, No

Why we recommend this question: Exposure to violence is a sensitive subject that will likely require a more highly skilled workforce to address than other types of social needs. This question comes from the U.S. Department of Justice and is a robust option if you only have room for one question regarding exposure to violence. It is clinically validated and written at a fifth grade level, which should be mostly accessible to lower literacy populations.

Alternative Options

Consult with experts in your health system to understand what screening and support programs may already exist. Significant research has been conducted in this area and a single screening question is rarely enough to identify issues of intimate partner violence, elder abuse, and/or community violence.

We recommend the following resources for additional information:

Intimate Partner Violence	*CDC Intimate Partner/Victimization Assessment Instruments for Healthcare Settings*
Elder or Caregiver Abuse	*University of Iowa Directory of Elder Abuse/Mistreatment Screening Instruments*
	National Initiative for the Care of the Elderly(Canada): Caregiver Abuse Screen
Child Abuse	*US Administration for Children & Families – List of Child Abuse/Trauma Screening Instruments*
Community Violence	*US Department of Justice – Exposure to Violence Instrument*

SOCIO-DEMOGRAPHIC INFORMATION

Essential to include on your screening form

Recommended Demographics to Collect

The following socio-demographic data elements will be useful for identifying patients' social needs, as well as patients' eligibility for specific benefits or resources.

DEMOGRAPHIC FIELD	WHERE TO COLLECT	REASON FOR COLLECTING
Age (Date of Birth)	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Gender	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Race and Ethnicity	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Marital Status	Already in EHR	May influence eligibility for resources or benefits, may help determine case complexity
Education Level	Already in EHR	May help determine case complexity
Language(s) Spoken	Screening Form	Confirm at screening to ensure services are being provided in a language the patient understands
Health Insurance Status	Screening Form	Confirm at screening if the EHR may not be up fully updated; finding viable health insurance may be a need for the patient
Current Benefits Received	Screening or Intake	May help determine which resources or benefits to discuss with the patient
Sexual Orientation	Intake Conversation	May influence eligibility for resources or benefits, may help determine case complexity
Immigration Status	Intake Conversation	May influence eligibility for resources or benefits, may help determine case complexity
Employment Status	Intake Conversation	Unemployment or under-employment may be a social need to discuss with the patient
Household Income	Intake Conversation	Influences eligibility for resources or benefits
Caring for Elder	Intake Conversation	May influence eligibility for resources or benefits, may help determine case complexity

CHILDCARE

Optional to include on your screening form
Examples: Childcare/preschool/after-school programs, prenatal support services, kids clothing and supplies, summer programs

Recommended Screening Question

Do problems getting child care make it difficult for you to work or study?

√ Yes, No

Why we recommend this question: Finding an ideal childcare question can be challenging since families of all incomes and backgrounds may have difficulty finding appropriate care. We recommend this question because it focuses on the intersection between childcare and income issues. This question is clinically validated from the Survey of Income and Program Participation and written at a sixth grade level, which should be mostly accessible to lower literacy populations.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
Do your children usually get the breakfast that their school provides? *Yes, No, Not Applicable* (SIPP)	✓		6th
During the past two years have you had a child care subsidy taken away? *Yes, No* (Children's HealthWatch Survey)	✓		6th
In the past three months, how often have you experienced child care breakdowns? *Often, Sometimes, Rarely, Never* (NSCW)	✓		5th
My family needs diapers, clothing, car seats and/or back to school supplies. *Yes, No* (Health Leads)	✗		7th
Would availability of child care affect hours spent/attendance at schooling, training, employment or job search? *Yes, No* (NLSY)	✓		11th

Sources & Additional Options

- *Children's HealthWatch Instrument 2013*
- *National Longitudinal Survey of Youth 1982-2012*
- *National Study of the Changing Workforce 2008*
- *US Census, Survey of Income and Program Participation 2008*

EDUCATION

Optional to include on your screening form
Examples: English as a Second Language (ESL/ESOL), high school equivalency (GED), college training programs, health literacy

Recommended Screening Question

Do you ever need help reading hospital materials?

√ Yes, No

Why we recommend this question: This question is commonly used to measure education level and health literacy, coming from the STOFHLA tool. It is written at an tenth grade reading level, which may be somewhat challenging for low-literacy populations to understand.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
Do you have a high school degree? *Yes, No* (WeCare)	✓	▼	1st
What is the highest level of schooling you have completed? (US Census)	✓	▼	6th
How confident are you filling out medical forms by yourself? *Extremely, Quite a bit, Somewhat, A little bit, Not at all* (STOFHLA)	✓	▽	7th
How often do you have a problem understanding what is told to you about your medical condition? *Always, Often, Sometimes, Occasionally, Never* (STOFHLA)	✓	▽	10th

Sources & Additional Options

- *Chew et al – STOFHLA – Brief Questions to Identify Patients with Inadequate Health Literacy*
- *US Census American Community Survey*
- *WeCare Social Needs Screening Tool*

EMPLOYMENT

Optional to include on your screening form

Examples: Under-employment, unemployment, job training

Recommended Screening Question

During the last four weeks, have you been actively looking for work?

√ Yes, No

Why we recommend this question: This question comes from the U.S. Census. It is a decent broad question, although it may miss discouraged workers who have dropped out of a job search and may provide false positives for patients who are self-sufficient in their job search. It is written at a fifth grade reading level, which should be mostly accessible to lower literacy populations.

Alternative Options

	CLINICALLY VALIDATED	PRECISION	GRADE LEVEL
Last week, did you work for pay at a job (or business)? *Yes, No* (US Census)	✓	▼	3rd
What was your main activity during most of the last 12 months? Worked for pay, attended school, household duties, unemployed, permanently unable to work, other (ILO)	✓	▼	6th
Do you need help finding a local career center and/or job training program? Yes, No (Health Leads)	✗	▽	7th
Do you have a job? *Yes, No* (WeCare)	✓	▼	1st
Do you have a disability that prevents you from accepting any kind of work during the next six months? *Yes, No* (US Census)	✓	▽	9th

Sources & Additional Options

- *Health Leads Screening Tool*
- *International Labor Office*
- *US Census American Community Survey*
- *WeCare Social Needs Screening Tool*

HEALTH BEHAVIORS, BEHAVIORAL/MENTAL HEALTH, SOCIAL ISOLATION & SUPPORT

Optional to include on your screening form

Recommended Screening Question

Most healthcare institutions already have screening instruments in place for tobacco use, alcohol and substance use, physical activity, diet, depression, and/or social isolation. These are complex issues that will likely require a more highly skilled workforce to address than other types of social needs. Consult with experts in your health system to understand what screening and support programs may already exist for these domains.

We recommend the following resources for additional information:

Tobacco, Alcohol, and Substance Use	*National Council for Behavioral Health*
	NIDA Drug Screening Tool
Physical Activity and Diet	*Family Nutrition and Physical Activity Screener*
	General Health Survey
	Nutritional Screening Assessment Instrument
	Duke Health Profile
Behavioral/ Mental Health	*National Council for Behavioral Health*
	ACES
	GAD-7
	Kessler Psychological Distress Scale (K10)
Social Isolation and Support	*PROMIS Social Isolation*
	Duke Health Profile
	Patient Activation Measures

About Health Leads

Health Leads is a social enterprise that envisions a healthcare system that addresses all patients' basic resource needs as a standard part of quality care. For 20 years, Health Leads has worked with leading healthcare organizations to tackle social co-morbidities by connecting patients to the community-based resources they need to be healthy – from food to transportation to healthcare benefits. Health Leads is committed to leveraging its tools, expertise and direct services to change what "counts" as healthcare – and accelerate the leadership, best practices, incentives and research required to improve the health and well-being of patients.

Learn more at **www.healthleadsusa.org**, reach us at **info@healthleadsusa.org** and follow us on **Twitter, Facebook** and **LinkedIn.**

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Suggested Changes to Tool

March 14, 2016

NOTE: THIS IS A WORKING DOCUMENT RESULTING FROM AN ITERATIVE PROCESS. PLEASE CHECK FOR UPDATES AND CONTACT MICHELLE JESTER AT MJESTER@NACHC.ORG FOR MORE INFORMATION AND TO JOIN THE MAILING LIST TO RECEIVE NOTIFICATIONS OF CHANGES.

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question.

OPTIONAL feature: Additional/alternative more granular response choices that roll-up.

See Appendix E of the IOM's 2009 report Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (available at: http://www.iom.edu/Reports/2009/RaceEthnicity Data.aspx) for a list of potential response choices.

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	American Indian/Alaskan Native		White
	Other (please write)_____		I choose not to answer this question.

OPTIONAL feature: Additional/alternative more granular response choices that roll-up.

See Appendix E of the IOM's 2009 report Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (available at: http://www.iom.edu/Reports/20 09/RaceEthnicity Data.aspx) for a list of potential response choices.

3. At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question.

[Definitions if needed for clarification:]

- ***Migratory agricultural worker:*** *is an individual whose principal employment is in agriculture and who establishes a temporary home for the purposes of such employment. Migratory agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. The family members may or may not move with the worker or establish a temporary home. (according to section 330(g) of the Public Health Service Act)*
- ***Seasonal agricultural workers:*** *individuals whose principal employment is in agriculture on a seasonal basis (e.g. picking fruit during the limited months of a picking season) but who do not establish a temporary home for purposes of employment. Seasonal agricultural workers are usually hired laborers who are paid piecework, hourly, or daily wages. (according to section 330(g) of the Public Health Service Act)*

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question.

5. What language are you most comfortable speaking? _____

	English		Language other than English (please write) _____		I choose not to answer this question.

Family & Home

6. How many family members, including yourself, do you currently live with?_____

	I choose not to answer this question.

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question.

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question.

[Definitions if needed for clarification:]

Homeless Patients*: Patients who lack housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing.*

"Homeless" for UDS reporting purposes, includes the following:

- ***Shelter:*** *Shelters for homeless persons are seen as temporary and generally provide for meals as well as a place to sleep for a limited number of days and hours of the day that a resident may stay at the shelter.*
- ***Transitional Housing:*** *Transitional housing units are generally small units (six persons is common) where persons who leave a shelter are provided extended housing stays—generally between 6 months and 2 years—in a service rich environment. Transitional housing provides for a greater level of independence than traditional shelters, and may require that the resident pay some or all of the rent, participate in the maintenance of the facility and/or cook their own meals. Count only those persons who are "transitioning" from a homeless environment. Do not include those who are transitioning from jail, an institutional treatment program, the military, schools or other institutions.*
- ***Doubled Up:*** *Patients who are living with others; the arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protracted period of time.*
- ***Street:*** *This category includes patients who are living outdoors, in a car, in an encampment, in makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.*
- ***Other:*** *This category may be used to report previously homeless patients who were housed when first seen, but who were still eligible for the Health Care for the Homeless program. Patients who reside in SRO (single room occupancy) hotels or motels, other day-to-day paid housing, as well as*

residents of permanent supportive housing or other housing programs that are targeted to homeless populations should also be classified as "other".

9. What address do you live at? (include street and zipcode)

_____

_____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than a high school degree		High school diploma or GED
	More than high school		I choose not to answer this question.

11. What is your current work situation?

	Unemployed and seeking work		Part time or temporary work
	Full time work		Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver) Please write_____
	I choose not to answer this question.		

OPTIONAL Feature: Additional response choices

Work less than 20 hours a week		Work 20-34 hours a week
Work 35-59 hours a week		Work 60 hours or more a week

OPTIONAL Feature: Additional question

How many jobs do you work?

	1 job		3 or more jobs

	2 jobs		I choose not to answer this question.

12. What is your main insurance?[1]

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (Not CHIP)		Other Public Insurance (CHIP)
	Private insurance		

OPTIONAL Feature: Additional question

Do you have insurance through your job?

	Yes		No		I choose not to answer this question.

13. During the past year, what was the total combined income for you and your family members you live with? This information will help us determine if you are eligible for any benefits.

[NOTE: For organizations that already collect income for other purposes (sliding fee scale, insurance eligibility, other benefits), please map that data such that patients are not asked about their income multiple times. Please report percent of patients by Federal Poverty Level or FPL for PRAPARE reporting purposes.]

	I choose not to answer this question.

[1] If patient is unable to answer, health center staff fill out by pulling the information from the EHR or PMS.

14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or any health care (medical, dental, mental health, vision)			
Yes	No	Phone	Yes	No	Other (please write) _____
		I choose not to answer this question			

Social and Emotional Health

15. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week
	1 or 2 times a week
	3 to 5 times a week
	More than 5 times a week
	I choose not to answer this question.

16. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		Quite a bit
	A little bit		Very much
	Somewhat		I choose not to answer this question

OPTIONAL Feature: Additional question

Ask the open-ended follow-up question "Who are the people or groups you usually see or talk to at these times?"

Optional Questions

16. In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this question.

OPTIONAL: What was your release date? _____

17. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? [Check all that apply]

	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

18. Are you a refugee?

	Yes		No		I choose not to answer this question.

19. What country are you from?

	United States		Country other than the United States (please write) _____		I choose not to answer this question.

20. Do you feel physically and emotionally safe where you currently live?

	Yes
	No
	Unsure
	I choose not to answer this question.

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes
	No
	Unsure
	I have not had a partner in the past year
	I choose not to answer this question.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz.  **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. **In the past 12 months…**		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes".			

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Modified per CTC-RI guidelines 4/10/2018,

AUDIT – Revised CHT FollowUp Only (30 Days)

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

Evaluation ID#_____ Date:_____

AUDIT – Revised CHT FollowUp (30 Days): Interview

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this last 30 days." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often did you have a drink containing alcohol?

(0) Never [Skip to Qs 9-10]
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often did you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last 30 days have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last 30 days have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last 30 days have you needed a first drink in the morning to get yourself going after a heavy drinking session?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last 30 days have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last 30 days have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last 6 months
(4) Yes, during the last 6 months

10. Has a relative, friend, doctor, or another health worker been concerned about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last 6 months
(4) Yes, during the last 6 months

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

Evaluation ID#_____ Date:_____

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz.  **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz. **~12% alcohol**	a 750 mL (25 oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

Evaluation ID#_____ Date:_____

AUDIT- Revised CHT FollowUp Only (30 Days): Self-Report

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol in the last 30 days. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often did you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
4. How often during the past 30 days have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
5. How often during the last 30 days have you failed to do what was normally expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
6. How often during the last 30 days have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
7. How often during the last 30 days have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
8. How often during the last 30 days have been unable to remember what happened the night before because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily	
9. Have you or someone else been injuring because of your drinking?	No		Yes, but not in the past 6 months		Yes, during the past 6 months	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past 6 months		Yes, during the past 6 months	
					Total	

Evaluation ID # _____ Date:_____

DAST-10 - Revised CHT
30-day FollowUp Only

The following questions concern information about your possible involvement with drugs, *not including alcohol and tobacco*, during the past 30 days.

When the words "drug abuse" are used, they mean (1) the use of prescribed or over-the-counter medications/drugs in excess of the directions, and (2) any non-medical use of drugs.

The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in this section.

In the past 30 days…	**Circle**	
1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you unable to stop abusing drugs when you want to?	Yes	No
4. Have you ever had blackouts for flashbacks as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
Scoring: Score 1 point for each question answered "Yes"	**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Modified per CTC-RI guidelines 4/10/2018/ Modified per CHT guidelines 9/2018

CAGEAID – Revised for
CHT FollowUp Only
(30 Days)

Evaluation ID #_____ Date_____

When thinking about drug use, include illegal drug use and use of prescription drugs other than as prescribed.

Questions:	**Circle**	
1. In the last 30 days, have you ever felt that you ought to cut down on your drinking or drug use?	Yes	No
2. In the last 30 days, have people annoyed you by criticizing your drinking or drug use?	Yes	No
3. In the last 30 days, have you ever felt bad or guilty about your drinking or drug use?	Yes	No
4. In the last 30 days, have ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes	No
Scoring: Score 1 point for each question answered "Yes"	**Score:**	

Intake Date (MM/DD/YYYY): ___ ___ /___ ___ /__ __ __ __

CHT (#): _____

Staff # (2 digits): ___ ___

CHT Evaluation Number (4 digits): ___ ___ ___ ___

Circle Mode of Administration:

1- Self Administered Paper – Data Entry Later
2- Self Administered Computer – Client Enters Data
3- Full Interview - Staff Enters Data
4- Phone Interview – Staff Enters Data
5- Some interview + Some Paper – staff enters data
6- Other:_____

5) What is the client's gender? (Do you consider yourself male or female?)

1- Male
2- Female
3- Transgender male (Anywhere in process of transitioning to male)
4- Transgender female (Anywhere in process of transitioning to female)
5- Other _____

6) What is client's Age (in years)? ___ ___

7) Is client Hispanic or Latinx? (Circle one)

No Yes

8) Does the client consider themself...? (Do you consider yourself…?)

1- American Indian or Alaskan Native
2- Asian or Asian American
3- Native Hawaiian or Pacific Islander
4- Black or African American
5- White or Caucasian
6- More than one race _____

9) Is client's primary language English? (Circle one)

No Yes

If No, primary language:_____

10) What is the client's 5-digit RI zip code: _0_ _2_ ___ ___ ___

INTAKE CHT EVALUATION Evaluation ID #_____ Date:_____

INTAKE INSTRUCTIONS: For each question, please tick in the one box that best describes your answer. Please answer the questions as you feel best. There are no right or wrong answers.

Section One

1. How confident are you filling out medical forms by yourself?	**Not at all confident** ☐1	**Not Very confident** ☐2	**Somewhat confident** ☐3	**Very Confident** ☐4	**Extremely Confident** ☐5
2. How often do you have someone help you read medical materials?	**None of the time** ☐5	**A little of the time** ☐4	**Some of the time** ☐3	**Most of the time** ☐2	**All of the time** ☐1
3. How often do you have problems learning about your medical condition because of difficulty understanding written information?	**None of the time** ☐5	**A little of the time** ☐4	**Some of the time** ☐3	**Most of the time** ☐2	**All of the time** ☐1

Section Two

AT THE MOMENT…

Thinking about your level of knowledge: How much do you…	**I know as much as I want**	**Slightly less than I want**	**Somewhat less than I want**	**Quite a bit less than I want**	**Very much less than I want**	
4. Understand your current illness or health problems?	☐1	☐2	☐3	☐4	☐5	
5. Know how best to look after yourself and stay healthy?	☐1	☐2	☐3	☐4	☐5	
Thinking about your level of understanding: How much do you…	**I understand as much as I want**	**Slightly less than I want**	**Somewhat less than I want**	**Quite a bit less than I want**	**Very much less than I want**	**Not applicable: I have no current health problems**
6. Understand your current illness or health problems?	☐1	☐2	☐3	☐4	☐5	☐0
7. Understand how to manage the symptoms of your illness?	☐1	☐2	☐3	☐4	☐5	☐0

Section Three

AT THE MOMENT….

Thinking about the <u>support</u> you have in life, from both your community health team and elsewhere, how much <u>support</u> do you have to help you…	**As much support as I need**	**Slightly less than I need**	**Somewhat less than I need**	**Quite a bit less than I need**	**Very much less than I need**	**Not applicable: I do not have or need support**
8. Manage in you daily life?	☐1	☐2	☐3	☐4	☐5	☐0
9. Deal with any anxieties or worries?	☐1	☐2	☐3	☐4	☐5	☐0
How <u>confident</u> are you that you are …	**Extremely confident**	**Very confident**	**Somewhat confident**	**Not very confident**	**Not at all confident**	**Not applicable: I have no current health problems**
10. Able to manage your health problems	☐1	☐2	☐3	☐4	☐5	☐0
11. Dealing with the cause of your health problems	☐1	☐2	☐3	☐4	☐5	☐0
12. On the right path to dealing with your health problems	☐1	☐2	☐3	☐4	☐5	☐0
For a variety of reasons, people don't always follow medical advice. How much of your health care team's advice are you following on:	**All of the advice**	**Most of the advice**	**Some of the advice**	**Not much of the advice**	**None of the advice**	**Not applicable: I have not received any advice**
13. Your medication(s) or treatment(s)	☐1	☐2	☐3	☐4	☐5	☐0
14. Leading a healthy lifestyle	☐1	☐2	☐3	☐4	☐5	☐0

Section Four

15. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

____Number of days [0 - 30]

16. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

____Number of days [0 - 30]

17. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

____Number of days [0 - 30]

Section Five

FINALLY….

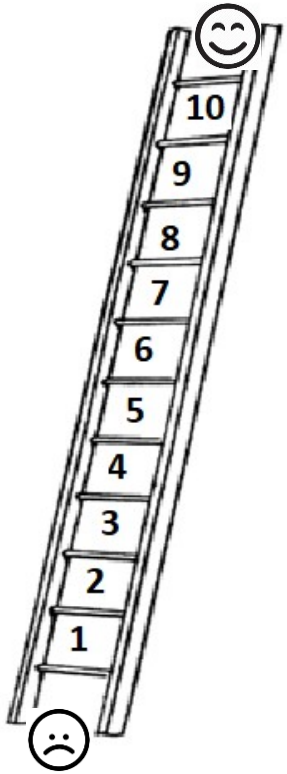
18. Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

On which step of the ladder would you say you personally feel you stand at this time?

____[1-10]

19. On which step do you think you will stand about five years from now?

____[1-10]



FOLLOW-UP CHT EVALUATION Evaluation ID #_____ Date:_____

INTAKE INSTRUCTIONS: For each question, please tick in the one box that best describes your answer. Please answer the questions as you feel best. There are no right or wrong answers.

Section One

1. How confident are you filling out medical forms by yourself?	**Not at all confident** ☐1	**Not Very confident** ☐2	**Somewhat confident** ☐3	**Very Confident** ☐4	**Extremely Confident** ☐5
2. How often do you have someone help you read medical materials?	**None of the time** ☐5	**A little of the time** ☐4	**Some of the time** ☐3	**Most of the time** ☐2	**All of the time** ☐1
3. How often do you have problems learning about your medical condition because of difficulty understanding written information?	**None of the time** ☐5	**A little of the time** ☐4	**Some of the time** ☐3	**Most of the time** ☐2	**All of the time** ☐1

Section Two

AT THE MOMENT…

Thinking about your level of knowledge: How much do you…	**I know as much as I want**	**Slightly less than I want**	**Somewhat less than I want**	**Quite a bit less than I want**	**Very much less than I want**	
4. Understand your current illness or health problems?	☐1	☐2	☐3	☐4	☐5	
5. Know how best to look after yourself and stay healthy?	☐1	☐2	☐3	☐4	☐5	
Thinking about your level of understanding: How much do you…	**I understand as much as I want**	**Slightly less than I want**	**Somewhat less than I want**	**Quite a bit less than I want**	**Very much less than I want**	**Not applicable: I have no current health problems**
6. Understand your current illness or health problems?	☐1	☐2	☐3	☐4	☐5	☐0
7. Understand how to manage the symptoms of your illness?	☐1	☐2	☐3	☐4	☐5	☐0

Section Three

AT THE MOMENT….

Thinking about the <u>support</u> you have in life, from both your community health team and elsewhere, how much <u>support</u> do you have to help you…	**As much support as I need**	**Slightly less than I need**	**Somewhat less than I need**	**Quite a bit less than I need**	**Very much less than I need**	**Not applicable: I do not have or need support**
8. Manage in you daily life?	☐1	☐2	☐3	☐4	☐5	☐0
9. Deal with any anxieties or worries?	☐1	☐2	☐3	☐4	☐5	☐0
How <u>confident</u> are you that you are …	**Extremely confident**	**Very confident**	**Somewhat confident**	**Not very confident**	**Not at all confident**	**Not applicable: I have no current health problems**
10. Able to manage your health problems	☐1	☐2	☐3	☐4	☐5	☐0
11. Dealing with the cause of your health problems	☐1	☐2	☐3	☐4	☐5	☐0
12. On the right path to dealing with your health problems	☐1	☐2	☐3	☐4	☐5	☐0
For a variety of reasons, people don't always follow medical advice. How much of your health care team's advice are you following on:	**All of the advice**	**Most of the advice**	**Some of the advice**	**Not much of the advice**	**None of the advice**	**Not applicable: I have not received any advice**
13. Your medication(s) or treatment(s)	☐1	☐2	☐3	☐4	☐5	☐0
14. Leading a healthy lifestyle	☐1	☐2	☐3	☐4	☐5	☐0

Section Four

15. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

____Number of days [0 - 30]

16. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

____Number of days [0 - 30]

17. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

____Number of days [0 - 30]

Section Five

FINALLY….

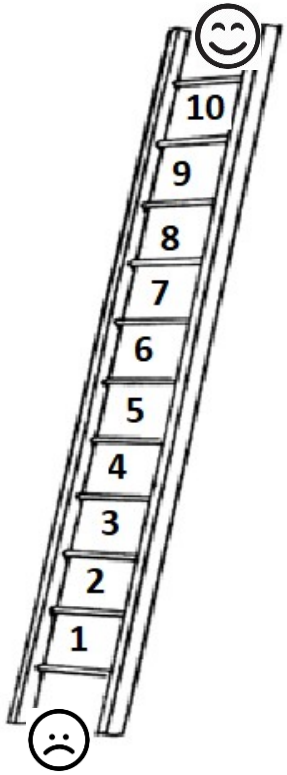
18. Please imagine a ladder with steps numbered from zero at the bottom to ten at the top. The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.

On which step of the ladder would you say you personally feel you stand at this time?

____[1-10]

19. On which step do you think you will stand about five years from now?

____[1-10]



CHT Patient Experience Survey

Section Six

Please rate how strongly you Disagree (1) or Agree (5) with the following statements about your experience with the Community Health Team (CHT):

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree	Not Applicable
1. CHT staff help me understand how to follow through with specialty care (cardiologist, behavioral health, orthopedic, urologist, endocrinologist, diabetes educator, etc.).	☐1	☐2	☐3	☐4	☐5	☐0
2. CHT staff help me understand when I should or should not go to the emergency room.	☐1	☐2	☐3	☐4	☐5	☐0
3. CHT staff connect me to community resources that help me with my health and wellness.	☐1	☐2	☐3	☐4	☐5	☐0
4. CHT staff help me overcome challenges.	☐1	☐2	☐3	☐4	☐5	☐0
5. CHT staff provide me with emotional support.	☐1	☐2	☐3	☐4	☐5	☐0
6. I feel comfortable talking openly and honestly with CHT staff.	☐1	☐2	☐3	☐4	☐5	☐0

_____

CHW FollowUp Status Survey

FollowUp Date(MM/DD/YYYY): ___ ___ /___ ___ /__ __ __ __

CHT (#): ___

CHW Staff # (2 digits): ___ ___

CHT Evaluation Number (4 digits): ___ ___ ___ ___

FollowUp or Discharge Reason: (circle one)

1- FollowUp Evaluation Only (still being followed)
2- Discharged-Completed Care
3- Discharged-Lost to FollowUp
4- Discharged-No Longer Interested in CHT Services
5- Discharged-Referred to Lower Level of Care (Outpatient, etc.)
6- Discharged-Referred to Same Level of Care (Another CHT)
7- Discharged-Referred to Higher Level of Care (Residential, Inpt., Hospice, etc.)
8- Discharged-Moved Out of Service Area
9- Discharged-Incarcerated
10- Discharged-Died
11- Other _____

	Was Any Intervention (Tx) given to this client?			<u>Only</u> If Yes, What was Status @ FollowUp?		
	No - 1	Tx Not Accepted - 2	Yes -3	No Progress-1	Some Progress-2	Good Progress-3
Any SDOH Issue						
Any BH Issue						

INTAKE CHT EVALUATION Evaluation ID_____ Date:_____

INSTRUCCIONES: Para cada pregunta, marque la casilla que mejor describa su respuesta. Por favor responde las preguntas como te sientes major. No hay respuestas correctas o incorrectas.

Seccion Uno

1. ¿Cuán seguro estás cumpliendo estas formas médicas por ti mismo?	**De ningum modo seguro** ☐1	**No mucho seguro** ☐2	**Um poco seguro** ☐3	**Mucho seguro** ☐4	**Extremadamente seguro** ☐5
2. ¿Con qué frecuencia usted tiene a alguien para ayudarle a leer los materiales médicos?	**Todo el tiempo** ☐1	**La mayoria del tiempo** ☐2	**Algunas veces** ☐3	**Un pouco del tiempo** ☐4	**Ninguno del tiempo** ☐5
3. ¿Con qué frecuencia usted tiene problemas para comprender sobre su condición médica debido a dificultad en entender la información escrita?	**Todo el tiempo** ☐1	**La mayoria del tiempo** ☐2	**Algunas veces** ☐3	**Un pouco del tiempo** ☐4	**Ninguno del tiempo** ☐5

Sección Dos

EN EL MOMENTO…

Pensando en su nivel de conocimiento: cuánto usted	**Sé tanto como quiero saber**	**Un poco menos de lo que quiero saber**	**Menos que yo quiero saber**	**Bastante menos que quiero saber**	**Mucho menos que quiero saber**	
4. Entienda su enfermedad actual o problemas de salud?	☐1	☐2	☐3	☐4	☐5	
5. ¿Sabes cómo mejor cuidar de ti y estar sano?	☐1	☐2	☐3	☐4	☐5	
Pensando en su nivel de comprensión: cuánto usted	**Comprendo tanto quanto quiero entender**	**Un poco menos de lo que quiero entender**	**Menos que quiero entender**	**Bastante menos que quiero entender**	**Mucho menos de lo que quiero entender**	**No aplicáble: yo no tengo problemas actuales de salud**
6. ¿Entiende su enfermedad actual o problemas de salud?	☐1	☐2	☐3	☐4	☐5	☐0
7. Comprender cómo controlar los síntomas de su enfermedad?	☐1	☐2	☐3	☐4	☐5	☐0

Sección Tres

EN EL MOMENTO…

Pensando en el suporte que usted tiene en la vida, tanto de su equipo de salud comunitaria y en otros lugares, cuanto soporte usted tiene para ayudarle ...	**Tanto cuanto apoyo como necesito**	**Un poco menos de lo que necesito**	**Menos que necessito**	**Suficiente menos que necessito**	**Mucho menos que necessito**	**No aplicáble: no necessito apoio o suporte**
8. Administrar en tu vida diaria?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
9. Hacer frente a cualquier ansiedad o preocupación?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
¿Cuán confiado está usted con:	**Extremadamente confiado**	**Mucho confiado**	**Un poco confiado**	**No mucho confiado**	**De ningum modo confiado**	**No aplicáble: no tengo problemas actuales de salud**
10. Capaz de controlar sus problemas de salud	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
11. tartar con la causa de sus problemas de salud	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
12. En el camino correcto para tartar con sus problemas de salud	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
Por una variedad de razones, la gente no siempre sigue las instrucciones médicas aconsejadas. ¿Cuántos consejos de tu equipo médico puedes seguir:	**Todos los consejos**	**La mayoría de los consejos**	**Algunos de los consejos**	**No mucho de los consejos**	**Ninguno de los consejos**	**No aplicable: Yo no recibí cualquier consejos**
13. Su (s) medicamento (s) o tratamiento (s)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
14. Tomando un estilo de vida saludable.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0

Sección Cuatro

15. Ahora piense en su salud física, que incluye enfermedades y lesiones físicas, por cuántos días durante los últimos 30 días ¿tu salud física no era buena?

____ Número de días [0 - 30]

16. Ahora piense en su salud mental, que incluye el estrés, la depresión y los problemas con las emociones, durante cuántos días durante los últimos 30 días, ¿tu salud mental no fue buena?

____ Número de días [0 - 30]

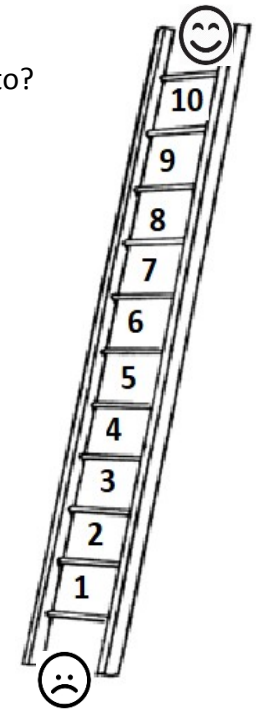
17. Durante los últimos 30 días, durante cuántos días la falta de salud física o mental le impidió realizar sus actividades habituales, como autocuidado, trabajo o recreación?

____ Número de días [0 - 30]

Sección Cinco

FINALMENTE….

18. Por favor, imagina una escalera con pasos numerados de cero en la parte inferior a diez en la parte superior. La parte superior de la escalera representa la mejor vida posible para usted y la parte inferior de la escalera representa la peor vida posible para ti.



¿En qué escalón de la escalera diría que personalmente siente que se para en este momento?

____ [1-10]

19. ¿En qué paso crees que se mantendrá dentro de cinco años a partir de ahora?

____ [1-10]

INTAKE CHT EVALUATION Evaluation ID_____ Date:_____

INSTRUÇÕES: Para cada pergunta, por favor, marque a caixa que melhor descreve sua resposta. Por favor, responda as perguntas como Você se sente melhor. Não há respostas certas ou erradas.

Secção Um

1. Quão confiante você está preenchendo estas formas médicos por si mesmo?	**De modo nenhum confiante** ☐1	**Não muito confidante** ☐2	**Um pouco confidante** ☐3	**Muito confiante** ☐4	**Extremamente confiante** ☐5
2. Com que frequência você tem alguém para ajudá-lo a ler materiais médicos?	**Todo o tempo** ☐1	**A maioria do tempo** ☐2	**Algumas vezes** ☐3	**Um pouco do tempo** ☐4	**Nenhum do tempo** ☐5
3. Com que freqüência você tem problemas para compreender sobre sua condição médica por causa de dificuldade em entender a informação escrita?	**Todo o tempo** ☐1	**A maioria do tempo** ☐2	**Algumas vezes** ☐3	**Um pouco do tempo** ☐4	**Nenhum do tempo** ☐5

Secção Dois

NO MOMENTO….

Pensando no seu nível de conhecimento: quanto você…	**Eu sei tanto quanto eu quero saber**	**Um pouco menos do que eu quero saber**	**Menos que eu quero saber**	**Bastante menos que eu quero saber**	**Muito menos que eu quero saber**	
4. Entenda sua doença atual ou problemas de saúde?	☐1	☐2	☐3	☐4	☐5	
5. Saiba como melhor cuidar de si e ficar saudável?	☐1	☐2	☐3	☐4	☐5	
Pensando no seu nível de compreensão: quanto você…	**Compreendo tanto quanto eu quero compreender**	**Um pouco menos do que eu quero compreender**	**Menos que eu quero compreender**	**Bastante menos que eu quero compreender**	**Muito menos que eu quero compreender**	**Não aplicável: Eu não tenho problemas actual de saúde**
6. Entenda sua doença atual ou problemas de saúde?	☐1	☐2	☐3	☐4	☐5	☐0
7. Entenda como controlar sintomas da sua doença?	☐1	☐2	☐3	☐4	☐5	☐0

Seção Três

NO MOMENTO….

Pensando no <u>suporte</u> que você tem na vida, tanto da sua equipe de saúde comunitária e em outros lugares, quanto <u>suporte</u> você tem para te ajudar ...	**Tanto quanto apoio como eu necessito**	**Um pouco menos do que eu preciso**	**Menos que eu necessito**	**Bastante menos que eu necessito**	**Muito menos que eu necessito**	**Não aplicável: eu não necissito apoio ou suporte**
8. Gerenciar em sua vida diária?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
9. Lidar com qualquer ansiedade ou preocupação?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
Quão <u>confiante</u> está você com:	**Extremamente confiante**	**Muito confiante**	**Um pouco confiante**	**Não muito confiante**	**De modo nenhum confiante**	**Não aplicável: eu não tenho problemas actual de saúde**
10. Capaz de controlar seus problemas de saúde	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
11. Lidando com a causa dos seus problemas de saúde	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
12. No caminho certo para lidar com seus problemas de saúde	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
Por uma variedade de razões, as pessoas nem sempre siga as orientações médicas aconselhadas. Quantos aconselhamentos da sua equipa medica voce consegue seguir:	**Todos os conselhos**	**A maioria dos conselhos**	**Alguns dos conselhos**	**Não muito dos conselhos**	**Nenhum dos conselhos**	**Não aplicável: eu não recebi qualquer conselhos**
13. O(s) seu(s) medicamento(s) ou tratamento(s)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
14. Levando um estilo de vida saudável	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0

Seção Quatro

15. Agora pensando em sua saúde física, que inclui doença física e lesão, por quantos dias nos últimos 30 dias sua saúde física não era boa?

____ Número de dias [0 - 30]

16. Agora pensando em sua saúde mental, que inclui estresse, depressão e problemas com emoções, por quantos dias
durante os últimos 30 dias sua saúde mental não foi boa?

____ Número de dias [0 - 30]

17. Durante os últimos 30 dias, por cerca de quantos dias a falta de saúde física ou mental impediu que você fizesse suas atividades habituais, como autocuidado, trabalho ou recreação?

____ Número de dias [0 - 30]

Seção Cinco

FINALMENTE….

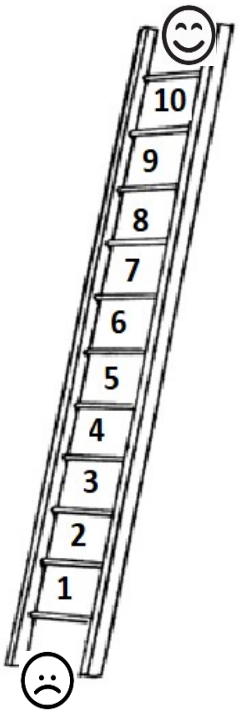
18. Por favor, imagine uma escada com degraus numerados de zero na parte inferior a dez na parte superior. O topo da escada representa a melhor vida possível para você e a parte inferior da escada representa a pior vida possível para você.

Em qual passo da escada você diria que, pessoalmente, você se sente neste momento?

____ [1-10]

19. Em qual etapa você acha que vai ficar daqui a cinco anos?

____ [1-10]



FOLLOW-UP CHT EVALUATION Evaluation ID_____ Date:_____

INSTRUCCIONES: Para cada pregunta, marque la casilla que mejor describa su respuesta. Por favor responde las preguntas como te sientes major. No hay respuestas correctas o incorrectas.

Seccion Uno

1. ¿Cuán seguro estás cumpliendo estas formas médicas por ti mismo?	**De ningum modo seguro** ☐1	**No mucho seguro** ☐2	**Um poco seguro** ☐3	**Mucho seguro** ☐4	**Extremadamente seguro** ☐5
2. ¿Con qué frecuencia usted tiene a alguien para ayudarle a leer los materiales médicos?	**Todo el tiempo** ☐1	**La mayoria del tiempo** ☐2	**Algunas veces** ☐3	**Un pouco del tiempo** ☐4	**Ninguno del tiempo** ☐5
3. ¿Con qué frecuencia usted tiene problemas para comprender sobre su condición médica debido a dificultad en entender la información escrita?	**Todo el tiempo** ☐1	**La mayoria del tiempo** ☐2	**Algunas veces** ☐3	**Un pouco del tiempo** ☐4	**Ninguno del tiempo** ☐5

Sección Dos

EN EL MOMENTO…

Pensando en su nivel de conocimiento: cuánto usted	**Sé tanto como quiero saber**	**Un poco menos de lo que quiero saber**	**Menos que yo quiero saber**	**Bastante menos que quiero saber**	**Mucho menos que quiero saber**	
4. Entienda su enfermedad actual o problemas de salud?	☐1	☐2	☐3	☐4	☐5	
5. ¿Sabes cómo mejor cuidar de ti y estar sano?	☐1	☐2	☐3	☐4	☐5	
Pensando en su nivel de comprensión: cuánto usted	**Comprendo tanto quanto quiero entender**	**Un poco menos de lo que quiero entender**	**Menos que quiero entender**	**Bastante menos que quiero entender**	**Mucho menos de lo que quiero entender**	**No aplicáble: yo no tengo problemas actuales de salud**
6. ¿Entiende su enfermedad actual o problemas de salud?	☐1	☐2	☐3	☐4	☐5	☐0
7. Comprender cómo controlar los síntomas de su enfermedad?	☐1	☐2	☐3	☐4	☐5	☐0

Sección Tres

EN EL MOMENTO…

Pensando en el suporte que usted tiene en la vida, tanto de su equipo de salud comunitaria y en otros lugares, cuanto soporte usted tiene para ayudarle ...	**Tanto cuanto apoyo como necesito**	**Un poco menos de lo que necesito**	**Menos que necessito**	**Suficiente menos que necessito**	**Mucho menos que necessito**	**No aplicáble: no necessito apoio o suporte**
8. Administrar en tu vida diaria?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
9. Hacer frente a cualquier ansiedad o preocupación?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
¿Cuán confiado está usted con:	**Extremadamente confiado**	**Mucho confiado**	**Un poco confiado**	**No mucho confiado**	**De ningum modo confiado**	**No aplicáble: no tengo problemas actuales de salud**
10. Capaz de controlar sus problemas de salud	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
11. tartar con la causa de sus problemas de salud	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
12. En el camino correcto para tartar con sus problemas de salud	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
Por una variedad de razones, la gente no siempre sigue las instrucciones médicas aconsejadas. ¿Cuántos consejos de tu equipo médico puedes seguir:	**Todos los consejos**	**La mayoría de los consejos**	**Algunos de los consejos**	**No mucho de los consejos**	**Ninguno de los consejos**	**No aplicable: Yo no recibí cualquier consejos**
13. Su (s) medicamento (s) o tratamiento (s)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
14. Tomando un estilo de vida saludable.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0

Sección Cuatro

15. Ahora piense en su salud física, que incluye enfermedades y lesiones físicas, por cuántos días durante los últimos 30 días ¿tu salud física no era buena?

____ Número de días [0 - 30]

16. Ahora piense en su salud mental, que incluye el estrés, la depresión y los problemas con las emociones, durante cuántos días durante los últimos 30 días, ¿tu salud mental no fue buena?

____ Número de días [0 - 30]

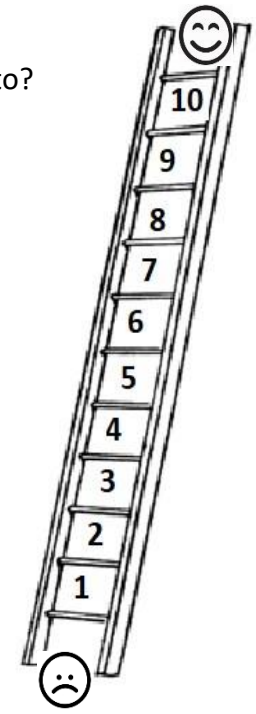
17. Durante los últimos 30 días, durante cuántos días la falta de salud física o mental le impidió realizar sus actividades habituales, como autocuidado, trabajo o recreación?

____ Número de días [0 - 30]

Sección Cinco

FINALMENTE….

18. Por favor, imagina una escalera con pasos numerados de cero en la parte inferior a diez en la parte superior. La parte superior de la escalera representa la mejor vida posible para usted y la parte inferior de la escalera representa la peor vida posible para ti.



¿En qué escalón de la escalera diría que personalmente siente que se para en este momento?

____ [1-10]

19. ¿En qué paso crees que se mantendrá dentro de cinco años a partir de ahora?

____ [1-10]

Encuesta de experiencia del paciente de CHT (solo seguimiento)

Sección Seis

Califique con qué grado de desacuerdo (1) o de acuerdo (5) con las siguientes afirmaciones sobre su experiencia con El Equipo de Salud Comunitaria (CHT):

	Fuertemente Desacuerdo	**Desacuerdo**	**No Acuerdo Ni Desacuerdo**	**Acuerdo plenamente**	**De acuerdo**	**No Aplicáble**
1. El personal de CHT me ayuda a entender cómo seguir con atención especializada (cardiólogo, salud del comportamiento, ortopedia, urólogo, endocrinólogo, educador en diabetes, etc.).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
2. El personal de CHT me ayuda a entender cuando debo o no debo ir a la sala de emergencias	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
3. El personal de CHT me conecta a recursos comunitarios que ayudan Yo con mi salud y bienestar.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
4. El personal de CHT me ayuda a supercar desafíos.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
5. El personal de CHT me proporciona Soporte emocional.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
6. Me siento cómodo hablando abiertamente Y honestamente con el personal de CHT.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0

FOLLOW-UP CHT EVALUATION Evaluation ID_____ Date:_____

INSTRUÇÕES: Para cada pergunta, por favor, marque a caixa que melhor descreve sua resposta. Por favor, responda as perguntas como Você se sente melhor. Não há respostas certas ou erradas.

Secção Um

1. Quão confiante você está preenchendo estas formas médicos por si mesmo?	**De modo nenhum confiante** ☐1	**Não muito confidante** ☐2	**Um pouco confidante** ☐3	**Muito confiante** ☐4	**Extremamente confiante** ☐5
2. Com que frequência você tem alguém para ajudá-lo a ler materiais médicos?	**Todo o tempo** ☐1	**A maioria do tempo** ☐2	**Algumas vezes** ☐3	**Um pouco do tempo** ☐4	**Nenhum do tempo** ☐5
3. Com que freqüência você tem problemas para compreender sobre sua condição médica por causa de dificuldade em entender a informação escrita?	**Todo o tempo** ☐1	**A maioria do tempo** ☐2	**Algumas vezes** ☐3	**Um pouco do tempo** ☐4	**Nenhum do tempo** ☐5

Secção Dois

NO MOMENTO….

Pensando no seu nível de conhecimento: quanto você…	**Eu sei tanto quanto eu quero saber**	**Um pouco menos do que eu quero saber**	**Menos que eu quero saber**	**Bastante menos que eu quero saber**	**Muito menos que eu quero saber**	
4. Entenda sua doença atual ou problemas de saúde?	☐1	☐2	☐3	☐4	☐5	
5. Saiba como melhor cuidar de si e ficar saudável?	☐1	☐2	☐3	☐4	☐5	
Pensando no seu nível de compreensão: quanto você…	**Compreendo tanto quanto eu quero compreender**	**Um pouco menos do que eu quero compreender**	**Menos que eu quero compreender**	**Bastante menos que eu quero compreender**	**Muito menos que eu quero compreender**	**Não aplicável: Eu não tenho problemas actual de saúde**
6. Entenda sua doença atual ou problemas de saúde?	☐1	☐2	☐3	☐4	☐5	☐0
7. Entenda como controlar sintomas da sua doença?	☐1	☐2	☐3	☐4	☐5	☐0

Seção Três

NO MOMENTO….

Pensando no <u>suporte</u> que você tem na vida, tanto da sua equipe de saúde comunitária e em outros lugares, quanto <u>suporte</u> você tem para te ajudar ...	**Tanto quanto apoio como eu necessito**	**Um pouco menos do que eu preciso**	**Menos que eu necessito**	**Bastante menos que eu necessito**	**Muito menos que eu necessito**	**Não aplicável: eu não necissito apoio ou suporte**
8. Gerenciar em sua vida diária?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
9. Lidar com qualquer ansiedade ou preocupação?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
Quão <u>confiante</u> está você com:	**Extremamente confiante**	**Muito confiante**	**Um pouco confiante**	**Não muito confiante**	**De modo nenhum confiante**	**Não aplicável: eu não tenho problemas actual de saúde**
10. Capaz de controlar seus problemas de saúde	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
11. Lidando com a causa dos seus problemas de saúde	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
12. No caminho certo para lidar com seus problemas de saúde	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
Por uma variedade de razões, as pessoas nem sempre siga as orientações médicas aconselhadas. Quantos aconselhamentos da sua equipa medica voce consegue seguir:	**Todos os conselhos**	**A maioria dos conselhos**	**Alguns dos conselhos**	**Não muito dos conselhos**	**Nenhum dos conselhos**	**Não aplicável: eu não recebi qualquer conselhos**
13. O(s) seu(s) medicamento(s) ou tratamento(s)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
14. Levando um estilo de vida saudável	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0

Seção Quatro

15. Agora pensando em sua saúde física, que inclui doença física e lesão, por quantos dias nos últimos 30 dias sua saúde física não era boa?

____ Número de dias [0 - 30]

16. Agora pensando em sua saúde mental, que inclui estresse, depressão e problemas com emoções, por quantos dias
durante os últimos 30 dias sua saúde mental não foi boa?

____ Número de dias [0 - 30]

17. Durante os últimos 30 dias, por cerca de quantos dias a falta de saúde física ou mental impediu que você fizesse suas atividades habituais, como autocuidado, trabalho ou recreação?

____ Número de dias [0 - 30]

Seção Cinco

FINALMENTE….

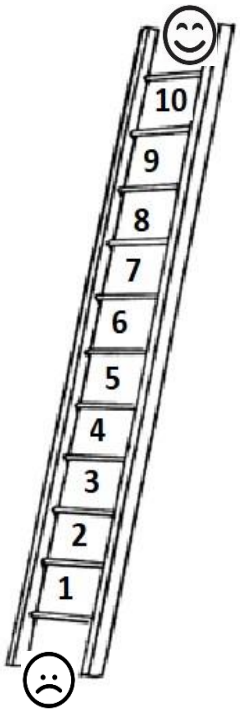
18. Por favor, imagine uma escada com degraus numerados de zero na parte inferior a dez na parte superior. O topo da escada representa a melhor vida possível para você e a parte inferior da escada representa a pior vida possível para você.

Em qual passo da escada você diria que, pessoalmente, você se sente neste momento?

____ [1-10]

19. Em qual etapa você acha que vai ficar daqui a cinco anos?

____ [1-10]



Pesquisa de Experiência do Paciente CHT (somente FollowUp)

Seção Seis

Por favor, avalie quão fortemente você discorda (1) ou concorda (5) com as seguintes declarações sobre sua experiência com a equipa de saúde da comunidade (CHT):

	Fortemente Discordo	**Discordo**	**Nem Concordo Nem Discordo**	**Concordo plenamente**	**Aceito**	**Não Aplicável**
1. A equipa da CHT me ajuda a entender como seguir adiante com cuidado de especialidade (cardiologista, saúde comportamental, ortopédica, urologista, endocrinologista, educador de diabetes, etc.).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
2. A equipa da CHT me ajuda a entender quando eu deveria ou não deveria ir a sala de emergência	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
3. A equipa da CHT me conecta recursos da comunidade que ajudam eu com minha saúde e bem estar.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
4. A equipa da CHT me ajuda a supercar desafios	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
5. A equipa da CHT me fornece suporte emocional	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0
6. Eu me sinto confortável falando abertamente e honestamente com o pessoal da CHT.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 0

Instructions for CHT Data Management

Intake Data Entry (Monthly)

- *Instructions Sheet*
- *Enter each survey into Qualtrics at the following website:*

  http://bit.ly/2oZ2zVWIntake

- *For each hardcopy survey from site #2 that you enter into Qualtrics, Create an Excel spreadsheet with each Evaluation ID # into one column and the associated UID# in the next column and the date of the Intake in a 3rd column. Email this spreadsheet to Colleen Redding.*

- Let Colleen Redding at credding@uri.edu know when data entry is completed.

FollowUp/Discharge Data Entry

- *Instructions Sheet*
- *FollowUp/Discharge data will start later and increasingly be included with monthly Intake Forms.*
- *Qualtrics Website for FollowUp Evaluation Forms*

  http://bit.ly/2x1N7NsFollowUp

- Let Colleen Redding at credding@uri.edu know when data entry is complete.

Thank you all again for your time and careful attention to these Program Evaluation data!

Instructions for CHT Data Management

Data Management Once Data Entry is Complete

- Examine Qualtrics data file for obvious duplicates & resolve if possible so that there is one unique entry/ number per participant
- Create a 7-digit Evaluation ID# merging Site# into column #1, Staff# into columns #2-3, and Evaluation# into columns #4-7
- Ensure no duplicate Evaluation ID#s
- Merge Qualtrics data with Excel spreadsheet data by Evaluation ID#
- Keep master dataset
- Create 4 separate datasets for that month's complete data entry by site (4 sites) in Excel.

FAQ - CHT Evaluation Data Collection & Reporting

Frequently Asked Questions (FAQ)

Q - When does this Evaluation data collection (SDOH, BH, Outcome Surveys @ Intake + FollowUp) start?

A – With intakes, effective 10/1/2018

Q - When does this Evaluation data collection end?

A – 6/30/2019 (with final data due on 7/15/2019)

Q – We cannot complete all follow-up evaluations in one day on 6/30/2019?

A – To spread out the work, if many clients will need followup evaluations in June, then can plan to administer them across early-mid-late June, 2019 to allow them to be completed during that last month.

Q – What is the timeframe for the FollowUp Evaluations?

A – At Discharge, 6-9 months from Intake, or 6/30/2019, whichever comes first.

Q - When is the last Intake date I should conduct for this Evaluation data collection?

A – 4/1/2019

Q – What is the least amount of time in CHT care where a follow-up survey still makes sense?

A – 8 weeks – Clients with less than 8 weeks in CHT care can simply submit the CHW's completed FollowUpStatus Survey without the full follow-up evaluation.

Q – Does every CHT client need a FollowUp Status Survey?

A – Yes, every client with an Intake needs a FollowUp Status Survey completed by the CHW, even when the client is no longer working with the CHT and has not completed any FollowUp Evaluation.

FAQ - CHT Evaluation Data Collection & Reporting

Q – My client cannot complete all this screening & evaluation in one sitting. Can I take more than one session to complete the Intake or FollowUp Evaluations?

A – Yes, Evaluations can be broken up into manageable time chunks, but should be completed within an 8-week window, as much as possible. Phone calls to complete intake or follow-up evaluations can also be conducted where appropriate.

Q – If we complete screening & evaluation in more than one sitting, which date should we use?

A – The first date starting either the Intake or the Followup Evaluation process should be used.

Q – My client has left care. I cannot complete any follow-up evaluation questions.

A – Ok, then the CHW should simply complete the FollowUp Status Survey indicating the best reason for discharge and their evaluation of this client.

Q – I have some of the SDOH or BH screening data collected in the medical record/EMR. Should I repeat these screenings or not?

A – If you feel it's important to repeat the screenings for any reason, then do so. If screenings were conducted within 8 weeks of the current evaluation date and you feel they still accurately reflect the client's current functioning, then you can simply use those screening results.

Q – My client has refused some screening questions.

A – Ok, then simply proceed to collect the data items that they were willing to answer and complete as much of the rest of the evaluation as possible. At follow-up or discharge, you can complete the FollowUp Status Survey indicating the best reason for follow-up/discharge and your evaluation of this client.

Q – I am filling in the data template and some data items are missing or nonexistent. How do I indicate that in the data spreadsheet?

A – You can simply leave those items that are missing blank.

FAQ - CHT Evaluation Data Collection & Reporting

Q – Help - I was using Qualtrics and entered some data incorrectly by mistake and it won't let me go back to correct it – what do I do now?

A – Please make a note of the Evaluation # and the item(s) affected and keep track of this in a monthly Error log to be shared with Colleen Redding at credding@uri.edu or call me @ (401) 874-4316, so we can ensure the data we use are correct.

Q – A client who came in and was fully evaluated and discharged has now re-entered care and was reassigned a New Evaluation ID # – what should I do?

A – Please make a note of both the Evaluation #s and let Colleen Redding know that these two Evaluation IDs are actually one person with 2 episodes of care at credding@uri.edu or call me @ (401) 874-4316, so we can ensure we treat these data correctly.

Q – I would like to enter Patient Experience Data only – Do I have to go through the Full FollowUpSurvey website for that?

A – No – we now have a Qualtrics website for entering Patient Experience Data only – You will still need to enter the CHT site number and the deidentified patient number first The Website is: http://bit.ly/2PBHLQ1PatientExperienceOnly

Thank you all again for your time and careful attention to these Program Evaluation data!

AGENCY Case Study: 50 Year old male. Moved back to Rhode from Texas in June of 2016 and presented to Agency in January of 2017. Brother lives in Texas but only has contact with patient if clean and sober. Patient had relapsed and returned to RI. Currently staying between a homeless shelter, sleeping outdoors and substandard housing with others who were actively using. Had been out of medical care for a little over two years. Presented at Agency concerned about 30-pound unintentional weight loss over last several months, abdominal pain, and rectal bleeding. Family history of pancreatic cancer. Patient did not have insurance and had attempted to file for SSDI but memory and mental health issues made it difficult to complete needed forms. History of polysubstance abuse. At time of first appointment was taking girlfriend's Suboxone.

	RISK DRIVERS	INTERVENTION	OUTCOMES
Medical Conditions	• Weight loss > 10% of Body weight • Memory impairment	• Supported patient to specialists and diagnostic testing for weight loss. PCP had been concerned about possible cancer dx. Provided support and accompanied patient for colonoscopy, onsite appointments, and subsequent testing.	• Patient obtained colonoscopy. R/O bowel cancer.
	• Hepatitis C (dx after starting care at Agency)	• Patient diagnosed with Hepatitis C. Connected with ID and prescribed Harvoni. Arranged for patient assistance and deliver of prescription due to insurance pending and homeless status. Supported patient to specialist/tx appointments and ultrasound	• Patient completed course of Harvoni and has cleared Hep C
	• Hyperammonemia, (dx after starting care at Agency)	• Provided BH support to patient in crisis with active	• Determined episode related to medical

	• Skin cancer (dx after starting care at Agency)	hallucinations. Patient admitted to Kent Hospital and diagnosed. • Assisted patient to dermatology for biopsy and scheduling follow-up.	condition (ammonia levels). Received tx • Patient is scheduled for MOHS and following dermatology treatment plan
Mental Health	• Polysubstance abuse • Schizoaffective D/O • PTSD • Generalized anxiety disorder • Depression	• Patient started on Suboxone in Thundermist MAT program	• Substance abuse in remission. Stable on Suboxone • Receiving med management from psychiatric nurse practitioner at Agency. CHT provides support and care coordination as necessary. • Pt able to articulate symptoms of decompensation and seek assistance from his PCP, psychiatric prescriber, CHT clinician • Improved compliance with appointment attendance and recommendations
Utilization	• Inpatient stay at Kent Hospital	• Patient initially refused medications for BH conditions. Connected with	• Pt able to articulate symptoms of decompensation and

		CHT BH clinician. Patient presented to clinic with new onset hallucinations requesting assistance.	seek assistance from his PCP, psychiatric prescriber, CHT clinician • Improved compliance with appointment attendance and recommendations
Functional Limitations	• Memory impairment and severe anxiety made it difficult for patient to come to appointments, complete paperwork and/or phone screenings.	• Assisted patient with housing applications, reapplication for SSDI, and navigating reinstating insurance	• Patient has his own apartment and is insured. SSDI reapplication is pending
Psychosocial/SDoH	• *Family:* Patient has brother in Texas moved back to RI due to estrangement. Initially had a girlfriend when returned to RI but relationship ended. • *Food Security:* Receiving SNAP • *Housing:* Homeless • *Transportation:* Needed assistance to appointments due to confusion.	• Worked with patient to reestablish healthy relationships with brother • Assisted patient to get food when wallet and EBT card was lost/stolen • Assisted with housing applications • Arranged for curb to curb assistance with Logisticare. Coordinated with Logisticare to pick patient up at various locations when patient was homeless. • Accompanied patient to	• Brother is providing financial and has reestablished relationship. Brother assists with monthly expenses. • Patient continued on SNAP • Patient is currently housed • Patient able to use Logisticare for appointments • Continue to support

		specialist appointments due to patients memory issues and confusion. Patient would present to wrong specialist office, not understand instructions and experience extreme anxiety.	patient with new diagnosis of skin cancer and treatment. Continue to support patient with finding cause of still consistent wt. loss and abd pain
	• *Financial:* Denied SSDI x3	• Assisted patient with SSDI refiling. Previous attempts to obtain SSDI involved only having information about a back injury. Now engaged in care and providing diagnosis information to support claim.	• SSDI denied three times. Next will be a hearing. Check in with SSDI attorney monthly to follow-up if any additional information and needed follow-up
	• *Insurance Status:* Patient uninsured. Unable to fill prescriptions for medications	• Supported patient in navigating reinstating insurance. Obtained Thundermist vouchering for medications when insurance was pending.	• Patient remains insured and is taking all medications as prescribed.

AGENCY Case Study: Patient is a 57-year-old female who was referred to the community health team due to

- multiple complex comorbidities,
- difficulty keeping appointments/ long lapses in care
- inconsistent medication adherence.
- additional weight gain
- depressed mood

	RISK DRIVERS	INTERVENTION	OUTCOMES
Medical Conditions	Type 2 diabetes	Pt met with a CDOE for diabetes education.	Reduced A1C from 8.5 to 5.6 No longer taking Metformin.
	Hypertension	Provided support and psychoeducation regarding comorbid conditions and self-management skills	Hypertension in control; currently trialing lower dose of Lisinopril.
	Obesity	PCP Referred pt to nutritionist and CHT reiterated lessons in the home (i.e. reviewing food labels, providing recipe books/suggestions).	Reduced BMI from 59 to 47 (pt is still losing).
		Discussed importance of physical activity and completed "walk and talk" sessions with Behavioral Health clinician to build stamina and confidence.	Pt met weight loss recommendations by bariatric surgeon and was approved for gastric sleeve surgery.

	Sleep apnea	Supported pt through process of applying for bariatric surgery (pt had to complete many tasks including endoscopies, counseling, psychiatric assessments before being approved).	Pt no longer wears a CPAP breathing machine.
Mental Health	PTSD	Pt worked with a Behavioral Health clinician to manage symptoms of depression and PTSD.	Pt reports a reduction in symptoms including nightmares, depressed mood and irritability.
	Depression	Behavioral Health clinician referred pt to psychiatric med mgt.	Pt able to articulate symptoms of decompensation and seek assistance from her PCP or psychiatric provider.
	Cannabis use	Discussed implications of ongoing marijuana use.	Pt discontinued all marijuana use as a condition of her bariatric surgery.
Utilization			Pt has only been hospitalized for her scheduled, planned bariatric surgery.

Functional Limitations	Poor health literacy and limited community supports impacted pts ability to successfully follow-through with weight loss and health goals.	Assisted pt with understanding how her health conditions impact her mood and mobility.	Pt able to use natural and community resources to navigate needs (logisitcare, family, friends, PCP).
Psychosocial/ SDOH	Transportation: struggled with mobility; cannot drive; utilizes a cane; did not know how to use the bus or public transportation prior to CHT involvement.	CHT Taught pt how to use logisticare and The RIPTA Ride Program (including bus transport) Assisted with certifying pt for curb-to-curb transportation with Logisticare.	Pt consistent attends both PCP and specialty appts. Pt able to use public transportation to get to/from grocery store and other public locations. Pt also able to coordinate with daughter for transportation needs.

CHT Case Study: 2018 Q2

61 Year old single male. Homeless, living in brother's basement. Complex medical history. Financial issues, disability issues, lack of support, anxiety and depression. Referred by PCP in December of 2017 for community resources and BH f/u. On 3 meds for BP issues only. He has a UHC Medicaid product.

Risk Drivers

Utilization: Two ED visits within 6 months. Score on RTT = 21

Health Conditions:. Frontal lobe CVA, stage 3 chronic kidney disease, hearing loss, hypertension, MDD.

Functional Limitations: MDD, anxiety, CVA causes memory loss.

Psycho-Social Factors:

Family: Doesn't have a good relationship with brother.

Housing: Homeless

Food: Food insecurity- has no resources

Transportation: Owns a vehicle and cannot afford to maintain.

Insurance: Medicaid

Financial: No source of income.

Behavioral Health: BHCM completed a BH Assessment after client scored positive on BH Screening tools. No medications at this time.

Intervention

Health Literacy: Client educated by CHW on PCP protocol for emergency visits.

Care Coordination: CHT BHCM coordinated with SSMH to ensure client was active. CHW continued to stay in contact with Social Security for application.

Medication Consult: referral to DOH Pharm to optimize medication regime including depression/anxiety.

Psycho-Social Factors:

Social/Emotional Support: Client is supported by SSMH and CHW.

Family: Reports that relationship with mother is strong, will continue to support.

Food Security: Completed SNAP application with CHW and was given a list of food pantries.

Housing: Applied for local subsidized housing with CHW.

Transportation: Drives to medical appointments only and was given information on Logisticare by CHW.

Financial: Applied for disability with CHW and is in process.

Behavioral Health: Client continues to see SSMH for BH needs.

Outcomes

Health Literacy: No ED visits in past 6 months. Score on RTT at this review = 9

Care Coordination: CHW continues to coordinate with NCM on any ongoing issues. Call to Eliza, NCM to see if Meds prescribed by SSMH.

Psycho-Social Factors:

Social/Emotional Support: ORS application completed with CHW.

Food Security: Approved for SNAP. Approximately $150 monthly.

Housing: Now living in subsidized housing in Hope Valley.

Transportation: Continues to be stable and utilizes his own vehicle for any appointments.

Financial: Approved for disability and looking for part-time employment.

Behavioral Health: Continues to see SSMH.

Patient Experience survey: to be completed via Interview by CHW

AGENCY CHT Case Study: 2018

Client is a 75 year old women who has a diagnosis of MS. Client was dx in 1984 and has limited function due to MS symptoms. Client has limited financial resources and has difficulty being able to financially manage her in home care as well as prescriptions and medical supplies required to best manage her chronic illness. Client lives independently and volunteers one day a week at local Hospital doing file work.

Risk Drivers

Utilization: Client referred from PCP office for resource, has Home Health currently in place.

Health Conditions: MS (DX in 1984), CHF, Diabetes, and Hypertension

Functional Limitations: Has not had ability to walk since mid 80s, can stand for short periods of time. Can transfer from wheel chair to shower bench/ scooter/etc. Receiving limited in home care from nursing agency.

Psycho-Social Factors:

Family: Has supportive brother who lives locally but she does not see as often as she would like.

Housing: Lives in subsidized elderly/ disabled housing

Transportation: Does not drive but uses RIPTA FLEX bus for all transportation needs.

Insurance: Medicare

Financial: Receives 1,348 monthly from SSDI. Pays out of pocket for home care, many medications, and medical supplies (including briefs that she wears daily).

Behavioral Health: No behavioral health concerns.
RTT score at time of intake: 15

Intervention

Health Literacy: Client has had education on how to best manage her health and has an understanding of healthy practices.

Care Coordination: PCP office made referral to CHT for resources support.

Social/Emotional Support: Client approved her brother to obtain access card to her apartment.

Community Resources:

Food Security: Client has engaged with the Johnny Cake Center of Peace dale.

Housing: Housing is stable

Transportation: Client reports being happy with the RIPTA services. She received a free bus pass.

Financial: Long term services and supports (LTSS) application was completed by CHW.

Behavioral Health: No intervention required.

Outcomes

Health Literacy: Client better able to manage her health with more supports from care agencies and financial supports. Home care hours have increased

Care Coordination: PCP updated on progress via monthly case review.

Social/Emotional Support: Clients brother now has key card access and checks in on client 2-3 times a week.

Community Resources:

Food Security: Client has aid do her food shopping for her and has received deliveries from Johnny Cake to help supplement.

Housing: Housing remains stable.

Transportation: Continues to utilize RIPTA services and has received free bus pass.

Financial: Client was approved for LTSS on 9/13 and they have picked up the cost of her prescriptions, medical supplies (included new shower bench and briefs), decreased her out of pocket cost for nursing agency and increased the hours of service.

Behavioral Health: No behavioral health concerns.
RTT score at time of discharge: 5

AGENCY CHT Case Study 2018

Patient is a 60 year old single white male who was referred to the CHT for ETOH and community resources and support (identified by SBIRT screening in ED). He has a significant HX of failed attempts @ treatment and sobriety. Denies present SI/SA. He does report a history of bipolar, PTSD, depression and anxiety.

Risk Drivers

Triage Score @ time of intake =22

Utilization: Client had 12 INPT admissions in 2017 (alcohol intoxication)

Health Conditions: Active Hepatitis C, reflux, HX of seizures, DTs, withdrawal. Smoker.

Functional Limitations: General weakness, severe Dt's, seizures .

Psycho-Social Factors

Social/Emotional Support: Relies on support from his brother who also has issues with alcohol and SA. No additional support.

Family: Relies on brother .

Housing: Client rents a 1st floor apartment. Potential eviction reactive to his brother owning a dog.

***Utility*:** Client has difficulty paying for heat.

Transportation: Does not have a car – needs Logisticare connection.

***Financia*l**: Client is on a fixed income; receives SSI.

Behavioral Health: Depression, anxiety, Bipolar, PTSD. Alcohol Dependence. Grief associated with finding SO expired in home.

Intervention

Utilization/health conditions/functional limitations: Connected with services at TMIST for medical treatment. Connected to smoking cessation program at TMIST.

Psycho-Social Factors

Social/Emotional Support: Introduced client to AA and their social support network.

Family: Relationship between client and his brother was negatively impacted by decision to evict him and his dog, for client to remain in his own apartment.

***Housing*.:** Housing now stable after eviction of client's brother and his dog.

Utility: Provided client with resources for heating assistance.

Transportation: Assisted client with registering for Logisticare services

Behavioral Health: Client was connected with TMIST for psychological treatment and medication management.

Outcomes

Utilization/health conditions: No INPT admissions in 2018. Actively on Harvoni for Hep C, additional medication for seizures and depression. Currently not smoking.

Functional Limitations: Weakness improved. DTs still impacting function.

Psycho-Social Factors

Social/Emotional Support: Client is actively engaging in AA, with both a group and sponsor.

Family: Relationship with brother strained due to brother's continued alcohol use.

Housing: Stable at present.

***Utility*:** Stable at present.

Transportation: Client currently connected with and utilizing Logisticare, and his bicycle.

Behavioral Health: Client has maintained alcohol abstinence, is actively engaged in 12-step programming, has developed a comprehensive recovery plan. Services at TMIST managing depression, anxiety, bipolar, PTSD, and grief/loss.

Triage Score @ time of reporting=15

AGENCY CHT Case Study: 2017 Q3

45 yr old single male. Complex medical conditions: obesity , chronic respiratory failure, severe ischemic cardiomyopathy, cardiac ejection fraction is 11% , A-fib, fractured ankle. Received referral from Home Health in May 2018. Client has financial issues and was kicked out of home at time of referral. RTT score at intake was a 37 and currently a 12.

Risk Drivers

Utilization: 5 inpatient stays and 2 ED visits prior to referral and 5 inpatient stays and 2 more ED visits since referral

Health Conditions: CHF, COPD, A-Fib, obesity, fractured ankle- walks with cane and boot

Functional Limitations: General weakness, cannot walk or stand for any length of time

Psycho-Social Factors:

Family: Has 3 children with ex-GF

Housing: was kicked out of home with ex-GF, homeless at time of referral (inpatient).

Transportation: Does not drive.

*Insurance: Medicaid/*Medicare dual

Financial: At time of referral SSDI had been stopped, can't afford medications, food insecurity, no housing

Behavioral Health: no BH indicated

Client has a felony record

Intervention

Health Literacy: client educated on when appropriate to go to ED or to call PCP - had defibrillator put in.

Care Coordination: Supported with specialist visits

Social/Emotional Support: Has family support from brother in CT and his children.

Community Resources:

Food Security: Has SNAP but GF will not give him his card.

Housing: Applying for housing currently at a rooming house in CT

Transportation: uses Logisticare for medical appointments

Financial: reinstated his SSDI of $773- secured assistance from SVDP and Pawcatuck Neighborhood Assoc. for rent owed. Working with lawyer to have child support adjusted.

Behavioral Health: none

Outcomes

Health Literacy: recently released from SNF and doing well at this point- has remained out of the hospital for 2 months

Care Coordination: just had a heart procedure and is feeling better

Social/Emotional Support: family.

Community Resources:

Food Security: got his card back from Ex.

Housing: continue to look for housing- intake scheduled with Open Doors

Transportation: relies on rides

Financial: just got a PT job at a local restaurant- completed application to have child support court ordered and adjusted to his income.

Behavioral Health: none

Agency CHT Case Study: 2017 Q3

Client is a 86 year old woman who lives alone in her home in North Kingstown. Her husband was a navy man who passed away 2.5 years ago. It was reported at the time of intake that she was was having memory issues, mini mental is 20/30. Assessed home safety, identified resources she may need, addressed increased feelings of depression. RTT score at intake was a 23 now a 17.

Risk Drivers

Utilization: Client's medical conditions CHF. Recent Fall – resulting in C2 fracture. Has memory issues, mini mental is 20/30.

Health Conditions: Fall risk, CHF. - Medications will continue to be bubble packed.

Functional Limitations: General weakness in her knees.

Psycho-Social Factors

Family: Son and daughter-in-law very involved.

Housing: Client owns her home. Needed some minor Roof repairs.

Transportation: Client had been driving her own vehicle.

Insurance: Medicare -Tri care for life.

Financial: SSI and Navy Pension

Behavioral Health: Depressed

Intervention

Health Literacy: Client educated on reducing fall hazard in her home. Established a set of rules and guidelines that provide safe living conditions.
Care Coordination: Patient was recently connected to Home Health Wellness Services. Will require in house supports. Frequency TBD.
Social/Emotional Support: Relies on support from Son and daughter in-law. All doctor's appointments will be attended with assistance of others.

Community Resources
Food Security: Will e stablish PeaPod Food Delivery –coordinate with CNA to assist with the " food shopping" and laundry -cooking restrictions in place .

Housing: CNA will assist with shower and bath. Housekeeping, laundry provided by others. Will begin explore VA services for LTC options.

Transportation: Will ensure transportation through - Logisticare., L & C Eldercare transport- (Linda) Tina Grills transporter.

Financial: All financial matters will be approved by family.

Behavioral Health: Provide on-going support through CHT/SBIRT worker.

Outcomes

Health Literacy: Addressed fall hazards. Client needs to use walker/cane for stability. Established a set of rules and guidelines that promote safe living conditions.

Care Coordination: Concord Home care will provide nursing 1x week – PT/OT, CNA 3x week.

Social/Emotional Support: Relies on support from her son and daughter in-law primarily. Receives on-going support through CHT.

Community Resources
Food Security: Establish PeaPod Food Delivery –coordinate with CNA to assist with the delivery -cooking limited to microwave only –Gas shut off

Housing: Limited to first floor ONLY –No basement trips. Explore VA services for LTC options.

Transportation: No driving will be allowed.

Financial: All financial matters will be approved by family.

Behavioral Health: On-going Support to address BH needs

AGENCY CHT Case Study: June 2018

60yr old male, who was released after a long-term incarceration one year ago and is currently homeless. Referred to CHT in February of 2018 for assistance with understanding medical coverage and housing. Patient is covered by Medicare, NHP Unity.

Risk Drivers

Utilization: ER visit in January of 2018 for chronic back pain and low blood sugar.

Health Conditions/Literacy: Type 2 Diabetes, Hepatitis C, Essential Hypertension, chronic back pain, concerns with short-term memory. Poor diet and insight into medical condition. Unable to obtain medications due to co-pay costs.

Social/Emotional Support: Patient identified one older sibling as support.

Functional Limitations: Chronic lower back pain impacting ability to maintain employment, low blood sugar.

Psycho-Social Factors:

Family: Separated from significant other roughly 6 months ago. Patient is connected with older sibling, no connection with his two children from previous relationship.

Food Security: Patient recently obtained SNAP benefits

Housing: Homeless, and living in his vehicle.

Transportation: Currently owns a vehicle.

Financial: Working part–time as truck driver. Due to chronic back pain, patient is currently applying for TDI.

Behavioral Health*:* Depression

Intervention

Health Conditions/Literacy: Provided with education on medical condition and care, reviewed diet and insulin schedule. CHW & PCP advocated for medication co-pay reduction.

Care Coordination: CHW & PCP are coordinating services, advocating for Neuropych evaluation to assess possible short-term memory issues.

Social/Emotional Support: Church congregation for social/emotional support.

Psycho-Social Factors:

Family: Reconnect with sibling and children

Housing: Completed RI Housing application. Actively searching for apartments.

Transportation: Maintain vehicle.

Financial: Working with patient to establish financial literacy and saving. Patient currently has an active checking and saving account.

Behavioral Health*:* Motivational Interviewing to encourage patient to consider referral to additional mental health services.

Outcomes

Utilization: ER visit in May for severe back pain exacerbated by truck driving

Health Conditions/Literacy: Patient has a better understanding of daily insulin intake. Medication co-pay has been reduced and Patient is taking medications as prescribed. Patient has Increased insight into diet. Patient utilizes cell phone to maintain scheduled appt reminders. Currently researching physical therapy to aid with chronic back pain.

Care Coordination: Patient meets weekly with CHW and maintains all PCP appts. PCP will make referral for Neuropsch.

Social/Emotional Support: Patient is actively engaged with local church

Functional Limitations: Patient is utilizing cell phone alerts for medication reminders

Psycho-Social Factors:

***Family*:** Considering outreaching children.

Housing: Multiple housing applications have been submitted. Patient able to stay with church members as needed.

Transportation: Active registration and insurance.

Financial: Patient applying for TDI benefits, possibly SSDI benefits.

Behavioral Health*:* Patient is utilizing faith-based supports as needed.

AGENCY CHT Case Study: Sept 2018

72yr old female, who recently was discharged from the hospital for difficulty breathing, resulting in a diagnoses of COPD. Referred to CHT in April of 2018 due to financial constraints which cause her to skip medications. Patient was at risk for repeated hospitalization dues to not taking medication for COPD.

Risk Drivers

Utilization: Hospitalized in April of 2018 due to inability to breathe.

Health Conditions/Literacy: Diagnosed with COPD Exacerbation, high cholesterol, arthritis and weight concerns. She often cannot afford medications.
Social/Emotional Support: Patient's only support is her son that lives with her.

Functional Limitations: Patient has difficulty breathing while walking and doing daily household chores especially when it is hot.
Psycho-Social Factors:
Family: Patient's husband is deceased and she is estranged from another son.

Food Security: Patient's income exceeds SNAP guidelines, but she often cannot afford groceries at the end of the month.

Housing: Currently living on the 2nd floor of an apartment building which recently had an infestation of bed bugs that took over one month to resolve. Patient had and application in with the House of Hope when referred to CHW.

Transportation: Patient uses Logisticare for medical appointments, and her son will bring her shopping when necessary.

Financial: Patient's rent is approximately half of her income per month, and she wants to find a lower cost apartment so that she can better afford medications and food. Patient's son contributes half of his paycheck per week. He works for minimum wage.

Behavioral Health: None.

Interventions

Health Conditions/Literacy: CHW provided education to the patient regarding the importance of taking breaks when walking, doing household chores, and completing daily activities.

Care Coordination: CHW coordinated with PCP, RIPAE, and the patient's pharmacy to assist with lowering prescription costs. CHW assisted the patient in working with her PCP to prescribe a more affordable medication. Coordinated with PCP to complete Pharmacy Support and Dietician referrals.

Social/Emotional Support: Patient states she is happy with her relationships.

Psycho-Social Factors:

Family: Patient is not interested in reaching out to her second son at this time.

Food Security: Patient uses son's weekly contribution to buy groceries to supplement her end of month shortfall. CHW provided patient with a list of nearby food pantries.

Housing: Currently working with House of Hope to find a new apartment.

Outcomes

Utilization: Patient has not been readmitted to the hospital.

Health Conditions/Literacy: Patient was prescribed a medication she can afford. However, patient is not able to take her preferred medication due to her inability to pay the co-pay costs.

Care Coordination: Patient was given a one time coupon for medication. Despite being approved for the RIPAE program, patient was ultimately unable to utilize her card due to maximum medication cost restrictions. As a result, patient's PCP prescribed a new medication she can afford. Pharmacy and Dietician referrals have been submitted.

Social/Emotional Support: No Concerns

Functional Limitations: Patient states she is not concerned with her limitations, she takes a break when needed and receives assistance from her son.

Psycho-Social Factors:

Family: Patient is happy with her relationship.

Housing: Patient is currently 100 on the housing list, and the CHW continues to work with House of Hope to monitor status.

Transportation: Patient reports no concerns

Financial: CHW is working with patient to explore cost saving options and effective budgeting.

Site 4 CHT Case Study: 2018, Q2

Female in her early 30's who lives alone in HUD housing, gets SSDI, has Medicare/Medicaid. Referred to CHT because of persistent apartment break-ins, harassment from other tenets in her building, since returning from trip. She wants to move. Patient described a broad and secretive conspiracy to CHT, led by other residents stalk, assault, sexually harass, and defile her apartment. Emergency Mental Health Evaluation arranged by CHT confirmed she was having a psychotic episode, however, she did not present a danger to herself or others and no further action could be taken.

Risk Drivers

Triage Score: 18
Utilization: 2 ER visit in 6 mos. prior to referral for Anxiety; 5 Psych admissions in 2 month span while homeless

Health Conditions/Literacy: Bipolar, Anorexia-Low BMI, Anxiety, Metabolic disease.
Behavioral Health/ Care Coordination: Private psychiatrist, little coordination w/ PCP, consult reports contradicts symptom presentation.

Poor Discharge planning:
- Brief IP stays, little change in mental status upon discharge, discharged to street with bus pass and list of shelters.
- Little to no coordination from discharge planners. Rarely returned calls from CHT. Provided conflicting information.

Housing: Street Sleeping Homeless: Abandoned HUD apartment-led to eviction.

Social/Emotional Support: Self isolated, pet cat is only source emotional support.

Functional Limitations: Apartment "trashed", will not prepare meals or do laundry, Inconsistent hygiene and med taking due to delusions, thoughts too disorder to manage finances and affairs.

Family: Thinks Father is part of conspiracy

Transportation: Walks, Does not drive, too paranoid to take bus

Intervention

Social/Emotional Support:/Engagement
-Established rapport under pretext of assisting patient to find new housing.
-Made frequent face-to face visits.
-Non-judgemental listening to delusions.
-CHT drove through community to locate her and maintain contact. While Homeless

Behavioral Health/ Care Coordination:
- CHW worked closely with Health Plan NCM. Attempted to get patient to agree to Health Home, she refused.

Utilization: CHT proactively and repeatedly contacted discharge planners.
- Physically went to facilities during visiting hours to get release of information forms signed.
- Persistently Advocated for patient to have warm hand –off to health home team and intake with rehousing organizations, and longer stays for patient to become psychiatrically stable before discharge. Patients was certified multiple times during final admission.

Housing: CHW convicted patient to extend last admission until group home bed became available.

Outcomes

Current Score: 4
Utilization: 1 ER since last BH discharge for non-psych reason.

Health Conditions/Literacy: Bipolar disorder well controlled, patient is gaining weight.

Care Coordination: New BH provider Release forms in place with .

Social/Emotional Support: Engaging with others, performs leisure activities in the community.

Functional Limitations:
Taking meds and performing ADLs.

Psycho-Social Factors:
Housing: Lives in group home, is working on going back to independent living

Family: Improved relationship with father

Transportation: More willing to use bus

Behavioral Health: Getting comprehensive BH care from Community Mental Health Center.

AGENCY CHT Case Study: 2018, Q3

Male in his 50's, immigrated from Liberia during the civil war. Experiencing chronic headaches and vertigo past 3 years. Symptoms caused him to lose job and stop driving. Many ED and specialist visits, no progress on treating/identifying cause of symptoms– pt. very frustrated. PCP wants him to go to psych, he refuses. No income, homeless-couch surfing, liminal English literacy, kids in Africa rely on him financially.

Risk Drivers

Triage Score: 22
Utilization: 2016-2017
14 ED Visits
Audiologist, Otolaryngologist, Gastroenterologist, 2 ENT's, Neurologist, LICSW, Several Radiology visit.
Health Conditions/Literacy:
Chronic Headaches/Vertigo, very frustrated over failure to find effective tx.
Care Coordination:
PCP trying to figure out cause of Headaches/Vertigo, will not see psychiatrist
Social/Emotional Support:
Support from tight knit immigrant community. Children in Africa, Girl friend out state. Very spiritual.
Functional Limitations:
Can't drive or work, English second language, stopped school after 4th grade, very limited English literacy.

Psycho-Social Factors:
Financial: No income. Lost job due to symptoms, exhausted unemployment and TDI
Family: Stressed over inability to send money to support children in Africa, causing conflict

Housing: Homeless, couch surfing

Transportation: Walks to destinations

Behavioral Health: PTSD, Depression

Intervention

Utilization: Frequent PCP visits

Health Conditions/Literacy: Health Coaching, Sinus surgery- no improvement reported post surgery, insurance would not cover Mayo clinic, saw faith healer in Africa

Care Coordination: Coaching to appointments and follow PCP recommendations

Social/Emotional Support: Very frequent visit and calls with CHW

Functional Limitations: Regularly go through mail and documents with CHW, referred to GED classes

Psycho-Social Factors:

Family: Coached to focus on what he can control

Housing: Assistance applying for subsidized housing

Transportation: Taught how to use Logisticare

Financial: Guided though SSDI process, lawyer referral

Behavioral Health: Coached to partial hospitalization

Outcomes

Current Triage Score: 11

Utilization: 2 ER visits in 2018, none for headache/dizziness

Health Conditions/Literacy:
Following PCP recommendations, going to acupuncture, reports improvement in symptoms.

Care Coordination: Going to appointments

Social/Emotional Support: Still checks in regularly with CHW and engaged with immigrant community.

Functional Limitations: started driving again, enrolled in GED class over the summer.

Psycho-Social Factors:
Financial: Got SSDI on appeal

Family: Paid for daughters' school tuition, eased strain with family

Housing: On list for public housing, has good priority standing

Transportation: Starting to drive again, uses Logisticare as needed.

Behavioral Health: Much improvement in mood.

Case Conference

Patient:

At time of referral:

- No follow up with PCP
- Severe self-neglect
- No home health support
- Patient resistant to assistance
- DEA case management inconsistent with provider medical attestation

CHT Interventions:

- Renewing Logisticare service for patient to facilitate rides to medical appointments
- Application for Meals on Wheels
- Budgeting assistance/financial planning
- Communication with DEA case manager to encourage care plan coordination
- Coordination with physical therapist and other service qualification criteria
- Weekly check-ins to identify further support needs

Outcomes:

- Patient presents more consistently for provider appointments
- Patient more receptive to assistance
- Approved for Meals on Wheels
- Family support system aware of increased needs
- DEA assisted living/home health services application completed and submitted to case manager with expected approval

Strengths:

- Patient is familiar with the process now and responds well to a routine of people coming to see him even though he is severely cognitively challenged and often does not remember they are coming.
- Communication facilitated by the CHT between EBCAP health center and DEA case manager has been crucial in the completion of applications necessary to connect patient with the level of care he requires.

Weaknesses:

- Patient's severely diminished cognition renders him unable to follow or remember many simple tasks, making successful follow through very challenging. Patient requires almost everything to be done for him.

Opportunities:

- Receiving consistent home-based care or moving into assisted living will provide patient with the support he needs to maintain his highest level of independence and self-agency while also living safely.

Challenges:

- Patient has a history of in-patient ETOH treatment and does not seek support with recovery.
- Patient makes risky decisions to obtain alcohol which sometimes result in physical injury or absence from his apartment when home visits/assessments are scheduled.
- Patient is not interested in moving out of his apartment even though he has been deemed not safe to live independently. The DEA case manager's job is to try and do everything she can to keep patient living independently so there is a potential conflict of interest in care planning.
- Potential concerns regarding patient's history of ETOH hospitalizations and eligibility for assisted living.

Community Health Team (CHT) Final Evaluation Data : 10/1/2018 – 6/30/2019

Colleen A. Redding, Ph.D.

Cancer Prevention Research Center

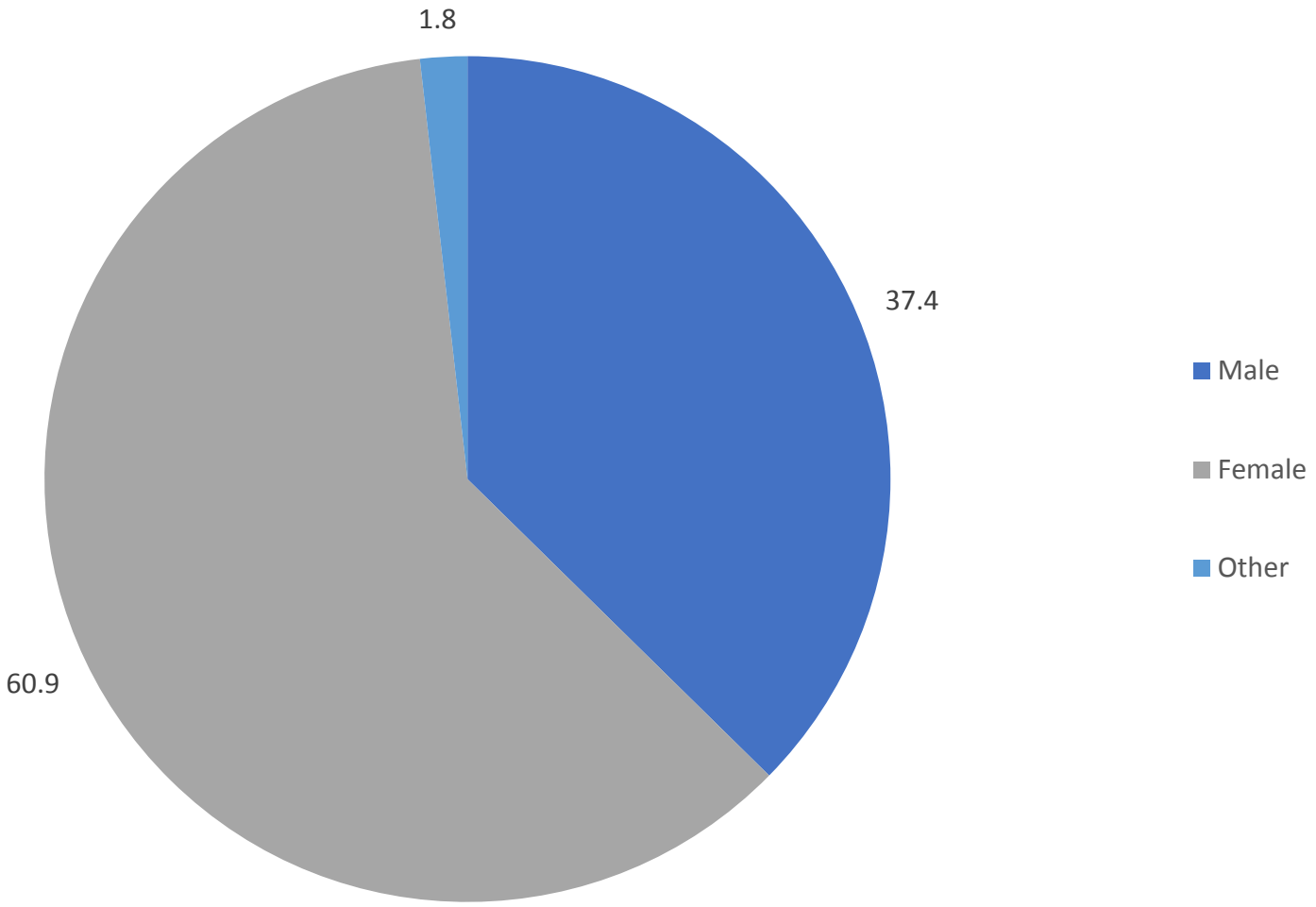
University of Rhode Island

Final CHT Evaluation Data

- Collected at 7 CHT teams at 4 sites
- Screened for:
  - Health Risks (RTT or IA)
  - Social Determinants of Health (Health Leads, PRAPARE, etc.)
  - Behavioral Health Risks (PHQ, GAD, DAST, AUDIT, CAGEAID)
  - Assessed Health Literacy, Health Information & Knowledge, Health Confidence, Support, Adherence, Quality of Life, & Wellbeing.
- CHT Evaluation data:
  - Pre-Post SBIRT CHT 10% Rescreened Substance Use data (n=56)
  - Intake CHT data (n=397) 10/1/2018 – 4/1/2019
  - FollowUp CHT data (n=388) 10/1/2018 – 6/30/2019

- Convenience Samples CHT Evaluation data:
  - Pre-Post Health Risk from 3 CHTs (n=71)
  - Pre-Post BH from 1 CHT (n=66)

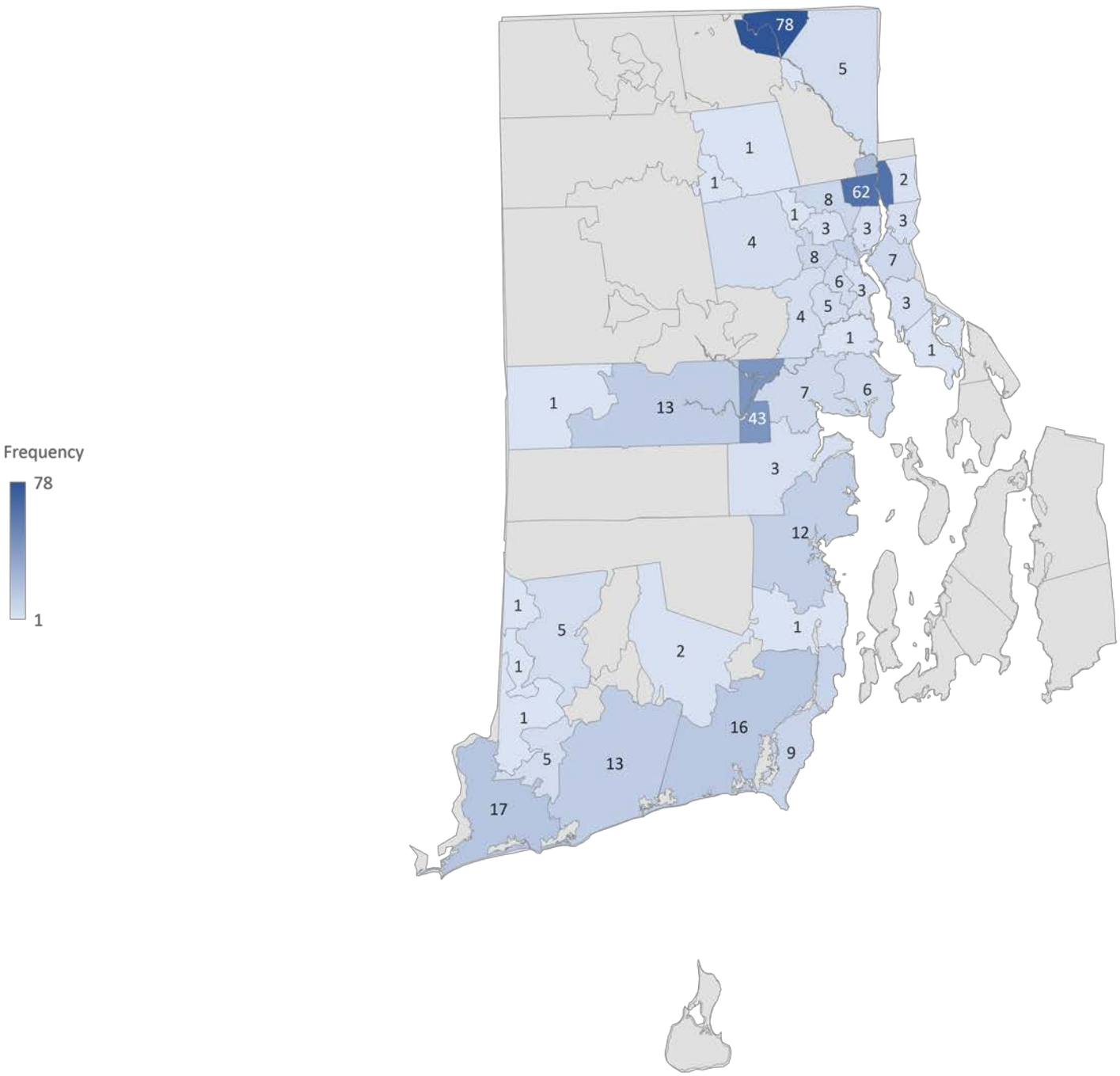
Gender



CHT Client Demographics

Age (years)	Mean = 54.1 (sd = 16.7)
Non-English Speaking	20.9%
Hispanic/Latinx	25.8%
Non-White	35.5%
White	64.5%
Refused to answer	17.1%
Black/African American	9.3%

RI CHT Reach by Zipcode



Intake CHT SDOH (N=342) – 83% had ≥ 1 SDOH need

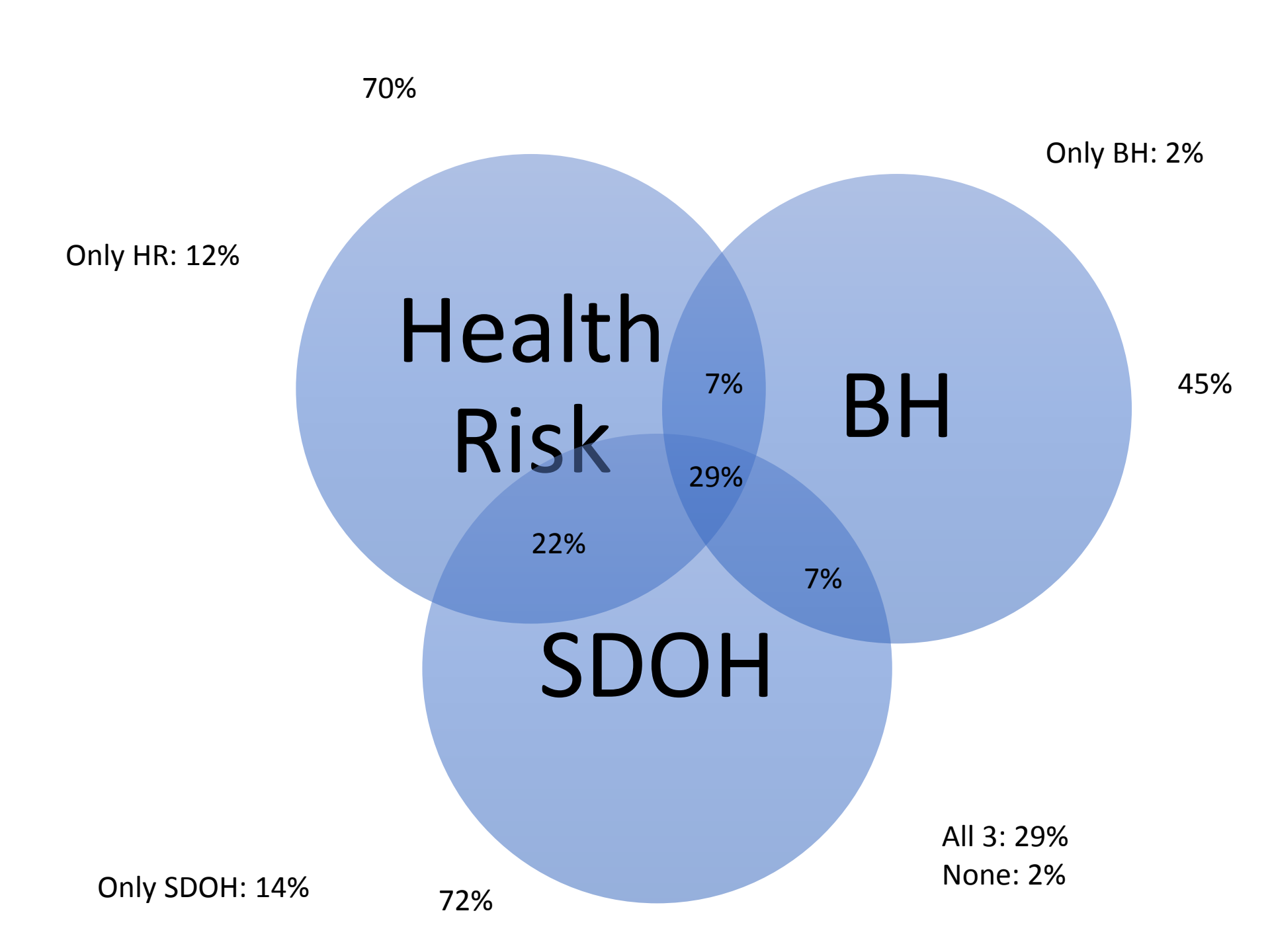
SDOH Needs (Median Number of SDOH = 2)	
Housing	45.5%
Finance/Utilities	41.2%
Transportation	39.9%
Food	39.0%
Caregiver Support	18.7%
Interpersonal Violence	16.3%

All SDOH Categories Showed Significant Changes From Intake to Follow Up (n=108-162)

	% reporting issue at intake	% no longer reporting issue at follow-up
Housing	**41.4%**	56.7%
Finance/ Utilities	**39.0%**	66.7%
Food Insecurity	**32.9%**	63.5%
Transportation	**31.0%**	44.9%
Caregiver Support	**22.2%**	50.0%
Interpersonal Violence	**19.3%**	71.4%

Health Screening Guidelines

Health Risk	
RTT Scores (4-39) >=15 (n=197)	65.5%
Impactability Algorithm (0-11) > 4 (n=170)	51.2%
Behavioral Health	
Anxiety – GAD2/7 (0-21) >= 10 (n=234 – 59% screened)	46.6%
Depression – PHQ2/9 (0-27) >=10 (n=330 – 83% screened)	47.3%
Substance Use – 81% screened	
AUDIT >= 16 (0-30) (n=149)	10.1%
DAST10 >= 3 (0-9) (n=163)	8.1%
CAGEAID >= 1 (0-4) (n=143)	0.0%


70%
Only BH: 2%
Only HR: 12%
Health Risk
7%
BH
45%
29%
22%
7%
SDOH
All 3: 29%
None: 2%
Only SDOH: 14%
72%

Intake Quality of Life – Number of Unhealthy Days out of 30

- Unhealthy Days due to Physical Health

  M=17.3 (SD= 11.3)

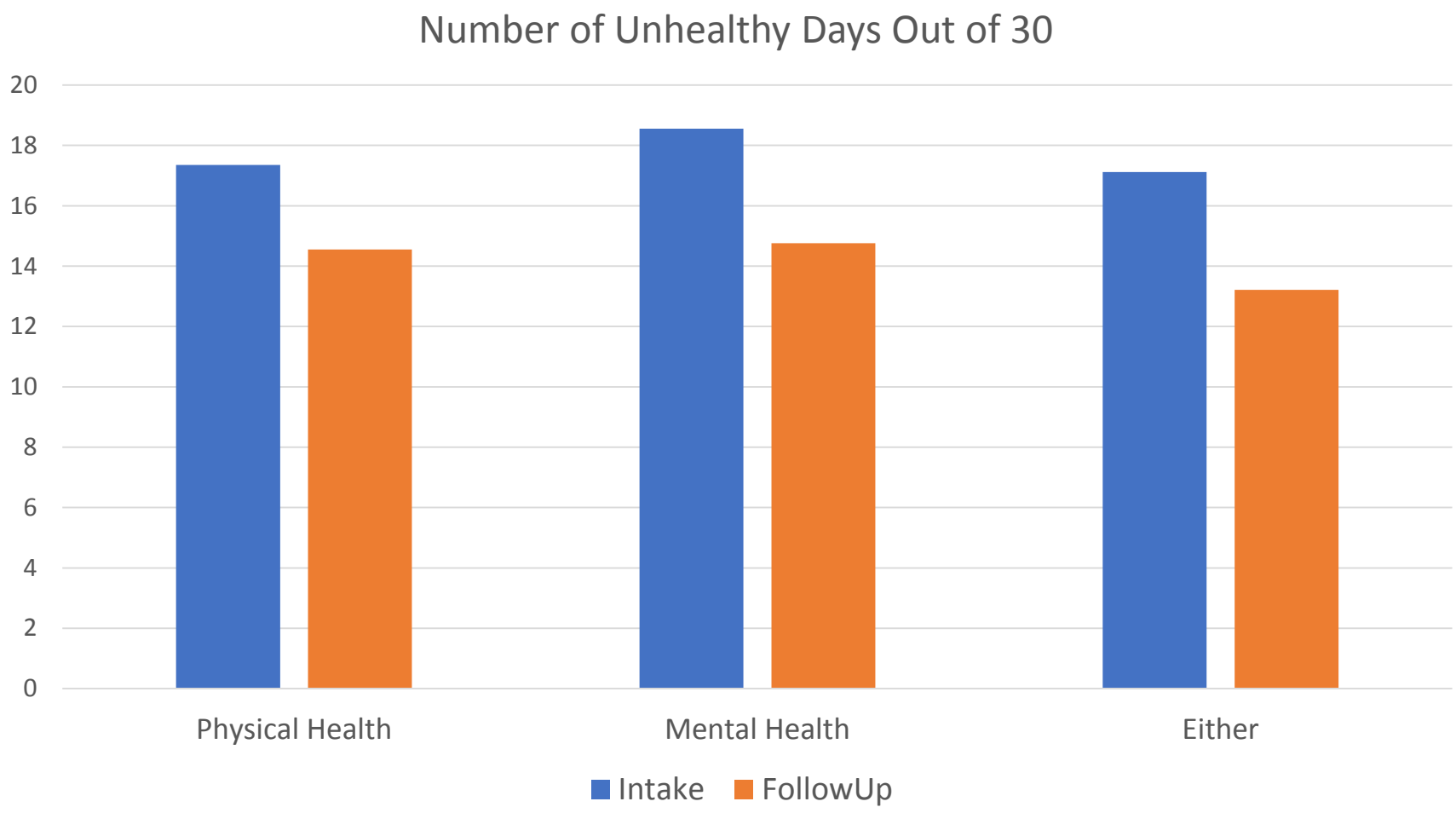
- Unhealthy Days due to Mental Health

  M=18.2 (SD= 11.4)

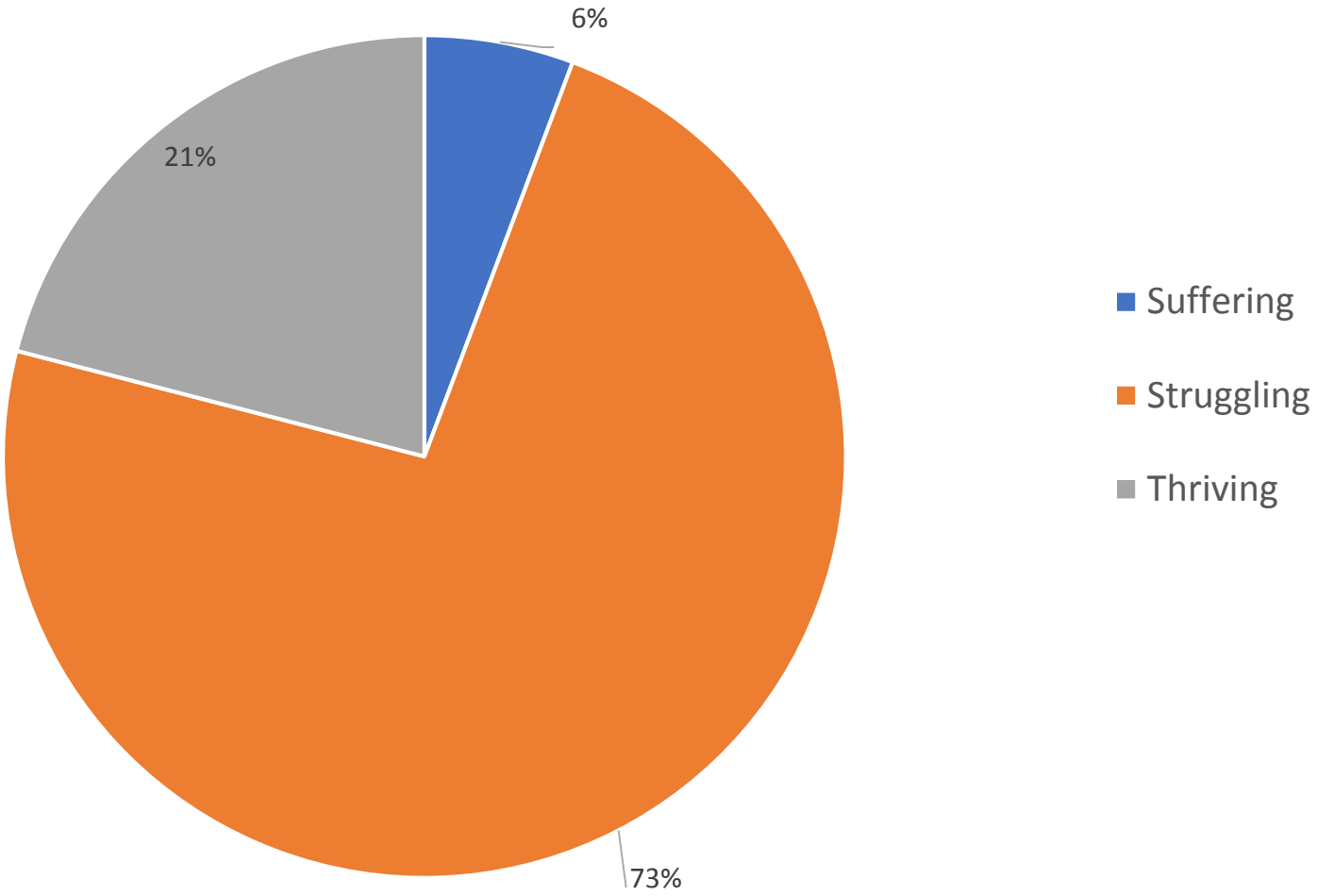
- Overall Unhealthy Days due to Either Physical or Mental Health

  M=16.8 (SD= 11.4)

Quality of Life – Number of Unhealthy Days Changes from Intake to Follow Up ($p < .05$)



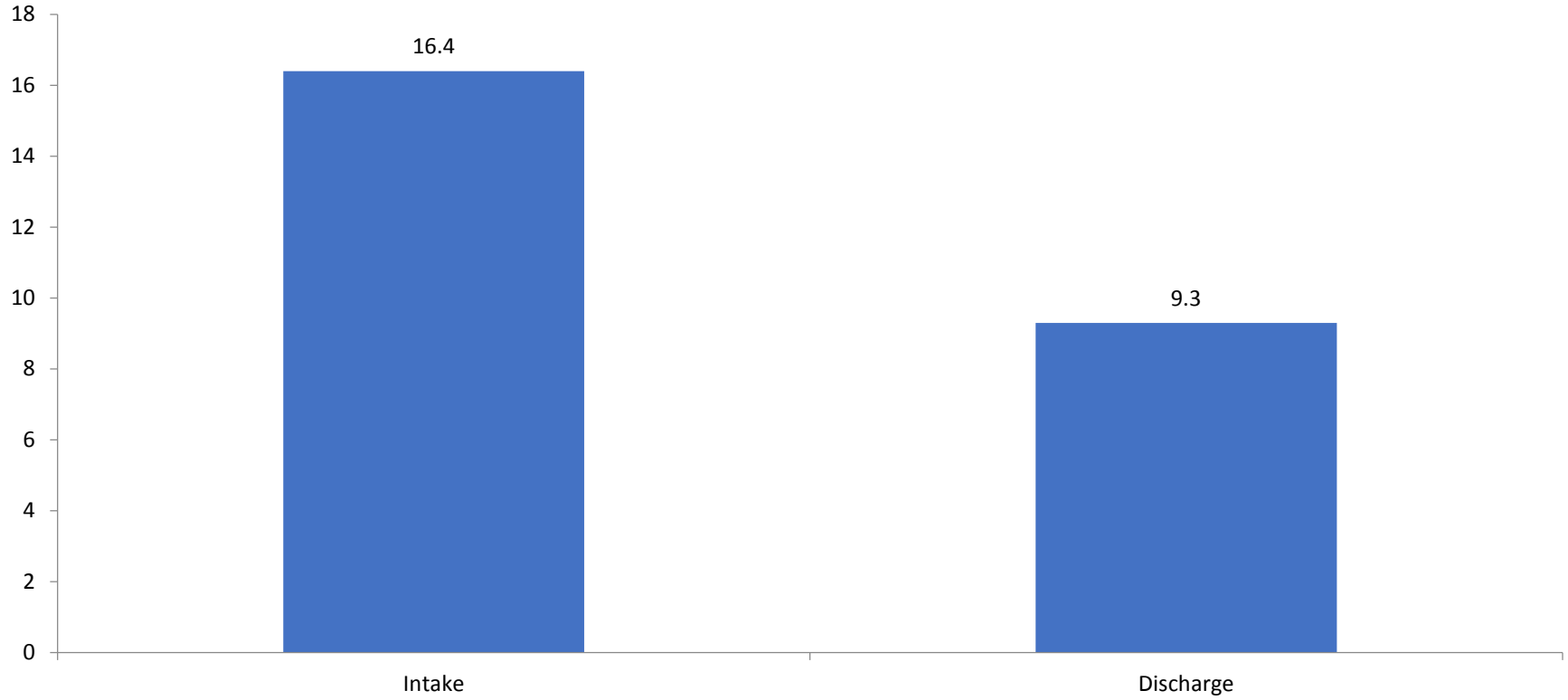
77% of CHT Patients at Intake were Struggling or Suffering (N=304)



Convenience Sample Pre-Post Changes in Health Risk

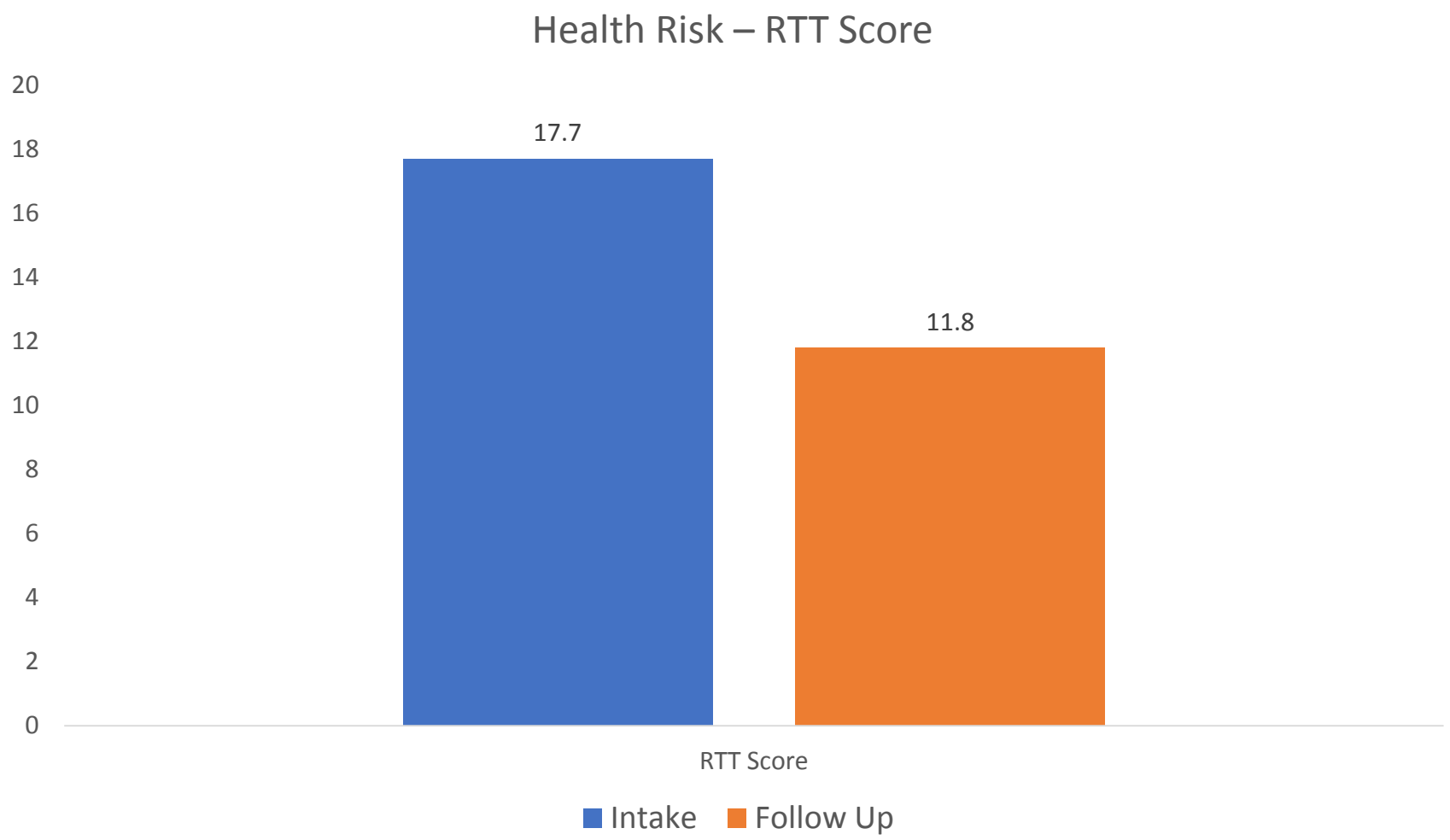
CHT Referral Triage Tool Scores (n=66)

***t* (65) = 11.84, *p* < .0001**

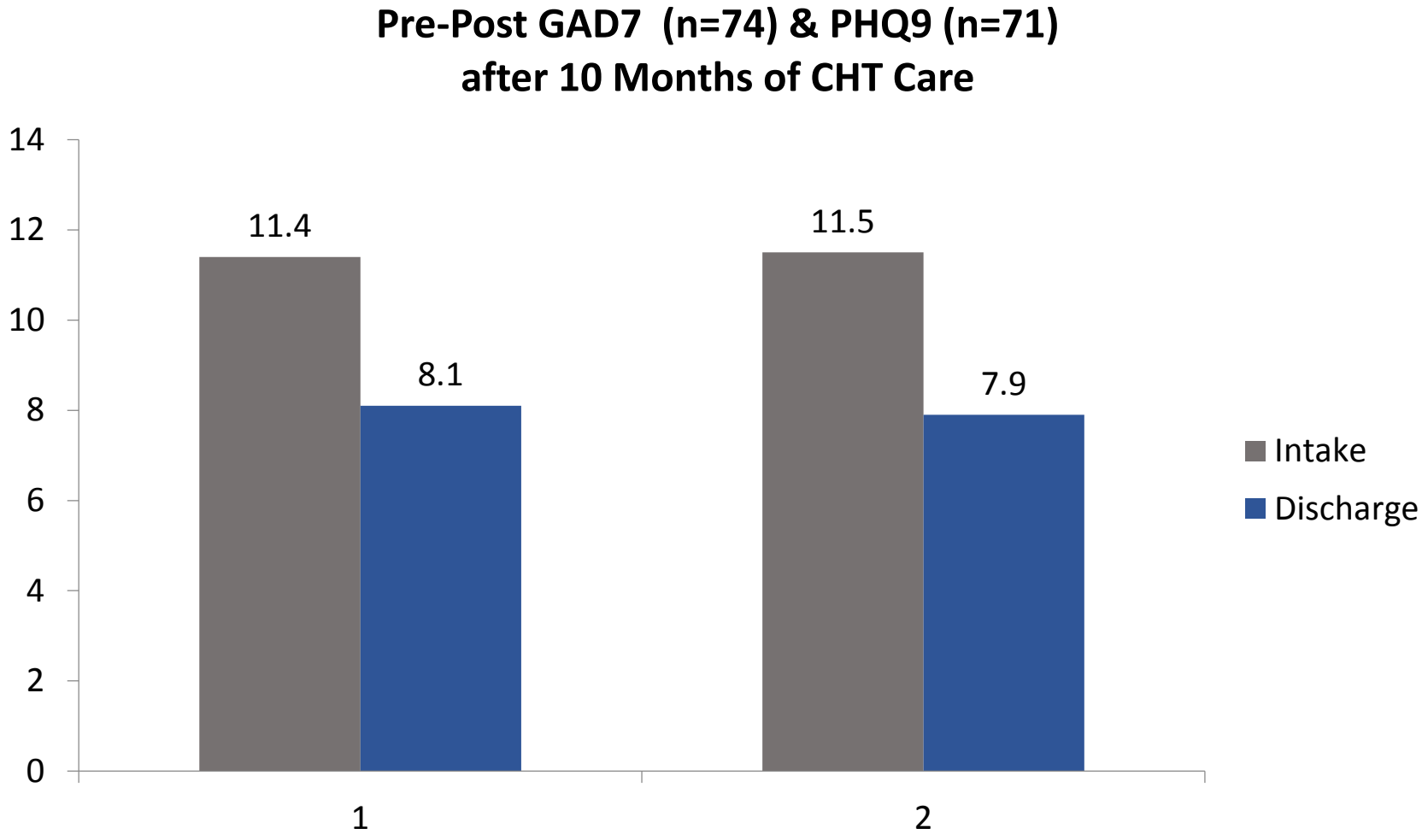


43% decrease in RTT score, intake to discharge – 7 months in care

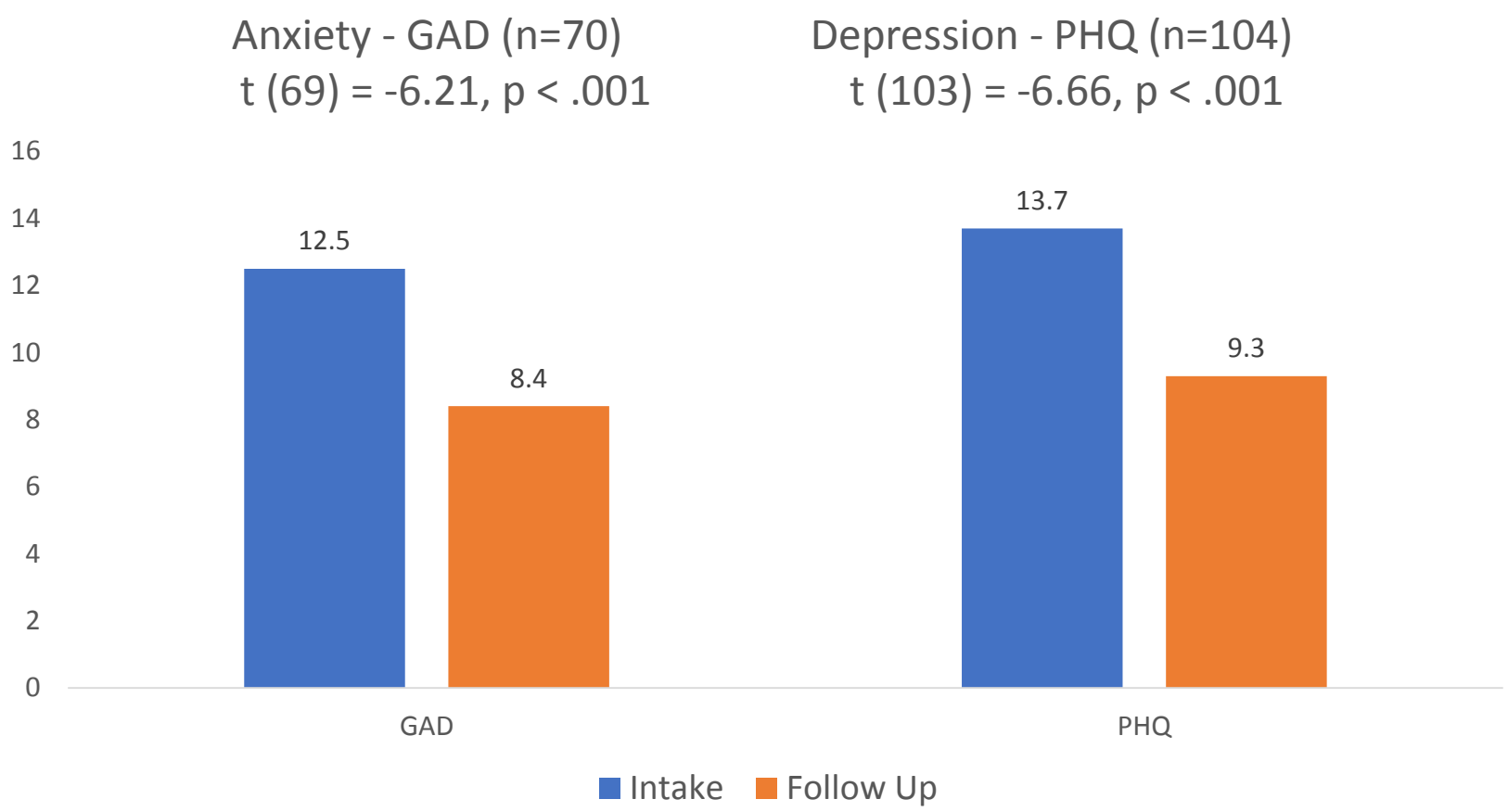
Health Risk – RTT Score from Intake-Follow Up
$t(105) = -10.4, p < .0001$



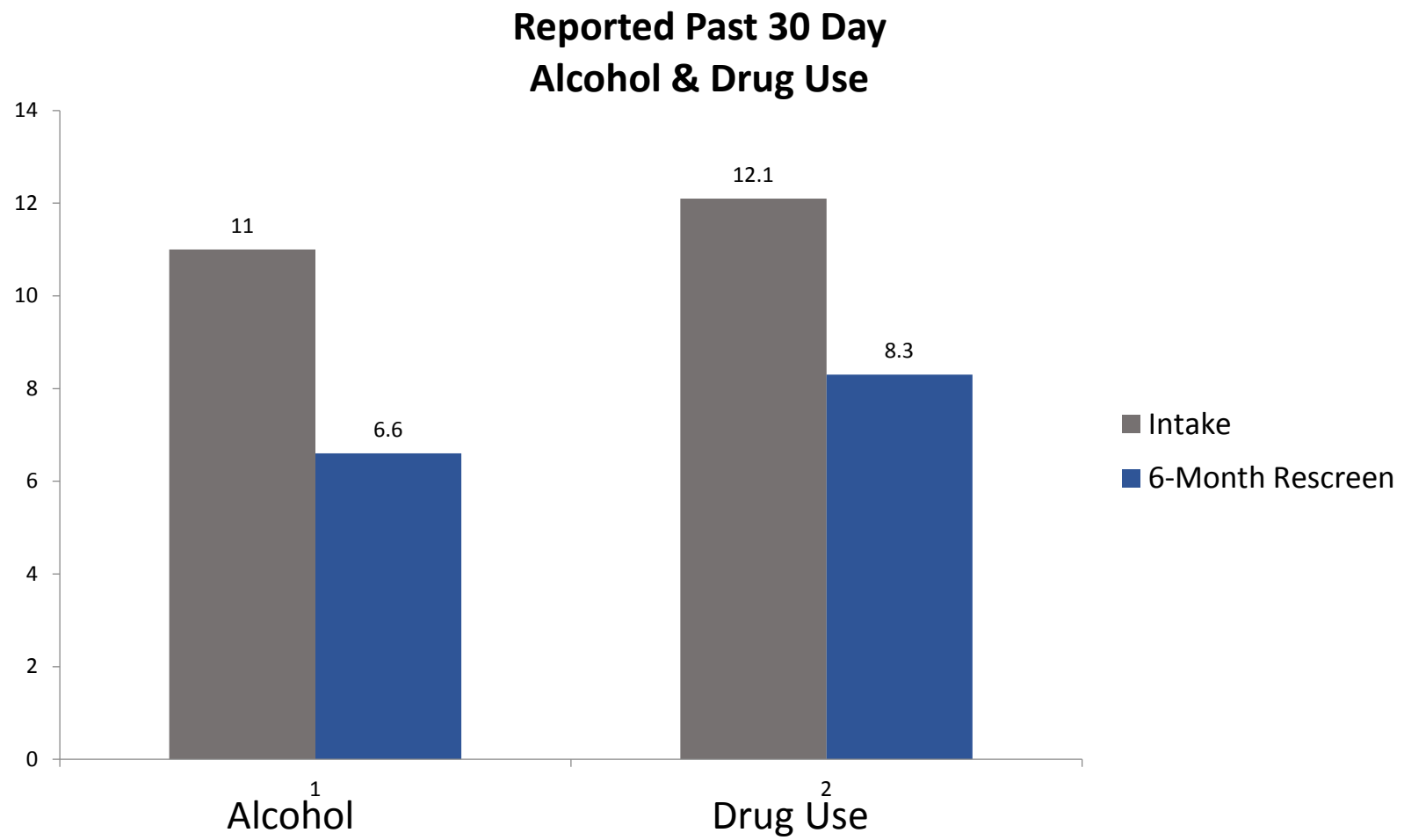
Convenience Sample Changes in Anxiety & Depression



CHT Sample Changes from Intake – Follow Up



CHT SBIRT Pre-Post 10% 6-month Rescreen Changes in Alcohol + Drug Use (N=56)



Almost All Evaluation Scales Improved

Health Literacy	No Change
Health Knowledge + Info.	Significant Improvement
Health Confidence	Significant Improvement
Support	Significant Improvement
Adherence	Significant Improvement
Quality Life Days – Physical Health	Significant Improvement
Quality Life Days - Mental Health	Significant Improvement
Quality Life Days - Either PH/MH	Significant Improvement
Life Evaluation Current	Significant Improvement
Life Evaluation Future	Significant Improvement

FollowUp & Discharge Reasons (N=365)

FollowUp/DC Reason		n	%
Evaluation Only		153	41.9%
DC/Completed Care		60	16.4%
DC/Lost to FollowUp		64	17.5%
DC/NoLonger Interested CHT Care		49	13.4%
DC/Referred Lower Level Care		6	1.6%
DC/Referred Same Level Care		3	0.8%
DC/Referred Higher Level Care		13	3.6%
DC/Moved Out of Area		7	1.9%
DC/ Incarcerated		0	0.0%
DC/ Died		3	0.8%
Other Discharge		7	1.9%

CHW Reported CHT SDOH Care (N=360)

Received SDOH Care?			
No		31	8.6%
Refused		8	2.2%
Yes		321	89.2%

SDOH Progress			
None		67	20.4%
Some		141	43.0%
Good		120	36.6%

CHW Reported CHT BH Care (N=310)

Received BH Treatment?		
No	123	39.7%
Refused	34	11.0%
Yes	153	49.4%
BH Progress		
None	44	26.7%
Some	73	44.2%
Good	48	29.1%

Patient Experience/Satisfaction With CHT Care (147-158)

Item	n	Mean	sd
CHT staff help me understand how to follow through with specialty care*	147	4.56	0.63
CHT staff help me understand when I should or should not go to the Emergency Room	134	4.55	0.64
CHT staff connect me to community resources that help me with my health and wellness*	156	4.52	0.70
CHT staff help me overcome challenges	157	4.44	0.78
CHT staff provide me with emotional support*	153	4.49	0.76
I feel comfortable talking openly and honestly with CHT staff	158	4.61	0.66

6-item alpha (n=126) = 0.89

3-item alpha* (n=141) = 0.87

Clinically & Statistically Significant Client Changes after 4.7 Months of CHT Care

- 33% Reductions in Health Risk, Depression, Anxiety, Substance Use
- Improvements in all SDOH categories
- Improvements in Numbers of Unhealthy Days /Quality of Life & Wellbeing categories
- Improvements in Health Knowledge & Information, Support, Health Confidence, Adherence, Current & Future Life Evaluation
- Excellent Patient Satisfaction & Experience with CHT Care