Evolution of the services

- 2009 ~ Mobile Clinic
  - Health Risk Assessment, Information on Resources and medical treatment
- 2012 ~ Shift toward providing a more consistent service
  - 2 nurses were assigned to the program
  - Documentation and workflow was updated
  - Access Group was formed to identify overlaps and gaps in services
- 2013/2014/2015 ~ Shift toward gathering more meaningful data
  - Shift was made to focus less on the number times community resource information was given out and more on the connections that were made
  - Closed Loop Referral Process was developed between the members of the Access Group
  - The work being done by the Mobile Clinic and the Access Group was incorporated into Scott County Public Health's SHIP Strategy
    - Decrease impact of chronic disease in Scott County by increasing access to needed medical care and addressing needs surrounding the Social Determinants of Health

2016

A certified EHR was implemented to improve the efficiency of point of care documentation and collection of data

A screening tool was developed to identify needs surrounding the Social Determinants of Health

- Financial-Resource Strain
  - Food Insecurity
  - Housing Insecurity
- Stress and Depression
- Social Connections or Isolation
- Exposure to Violence
- Inadequate Quality of Diet
- Inadequate Physical Activity
- Tobacco Use
- Excessive Use of Alcohol

The Access group continues to meet to work on building partnerships with community resources whose services address the issues we are screening for.

Screening for needs and referring to resources is NOT a new service
The effort is intended to improve the current practices and follow up

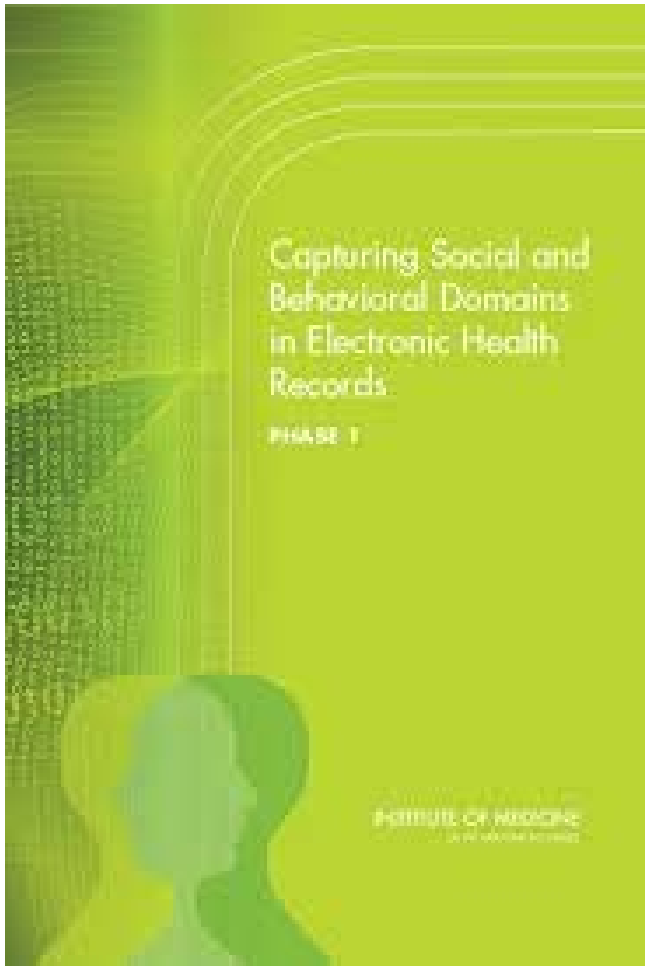
Institute of Medicine (IOM)

Capturing Social and Behavioral Domains in Electronic Health Records (EHRs)

The IOM was asked to form a committee to identify domains and measures that capture the ***social determinants of health*** to inform the development of recommendations for Stage 3 meaningful use of electronic health records (EHRs).

Standardized use of EHRs that include social and behavioral domains could provide better patient care, improve population health, and enable more informative research

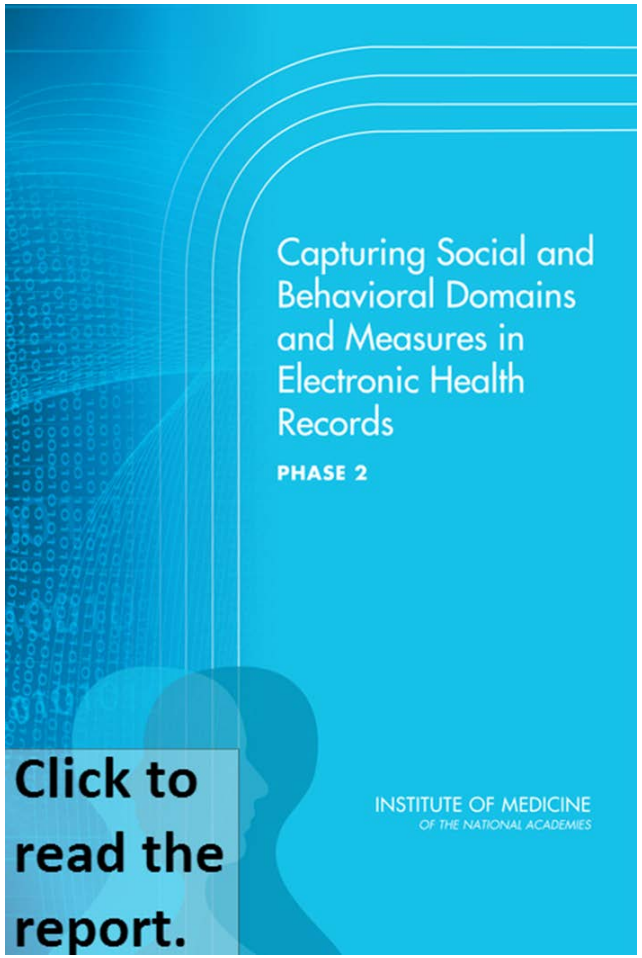
Capturing Social and Behavioral Domains in Electronic Health Records (EHRs)



PHASE 1 ~

- Identify specific domains to be considered by the Office of the National Coordinator.
- Specify criteria that should be used in deciding which domains should be included,
- Identify core social and behavioral domains to be included in all EHRs, and
- Identify any domains that should be included for specific populations or settings defined by age, socioeconomic status, race/ethnicity, disease or other characteristics.

Capturing Social and Behavioral Domains in Electronic Health Records (EHRs)



PHASE 2 ~

- What specific measures under each domain specified in Phase 1 should be included in EHRs?
- What are the obstacles to adding these measures to the EHR and how can these obstacles be overcome?
- What are the possibilities for linking EHRs to public health departments, social service agencies, or other relevant non-healthcare organizations?

Core Domains & Measures

DOMAINS	CURRENT EXISTING MEASURES
Alcohol Use	AUDIT-C (3 Q)
Race and Ethnicity	Census tract-median Income
Residential Address	Census tract-median Income
Tobacco Use	NHIS (2 Q)
Depression	PHQ-2 (2 Q)
Education	Educational attainment (2 Q)
Financial Resource Strain	Overall financial resource strain (1 Q)
Intimate Partner Violence	HARK (4 Q)
Physical Activity	Exercise Vital Sign (2 Q)
Social Connections & Social Isolation	NHANES III (4 Q)
Stress	Elo et al. (2003) (1 Q)

NOTE:
Domains/Measures are listed in alphabetical order; Domains/measures in the shaded area are currently frequently collected in clinical settings; domains/measures not in the shaded area are additional items not routinely collected in clinical settings.

Development of the Tool

- Recommended measures for each domain were blended into a single screening tool.
- Question responses generate a score in each domain and needs surrounding the social determinants of health are identified based on that score.
- In addition to offering assistance with needs identified in the tool, clients are asked what concerns are most important to them, and assistance is provided based on the client's priorities.

The Screening Tool

- Clients answer screening questions electronically or on paper
- Client's answers are entered the tool
- The tool identifies:
  - Needs surrounding the Social Determinant of Health by assigning a score in each area
  - Trends in the population screened by aggregating all responses and identified needs.

Individualized Community Care Plan

A plan of care that provides
health information
and
linkages to services/resources in the community
based on the client's specific needs

Linkages may include:

- Navigators to assist with state health plan applications
- St. Mary's Health Clinic (or other Federal Qualified Health Centers)
- Mental Health resources
- Local food resources (food shelves, fare for all, community gardens)
- Smoking Cessation Programs
- Diabetes Prevention Programs

Nurses continue active contact and follow up with the client and the community partners the client was referred to ensure connections are made and needs are addressed