Transforming Lives

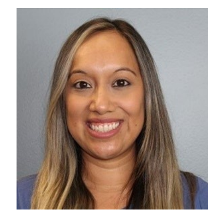
Lesson Objectives

1. Identifying your "Why" and Need for Implementing Interventions Non-Medical Driver of Health (NMDOH)
2. Describe the framework for Evaluation, Assessment and Interventions used for Implementing NMDOH Initiatives
3. Describe how the Health Home Project used NMDOH to improve health outcomes
4. Describe how the Food RX Program was developed and addressed Food Insecurity as a Referral Program

Practical Steps to Integrating NMDOH Screening and Referral Program

Key Lessons and Outcomes

Dr. Stanley Williams, PhD Director of Integrated Health



Janeth Martinez, MA, LPC
Project Director Integrated Health Certified Community Behavioral Health Clinic (CCBHC) Expansion Program

Dr. Stanley Williams, PhD
Director of Integrated Health

Theresa Pettigrew - Beason, LPC-S
Practice Manager Optum Project Integrated Care Health Home

The Harris Center

Houston, TX

As the largest behavioral and developmental disability care center in Texas, The Harris Center provides a full continuum of services to 88 sites across Harris County and serves over 90,000 individuals annually.

Services are offered in over 40+ languages to better serve one of the most diverse and multi-cultural communities in the nation.

The Harris Center is the state-designated Local Mental Health Authority and the Local Intellectual and Developmental Disability Authority serving Harris County, Texas.

The Why – Evaluation – Why Address Non-Medical Drivers of Health

Agency and Organization Adoption of Non-Medical Drivers as Part of Culture and Service Delivery

We began to Understand NMDOH Needs at an Individual and Community Level – the Role of Needs Assessments

"Social determinants are the main drivers of health disparities, which are defined by the"
World Health Organization- WHO

Self-actualization
Achieving one's full potential

Esteem
Respect, confidence, feeling of accomplishment

Belonging
Healthy relationships, friends

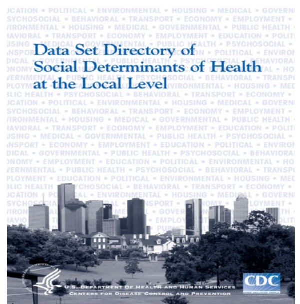
Safety
Security of body, finances, resources, family, property

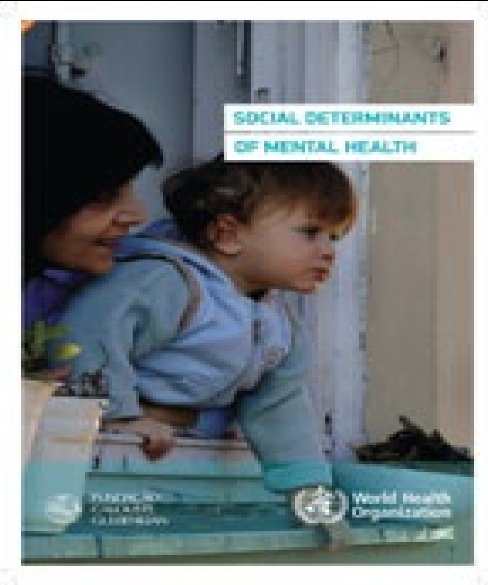
Physiological
Food, water, shelter, sleep

Physiological: *Help me to have a place to live where people can visit and consistently afford food for myself and family*.
Safety: *Help me prevent physical/financial/emotional harm to myself and family*.
Belonging: *Help me to maintain healthy relationships with others; not remain addicted, improve my mental health conditions to be accepted and not isolated*
Esteem: *Help me with being amotivational about wanting to feel accomplished and self-confident- being employed, being – valued by co-workers, earning a wage*
Self-actualization: *Help me be the best version of myself*.

Maslow's 'Hierarchy of Needs': prioritizing progress
Abraham Maslow proposed his Hierarchy of Needs as a "Theory of Human Motivation" in 1943. His pyramid (shown below) defines five levels of human needs. The pyramid characterizes how humans tend to prioritize the progress they're trying to make in their lives. Maslow found that people seek to satisfy needs on a higher level only when the needs on the underlying levels and foundation have been adequately fulfilled.

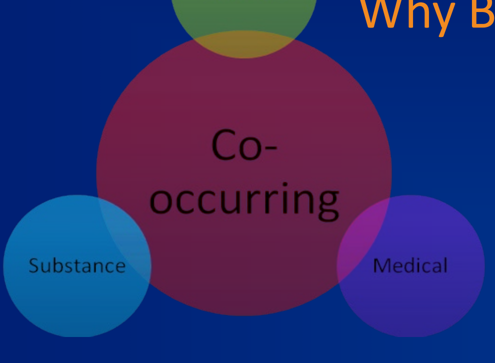
We learned through Literature Reviews –NMDOH – "Looks like its here to stay" – and is imbedded in CMS and payor policy and practice guidelines





An enormous volume of literature has catalogued the impact of the social determinants on human health.

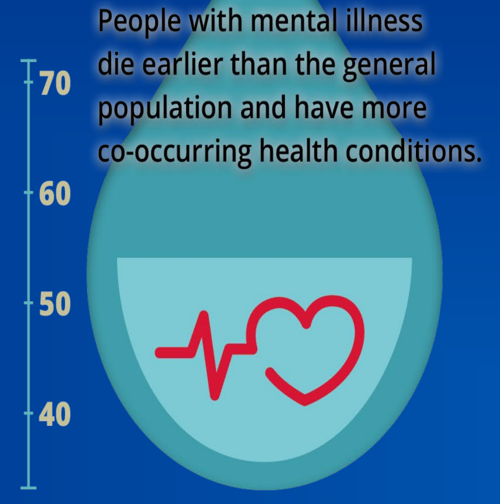
All the research shows the lack of addressing social determinants models—worsened health care outcomes.

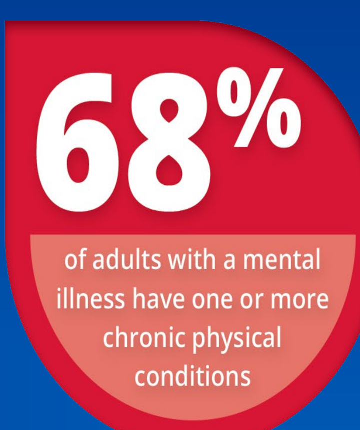


Why Behavioral Health Practitioners Need Competency an Up Stream Approach for Early Interventions to Prevent downstream Poor Health Outcomes

- Individuals with SMI die on average at the age of 53 years old
- Have elevated (and often undiagnosed) rates of:
  - hypertension,
  - diabetes,
  - obesity
  - cardiovascular disease
- Patient Challenges- Non-Medical Drivers Disparities within People with SMI hampers self-care, access to care, medication compliance, adherence to primary care & medical treatment plans

The PROBLEM





Chronic conditions and comorbid psychological disorders Milliman Research Report. July 2008

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.

40%
10%
30%
20 %

Socioeconomic Factors

Education
Job Status
Family/Social Support
Income
Community Safety

Physical Environment

Health Behaviors

Tobacco Use
Diet & Exercise
Alcohol Use
Sexual Activity

Health Care

Access to Care
Quality of Care

SDOH Impact

- **20 percent** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment**, **social determinants** and **behavioral factors** drive **80 percent** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

©2018 American Hospital Association

The What does Internal Data and Information show – Assessment–

Why Address Non-Medical Drivers of Health

Harris Center Survey – Determinants of Health Findings

"Social determinants of health (SDOH) are known to influence mental health outcomes, which are independent risk factors for poor health status, emotional wellness and physical illness."
Journal of the American Medical Informatics Association, 26(8-9), 2019, 895–899

Eight key DOH related findings from the Harris Center survey revealed the following:

The Harris Center, anticipating the potential of the significant and devastating impact of COVID-19 on direct behavioral health patient care developed and administered a survey entitled *Harris Center COVID-19 & Impact Social Determinants of Health.*[18] This survey was administered to patients by care managers through telephonic, socially distanced in person contact, and telehealth between April 2020 and April 2021. The survey was administered to 7,560 individual clients using a random number recruitment of active outpatient adult (81% adults) and children (19%) with SMI and or SED conditions.

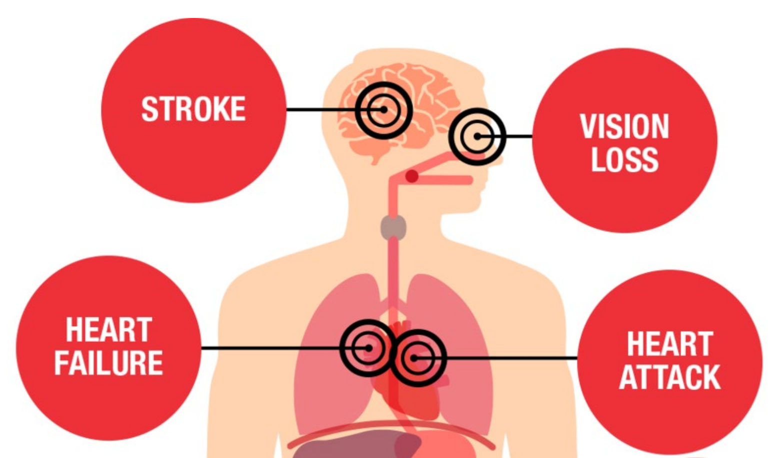
***Food Insecurity**	34.69% Believed that they would run out of food
***Percent Uninsured:**	39.26 % Uninsured
Economic Insecurity	56.86% Found it difficult to pay for basic needs (i.e., food)
Feeling lonely & isolated:	54.16% Frequently felt lonely and isolated
***Fearful about the future:**	52.46%
***Can't keep up with medications:**	44.49%
***Lost access to health appointments:**	24.75%
***Have not seen a healthcare provider**	31.43% in last year

Population Health Snapshot of Current Harris Center Clients

- Over 11,000 client have a blood pressure range between elevated to hypertensive crisis
- Over 12,000 clients are either overweight or obese

Out of 19,303 who were administered vitals examination

Review of data from Dr. Scott Hickey, Health Analytics Director, The Harris Center – Oct 2021 Data



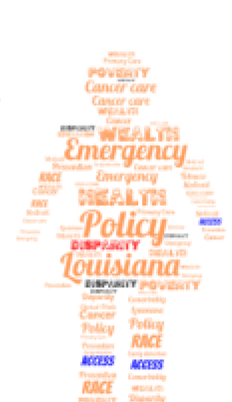
High Blood Pressure Threats –From American Heart Association https://www.heart.org/en/health-topics/high-blood-pressure/health-threats-from-high-blood-pressure

Don't Let Your Blood Pressure Erupt

Blood Pressure Category for Adults	Systolic mmHg (upper number)		Diastolic mmHg (lower number)
HYPERTENSIVE CRISIS (Consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120
HIGH BLOOD PRESSURE (Hypertension) Stage 2	140 OR HIGHER	or	90 OR HIGHER
HIGH BLOOD PRESSURE (Hypertension) Stage 1	130–139	or	80–89
ELEVATED	120–129	and	LESS THAN 80
NORMAL	LESS THAN 120	and	LESS THAN 80

2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *J Am Coll Cardiol* 2017;Nov 13.

Transforming Lives



Health Disparities were associated with unmet Non-Medical Drivers of Health Factors:

- *Access problems*
- High rates of physical illness with mental illness
- Premature mortality
- People with mental illness receive a lower quality of care in primary care settings
- High cost of physical illness with mental illness

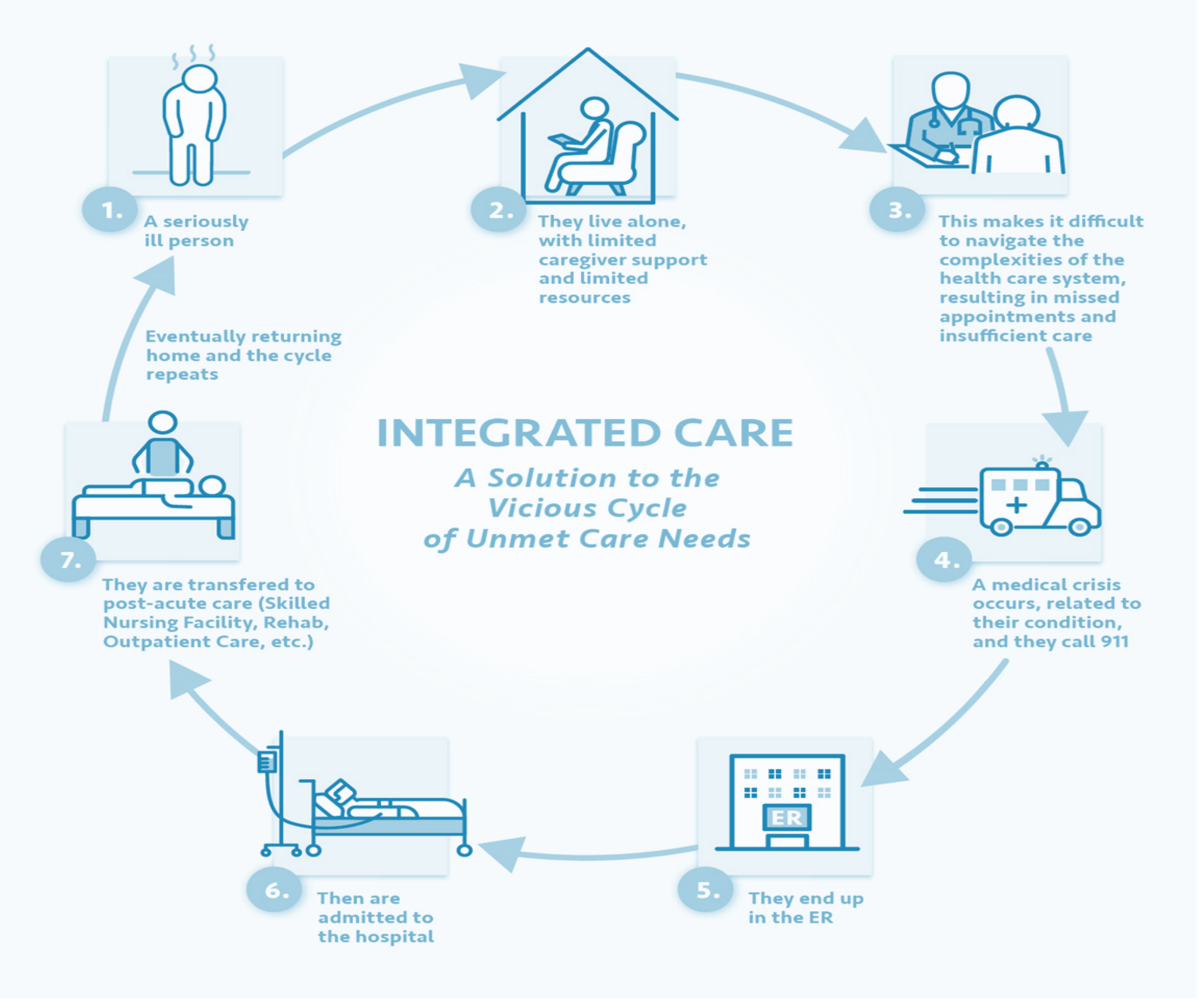
Definition of Health Disparities “Health disparities are differences in the incidence, prevalence, mortality, andburden of diseases and other adverse health conditions that exist among specific (racial and ethnic, cultural, gender) populations in the United States. ”

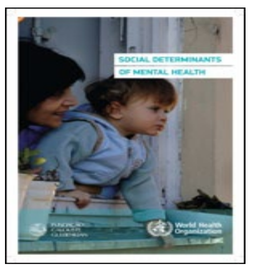
Populations in which disparities exist experience worse outcomes for chronic conditions, have higher health care cost, experience lower quality of life

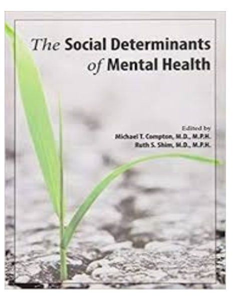
People with Serious Mental Health & Co-Occurring Chronic Health Conditions – Vicious Cycle of Unmet Needs -

Some believe that the lack of proper care addressing SDOH and integrated health of people with behavioral health conditions results in Health Disparities

Improper Treatment Leads to Iatrogenic disease:
Any adverse conditions in a patient occurring as a result of treatment that does not incorporate the proper diagnosis, manner of treatment, failure to address conditions and problems.







The Social Determinants of Mental Health

under employment/ unemployment
adverse early life experiences
food insecurity
housing instability
Poor Mental Health and Risk of Mental Illness
poor access to and quality of health care
social exclusion/ social isolation
low education/ educational inequality

Income and employment
Food security
Housing affordability and quality
Transportation
Other basic needs

Household Material Well-Being

Parent Personal Well-Being

Mental health, depression
Substance use/addiction
Stress
Mindfulness
Resiliency

Children's Well-being and Healthy Physical, Cognitive, Social, and Emotional-Behavioral Development

Partner support or conflict/violence
Social ties and connections
Membership, civic participation
Inclusion or discrimination
Community social capital

Family Social Well-Being

Parental Relationship Well-Being

Bonding and attachment
Positive activity, reading, play
Knowledge of development
Knowledge of parenting
Relationship security, stability

CAHMI. SDOH TWG. Bruner et al. August 2018.

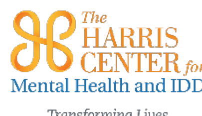
We Explored Role of Assessments & Interventions

Addressing the social determinants of mental health requires taking an approach distinct from the typical clinical interventions of psychiatrists and other mental health professionals in everyday practice.

Evaluation and one-on-one interventions, such as care coordination must be employed, but doing so yields less overall population impact. Population-based, risk stratification, hot-spotting and using evaluation tools – will target greater population needs

However; on an individual patient basis, care coordinators can begin to address SDOH domains and risk factors stemming from the social determinants of mental health by identifying the family/social network, economic, and environmental factors that influence illness and hinder positive patient outcomes. Educating patients on how these factors can lead to poor mental health may lead to some gains through changes in individual decision-making and health behaviors.

Texas Health and Human Services – Texas Council of Community Centers – State Behavioral Health: Local Mental Health Authority – will use the AAFM tool for all Local Mental Health Authorities -



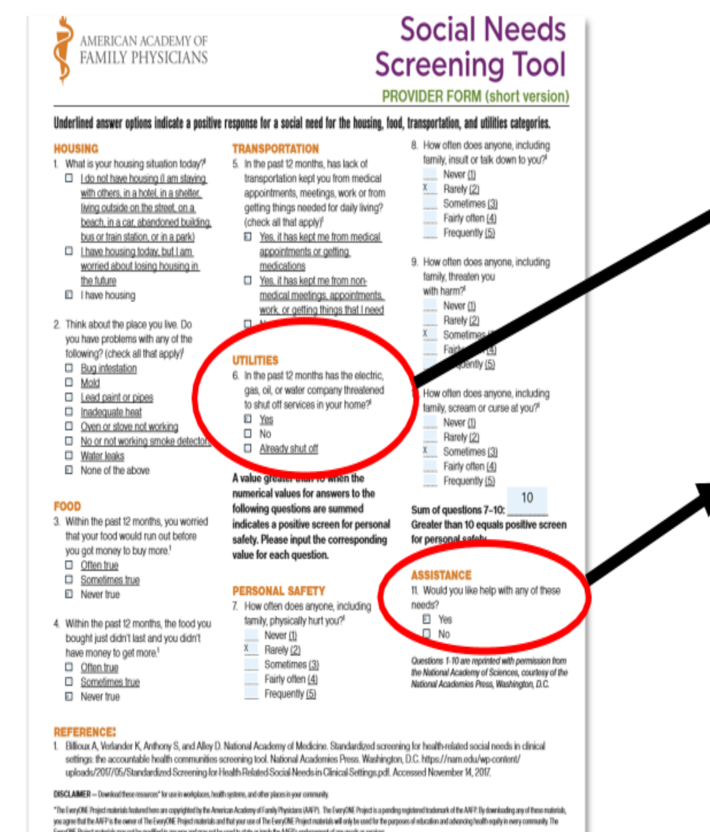
Assessment of Social Factors impacting Health Care Quality in Texas Medicaid

As Required by the Centers for Medicare and Medicaid Services

Delivery System Reform Incentive Payment (DSRIP) Transition Plan Milestone

Health and Human Services Commission

March 2021



AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

PROVIDER FORM (short version)

Underlined answer options indicate a positive response for a social need for the housing, food, transportation, and utilities categories.

HOUSING

1. What is your housing situation today?
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ I have housing today, but I am worried about losing housing in the future
   - ☒ I have housing
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☒ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☒ Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[1]
   - ☐ Often true
   - ☐ Sometimes true
   - ☒ Never true

TRANSPORTATION

5. In the past 12 months, 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 getting medications
   - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☒ Yes
   - ☐ No
   - ☐ Already shut off

PERSONAL SAFETY

7. How often does anyone, including family, physically hurt you?[1]
   - Never (1)
   - x Rarely (2)
   - Sometimes (3)
   - Fairly often (4)
   - Frequently (5)
8. How often does anyone, including family, insult or talk down to you?[1]
   - Never (1)
   - x Rarely (2)
   - Sometimes (3)
   - Fairly often (4)
   - Frequently (5)
9. How often does anyone, including family, threaten you with harm?[1]
   - Never (1)
   - Rarely (2)
   - x Sometimes (3)
   - Fairly often (4)
   - Frequently (5)
10. How often does anyone, including family, scream or curse at you?[1]
   - Never (1)
   - Rarely (2)
   - x Sometimes (3)
   - Fairly often (4)
   - Frequently (5)

A value greater than 10 when the numerical values for answers to the following questions are summed indicates a positive screen for personal safety. Please input the corresponding value for each question.

Sum of questions 7–10: 10

Greater than 10 equals positive screen for personal safety

ASSISTANCE

11. Would you like help with any of these needs?
   - ☒ Yes
   - ☐ No

Questions 1-10 are reprinted with permission from the National Academy of Sciences, courtesy of the National Academies Press, Washington, D.C.

REFERENCE:

1. Billioux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press. Washington, D.C. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf. Accessed November 14, 2017.

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[1]
   - ☒ Yes
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ASSISTANCE

11. Would you like help with any of these needs?
   - ☒ Yes
   - ☐ No

Current Development – Part of Harris County Health Exchange –Health Equity Coalition

EHF: Care Management Platform - & Primary Care/Health Home Optimization – AAFP Social Needs Tool

Compass Rose – EPIC EHR

Coordinated Care Management

The comprehensive health and social care record in Epic moves healthcare beyond clinics and hospitals. Coordinated Care Management provides case management tools to roll out population health, social, and community related programs to improve a person's well-being through care management and outreach.

A Comprehensive View of Wellness

Coordinated Care Management can help your organization keep more people well. Use tools in Epic to address social determinants of health, map support networks, connect people to community services, and measure outreach and program effectiveness. If you're interested in installing Coordinated Care Management, talk to your Epic representative to discuss how these tools fit your needs.

Address Social Determinants of Health

With EpicCare, clinicians, social service providers, and community partners can capture a person's social determinants of health – such as isolation, depression, food insecurity, and barriers to reliable transportation. Social determinants can also be submitted directly in MyChart. Users have easy access to this information in the Epic chart and can use it, combined with medical information, to inform the care and services they provide.

With Epic's Coordinated Care Management license, you can use social determinants of health history to drive decision support, risk stratification, and analytics. These tools help you target outreach and program enrollment to the most vulnerable in your population, leading to improved health outcomes and reduced costs through prevention.

Coordinate Programs

With program management tools, you can organize and manage large-scale programs – like chronic care management and child welfare services – that benefit many different types of populations in your community. You can:

- Identify candidates for programs with decision support and reporting.
- Enroll program participants with referrals and applications, including a transparent application status visible in MyChart.
- Establish a program's targets and timelines in order to track the program's status relative to its goals.
- Track the services a person receives for each program he's enrolled in.
- Securely share a person's assessments and documents across multiple programs and provide confidential information specifically to program staff who need access.
- Manage staff workloads by visualizing program data like case load distribution by case manager and outstanding tasks by owner.
- Improve population health by enrolling consumers in structured programs, which include milestone tracking, integrated client plans, and actionable population reports with discrete, measurable outcomes.
- Providers bring care to people where they are with a mobile toolset for telehealth and home visits.

Integrated Behavioral Health Whole-Person Approach

By building an infrastructure around integrative health,collaborations, Non-Medical Drivers of Health (NMDOH), data directed clinical decisions that correlate to measures, we can create a bridge to improve health outcomes

Redefine specialty mental health and consider the whole person – not just mental illness, Include SDOH

Remove barriers that limit access to care and address health disparities

Improve overall health and well being of all vulnerable and at-risk behavioral health populations for preventable hospital and ER Admissions

What Can we Do to Address Gaps in NMDOH– Intervention–
Why Address Non-Medical Drivers of Health

Collaborative Projects: Interventions for Implementing Non-Medical Drivers of Health Approaches to Improve Health Outcomes

Integrative Behavioral Health Home

Food RX – Food as Medicine

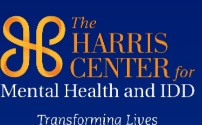
Collaborative Partners

Transforming Lives

The Harris Center Health Home

Your Health and Wellness Partner

Review of Goals



The Harris Center Health Home

Goals

Improve overall wellness of members to include their self-management of conditions

Increased member participation in the health home program based upon enrollment rates for attributed members (target goal is 50% enrollment for all attributed members within a 12 month period)

- Reductions in avoidable hospital admissions and emergency room use
- Reductions in overall hospital readmission rates
- Reduced lengths of stay in the hospital when hospitalizations are necessary
- Improved rates for follow up after hospitalization (FUH) for behavioral and medical inpatient and ER visits • Improved adherence to recommended treatments (including medications and specialty care)
- Improved access to primary care, based on key metrics related (e.g., diabetes care)

Opportunity

One of Four behavioral Health Organizations participating in the National Pilot

Target 1500 of the highest risk Optum Members (costing approximately $100K in claims per member)

Only about 25% Harris Center clients

Re-admissions Reduction Interventions

Targeting specific social determinants known to affect outcomes for seriously mental ill patients. These include:

- Unemployment
- Homelessness
- Lack of Transportation
- Lack of Access to Health Insurance and Primary Care Services
- Substance Use
- Low Health Literacy Levels
- Unsafe Social Environments

The HARRIS CENTER - Behavioral Health Home
Care Management Six Steps – Team-Based Care Model

1. Member Identification & Analytics

- Real-time Utilization data
- Population Health Risk Stratification
- Utilization of Community & Health Exchanges as part of data collection and analysis

2. Integrative Health- Care Management

- Weekly & monthly team meetings
- Care –based upon analytics and health outcome improvements
- Whole care approach with integrative health care plan addressing health, behavioral health team monitoring and outcomes for both health and behavioral health outcomes and bench marks.
- Care Coordination with other health providers, PCP, law enforcement, criminal justice system, SDOH resource referral and follow-up
- Best practices (stages of change, motivational counseling) behavioral change
- Member advocacy
- Non-traditional hours and scheduling

6. Health Coaching

- Health Promotions & Wellness Strategies
- Coaching and monitoring health outcomes
- Health system navigation
- Medication education

3. Physical Health/Healthcare

- Care Coordination with Harris Center Integrated Health Clinic, Community PCPs, other providers – hospital, ED
- Health Promotions, disease & medication management

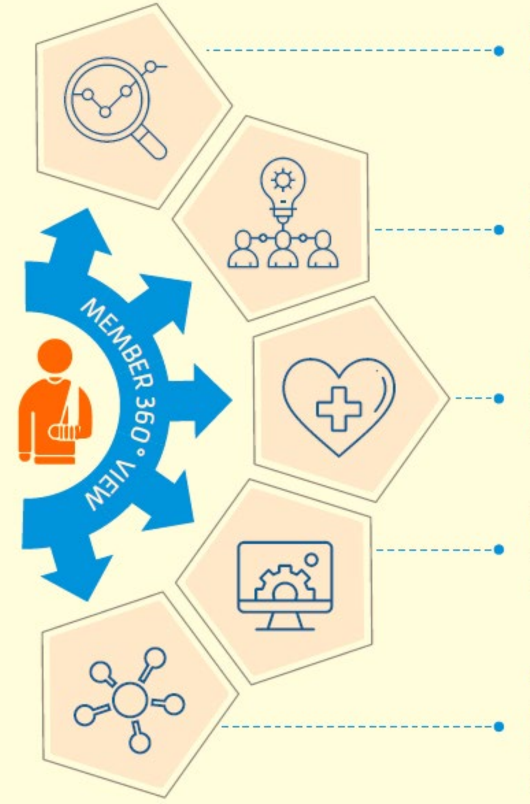
5. Social Determinants of Needs

- SDOH Assessment – include strategies in individualized care plan
- Comprehensive resource list development & resource connections – monthly monitor resources for qualifications & accuracy
- Trained in SAMHSA SOAR program -

4. Integrative Behavioral Healthcare

- In-person & televisual care
- Specialized treatment addressing mental health, substance use, criminal justice factors; SDOH; and integrative health

ANALYTICS-DRIVEN INSIGHTS ARE KEY TO POPULATION HEALTH SUCCESS



Precisely identify who should be intervened with today to reduce and mitigate future risk

Quickly determine where resources should be focused to have the greatest impact on clinical and financial outcomes

Intervene with members based on known attributes and behaviors to reduce and mitigate future risk

Operationalize the analytics as part of day-to-day workflow of member engagement and care management operations

Create a closed loop feedback approach including tracking trend of the population programs and the efficiency of engagement operations implemented

Utilizing Optum Portal – Data

1. Data-driven decisions
2. Identification of high-utilizer and assignments
3. Care coordination and collaborative contacts with patient care team
4. Gaps in Care and Social Determinants of Health

How Will We Track
and Monitor

United Health/Optum Partnership Details:

- Per member per month (PMPM) payment structure
- Total cost of care shared savings
- Performance measures as part of shared savings bonus payout

Health Home Measures

- Follow-Up After Hospitalization for Mental Illness (HEDIS® - FUH): 7-day
- Comprehensive Diabetes Care HH - Composite 1 (HEDIS® - CDC): Eye exam
- Child and Adolescent Well-Care Visits (HEDIS® - WCV)
- Plan All-Cause Readmissions (HEDIS® - PCR)
- Ambulatory Care: AMB HH (CMS)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS® - SSD)
- Inpatient Utilization General Hospital/Acute Care HH (HEDIS® IPU)
- Rate of Inpatient Behavioral Health Admissions - TPI (Custom)
- Medication Adherence: Mood Stabilizers, Anti-Psychotics and Anti-Depressants- MA-MS, MA-AP, MA-AD (Custom)

Reporting Only Measures

- Follow-Up After Hospitalization for Mental Illness HH (HEDIS® - FUH): 30-day
- Behavioral Health Inpatient Days - TPI-DAYS (Custom)
- 7- and 30-Day Inpatient Behavioral Health & Residential Treatment Facility Readmission Rate TPR-7, TPR-30 (Custom)

Our Measures

Quality Measures Performance Report 2023 Quarter 2

OPTUM TEAM
THE HARRIS CENTER

Medication Adherence: Anti-Depressants

Increased member adherence of Anti-Depressants by 55.22% from the baseline of 32.05%.

Medication Adherence: Anti-Psychotics

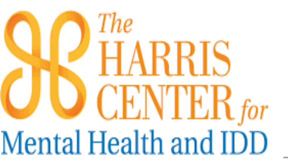
Increased member adherence of Anti-Psychotics by 54.41% from the baseline of 32.09%.

Medication Adherence: Mood Stabilizers

Increased member adherence of Mood Stabilizers by 40.02% from the baseline of 35.91%.

Plan All Cause Readmission Rate

Decreased Plan All Cause Readmission by 5.14 % from the baseline of 41.25%.



Transforming Lives

Utilization Measures Performance Report 2023 Quarter 2

OPTUM TEAM
THE HARRIS CENTER

Emergency Department Visits

Decreased Emergency Department Visits by 50.59% from a baseline of 613.46 ER visits.

Inpatient Utilization-General Hospital Acute Care

Reduced Inpatient Utilization of General Hospital Visits by 55.25% from a baseline of 174.79 Inpatient General Hospitalization Visits. Reducing the number to 78.21 visits.

Rate of Inpatient Behavioral Health Admissions

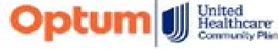
Reduced the rate of Inpatient Behavioral Health Admissions by 49.07% from baseline of 179.13 Inpatient Behavioral Health Admissions. Reducing the number to 91.23 admissions.

Quarterly Performance Report 2023 Q2

Measure	Numerator	Denominator	Baseline	Your Performance	Percentage Change from Baseline	Points Earned
Medication Adherence: Anti-Depressants	353	690	32.96%	51.16%	55.22%	2.0
Medication Adherence: Anti-Psychotics	338	683	32.05%	49.49%	54.41%	2.0
Medication Adherence: Mood Stabilizers	365	726	35.91%	50.28%	40.02%	2.0
Plan All-Cause Readmission Rate	558	1,426	41.25%	39.13%	-5.14%	1.0
Utilization Measures						
Measure	**Numerator**	**Denominator**	**Baseline**	**Your Performance**	**Percentage Change from Baseline**	**Points Earned**
Ambulatory Care – Emergency Department Visits	3,406	11,214	613.46	303.73	-50.49%	2.0
Inpatient Utilization - General Hospital/Acute Care	877	11,214	174.79	78.21	-55.25%	2.0
Rate of Inpatient Behavioral Health Admissions	1,023	11,214	179.13	91.23	-49.07%	2.0
Total Quality/Utilization Points Earned:						**13.0**
Percentage of Quality/Utilization Points Earned:						**59.09%**

Excellent work!

% Quality/Utilization Points Earned:
The percentage of quality/utilization points earned out of the total available. The Harris Center earned the maximum points !



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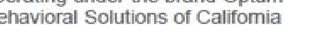


Food is Medicine

Food is the main contributor to health and chronic conditions. Food is medicine, and research demonstrates that regular intake of fresh produce helps to improve the health of individuals with prediabetes and diabetes.

The Rx for Fresh Fruits and Vegetables program (RxFFV) is designed to assist food-insecure individuals with diabetes and prediabetes in managing their condition by providing access to fresh fruits and vegetables through partnerships with Idaho healthcare clinics, community organizations, insurance companies, and retailers.

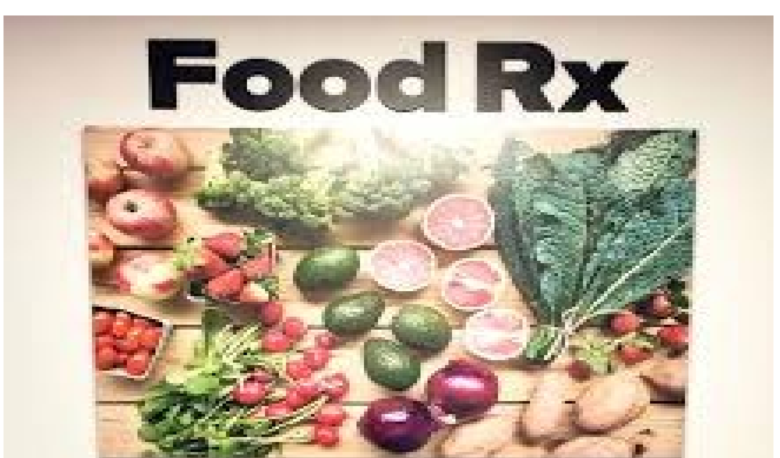
How does it work?

Screened by Healthcare Partner/ Stay in Community Health Program

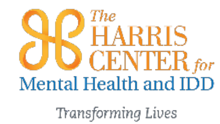
Get **Food**Rx card

Get groceries from Food for Change Market

FoodRX Market Trailer



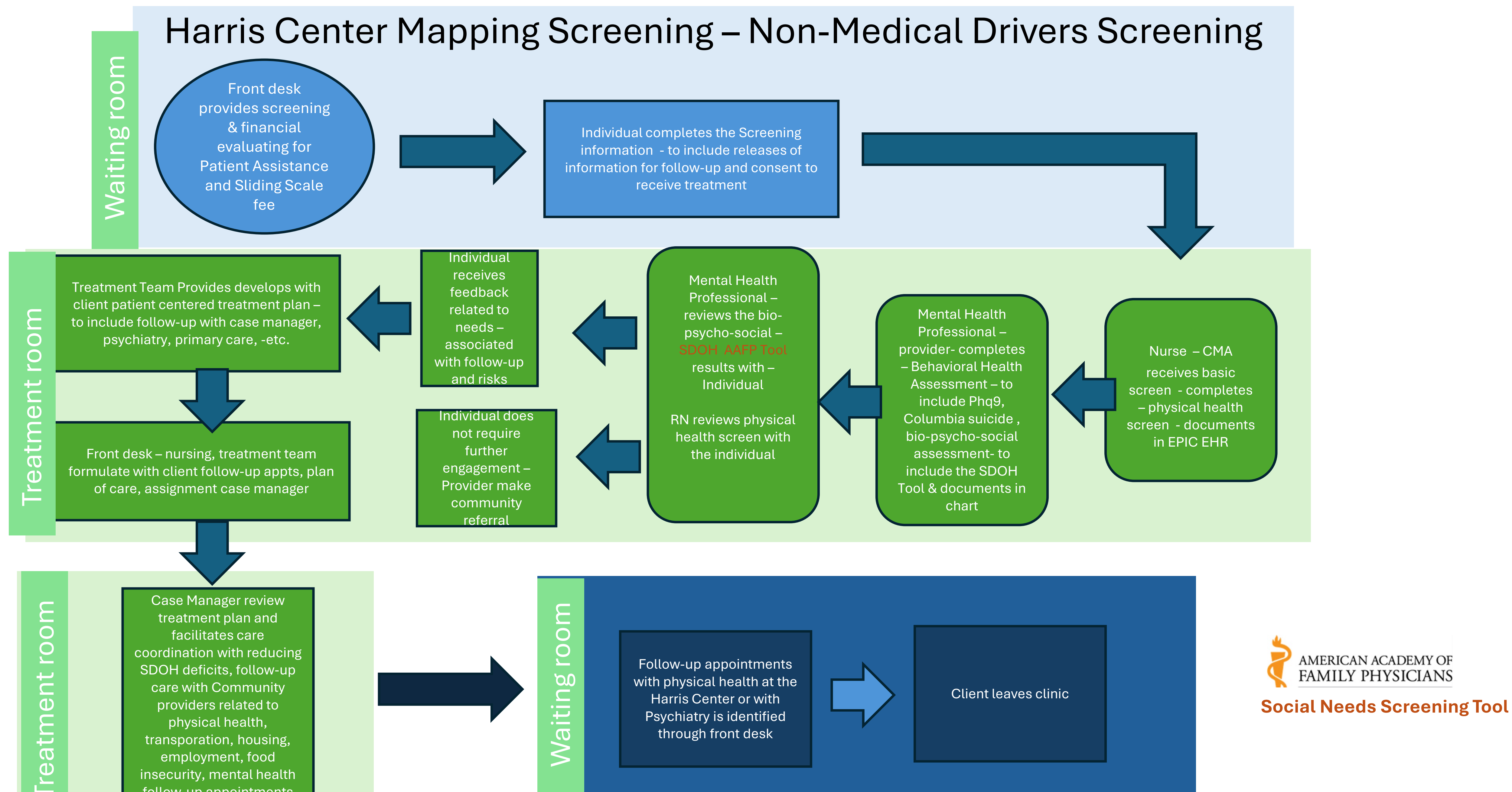
Addressing Food Insecurity



What is Food Insecurity?

Food insecurity (FI) is a lack of consistent access to enough nutritious food for an active, healthy life due to a lack of resources.

Source: National Institute for Health Care Management Foundation


Harris Center Mapping Screening – Non-Medical Drivers Screening
Waiting room
Front desk provides screening & financial evaluating for Patient Assistance and Sliding Scale fee
Individual completes the Screening information - to include releases of information for follow-up and consent to receive treatment
Treatment room
Nurse – CMA receives basic screen - completes – physical health screen - documents in EPIC EHR
Mental Health Professional – provider- completes – Behavioral Health Assessment – to include Phq9, Columbia suicide , bio-psycho-social assessment- to include the SDOH Tool & documents in chart
Mental Health Professional – reviews the bio-psycho-social – SDOH AAFP Tool results with – Individual
RN reviews physical health screen with the individual
Individual receives feedback related to needs – associated with follow-up and risks
Individual does not require further engagement – Provider make community referral
Treatment Team Provides develops with client patient centered treatment plan – to include follow-up with case manager, psychiatry, primary care, -etc.
Front desk – nursing, treatment team formulate with client follow-up appts, plan of care, assignment case manager
Treatment room
Case Manager review treatment plan and facilitates care coordination with reducing SDOH deficits, follow-up care with Community providers related to physical health, transporation, housing, employment, food insecurity, mental health follow-up appointments
Waiting room
Follow-up appointments with physical health at the Harris Center or with Psychiatry is identified through front desk
Client leaves clinic
AMERICAN ACADEMY OF FAMILY PHYSICIANS
Social Needs Screening Tool

Food Insecurity Screening

The HARRIS CENTER for Mental Health and IDD
Transforming Lives

For each statement, please tell me whether the statement was

"Often true, sometimes true, or never true" for your household:

Within the past 12 months, we worried whether our food would run out before we got money to buy more.

a) *Often true*
b) *Sometimes true*
c) *Never true*
d) *Don't know, or refused*

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

a) *Often true*
b) *Sometimes true*
c) *Never true*
d) *Don't know, or refused*

Hager, E.R., Quigg, A.M., Black, M.M., Coleman, S.M., Heeren, T., Rose-Jacobs, R.,…Frank, D.A.(2010). Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics, 126(1), e26-e32.*

Food Rx enrollment process

Screen for Eligibility → **Enroll into Food Truck** → **Redeem Food**

Screen for Eligibility

- All patients are screened for Food insecurity using 2 item-Hunger vital signs – Janeth & Team
- Patients that screen positive and/or meet qualifying criteria may opt into the Food Rx program – SAI contacts clients with opportunity - gets them to opt in – tell them there are enrollment form, quality of life survey, once dates of food truck delivery – let them know dates, make sure they have means to take home

Enroll into Food Truck

- Clients assigned unique Food ID number
- Client completes enrollment form (Forms Assembly)
- Patient completes Quality of Life survey
- FIRST Link refer to HFB for SNAP application assistance

Redeem Food

- Identified Patients will get 30 lbs of fresh produce and additional items twice a month at our sites

- **Harris Center**
- Identify the staff members from each site that will be the POC
- Eligibility will include screening positive for FI as well as the Daily Living Assessment, financial Screen of needs (both shared by Harris Center) and Quality of Life (shared by HFB) will be gathered to show the impact of the program:
- SDOH - two Hunger Vital Signs - Janeth
- Provide best dates and times to provide site assessment at each location for market trailer: Dates for site review: Completed
- Population health target at each of the four clinics – abnormal screens and data related to Health Risks – High Blood Pressure, Diabetes, other health concerns, Non-medical drivers of health screening results - Financial screening form: Janeth – Anna-Dr. Hickey-& Team

Site	*Staff Member– verify DLA – tell about the program- add to treatment plan – get the okay- ask if they can come to site to get 30 lbs of food to take home 2 x a month*	*Market Trailer – individuals that will oversee the check-in process*	*Identify patients and spread sheet with positive -two questions SDOH, poverty, health condition, Financial, DLA, & the site location*
Southwest (77074) -	Food Bank Services -	Peers	Care Navigators
Southeast (77087) -	Food Bank Services	Peers	Care Navigators
Northwest (77092) -	Food Bank Services	Peers	Care Navigators
Northeast (77028) -	Food Bank Services	Peers	Care Navigators

Food Rx enrollment process

Program Duration

- Patients remain eligible for set duration.
- Average time is 6 months

Data

- Screenings and surveys administered at baseline, 6 month intervals, program completion
- Client tracks health outcomes – every 6 months – part of Assessment

Note: Since April 2024 – over 1000 clients x 25 lbs of food = 25,000 lbs of food.

Trying to provide behavioral health treatment without addressing Non-Medical Drivers and Health Disparities–

is like spraying greater and greater quantities of pesticides on crops growing in unsuitable soil—the plants will not thrive.