



# CommonSpirit Health's Journey in Developing the Total Health Roadmap

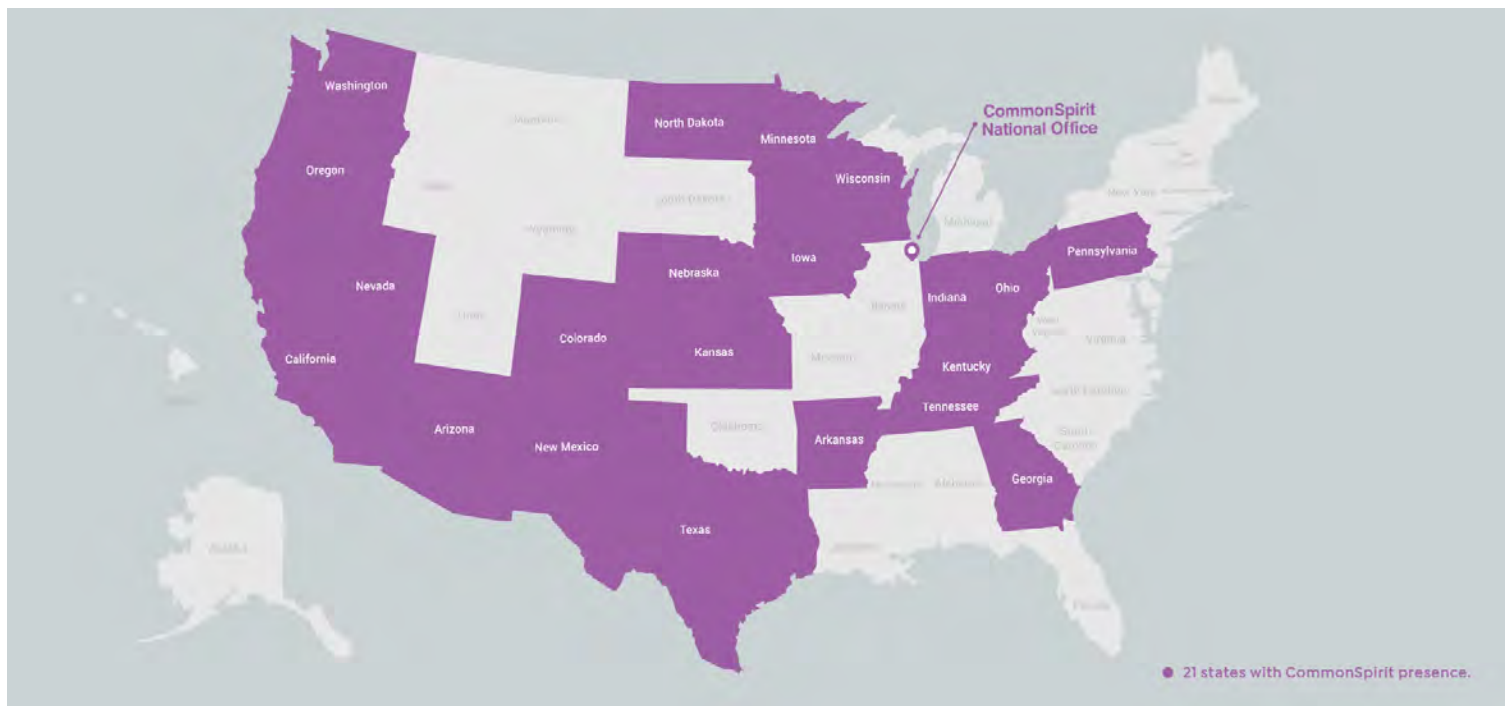
*Emergence of the essential role of community  
health workers in addressing social determinants  
of health in primary care*

Elizabeth Evans, Program Director, CHI National Foundation  
Shannon Duval, SVP, Philanthropy, Commonspirit Health

**CommonSpirit Health** was formed by the alignment of Catholic Health Initiatives (CHI) and Dignity Health.

Founded by women religious, both health systems have a long, proud legacy of serving all people in need, especially those who have been made vulnerable by poverty, age, and other hardships.

CommonSpirit Health is continuing these legacies by actively advocating for positive social change. [www.commonspirithealth.org](http://www.commonspirithealth.org)



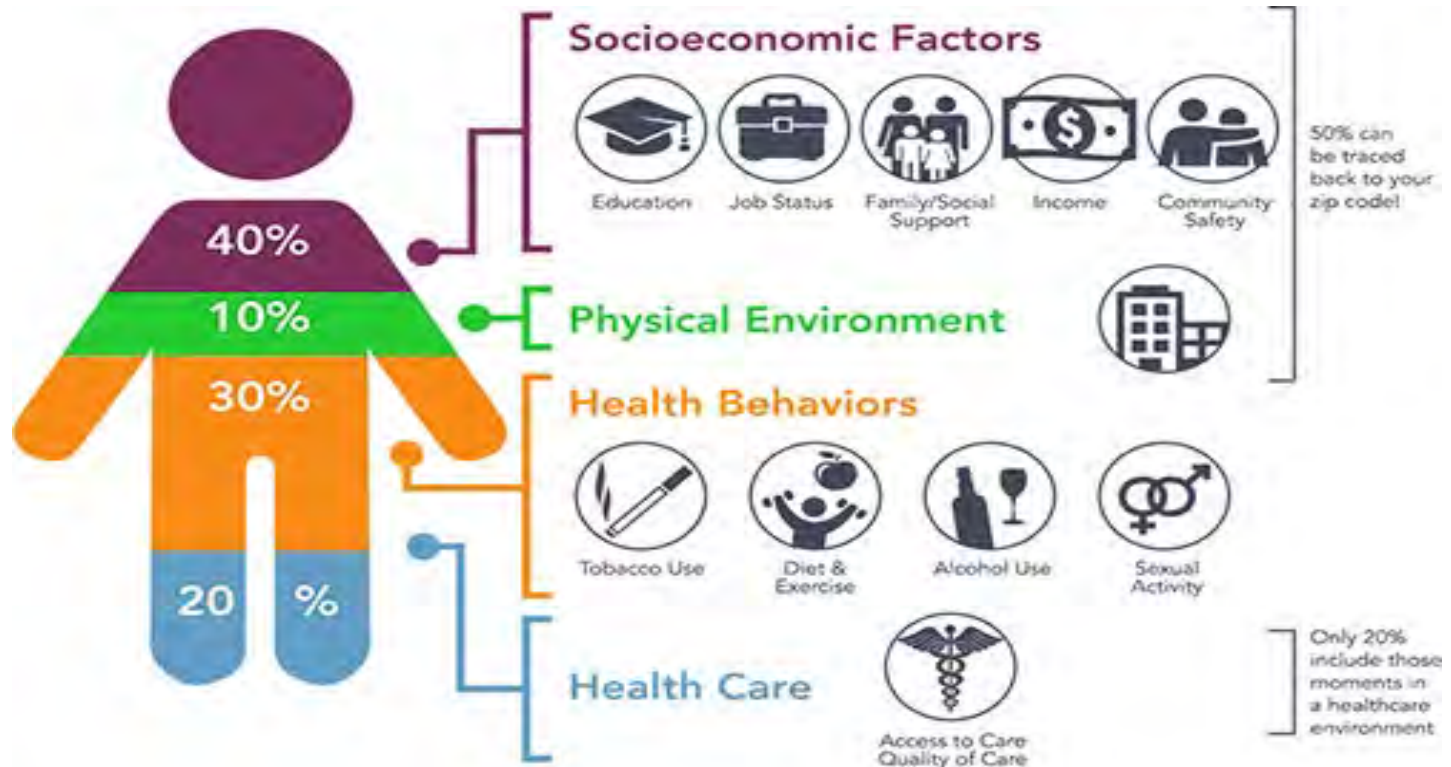


*Empathy is the starting point for creating  
a community and taking action.*

*It's the impetus for creating change.*

*Max Carver*

***Social determinants of health are those externalities of life circumstance that can negatively impact an individual's ability or desire to pursue healthy choices and achieve a healthy lifestyle and state of being.***



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2018)

The figure was borrowed from ProMedica.

<https://www.promedica.org/socialdeterminants/pages/default.aspx>



### CHI HEALTH INITIATIVES VISION

AS A MINISTRY OF THE CATHOLIC CHURCH WILL LEAD THE TRANSFORMATION OF HEALTHCARE TO IMPROVE OPTIMAL HEALTH AND WELL-BEING FOR THE INDIVIDUALS AND COMMUNITIES WE SERVE, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE

THE HEALTH FORUM DEMAND NARRATIVE  
FRUITFUL CHANGE  
JUN 11, 2016

## HORIZON ONE - 1 YEAR

### SOCIAL DETERMINANTS

**GOALS**

- Develop a common vision for health policies
- Adoption of recommended social determinants of health policies & best practices
- Access to healthcare resources
- Markets will think about social determinants
- Health needs captured
- Health resource providers & value being delivered
- Community forum - all sites
- Mutual confidence
- Shared data

### SUPPORT HEALTHY BEGINNINGS FOR EVERY CHILDHOOD

**GOALS**

- Shared Vision/Goals
- Individual: shared plan & define necessary
- Community: shared plan & define necessary
- National: shared plan & define necessary

### ADDRESSING BEHAVIORAL & MENTAL HEALTH

**GOALS**

- Co-locate all integrated behavioral health model with community stakeholders
- Community "urgent state" by market/division
- Gap analysis/asset identification
- Contract plan to address identified gaps and opportunities

### ESSENTIAL PARTNERSHIPS

**GOALS**

- Gain a full understanding of our communities current state and identify potential needs of pilots - CH focuses internal learning coalition and funding strategy
- Understand current state
- Identify existing coalitions/markets
- Select to potential pilot sites/needs across the nation

### CHI'S COMMUNITY ROLE

**GOALS**

- Added community coalition on plan to move forward (in multiple CH regions) to pilot in region
- National: CH coalition/sector local health & communities to pilots into economic local voice
- Locally: identify/lead structured pilot practices & design pilot
- Pilot: community coalition

### BOARD COMPETENCIES

**GOALS**

- 1) Turnover this year (1/3)
- 2) Board level services
- 3) Oversee

### LEADERSHIP COMPETENCIES & COMPOSITION

**GOALS**

- Prepare new leadership composition and accelerate momentum to CH vision (inter-sector)
- Assess current competency (eg. - D&S)
- Micro-mentoring focus on board, CH analysis & opportunities defined
- Define key stakeholders & formal SC team leaders
- Strategic
- Leverage ability to connect with a wide range of community that are supportive of their vision

## HORIZON TWO - 3 YEARS

### GOALS

- Community health for all members
- Personal care/prevention
- Strategic prevention in 1/2 2/3 worked in 1/2
- Annual meetings (local)
- An overall health community defined
- Incentive
- System wide incentive shared w/ multiple community stakeholders
- Accountability established

### GOALS

- Process intervention
- National: shared plan & define necessary
- Community: shared plan & define necessary
- National: shared plan & define necessary

### GOALS

- 100% CHI communities will have tiered access to an integrated behavioral health model
- Phased model expansion
- Community ownership of model
- Access to resources, infrastructure, funding, etc.
- Build a sustainable framework

### GOALS

- Collect data from pilot locations and determine scalability and sustainability - celebrate wins with communities
- 4th Board-making model to track metrics of pilot programs
- Report Year 2 planning
- Select phase 2 pilots
- Optimize on resources, infrastructure, funding, etc.
- Build a sustainable framework

### GOALS

- Board level services
- Oversee
- Turnover this year (1/3)
- Board level services
- Oversee

### GOALS

- All boards have participated in integrated pilot process
- Refined metrics to assess process
- Appropriate adjustments with board services, functions, roles, content parameters

### GOALS

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- Assess current competency (eg. - D&S)
- Micro-mentoring focus on board, CH analysis & opportunities defined
- Define key stakeholders & formal SC team leaders
- Strategic
- Leverage ability to connect with a wide range of community that are supportive of their vision

## HORIZON THREE - 5 YEARS

### GOALS

- Community health for all members
- Personal care/prevention
- Strategic prevention in 1/2 2/3 worked in 1/2
- Annual meetings (local)
- An overall health community defined
- Incentive
- System wide incentive shared w/ multiple community stakeholders
- Accountability established

### GOALS

- Process intervention
- National: shared plan & define necessary
- Community: shared plan & define necessary
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# SOCIAL DETERMINANTS HEALTHY BEGINNINGS BEHAVIORAL HEALTH ESSENTIAL PARTNERSHIPS COMMUNITY ROLE BOARD COMPETENCIES LEADERSHIP COMPETENCIES



LEADERSHIP!

# CURRENT FOCUS

*3 Strategies:*

**Transforming** our roles as providers

**Strengthening** our roles as community organizations

**Strengthening** leadership accountabilities

***...grounded in our commitment to healthier communities, the focus is on building a framework for successful scaling.***

***FUNDING:** \$2.5M from Robert Wood Johnson Foundation, matched by \$2.5M from the CHI Mission and Ministry Fund.*

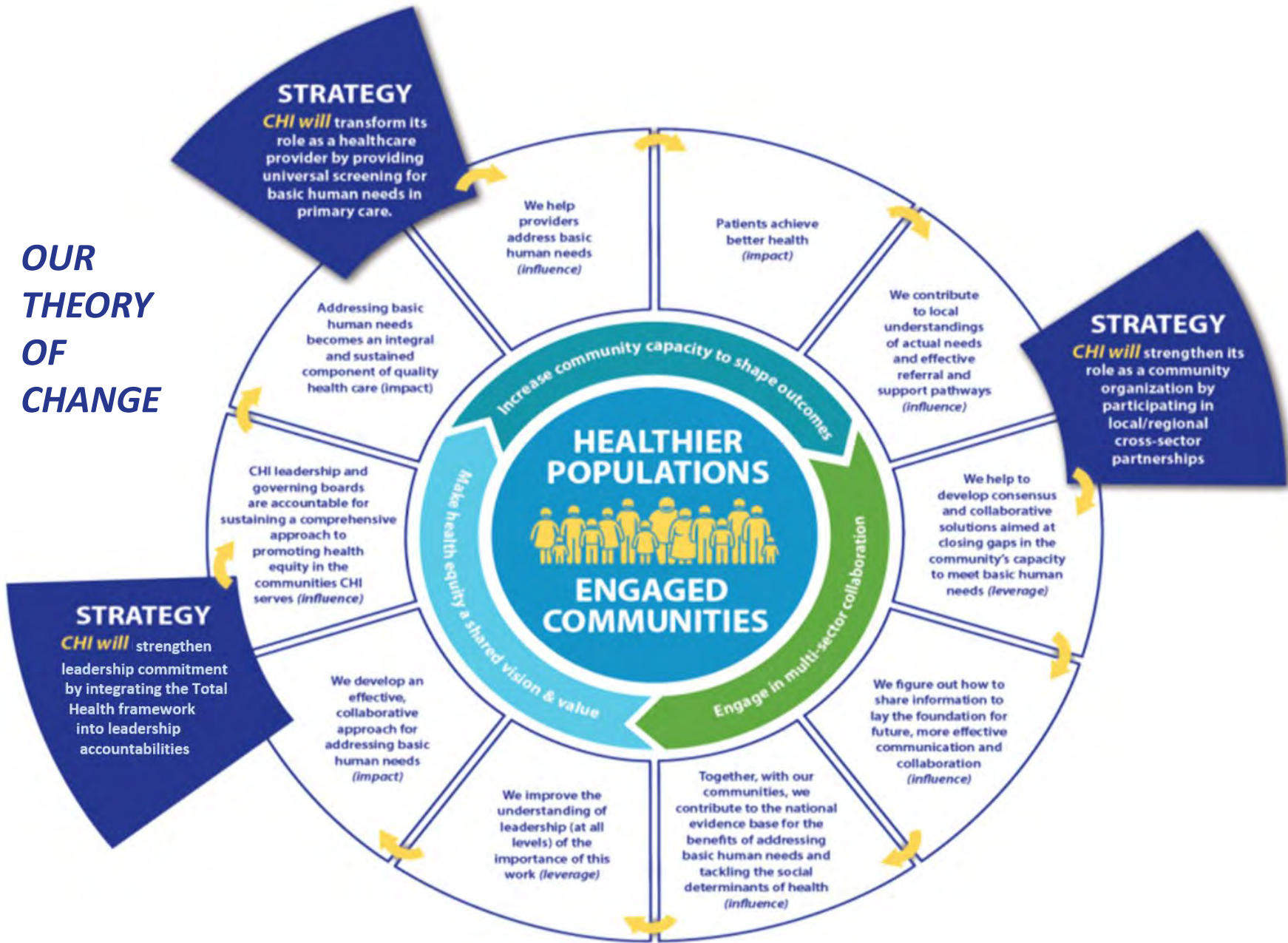
*Implementation began July 2017; funding will support development and pilot activities through June 2020.*



**VISION:**

*Rooted in our foundational values of human dignity and social justice, we are an enduring network of healthcare anchor organizations fully engaged with their local communities to ensure individuals and families have every opportunity to live the healthiest lives possible.*

# OUR THEORY OF CHANGE





# *Communities in action: Pathways to health equity*



**Aligned efforts across these strategies are necessary to foster the growth of a learning healthcare organization and to make an impact on total health in our communities.**

National Academies of Sciences, Engineering, and Medicine. 2017. *Communities in action: Pathways to health equity*. Washington, DC: The National Academies Press.

Available at <http://nationalacademies.org/hmd/Reports/2017/communities-in-action-pathways-to-health-equity.aspx>.

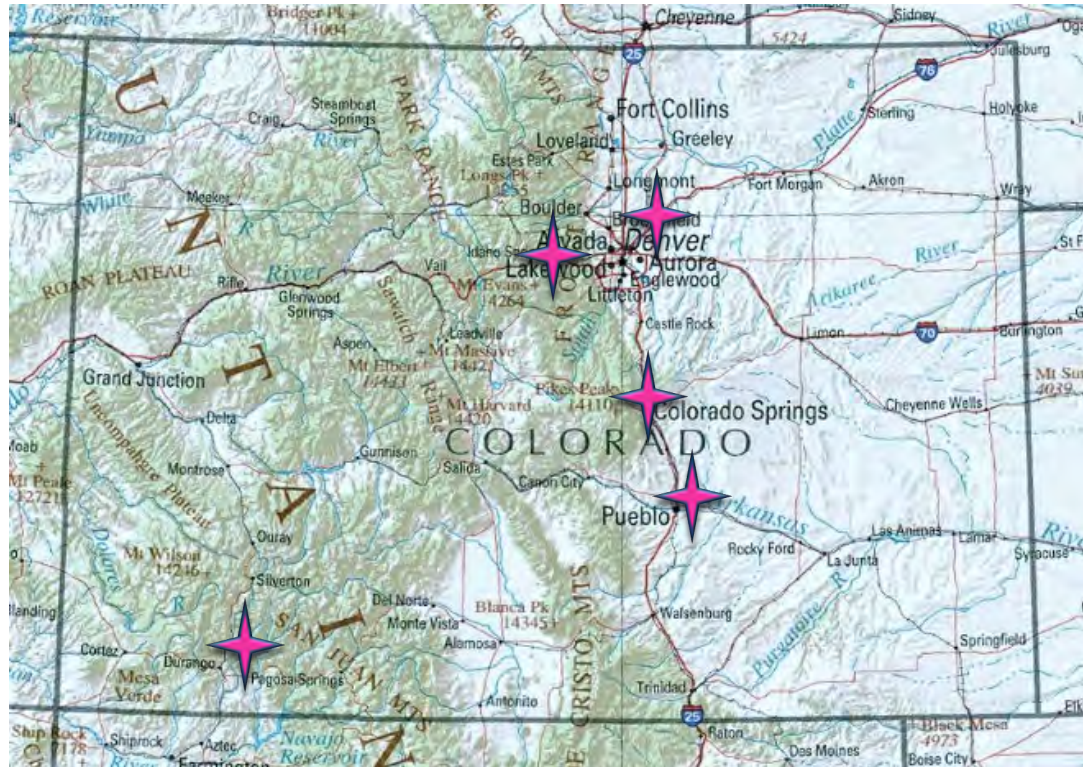
## STRATEGY 1: Transforming our roles as providers

- Full time Community Health Workers (CHWs) are integrated into care teams in 12 clinics
- We are identifying significant needs, and patients value the assistance provided by CHWs
- Approaching universal screening
- Developing framework of robust resource databases
- Developing strong technology solutions to manage and leverage data to inform next steps

*Universal screening is defined as every patient is OFFERED the screen*

# COLORADO – Centura Health

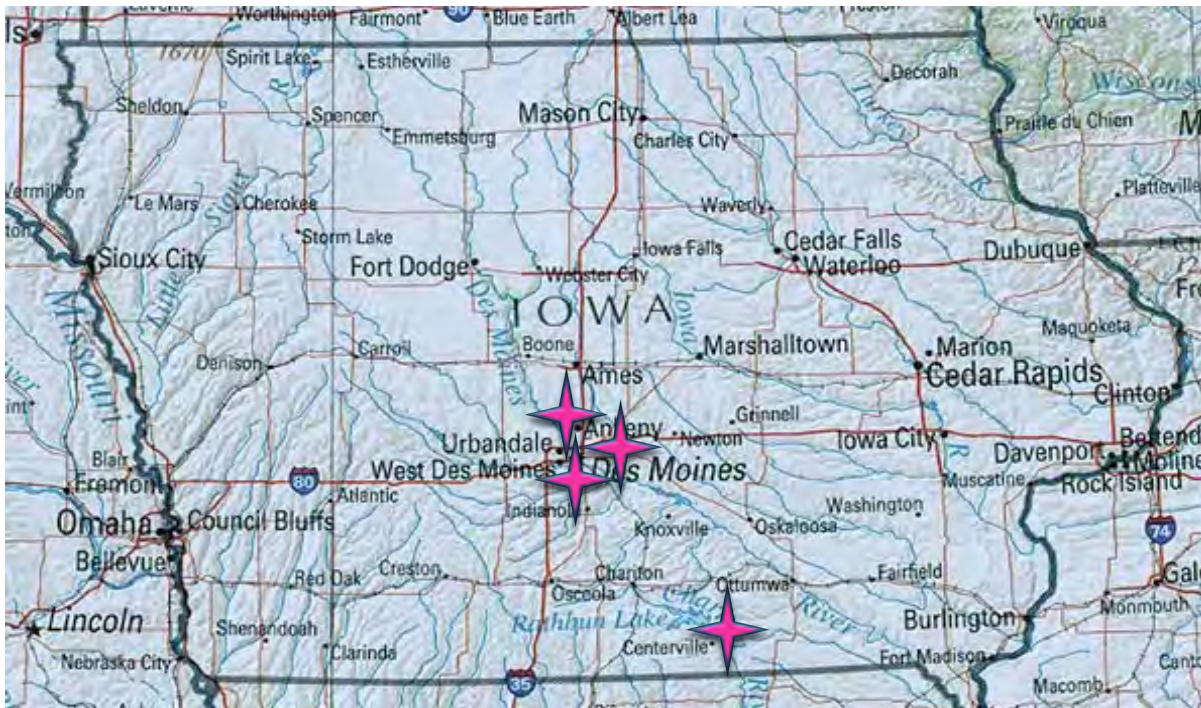
*Joint Operating Agreement between legacy Catholic Health Initiatives and the Adventist Health System*



- 2 family medicine residency clinics (Westminster, Pueblo)
- 1 rural clinic in rural mountains (Durango)
- 1 safety net clinic (Colorado Springs)
- 1 urban health clinic (Golden)

# IOWA –MercyOne

*Joint Operating Agreement between legacy Catholic Health Initiatives and Trinity Health*



Embedded in the Accountable Health Community/Clinically Integrated Network

- 3 urban health clinics in Des Moines area
- 1 rural clinic in Centerville
- Plans for expansion to 2 additional rural health clinics via SIM funds

# KENTUCKY – CHI St. Joseph Health

*Wholly owned by legacy CHI*



3 rural sites

- family medicine clinics in Berea and London
- pediatric and adolescent medicine clinic in London










# PROJECT REQUIREMENTS

*Our requirements are designed to ensure the appropriate process and technologic frameworks are in place to support effective use of data to understand better the needs of our patients and to inform improvements in care delivery.*

- use of a core set of common screening questions across all pilot clinics
- integration of at least one full time community health worker (CHW) into each pilot clinic
- integration of technology to support electronic capture of screening results and the care management activities of the CHW
- development of the ability to track and report clinical outcomes in parallel to outcomes of the screening/referral/follow up managed by the CHWs

# SCREENING

What we have learned from our patients –  
over 40,000 screened to date; 1 in 5 indicate need

		Circle One
	In the last 12 months, were you worried that your food would run out before you got money to buy more?	<b>YES</b> NO
	Are you worried or concerned that in the next 2 months, you may not have stable housing that you own, rent, or stay in as a part of a household?	YES NO
	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	YES NO
	In the last 12 months, did you skip medications to save money?	<b>YES</b> NO
	In the past 12 months, has lack of transportation kept you from the doctor, work, or from meeting other needs?	<b>YES</b> NO
	Are you worried about your physical or emotional safety where you currently live?	YES NO
	Do you ever need help reading medical materials?	YES NO
	<b>Would you like to receive help with any of these needs?</b>	YES <b>NO</b>
	<b>Are any of your needs urgent?</b> <i>For example: I don't have food tonight, I don't have a place to sleep tonight</i>	YES NO

*The most commonly identified needs are food insecurity, financial stress (skipping medications), and lack of transportation*

*Nearly half of patients with needs refuse assistance*

## What our providers are telling us

- CHWs and the support they provide are valued by clinical teams
- “Warm handoffs” between providers and CHWs are becoming more frequent
- Increased acceptance of adding screener to everyday workflow
- The fact that the program is “payer-agnostic” is a plus

### Pre-implementation survey:

- Lack of confidence by providers in knowing what resources are available
- Lack of time to address social/basic human needs during visit
- Recognition that SDoH are essential factors in patient ability to manage health



## CHALLENGES

Follow up – patients with the deepest needs are often the most difficult to contact and assist with follow through

Contract negotiation and technology integration was slower than expected – relying on paper-based processes

Location of appropriate resources for patients/capacity of local resources

Achieving universal screening in all clinics – determining reasonable workloads and avoiding CHW burnout

## NEXT STEPS

- *Explore better referral and follow up processes – including sharing information with community partners/electronic referrals*
- *Explore better integration of case management technology into EHR*
- *Engage more fully in local collaboratives to address resource gaps*
- *Develop ongoing training and support for Community Health Workers*

## ***LESSONS LEARNED***

- Do not expect that all who identify needs will want assistance – it may take time for this new element to be accepted as part of the care provided in the clinics
- Regularly engage CHWs in discussions of process improvement and to assess the variety and depth of needs encountered – **have a strong coordinator in place**
- Be prepared to face gaps in resources in the local community



## ***STRATEGY 2: Strengthening Our Roles as Community Organizations***

### **AT THE COMMUNITY LEVEL:**

- Using the information gleaned from screening and referral to inform community conversations
- Engaging with community partners to develop plans for closing resource gaps
- Identifying other model programs at work in other legacy CHI and Dignity Health markets and communities

### **AT THE NATIONAL LEVEL:**

- Participating in multi-system collaboratives that focus on advancing the role of health systems in addressing community needs
- Developing a learning platform/shared practices library

# PROGRESS

## AT THE LOCAL LEVEL

- CHWs have established good working relationships with area agencies
- Connecting with ongoing work of local healthy community initiatives, Mission, Advocacy, and community collaborations

## AT THE NATIONAL LEVEL

- Our work is generating interest from other national groups and initiatives
- We are founding members of the Healthcare Anchor Network

## **CHALLENGES at the Community Level**

- Achieving universal screening– determining the true scope of need
- Understanding the true capacity of local communities to meet needs, and expanding our definition of sustainability
- Technology integration –to generate data to inform conversations regarding resources available (or not available) to meet identified needs

## **CHALLENGES at the National Level**

- Identifying how and where we can contribute to the national evidence base
- Connecting our work with other national initiatives and developing an effective learning platform for our system
- Expanding our definition of sustainability outside of conventional reimbursement models

## LESSONS LEARNED

- *Significant effort is required to identify good resources and establish working relationships with community partners*
- We need to develop common language and principles of how we, as a national organization and as local/regional systems address health equity and collaborate with our communities
- We need to invest in development of operational infrastructure and processes to assist our markets in implementation and evaluation, thus making the case for effective programming and sustainability

## **STRATEGY 3: Strengthening Leadership Accountabilities**

- Assessing current engagement of leadership in local, regional, and national initiatives
- Exploring the use of the *Pathways to Population Health* framework



### **NEXT STEPS**

- *Development/adoption of definitions of terms and guideposts that clarify our approach to advancing health equity in our communities*
- *Developing an effective learning platform that supports work in our diverse communities*
- *Developing metrics that reflect both national and local specific commitments to achieving health equity*



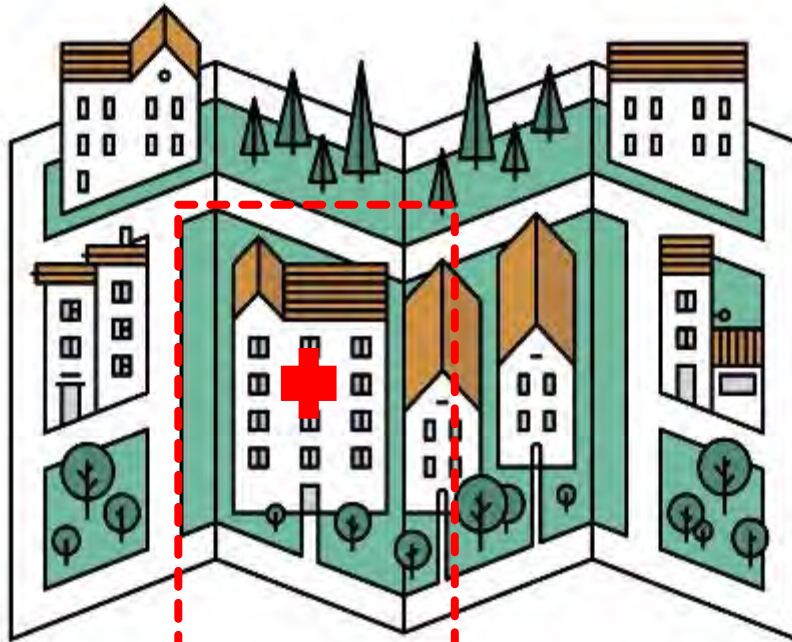


ADAPTED Table 2 from P2PH Framework – Portfolios of Population Health

	Portfolio 4: Communities of Solutions	Portfolio 3: Community Health and Well-Being	Portfolio 2: Social and/or Spiritual Well-Being	Portfolio 1: Physical and/or Mental Health
Type of population	Place-based and defined	Place-based and defined	Defined	Defined
Focus of work	Whole community transformation with a focus on long-term structural changes needed for a thriving, equitable community	Improvement of health, well-being, and equity focused on specific topics across a place-based or defined population	Proactively address social and spiritual drivers for the population for which your organization is directly responsible (e.g., patients, employees)	Proactively address mental and/or physical health for the population for which your organization is directly responsible (e.g., patients, employees)
		STRATEGIC AIMS 2 & 3	STRATEGIC AIM 1	



# ADDRESSING HEALTH EQUITY



## WITHIN OUR WALLS

- Covered Lives
- Improving Access
- 123 Equity Pledge
- Diversity & Inclusion
- Transformation

## OUTSIDE OUR WALLS:

### As Anchor Institutions

- Community investment
- Community benefit
- CHNA/CHIP

### As Partners With Other Agencies

- Understanding the basic human needs of our patients
- Communicating and coordinating with other agencies to address need
- Contributing to development of effective plans to reduce disparities

# HEALTH SYSTEM ASSETS

## FUNCTIONAL ASSETS

- Community planning & leadership
- Business & financing
- Partnering capacity
- Communications
- Government relations
- Public policy
- Healthcare services
- Research, Data, and Technology
- Diversity & Inclusion
- Labor-Management Relations
- Reputation

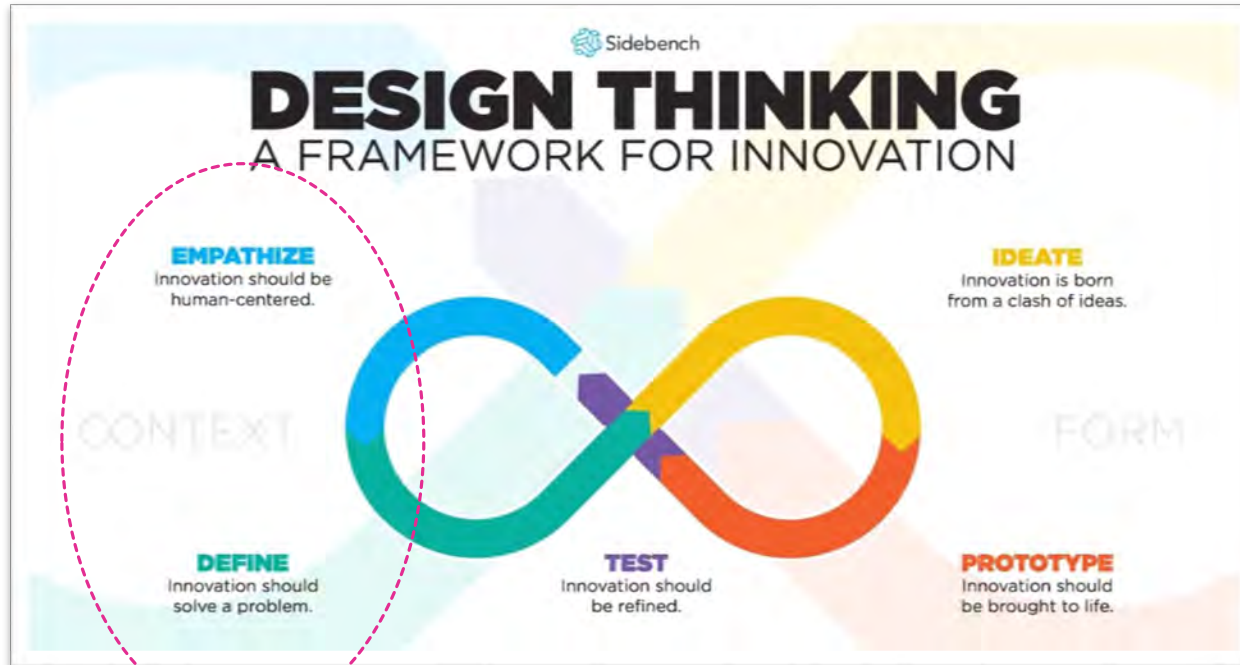
## DISCRETIONARY ASSETS

- Community Benefit Grants
- Community Health Initiatives
- Social & Economic Support Services
- Foundation & Philanthropic initiatives

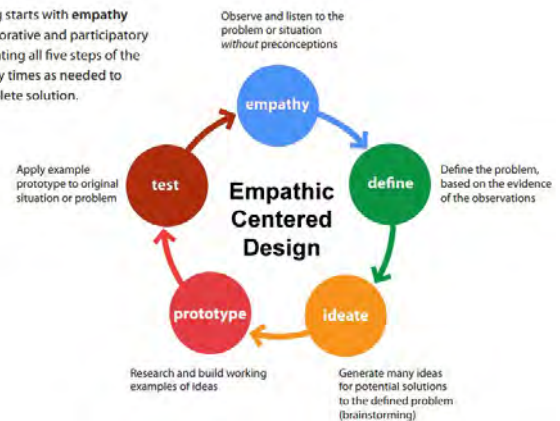
## ECONOMIC ASSETS

- Hiring and Workforce
- Procurement/Purchasing
- Treasury/Investment
- Construction
- Real Estate/Facilities

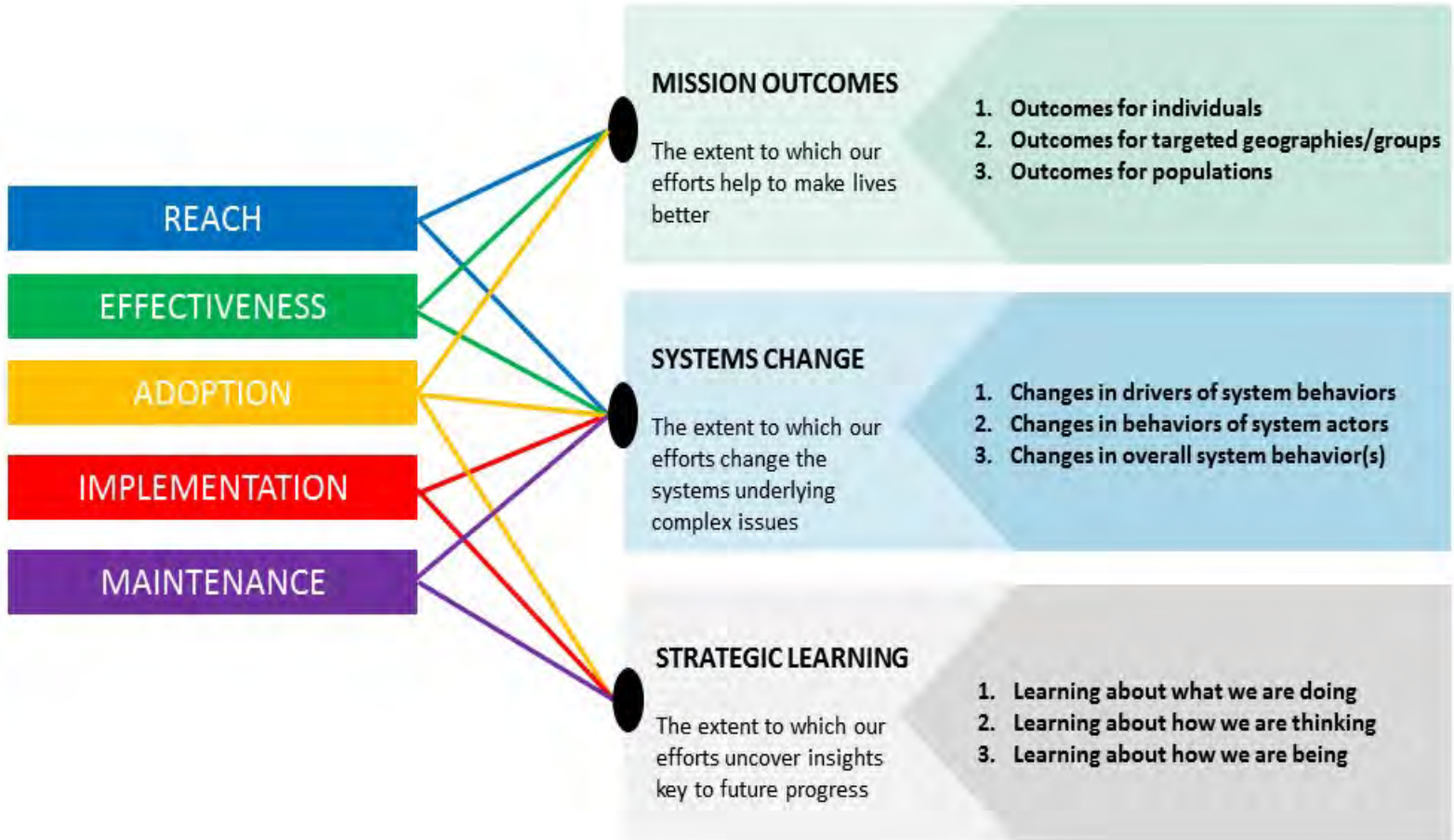
# IMPLEMENTATION EVALUATION



Design thinking starts with **empathy** and uses collaborative and participatory methods, repeating all five steps of the process as many times as needed to achieve a complete solution.



# CONNECTING FRAMEWORKS








Cabaj, M. (2018) Evaluating Systems Change Results: An Inquiry Framework. Available online: <http://www.tamarackcommunity.ca/library/paper-evaluating-systems-change-results-an-inquiry-framework>

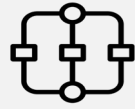



## ROLE OF A NATIONAL TEAM FOR SCALING AND SPREAD

DIMENSION	DESCRIPTION	
<b>Scaling Out (Beneficiaries)</b>	The expansion of an innovation and/or its replication and adaptation in different contexts. As a result, it has more beneficiaries.	establishing key requirements and understanding the essentials of successful implementation and necessary adaptations for spread to other communities
<b>Scaling Up (Systems)</b>	Changing institutions' policies, regulations, laws, working relationships, resource flows and practices in ways that enable (rather than undermine) the performance and expansion of the innovation.	identifying effective methods of engaging with community partners and identifying payment and policy levers that can assist with spread
<b>Scaling Deep (Culture)</b>	Changing the 'hearts and minds' of people, the organization, system or community (e.g., in terms of narrative, values, beliefs and identities) so that the idea of underlying the social innovation is supported and embedded in the cultural DNA.	reexamining health care's role in the overall health of our communities and NAMING our commitment to healthier communities in our system strategies
<b>Scaling Scribe (New Innovation)</b>	Encouraging, legitimizing and cultivating other ideas and innovations that see the same outcomes as the original innovation, but in different ways.	developing a better platform/improved pathways for encouraging and evaluating other collaborative efforts that contribute to community health and wellbeing
<b>Scaling Infrastructure (Capacity)</b>	Improving the capacity of a system of community to scale the work through such things as capital, data, talent, knowledge, networks.	recognizing opportunities to tie together efforts across the continuum of community health and wellbeing – and ensuring the entire continuum is represented in system strategies



Cabaj, M. (2018) What We Know So Far About Evaluating Efforts to Scale Social Innovation. Available online: <http://www.tamarackcommunity.ca/library/evaluating-efforts-scale-social-innovation>

# ROLES OF THE NATIONAL COORDINATING TEAM

-  SUPPORT ENGAGED DISCUSSION
-  IDEA MINING
-  MAKE CONNECTIONS
-  OVERCOME OBSTACLES
-  REFINE THE ROADMAP
-  DEVELOP LEADERSHIP

-  DEVELOP INTEGRATIVE WORKFLOWS
-  ASSESS TRAINING & SKILL DEVELOPMENT NEEDS
-  INTEGRATE EFFECTIVE TECHNOLOGY
-  DEVELOP USEFUL METRICS

-  DOCUMENT & COMMUNICATE
-  CONVENE LEADERSHIP
-  NETWORK WITH NEW PARTNERS

-  MANAGE CONTRACTS & AGREEMENTS
-  STEWARD FUNDS & PLAN FOR SUSTAINABILITY

Network development and management *at multiple levels* is essential.

## Current Focus of the Advisory Committee on Interdisciplinary, Community-Based Linkages

*Promoting the inclusion of population health, at the nexus of primary health care delivery and public health, as a method of identifying place based risks, its root causes, and possible interventions to address the structural and social determinants of health and to prepare clinicians to serve as change agents promoting primary prevention.*





# DEVELOPING ADVOCATES

*Always design a thing by considering it in its next larger context - a chair in a room, a room in a house, a house in an environment, an environment in a city plan.*

*--Eero Saarinen*

## **Start with...**

What kinds of needs do my patients have?

How many of my patients have similar concerns and needs?

Are my patients linking up to available resources? If not, why?

## **And then...**

Why do my patients continue to have these concerns?

Are these concerns symptoms of larger issues in my local community?

What gaps do we need to close to address these issues?

**What role can I and/or my organization play in addressing these issues?**

## ESSENTIAL ROLES OF CHWs

- Patient counselors and advocates
- **Front-line links to community agencies and partners**

***Lesson Learned:** It is essential that CHWs feel that their work is part of a bigger picture – and that their contributions to value of the care we provide are recognized by clinical teams and system leadership.*

## What matters in building local networks and collaborations to address social determinants

- Begin with where your organization can make an impact, but avoid “medicalizing” social needs
- Local data combined with patient stories are more powerful than county-level statistics for engaging internal leadership as well as new sectors in the community (i.e., business)
- Design thinking processes and adaptations – **START with empathy**
  - **RECOGNIZE** the impact of drivers, pressures and internal workflows in primary care
  - **ACKNOWLEDGE** differences in culture, workflow, and funding resources in social service agencies
  - **CONSIDER** the impact of increased referrals on capacity of local resources



# **APPENDIX: PATIENT STORIES**

**Laura** is a 74-year old woman living in a small rural town with no vehicle of her own. In order to see her physician or travel to a larger town for goods and other services, Laura has to pay \$30. I first met Laura when she indicated she needed assistance with food and utility bills; she had been turned away from one food bank based on her address, and when she visited the second food bank, it was closed.

Despite leaving multiple messages at the second food bank, Laura did not receive any return phone calls. I stepped in to contact the food banks, but I did not receive any answers either. I then called a representative of a larger network of food banks in the area, who reached out to the second food bank, which then contacted me. I worked with the food bank to have food delivered right away and set up a monthly delivery schedule thereafter.

***My working relationship with our area food bank network proved very valuable in my attempts to help Laura.***

All patient names have been changed to protect privacy.



**Judith** came to me needing assistance with resources to help with expenses related to raising her grandchildren. At the start of our conversation, Judith was concerned that I would not be able to help unless I knew of a resource that could provide the gallon of milk and loaf of bread that her growing grandchildren went through each day.

I did not have a resource specifically for that, but instead knew of an area program that supports grandparents who are raising their grandchildren. I connected Judith to this resource, and at follow-up, I learned that she had received \$200 for each child for back-to-school clothes. ***This reminded me of how important it was for me to reach out and meet with our community resources, otherwise, I would not have known about the grandparent program.*** Also, I take heart in knowing that sometimes I can help families meet their needs in a round-about way. With Judith, I did not have a resource specifically for her food needs, but I was able to help her find assistance with other expenses, which left more money in her budget for groceries. ***I think universal screening is key to identifying patients who need assistance. Without screening, we might never have identified Judith's concerns and the stress she was facing in raising her grandchildren.***

All patient names have been changed to protect privacy.



Since November 2018, one of our pilot clinics has referred five patients to SafeNet Rx for medication. The no-cost prescriptions from SafeNet Rx have saved those patients a total of \$2,905. This success was possible because we worked together to take the SafeNet Rx process implemented at one clinic and adapt it to the other clinic.

**Faye**, a Medicare patient who was in the “donut hole” and could not afford her diabetes medication, was assisted through this process.

Another patient was **Patricia**, who was without insurance due to a job change and questions about Medicaid eligibility with the corresponding salary increase. Because Patricia was without insurance, she was not taking her medications for diabetes and depression. The SafeNet Rx prescriptions allowed her to take better care of herself and maintain her job.

All patient names have been changed to protect privacy.



**Richard** is a 46-year-old single male **with significant behavioral health concerns**. He works full-time but is unable to afford the high deductible insurance his employer offers him. Richard currently qualifies for only \$15 per month of SNAP benefits, which is clearly not enough to get through the month.

Richard often struggles just to get through the day – he often misses work days or hours when he is having a particularly rough time. Richard has not been able to go to therapy or to afford the medications that could help him – he often feels hopeless.

I was connected with Richard and we discovered that he qualified for the Working Adults With Disabilities program in our state, Richard teared up and hugged and thanked me. This will help him get the medication and therapy he needs. I also gave Richard the local 24/7 crisis line, a list of food pantries, information about the USDA's emergency food assistance program, and information about the non-emergency medical transportation program to help Richard get to his appointments when needed.

All patient names have been changed to protect privacy.





**Lewis** indicated he needed assistance in housing and food on the patient screener. I was able to meet with him right away, and Lewis explained that he was living on Social Security benefits and had recently secured a part time job. He was living with a friend in the mountains, however, his friend was going to be moving soon, so he was losing his home.

I talked to Lewis about SNAP benefits and other food security programs available in our area, and I put in a referral for him. As we talked about his housing concerns, Lewis explained to me that **he had a prior conviction for a felony**, and that he has had a hard time finding affordable apartments that will allow him to live there. We discussed some options, and I asked if I could do some research and follow up with him on housing options. It took some digging, but I found a men's shelter in our area that will welcome Lewis while he transitions to new housing. After some additional phone calls and referrals, I found an apartment complex that accepts persons on Social Security with prior convictions that did not have a waiting list! ***I contacted Lewis and he moved in a week later.***

All patient names have been changed to protect privacy.



**Jacob** screened positive for food and utilities. In his initial call with me, he stated he had been struggling to pay his bills since he lost his job recently. Jacob is currently working three days a week bartending but is interested in sales and hopes to find a full-time job soon.

I used motivational interviewing to discuss his needs in more detail, and Jacob agreed to complete a SNAP application online with assistance from me. With his permission, I also provided Jacob with resources that may help with employment opportunities and utility assistance.

Jacob indicated that he struggles with his pride and asking others for help – and he told me ***“I would have never asked for help if I had not taken the survey.”***

All patient names have been changed to protect privacy.



**Arthur** had visited the clinic several times, presenting significant GI problems. We worked with his Nurse Practitioner and finally figured out that he had no refrigerator in his studio apartment. Arthur was often eating food that had spoiled.

We worked with our resource agencies to find Arthur a small refrigerator that would serve his needs and keep him healthier.

All patient names have been changed to protect privacy.



**Allie** is a 16-year-old teen mother who is working toward getting her high school diploma. Allie didn't want food stamps – she wanted a job. We worked with her to write her resume and post it on the Indeed.com website. Because of the posting, she was called to an interview with a regional grocery chain.

***Allie got the job and has begun her computer training.***

All patient names have been changed to protect privacy.



**Sarah** came for the follow up appointment after her visit to the emergency room, which had led to a hospital stay. Sarah is a **victim of domestic violence**, and she was physically abused by her former partner and was left with serious bodily injuries.

Sarah also told us that she has **struggled with substance abuse**, and she has lost the custody of her children in past. At the time we met with her, she had been sober for over a month. But she had significant food, housing, financial and legal needs. We referred her to several available resources, including SNAP benefits, food banks, the county action center, local housing resources, and legal resources also available through the county. A week later, Sarah had received SNAP, utilized food banks and was on the waiting list for several housing complexes. During one of our follow-up phone calls, Sarah said she was ready to be admitted to a rehab program. We walked her through some of the preliminary steps to find out how we could leverage Medicaid to cover the cost of rehab program. **Several weeks later, Sarah came to our clinic again, and this time she was smiling.** She proudly shared that she is admitted to an outpatient treatment program, and she was allowed to visit her kids the following week.

All patient names have been changed to protect privacy.



**Maddie** is a young mom whose **toddler daughter has a disability**. She is new to our state and has a good full-time job. Unfortunately, Maddie earns too much to qualify for most assistance programs, and she has had to take a lot of time off from work for her daughter's therapies.

We helped her apply for a waiver to provide respite care, but the wait list is over two years. We helped Maddie apply for Social Security for her child, and we were able to get her child's diapers covered under Medicaid because of the child's diagnosis. This saved Maddie over \$100 a month. We also connected her to Habitat for Humanity in hopes of securing housing that will be accessible.

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**I received a phone call from an area social worker** to ask if I could help one of our clinic's patients. **Tom** was in need of a specialized bed for his son **Max**, who has cerebral palsy. Max was sleeping on the floor because the family did not have a safe bed for him. I talked with Tom and then went to work with area medical equipment suppliers to secure a hospital bed for Max.

*I noticed that it had been a year since Max was seen in our clinic, so I helped Tom arrange for an appointment so that we could secure the needed physician referral for the bed to be covered by insurance.* Tom and Max came in the next day, and within a few days after that, Max had his new bed delivered. I circled back with the social worker to let her know that we were able to help Tom and Max.

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*Lisa* answered yes to every question on our screening form. Lisa is employed, but she and her husband were living in a car with their two-year-old and five-month-old children. Lisa indicated that she and her husband had been **“fishing for their food.”** Lisa’s husband suffers from PTSD due to his military service and often drinks heavily.

I was able to get the family into a room at a local shelter for three nights. I also worked with Lisa to locate her husband’s Honorable Discharge paperwork, which was then forwarded to a local Elks Club that works with military families to secure housing. The Club located a good option for housing and paid for a hotel room for the seven-week wait period. I also helped Lisa apply for SNAP benefits and provided information on local soup kitchens and food banks. A local family center was able to provide diapers and clothing for the children, and we were able to obtain vouchers for gas so that Lisa could make it to work. I also helped Lisa connect to counselors to assist with her husband’s struggles with PTSD and alcohol.

*Each time a member of Lisa’s family comes to the clinic for care, I check in to see how things are going and to provide support.*

All patient names have been changed to protect privacy.





**Edie** screened positive with crisis and safety concerns. When I met with her, Edie was confused and disoriented. After conducting a motivational interview, I learned she was a victim of domestic violence and she feels unsafe at home.

I immediately formed a team with behavioral health provider and clinic nurse to arrange her admission to the Emergency Department (ED) for further assessment. We provided Edie with the contact information for few community resources in the area and we made sure she finds a temporary place to stay. In follow up, Edie told us ***“Thank you, I am finally safe at home.”***

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**Frannie**, a young mother of two met with me to complete a survey. Frannie indicated to her provider and to me that she does not feel safe at home. She recently got a job and was going to start getting her own income soon, and she needed help getting formula beyond what she received through WIC.

I assisted Frannie with a SNAP application and helped her contact a crisis service nearby. Frannie was able to move out of the house and away from her abusive husband. She is in school now and is managing her labs, appointments, and medications responsibly. I check in at Frannie's PCP appointments for regular follow up.

All patient names have been changed to protect privacy.



***Dale and Sherry*** met with the Sherry's primary care provider to talk about her moving home from an assisted living facility for those with dementia. Sherry's provider asked me for help, and I spoke with the assisted living director and the hospital social worker for guidance.

Sherry was scheduled to move home the next month with services in place such as home delivered meals, in-home nursing and a home care aide, an emergency response button, and a neighbor regularly checking in with the couple. We also put a plan in place for Sherry to receive respite services if Dale should be admitted to the hospital and could not care for her short-term.

All patient names have been changed to protect privacy.



I connected with *Kim*, who was on short-term disability and was behind on her utility bill. Her provider had written a letter to the utility company requesting that they give her an extension before disconnecting. Kim was reluctant to ask for help, so I offered to go with her to a community resource agency to request utility assistance.

During that appointment I also learned that Kim needed a new tire for her car; she was driving on the spare “donut” tire. It is difficult to find resources for car repairs, so I asked Kim if she is a member of a church that may be able to help. She was a long-time member of a local congregation and gave me permission to call on her behalf to see if they may be able to help. I explained the situation to the church representative and was able to provide confirmation that the tire was a need. Upon follow-up with Kim, I learned the church purchased two new tires for her car.

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**Barbara** screened positive for a transportation need. She was recently diagnosed with a recurrence of cancer, and she expressed concern about being well enough to pick her daughter up from school after her chemotherapy appointments. Barbara told me that she does not live in a safe neighborhood and does not feel comfortable with her daughter walking home from school.

Barbara consented for me to contact the school on her behalf. I called and spoke to the principal and submitted a special request for transportation for Barbara's daughter to ride the bus. She was grateful for my help and promised to keep us posted on her outcomes.

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**Harry** called and said he had picked up my business card while he was in the clinic. He asked if I could help him with getting some dental care. I explained my work and asked if I could go through the screener with him. After completing the screen, Harry noted that he needed help with food, his next property tax bill, getting a hearing exam, and accessing dental care.

Harry lives alone and says that he makes \$1,327/month, but that is too much to receive food stamps. He said that he moved to this county not too long ago to be close to his grandson. He said there is almost 18 acres associated with the property and that he cannot afford to pay the property taxes. I referred Harry to a contact at the local USDA office to see what resources might be available to help Harry with taxes on his rural property. The USDA office and Harry's daughter-in-law helped him reclassify his property as a farm and they were able to apply for a grant that will help Harry finish his tiny home, as he is disabled. I was also able to help Harry locate food resources through local pantries and set him up for assistance with hearing aids and affordable dental care.

All patient names have been changed to protect privacy.



**Shonda** screened positive for food, transportation and utilities. Upon speaking with her, I learned she was on food stamps but lost them when her husband passed away. Shonda just couldn't get herself to reapply. I sat with her while she spoke of him and how he did everything for her. He drove her everywhere, did the shopping, payed the bills, etc. She stated her only job was to cook and help keep the house tidy. With him now gone, she cannot seem to navigate simple tasks.

I asked Shonda to come back with her ID and income verification so we could apply for SNAP together. I gave her a couple of resources for transportation that could help her get to appointments and one that would even take her to the grocery store. Once I asked about utilities, she informed me that her only source of heat was a wood burning stove. She knew how to start a fire but there was no way she could chop wood and buying it was out of her budget. She had been without heat for two months! I got in touch with the county that has a program that lets inmates thin the National Forests in exchange for money. They donated her two entire cords of wood!

***Shonda wrote a note to the office thanking me for my guidance. Her provider also thanked me as they wouldn't have had enough time to listen to her and had no idea of some of the resources provided.***

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