Contact Information :

Submitter - Catherine Carter, Submitter Title - Pediatric Nurse Practitioner/Practice Manager, Submitter email and phone number – ccarter@kidscreekcc.com, 231-935-0555
Physician Organization – Northern Physicians Organization
Practice name - Kids Creek Children's Clinic
Practice address – 5024 N. Royal Dr. Traverse City, MI 49684
Number of providers - 6 physicians, 3 nurse practitioners.
Description of care team - The Kids Creek Children's Clinic care team at the time of this project was comprised of Catherine Carter, RN, MS, CPNP, (practice manager), Stephanie Galdes, DO (physician champion), and Lynn Bryant, MSW (care manager).

Category:

Addressing Social Determinants of Health

Title:

Implementation of a Social Determinants of Health Assessment Tool by Kids Creek Children's Clinic

Summary :

- A Social Determinants of Health (SDoH) Screening project was implemented at Kids Creek Children's Clinic during the period from 6/1/17 to 10/1/17 (however our program is ongoing and has expanded!).
- During the implementation, our Social Needs Screening Tool (attached) was completed by 1863 patients/parents. In addition, a Community Resources Guide (1 page front and back) was distributed to each patient/parent.
- While the needs of most families were met by the Community Resources Guide, 14 referrals were made to our Care Manager for more intervention.
- The project resulted in a greater understanding by all Kids Creek Children's Clinic staff of the effect of Social Determinants on our patients' health.

Goal :

The goal of the Kids Creek Children's Clinic Social Determinants of Health Assessment Tool implementation project is to screen all our active patients once a year for their Social Determinants of Health needs and to assist them in the appropriate way – either by referral or information sharing.

Development/Implementation/Results:

The program was developed by Catherine Carter, PNP, practice manager of Kids Creek Children's Clinic, as part of our Patient Centered Medical Home development (it achieved Capability 10.5) and as part of the Medicaid SIM program.

A Social Needs Screening tool was given to each patient/parent by the front desk staff at their yearly well child visit (or one of their well child visits within the year for younger children). In addition, a local Community Resources Guide was handed out to each patient/parent of patient to take home. Examples of both are included as Appendices.

The SDoH tool was then reviewed by the provider who saw the patient that day and needed referrals were made, including possible referral to care management. For tracking purposes, the completion of the needs assessment was documented in structured data in our EHR (eClinical Works) by our clinical staff while rooming the patient. Later, our front desk staff scanned the Social Needs Screening Tool into the patient's chart in the EHR.

Out of approximately 6000 active patients, 1863 were screened for Social Determinants of Health in the initial 4 month implementation period. We chose each child's yearly well child check up as the ideal screening time, as many children are healthy and are only seen once a year. The yearly check up is also when we update demographics, educate about PCMH and update HIPAA and privacy practice signatures. All patients/parents were given their own copy of a Community Resources Guide, and 14 referrals were made to Care Management specifically for help with Social Determinants of Health. While other SDoH screenings were positive, they were handled through the provider or the parent/patient declined referral to care management. Since our numbers were measured through structured data, only referrals to care management were able to be reported.

Our assessment of success was process-based. We felt that almost a third of our patient population being screened across 4 months was a success. We received feedback from parents appreciating the information we gave them and the help our Care Manager offered. During some of the visits our Care Manager had with families, she identified a need for hygiene products, as these items are often not available in food pantries and are not covered by Bridge Cards. Our staff decided to start a hygiene product/toiletry cupboard for our Care Managers or providers to access when these needs are identified. It is gratifying to see families receive supplies they need ranging from toothbrushes and toothpaste to feminine products and laundry detergent. The increased awareness of the needs our families face and how a lack of resources affects their ability to care for their children has brought a new perspective to our staff and has been helpful as they care for our patients.

New Developments :

Since the implementation of our SDoH Screening program, we have revised/updated our SDoH screening tool twice. While some folks were offended by the tool in the beginning and resistant to referral to care management, feedback from our patients/parents has become more and more positive. Many folks are using our current screening tool to communicate problems they are not comfortable discussing out loud with our staff. More and more have requested referral to care management. Over the last two years, we have increased our available care management hours, and just had one of our Nurse Practitioners become trained as a care manager to add a clinical component to the services we offer. Implementing SDoH screening in 2017 really promoted our care management program and lead to the development of the more extensive program we now offer.

Why am I proud of this project?

In 2012, when Kids Creek Children's Clinic was first introduced to the whole concept of the Patient Centered Medical home by the Northern Physician's Organization, none of us understood the concept of Community Resources (as it was referred to then) and their impact on our patient's health. After implementing Domain 10, I personally will never forget opening the door to an exam room to see a patient and physically running into a mother taking a photo with her cell phone of the Community Resources Guide that had been posted on the inside of the door of the exam room to fulfill a capability requirement. While she was at first embarrassed that I had caught her, I told her how happy I was that she was finding the Guide useful and sent her home with her own copy. During that visit, I personally went from being a huge skeptic about the need to assess SDoH to being a believer in its value.

Over time, our entire staff realized some of the burdens our families bear as they try to successfully raise their children. Our focus on Community Resources – more appropriately termed Social Determinants of Health, has expanded to include our staff embracing the importance of identifying needs our families have and helping with them. For several years our office has participated in the Paper Angels program through Child and Family Services to provide children in foster care with gifts during the holidays. This has even expanded to include the families/patients in our practice – we put a Paper Angel tree in our lobby, and parents bring their children in to select angels and then bring the gifts back for the foster children. Our staff continues to bring in hygiene products without prompting for our toiletry closet. Parents are so grateful when they receive something as simple as soap. If we improve the health of one child by assisting them with Social Determinants of Health needs, it shows that the work matters.

If we win.....

Any funds we might be awarded will help support our increase in care management time available to our patients. In addition, some of our staff recently suggested a lending library in our waiting room to promote reading rather than screen time. We have always had children's books in our exam rooms for entertainment while patients/parents wait, and recently parents and children have asked to borrow books. Funds awarded could help get this started. Hopefully families will participate also by bringing in books their children have outgrown to contribute to the library and to promote a community atmosphere. Since none of this would have been possible without our wonderful staff, we would also hope to use funds to recognize them for their work on this project!

Kids Creek Children's Clinic
Health Leads Survey
(Must be completed by a Legal Guardian of the patient)

Patient:_____ **Patient DOB:** _____

Person completing form (name):_____

Relationship to patient:_____ **Best number to contact you:** _____

Date: _____ **Best time(s) to call:** _____

	In the past 2 months, has **your child's health** kept you or your child from usual activities, such as school, work or extracurricular events? In the past 12 months, has there been a time your child needed to see a doctor but, was unable to **because of the cost**?	Yes No Yes No
	In the past 2 weeks, have **you felt overwhelmed by your child's behavior** at home or school?	Yes No
	In the past 2 months have you been concerned that your child is being bullied at school, on the bus, or online? Do you want help with finishing a GED, college or learning a trade?	Yes No Yes No
	In the past 2 weeks have you been worried that your child could be feeling depressed or having anxiety that is making it difficult for them to enjoy normal activities?	Yes No
	Does the **cost of child care make it difficult for you to work** or study? Is it hard to find work or another **source of income** to meet your family's needs?	Yes No Yes No
	In the last 12 months, did you **ever eat less than you felt you should** because there wasn't enough food or money for food?	Yes No
	Are you **afraid that you or your child/children might be hurt** in your home or neighborhood?	Yes No
	In the last 12 months, have you ever had to miss school, work or been unable to go to the store because you didn't have a way to get there?	Yes No
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Yes No
	Are you worried that in the next few months, **you may not have stable housing?**	Yes No
	If you checked yes to any boxes above, **would you like to receive assistance** with any of these needs?	Yes No
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight?	**Yes** No

Any additional comments you would like to share with us:_____

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If, you answered yes to wanting assistance, a Care Manager will be in contact with you.