CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Accountable Health Communities

A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool:

Promising Practices and Key Insights

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Contents

Acronyms

Acronym	Definition
AHC	Accountable Health Communities
AHRQ	Agency for Healthcare Research and Quality
CDS	Clinical delivery site
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
C-SNAP	Children's Sentinel Nutritional Assessment Program
DMAIC	Define, Measure, Analyze, Improve, Control
ED	Emergency department
HRSN	Health-related social need
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
LOINC	Logical Observation Identifiers Names and Codes
NIDA	National Institute on Drug Abuse
SGM	Sexual and gender minorities
SNOMED-CT	Systematized Nomenclature of Medicine Clinical Terms
PHI	Personally identifiable health information
PRAPARE	The Protocol for Responding to and Assessing Patients' Risks and Experiences
QI	Quality improvement
TEP	Technical expert panel

Executive Summary

In this document, we describe the health-related social needs (HRSN) Screening Tool from the Accountable Health Communities (AHC) Model and share promising practices for universal screening. HRSNs are individual-level, adverse social conditions that negatively impact a person's health or health care. HRSNs are distinguished from social determinants of health—the structural and contextual factors that shape everyone's lives for better or worse—and can be identified by the health care system and addressed in partnership with community resources. Identifying and addressing HRSNs can have many benefits, including improvements to individuals' health and reduced health care spending. We prepared this guide for health care and social service providers who are increasingly adopting the practice of universal HRSN screening.

Health-related social needs

HRSNs are individual-level, adverse social conditions that can negatively impact a person's health or health care. Examples include food insecurity, housing instability, and lack of access to transportation. Screening for HRSNs as part of routine clinical care allows health care providers to efficiently identify and potentially help address HRSNs among patients they serve.

In Chapter 1, we introduce the AHC Model and the AHC HRSN Screening Tool. The AHC Model, a nationwide initiative funded by the Centers for Medicare & Medicaid Services (CMS) Innovation Center, aims to test whether systematically identifying and addressing HRSNs among community-dwelling Medicare and Medicaid beneficiaries through screening, referral, and community navigation services decreases health care use and impacts cost. For more information on the AHC Model, see Appendix B and the AHC Model website. The AHC HRSN Screening Tool was developed for the AHC Model to enable a quick assessment of HRSNs from five domains determined to be "core needs" by CMS (living situation, food, transportation, utilities, and safety) and eight supplemental domains (financial strain, employment, family and community support, education, physical activity, substance use, mental health, and disabilities). The AHC HRSN Screening Tool is appropriate for use in a wide range of clinical settings, including primary care practices, emergency departments (EDs), labor and delivery units, inpatient psychiatric units, behavioral health clinics, and other places where people access clinical care.

The tool is available in three versions: (1) a standard, self-administered version, (2) a proxy version in which questions are adapted to enable someone to answer on behalf of the patient, and (3) a multiuse version that includes language for a proxy as well as for patients answering for themselves (all are included in Appendix A).

In Chapter 2, we provide an overview of the AHC HRSN Screening Tool. For each domain, we present and describe the related screening questions, discuss the scoring process, and explain how to determine a positive screen. We also describe how to administer the tool outside the AHC Model.

In the final chapter of this guide, Promising Practices for Universal HRSN Screening, we share screening strategies that are based on the experiences of AHC Model awardees (see list below). Implementing universal HRSN screening in clinical settings requires planning—aligning priorities, training staff, and developing customized screening protocols—and the strategies shared in this guide are meant to inform effective universal HRSN screening in a wide range of clinical settings.

Promising practices for universal screening

- Cultivate staff buy-in
- Tailor staffing models to site features
- Provide dedicated training on screening
- Use customized scripts to engage patients in screening
- To maximize patient participation, consider the timing, location, and process for screening
- Anticipate population-specific needs
- Train staff to manage privacy and address safety concerns
- Institute continuous quality improvement
- Prepare staff to respond to common questions

Chapter 1: Introduction to Universal Screening for HRSNs

Health-related social needs (HRSNs) are distinguished from social determinants of health, which refer to the structural and contextual factors that shape everyone's lives for better or worse and that require system-level solutions to improve. One can view HRSNs as the resulting effects of social determinants of health that negatively impact an individual's circumstances and that are in the purview of health care providers to identify and help address.[1,2]

Examples of HRSNs include lack of access to healthy food, housing, or transportation. These and other HRSNs have been linked to poorer health outcomes, greater use of emergency departments (EDs) and hospitals, and higher health care costs.[3,4,5] Identifying and addressing HRSNs can have many benefits, including improvements to individuals' health and reduced health care spending.[6,7]

The settings where people receive health care, such as primary care offices and hospitals, are well positioned to identify and address HRSNs, particularly given the trust many people put in health care providers. In addition, recent health care reforms provide incentives for providers to focus on population health and individual social needs.[8] Some state Medicaid programs and health plans, for example, are beginning to use quality measures related to HRSN screening. Beginning in 2021, HRSNs that contribute to more complex medical decision making can be used to determine the appropriate code for billing evaluation and management visits in Medicare.[9] Several pilot programs have shown that identifying HRSNs during medical visits is feasible and helps connect patients to community resources that can address unmet needs.[1,5,10] Universal screening for HRSNs as part of routine care offers a standardized way for health care providers to identify HRSNs, tailor care in response to them, and help patients resolve them through referral to community resources.

The AHC Model aims to test whether systematically identifying and addressing HRSNs decreases health care use and impacts cost. The AHC Model uses the AHC HRSN Screening Tool to identify HRSNs among community-dwelling Medicare and Medicaid beneficiaries seen in a range of health care settings, including physician practices, EDs, labor and delivery units, and psychiatric wards. More information on the AHC Model is available in Appendix B and on the AHC Model website. There are other similar tools that are also commonly used to identify HRSNs in patients in various health care settings. For more information on these tools, please see Appendix D.

Examples of health-related social needs

- Housing instability
- Safety needs
- Food insecurity
- Lack of education
- Utility needs
- Lack of access to transportation
- Financial strain
- Unemployment
- Lack of access to affordable health care or medicine
- Social isolation
- Stress

> "Social determinants of health is an abstract term, but for millions of Americans, it is a very tangible, frightening challenge: How can someone manage diabetes if they are constantly worrying about how they're going to afford their meals each week? How can a mother with an asthmatic son really improve his health if it's their living environment that's driving his condition? This can feel like a frustrating, almost fruitless position for a healthcare provider, who understands what is driving the health conditions they're trying to treat, who wants to help, but can't simply write a prescription for healthy meals, a new home, or clean air."
>
> **– Alex M. Azar, Former Secretary of the United States Department of Health and Human Services[11]**

Examples of screening locations

Hospital settings

- Emergency departments
- Internal medicine units
- Labor and delivery units
- Heart and vascular units

Outpatient clinics

- Cancer centers
- Federally-qualified health centers
- Indian health clinics
- Pediatric clinics
- Primary care practices
- Outpatient behavioral health centers
- Obstetrics and gynecology offices
- Urgent care centers
- Women, Infants, and Children Clinics

Other health care settings

- Dental offices
- Home health providers
- Mobile clinics
- Pharmacies
- Public health offices and programs
- Homeless shelter-based clinics

Screening for HRSNs is becoming more prevalent, offering an opportunity to gather more evidence on screening effects and identify best practices.[12] The AHC Model is producing insights on how best to screen for HRSNs in many settings (see the list to the left for examples of screening locations). Although the AHC Model focuses on HRSNs among community-dwelling Medicare and Medicaid beneficiaries, the AHC HRSN Screening Tool can be used universally to screen patients with any insurance status or type, including commercially insured and uninsured individuals.

As the health care system shifts from traditional fee-for-service payments to value-based payments that incentivize improving population health and preventing poor health outcomes, there is a growing opportunity for health care providers to help identify and address HRSNs among their patients. Using the AHC HRSN Screening Tool is an appealing option for health care providers seeking to prevent chronic illnesses and improve health outcomes, given the extent to which social context is known to influence health care and health outcomes. Health care and social service providers can apply the lessons described in this guide to implement and improve universal HRSN screening in a wide range of health care settings to help identify HRSNs among patients they serve.

In the next chapter, we describe the AHC Model HRSN Screening Tool in detail and provide guidance on its use; the subsequent chapter shares promising practices for HRSN screening drawn from the AHC Model to promote effective, universal screening for HRSNs.

> "We have already had so many heart-warming stories from the work with patients… people now getting food, and even one patient has gotten a part-time job. In many ways, I'm embarrassed that we hadn't been addressing these social determinant barriers/gaps before."
>
> – AHC Model awardee

Chapter 2: Using the AHC HRSN Screening Tool

This chapter describes the AHC HRSN Screening Tool developed for the AHC Model and includes information on how to administer it. See Appendix A for standard, proxy, and multiuse versions of the AHC HRSN Screening Tool.

2.1. USE OF THE AHC HRSN SCREENING TOOL OUTSIDE OF THE AHC MODEL

Although CMS developed the AHC HRSN Screening Tool specifically for CMS's AHC Model, it is appropriate and widely applicable for use across health care settings. Recent studies have shown the effectiveness of using screening tools that combine multiple HRSNs.[3] The AHC HRSN Screening Tool combines questions to enable a quick assessment of HRSNs from 13 domains. See Appendix C for more information on the development of the AHC HRSN Screening Tool.

In developing the AHC HRSN Screening Tool, CMS secured permissions from the original authors of the questions to use, copy, modify, publish, and distribute the questions for the AHC Model and CMS use only. Organizations that seek to use AHC HRSN Screening Tool questions will need to include appropriate citations and for certain items, will need to notify authors of their plans. CMS encourages potential users to reference the Accountable Health Communities Health-Related Social Needs Screening Tool Citation and Notification Information available on the AHC Model website, which includes guidance for notifying the original authors and their contact information, when applicable.

2.2. DETAILED OVERVIEW OF THE AHC HRSN SCREENING TOOL

The AHC HRSN Screening Tool is divided into the following five sections:

- **Sample introduction text.** This section includes a suggested script to help screeners explain to patients the purpose of the tool, the confidentiality of responses, and the goals for improving care.
- **Information (eligibility).** This section includes three questions that the AHC Model requires awardees to administer to determine a beneficiary's eligibility for completing the rest of the tool and participating in the AHC Model's navigation intervention. The questions ask (1) who is completing the tool (the patient or a proxy), (2) the number of the patient's ED visits in the previous 12 months, and (3) whether the patient resides in the community. The AHC HRSN Screening Tool can be used universally to screen people with any insurance status or type.
- **Core domains.** This section includes questions related to the five HRSNs determined to be "core needs" by CMS. All AHC Model awardees are required to screen for five core domains: living situation, food, transportation, utilities, and safety. Organizations using the AHC HRSN Screening Tool outside the AHC Model can determine which domains to include in their screening, based on the unique constellation of priority HRSNs in their communities and the availability of community resources to address them.
- **Supplemental domains.** This section contains questions related to eight additional domains: financial strain, employment, family and community support, education, physical activity, substance use, mental health, and disabilities. AHC Model awardees are not required to screen for these optional domains but may choose to include any of them when administering the AHC HRSN Screening Tool. Organizations using the AHC HRSN Screening Tool outside the AHC Model can assess the appropriateness of including any of the supplemental domains based on the prevalence of particular HRSNs in their communities, the ability to tailor or adjust care, and the availability of community resources to address those HRSNs.
- **Background (demographics).** This section comprises demographic questions that AHC Model awardees are required to include in their screening. The questions ask about a patient's sex, race, ethnicity, level of education, household size, and household income. Collecting this information is beneficial because it may provide insight into whether particular HRSNs are more prevalent among certain demographic groups. This information may also be useful for monitoring and evaluating health equity, and it may help determine whether any interventions based on screening inadvertently create or worsen disparities. Asking demographic questions may seem invasive to patients; therefore, CMS placed this section at the end of the AHC HRSN Screening Tool to keep patients engaged and not discourage them from completing screening. Organizations using the tool outside the AHC Model may choose to exclude these questions, adapt them to align with their internal protocols, or substitute a different set of demographic questions. Organizations may also wish to refer to the Inventory of Resources for Standardized Demographic and Language Data Collection, developed by the CMS Office of Minority Health, for further information on collecting standardized patient demographic data.

The remainder of this chapter describes the sample introduction text and the domains included in the AHC HRSN Screening Tool.

2.3 SAMPLE INTRODUCTION TEXT

It is important to explain the purpose of screening before administering the tool so patients will understand why they are being asked these questions. The following sample introduction statement is included in the AHC HRSN Screening Tool and can be personalized as needed:

This screening tool is being offered to help connect you to services in your community that may improve your health. Many of these services are low cost or free of charge. By answering these questions, we may be able to provide you with connections to services or programs that may help you. Your information will be kept confidential except where law requires mandatory reporting. The information that you provide will not affect your insurance. You should answer the questions in your own way. There are no right or wrong answers.

The introductory statement is an opportunity to build trust and confidence in the screening process. For promising practices around introducing the tool using tailored scripts to engage patients, see Section 3.4 of Chapter 3.

2.4 HRSN DOMAIN SELECTION AND SCORING PROCEDURES

Organizations can determine in advance which core and supplemental domains they intend to include in screening by considering the prevalence of particular needs in their communities, existing usual care processes that support patients when social needs are identified, and the availability of resources in the community to address such needs. It is important to develop usual care processes to support patients with HRSNs identified through screening. These processes may include connecting patients with HRSNs to a social worker, community health worker, care manager, or care coordinator, or providing patients with a written community referral summary to connect them to local community service providers who can help them resolve unmet needs. Some organizations may choose to offer navigation services that guide patients with unmet needs to community resources.

For organizations offering additional programs, the tool's scoring thresholds may be used to determine whether a patient qualifies for the additional programs.

In addition to connecting individuals to critical resources, HRSN screening enables health care providers to tailor their clinical approaches when providing care. As noted in Section 2.2, screening for a range of HRSNs can be useful for identifying the needs that exist in the community and whether particular patient populations experience certain needs more frequently or more acutely. Universal screening of patients in clinical settings can also inform larger, community-wide efforts to ensure the availability of and access to community services that are responsive to the needs of the patient population.

2.5 CORE DOMAINS

In this section, we discuss the screening questions associated with the five core domains of the AHC HRSN Screening Tool: (1) living situation, (2) food, (3) transportation, (4) utilities, and (5) safety. For each domain, we present and describe the related screening questions, discuss the scoring process, and explain how to determine a positive screen. We recommend asking these questions in the order that they appear in the AHC HRSN Screening Tool. Keep in mind that patients may skip questions they do not want to answer, which may prevent determining a positive screen for some domains. The screening questions and the original question authors are referenced in The Accountable Health Communities Health-Related Social Needs Screening Tool Citation and Notification Information, available on the AHC Model website.

Living situation: The two questions in this domain will identify whether the patient has an HRSN related to housing stability and/or housing quality.

Question	Response options	HRSN identified
Question #4: What is your living situation today?	I have a steady place to live.	
	I have a place to live today, but I am worried about losing it in the future.	✔
	I do not have a steady place to live (I am temporarily 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).	✔
Question #5: Think about the place you live. Do you have problems with any of the following?	Pests such as bugs, ants, or mice	✔
	Mold	✔
	Lead paint or pipes	✔
	Lack of heat	✔
	Oven or stove not working	✔
	Smoke detectors missing or not working	✔
	Water leaks	✔
	None of the above	
Scoring: Patients have an HRSN in the living situation domain **if they select any of the response options with a check mark for at least one of the two questions.**		

Food: The two questions in this domain will identify whether the patient has an HRSN related to purchasing food. Both questions share the same response options.

Instructional text: Some people have made the following statements about their food situation. Please answer whether the statements were **Often, Sometimes, Never** true for you and your household in the last 12 months.

Question	Response options	HRSN identified
Question #6: Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true	✔
Question #7: Within the past 12 months, the food you bought just didn't last, and you didn't have money to get more.	Sometimes true	✔
	Never true	
Scoring: Patients are identified as having an HRSN in the food domain **if they select any of the response options with a check mark for at least one of the two questions.**		

Transportation: The question in this domain will identify whether the patient has an HRSN related to accessing reliable transportation.

Question	Response options	HRSN identified
Question #8: In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?	Yes	✔
	No	
Scoring: Patients are identified as having an HRSN in the transportation domain **if they respond "Yes" to the question.**		

Utilities: The question in this domain will identify whether the patient has an HRSN related to difficulty in paying utility bills.

Question	Response options	HRSN identified
Question #9: In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes	✔
	No	
	Already shut off	✔
Scoring: Patients are identified as having an HRSN in the utilities domain **if they select any of the response options with a check mark.**		

Safety: The four questions in this domain will identify whether the patient has an HRSN related to violence and/or elder or child abuse. All four questions share the same response options.

Instructional text: Because violence and abuse happen to a lot of people and affect their health, we ask the following questions.

Question	Response options	Scoring value
Question #10: How often does anyone, including family and friends, physically hurt you?	Never	1
Question #11: How often does anyone, including family and friends, insult or talk down to you?	Rarely	2
Question #12: How often does anyone, including family and friends, threaten you with harm?	Sometimes	3
Question #13: How often does anyone, including family and friends, scream or curse at you?	Fairly often	4
	Frequently	5
Scoring: Each question is scored from 1 to 5, based on the response option. Add up the scoring value for all four questions. Totals will range from 4 to 20. **A score of 11 or higher meets the threshold for identifying a safety need.** Organizations should develop a protocol to immediately assess any safety needs for urgency and have referral resources on hand to address such urgent situations. For patients with scores between 5 and 10, screeners should follow their organization's usual care processes.		

2.6 SUPPLEMENTAL DOMAINS

In this section, we discuss the use of the eight supplemental domains: (1) financial strain, (2) employment, (3) family and community support, (4) education, (5) physical activity, (6) substance use, (7) mental health, and (8) disability. For each supplemental domain, we present and describe the related screening questions, discuss the scoring process, and explain how to determine a positive screen.

Financial strain: The question in the financial strain domain will identify whether the patient has an HRSN related to their ability to pay for basic necessities.

Question	Response options	HRSN identified
Question #14: How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is…	Very hard	✔
	Somewhat hard	✔
	Not hard at all	
Scoring: Patients are identified as having an HRSN in the financial strain domain **if they select any of the response options with a check mark.**		

Employment: The question in the employment domain will identify whether the patient has an HRSN related to obtaining and maintaining employment.

Question	Response options	HRSN identified
Question #15: Do you want help finding or keeping work or a job?	Yes, help finding work	✔
	Yes, help keeping work	✔
	I do not need or want help	
Scoring: Patients are identified as having an HRSN in the employment domain **if they select any of the response options with a check mark.**		

Family and community support: The two questions in the family and community support domain will identify whether the patient has a need related to their ability to perform daily activities independently and whether they feel isolated or alone.

Question	Response options	HRSN identified
Question #16: If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, caring for children or dependents, managing finances, etc., do you get the help you need?	I don't need any help	
	I get all the help I need	
	I could use a little more help	✔
	I need a lot more help	✔

Question #17: How often do you feel lonely or isolated from those around you?	Never	
	Rarely	
	Sometimes	
	Often	✔
	Always	✔
Scoring: Patients are identified as having an HRSN in the family and community support domain **if they select any of the response options with a check mark for at least one of the two questions.**		

Education: The two questions in the education domain will identify whether the patient has an HRSN related to schooling or training. Both questions share the same response options.

Question	Response options	HRSN identified
Question #18: Do you speak a language other than English at home?	Yes	✔
Question #19: Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED, or equivalent.	No	
Scoring: Patients are identified as having an HRSN in the education domain **if they check "yes" as their answer to at least one of the two questions.**		

Physical activity: The two questions in the physical activity domain will identify whether the patient has an HRSN related to weekly exercise.

Question	Response options	Scoring value
Question #20: In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?	0	0
	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7

Question	Response options	Scoring value
Question #21: On average, how many minutes did you usually spend exercising at this level on one of those days?	10	10
	20	20
	30	30
	40	40
	50	50
	60	60
	90	90
	120	120
	150 or greater	**150 or greater**
Scoring: Whether patients are identified as having an HRSN in the physical activity domain depends on (1) the amount of exercise patients engage in each week and (2) the individual's age. First, calculate [number of days selected] x [number of minutes selected] = [number of minutes of exercise per week]. Second, apply the applicable age threshold: • **Under 6 years old:** No matter the calculation, an HRSN may not be identified • **Age 6 to 17:** Fewer than an average of 60 minutes per day indicates an HRSN • **Age 18 or older:** Fewer than 150 minutes per week indicates an HRSN **Example:** If a 57-year-old indicates that she exercises two days a week for 40 minutes, her score would be 80 minutes per week [2 days x 40 minutes = 80 minute per week. Because she is over 18 and exercises fewer than 150 minutes per week, she has an identified HRSN for the Physical Activity domain.		

Substance use: The four questions in the substance use domain will identify whether the patient has an HRSN related to alcohol, tobacco, and/or drug use. All questions in this domain use the same response options.

Instructional text: The next questions relate to your experience with alcohol, tobacco, and drugs. Some of the substances are prescribed by a doctor (such as pain medications), but you need to count them only if you have taken them for reasons or in doses other than as prescribed. One question is about illegal drug use—we ask it only to identify community services that may be available to help you.

Question	Response options	HRSN identified
Question #22: How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.	Never	
Question #23: How many times in the past 12 months, have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarette)?	Once or twice	✔
Question #24: How many times in the past 12 months, have you used prescription drugs for non-medical reasons?	Monthly	✔
Question #25: How many times in the past 12 months, have you used illegal drugs?	Weekly	✔
	Daily or almost daily	✔
Scoring: Patients are identified as having an HRSN in the substance use domain **if they select any of the response options with a check mark for at least one of the four questions.**		

Mental health: The two questions in the mental health domain will identify whether the patient has an HRSN related to mental health challenges. Questions 26a and 26b share the same response options.

Instructional text: Over the past two weeks, how often have you been bothered by any of the following problems?

Question	Response options	HRSN identified
Question #26a: Little interest or pleasure in doing things? **Question #26b:** Feeling down, depressed, or hopeless?	Not at all	0
	Several days	1
	More than half the days	2
	Nearly every day	3

Question	Response options	HRSN identified
Question #27: Stress means a situation in which a person feels tense, restless, nervous, or anxious or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?	Not at all	
	A little bit	✔
	Somewhat	✔
	Quite a bit	✔
	Very much	✔
Scoring: Each answer option for the first question is scored from 0 to 3. Add up the scoring value for both parts of the first question. Score totals will range from 0 to 6. Patients are identified as having an HRSN in the mental health domain **if they have a combined score of 3 or higher for the first question, or if they select any response with a check mark for the second question**		

Disabilities: The two questions in the disabilities domain will identify whether the patient has an HRSN related to a physical, mental, or emotional condition. Both questions share the same response options.

Question	Response options	HRSN identified
Question #28: Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)	Yes	✔
Question #29: Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)	No	
Scoring: Patients are identified as having an HRSN in the disabilities domain **if they respond "Yes" to at least one of the two questions.**		

2.7 AHC HRSN SCREENING TOOL ADMINISTRATION

There are three versions of the AHC HRSN Screening Tool:

- The **standard version,** intended for self-administration, includes all of the questions discussed in this chapter.
- The **proxy version** is almost identical to the standard version, with two differences: questions are adapted to enable parents, guardians, or caregivers to answer on behalf of a patient; and it includes gender-inclusive language. This version is appropriate to use with children and patients with cognitive or physical disabilities that prevent them from participating on their own.
- The **multiuse version** includes language for a proxy as well as for patients answering for themselves and it incorporates gender-inclusive language.

There are three modes of administering the AHC HRSN Screening Tool:

- **Self-administered:** In most cases, patients will self-administer the standard or multiuse AHC HRSN Screening Tool with little or no assistance required. Patients should be encouraged to ask questions about anything that is unclear or ask the screener to read or help explain any questions.
- **Proxy-administered:** In cases in which a proxy will complete the screening on behalf of the patient, it is important to remind the parent, guardian, or caregiver that they are answering for the patient, not for themselves. Usually, the proxy can complete the AHC HRSN Screening Tool on their own and will not require assistance. Proxies should be encouraged to ask questions about anything that is unclear or ask the screener to read or help explain any questions.
- **Screener-administered:** When a screener administers the AHC HRSN Screening Tool, the screener may have to read the questions aloud to the patient. If so, it is important that the screener uses a private and quiet space where the patient can comfortably answer sensitive questions. The screener should also provide clear instructions for how the patient should answer each question and reinforce that it is OK for the patient to change answers as necessary.

2.8 ADMINISTRATION LOGISTICS

There are a number of logistical considerations for administering the AHC HRSN Screening Tool:

- **How frequently screening should occur:** In the AHC Model, patients are offered HRSN screening at least once every 12 months; they may be screened more frequently, as their needs may change.
- **Where screenings should occur:** The AHC HRSN Screening Tool is versatile and may be administered in various health care settings, such as physician practices, EDs, hospital psychiatric departments, labor and delivery units, mobile clinics, or public health departments. It may also be administered during home or telehealth visits. For a list of possible settings to conduct screening, please see Chapter 1.
- **When screenings should occur:** In the AHC Model, screening can take place before, during, or after a clinical visit. There are benefits to each approach. An organization may offer pre-visit screening by phone or text message when a patient is reminded of or registers for a clinical appointment. In-visit screening occurs during a clinical visit (in person or via telehealth). Post-visit screening occurs after a patient has received care; this approach is particularly useful when patients receive care in busy clinical settings or for urgent conditions, such as in the ED.

Chapter 3: Promising Practices for Universal HRSN Screening

Implementing universal HRSN screening in clinical settings requires planning—aligning priorities, training staff, and developing customized screening protocols. The strategies below are based on the experiences of AHC Model awardees and advice from leaders in the field with experience implementing HRSN screening.

3.1. CULTIVATE STAFF BUY-IN

Successful screening depends on support at all levels. Leadership support shows staff that screening is an organizational priority. Buy-in from providers and other staff at the clinical site helps create a culture in which staff appreciate the value of screening and accept it as a routine part of clinical care. In addition, buy-in among screening staff is key to ensuring screening is consistent and universal. Consider the following tips to build and sustain staff buy-in:

- Build support among organizational leaders by sharing information on the impact of HRSNs on specific health outcomes, findings from HRSN screening studies, data on the prevalence of HRSNs in the communities they serve, and additional resources (webinars, videos, or written materials) that may promote understanding of the significance of HRSNs.
- Engage organizational leaders to work with community partners in developing a plan for regularly assessing the availability of community resources.
- Determine in advance how changes in the availability of community resources will affect screening and referral procedures. Refer to Section 2.4 of Chapter 2 for information on selecting domains in consideration of community needs and available resources.
- Should the availability of a particular resource change (such as the opening of a new food pantry), retrain staff on how to conduct screening and referral.
- Ensure staff are aware of the community resources that are available to address HRSNs identified through screening by creating and maintaining a community resource inventory that is regularly updated following periodic assessments of community resources.
- Identify an on-site champion who can serve as a role model and source of information to other staff, foster awareness of screening to all staff at the site, and reinforce that the site values and prioritizes screening.
- Share patient success stories that illustrate the positive impact of screening and referral on individual health and quality of life to further motivate staff engagement and to engage patients (see list below).
- Engage staff in designing and leading quality improvement projects to strengthen screening efforts. See Section 3.8 later in the chapter for more information on instituting quality improvement.

Strategies for sharing screening success stories

- Videos
- Testimonials
- Newsletters
- Staff meetings
- Posters in patient and staff areas

- Promote staff buy-in by providing opportunities for staff to voice concerns and to discuss challenges with screening, and be responsive to staff feedback.
- Address any staff resistance through targeted interventions such as:
  - Holding one-on-one meetings to address individual staff concerns.
  - Holding interdisciplinary meetings within the organization to review staff roles and alleviate staff anxiety about the additional responsibility of screening and new clinical workflows.
  - Connecting leaders who are new to HRSN screening with leaders of successful screening programs.
  - Developing or drawing on partnerships with community service providers and inviting their representatives to speak with staff about how screening supports their work.

3.2. TAILOR STAFFING MODELS TO SITE FEATURES

It is important to identify staff who will be responsible for screening and tailor the staffing approach to enable smooth integration of screening in each clinical setting. For example, practices that are part of a university health system may find it useful to train student interns to conduct screening. Practices in which front desk staff and medical assistants already offer other screenings may find it best to use existing staff. In Table 3.1, we provide brief descriptions of common staffing models and key benefits, challenges, and considerations associated with each.

Table 3.1. Overview of staffing models used by AHC awardees

Staffing model	Benefits	Challenges and considerations
Existing staff • Front desk staff • Medical assistants	• Eliminates need to hire new staff • Facilitates seamless integration of screening into existing workflows	• Increases burden on staff • Risks staff burnout or turnover
Dedicated screeners • Community health workers • Community members reflective of the populations served	• Avoids overburdening existing staff • Enables hiring of screeners with good interpersonal skills	• Requires funding • Takes time and resources to identify appropriate candidates
Volunteers • People from local community organizations • Student interns	• Avoids overburdening existing staff • Avoids need for additional funds • Strengthens community partnerships	• Risks incomplete coverage (for example, students may not be available during school breaks and may turn over each semester) • Takes time to recruit and train volunteers

3.3. PROVIDE DEDICATED TRAINING ON SCREENING

Standardized training on all aspects of screening promotes adherence to effective screening strategies and facilitates bringing on new staff. Consider the guidance below when developing effective training.

- Cover the basic components, including how to introduce and conduct screening, document responses, provide referrals, and share findings with providers.
- Review each question in the Screening Tool to ensure staff understand that it is important to read all questions when administering it. Remind staff that patients can refuse to answer any question.
- Accommodate various learning styles by using multiple training approaches, such as in-person presentations, pre-recorded or live virtual events, written materials, videos, interactive trainings (such as role-playing), and discussions.
- Archive on-demand trainings to facilitate training of new staff and provide existing staff with refresher resources.
- Develop a process for new staff to shadow and practice screening with experienced staff.
- Describe the importance of HRSNs and screening in standard training protocols for all new staff.
- While strict fidelity to the screening tool is important, providing staff with scripts that they can tailor to their personal preferences can help increase buy-in among staff and make it easier for them to engage patients in screening (see next section for more information).

Key topics for training on screening for health-related social needs

- **Program overview:** significance of addressing health-related social needs, including the *why* of screening.
- **Screening workflows:** determining eligibility, engaging patients, obtaining consent, conducting screening, documenting responses, and offering referrals to community resources.
- **Data collection and privacy:** data systems and security protocols.
- **Communication skills:** how to engage patients in screening.
- **Scripting:** using tailored scripts to introduce screening (see next section).
- **Common challenges:** known or anticipated challenges and possible mitigation strategies.

3.4. USE CUSTOMIZED SCRIPTS TO ENGAGE PATIENTS IN SCREENING

Using the right language can help foster trust and build confidence with patients. Co-creating scripted language with screening staff is a key strategy for helping staff set the right tone with patients in a way that reflects their personal style and increases the chance that a patient will agree to participate in screening. Organizations are encouraged to work with screening staff to develop tailored and personalized introductory screening scripts to describe their screening programs and may choose to modify the example provided below. Consider the following tips to help engage patients in screening:

- Use a warm and personal approach and smile when speaking with patients, even if they decline or ask questions. Patients are more likely to participate when they feel at ease.
- Let patients know that you offer to screen everyone.
- If patients interrupt and say they have completed the screening before, gently let them know that the organization offers periodic rescreening because patients' circumstances may have changed. As an example, the screener could say: "Patients may have taken in their grandkids or foster children, a car may have broken down, or there may have been a change in job status since the last screening, and we want to make sure we're providing these community resources to any patient who could use them."
- If patients are hesitant, let them know that screening takes less than five minutes, all questions are optional, and any information they share is confidential and will not affect their insurance coverage or health care. Remind patients that the goal is to identify resources that could be helpful to them and that their information is still valuable to the program even if they do not have any needs.

Sample screening introduction script from the Accountable Health Communities Model

Your health and wellness are very important to us at [organization]. Too often, when folks are struggling with non-medical needs that can impact health, like housing or food, they don't get the help they need. [Organization] participates in [screening program name] because we really care about meeting all our patients' needs. This program connects you to resources in the community that may improve your health. Many of these services are low cost or free of charge. You may be eligible for free personal assistance to connect to community resources. If so, a member of our team will call you from a [organization] phone number.

We encourage you to participate in this short screening today, even if you don't need any resources. The information you share with us will not affect your insurance or the services you receive from your health care provider. There is no requirement to answer any question, and you may end the screening at any point. The information you share will become part of your confidential health record to help your health care providers understand your needs. If you agree, we may verbally discuss your needs with community agencies that may help resolve your needs. You can change your mind at any time by contacting [organization's phone number or email].

3.5. TO MAXIMIZE PATIENT PARTICIPATION, CONSIDER THE TIMING, LOCATION, AND PROCESS FOR SCREENING

An effective protocol can help staff integrate screening into existing processes and troubleshoot challenges to optimize the screening process. Protocols should describe each of the steps involved in screening. Consider the staff, time, and spaces needed for screening. Assess the following factors when developing screening protocols:

- **Patient experience.** Aim for minimal disruption by considering how screening impacts the following aspects of the visit:
  - Flow through the space, including how easy it is for the patient to get from one point to another. Avoid having the patient retrace their steps through the site (such as returning to the waiting room) to participate in screening.
  - Emotional experience, such as how welcoming and knowledgeable the staff are. Aim for the screening to be a positive experience with minimal disruption, reassuring the patient that screening will not affect clinical care.
  - Length of visit, including how much additional time is required for screening. Aim for the screening to be brief (5–10 minutes) and not impact the patient's time with the provider.
- **How referrals take place.** Determine how patients who screen positive for HRSNs will be referred to community resources and/or to staff who will assist them in addressing these needs.
- **When screening occurs.** Consider the points at which screening could occur (for example, before the visit, during check in, when vitals are collected, and after the visit) to identify when to conduct it. Consider who will score the screening tool to determine positive screening results and whether a referral is necessary.
- **Appropriate space for screening.** Because screening includes sensitive questions, consider using a private area to create a respectful and safe environment.
- **Appropriate accommodations.** Specify procedures for providing reasonable accommodations for people with disabilities and translation services for non-English speakers.
- **Staff involved.** Identify the staff who conduct screening and those who support it, formalize their roles and responsibilities, and educate them on everyone's role.
- **Integration with electronic health records or other data systems.** Explore ways to increase screening efficiency and data accessibility via integration with existing systems and codes. Refer to the Social Interventions Research & Evaluation Network's Compendium of Medical Terminology Codes for Social Risk Factors for a crosswalk of HRSN data to the Logical Observation Identifiers Names and Codes (LOINC), the Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT), ICD-10-CM, and the Current Procedural Terminology (CPT).
- **Modification of clinical workflows to integrate screening.** There are many tools to guide the development of workflows. Flowcharts, for example, depict the steps involved in a process and can be used to pinpoint the best time and place to integrate screening into clinical processes. For additional guidance on using tools to collect and analyze workflow information, visit the Agency for Healthcare Research and Quality (AHRQ) Digital Healthcare Research webpages on workflows and workflow tools.

3.6. ANTICIPATE POPULATION-SPECIFIC NEEDS

To maintain consistent quality, special considerations may be warranted when screening particular patient populations. In Table 3.2, we describe potential challenges and strategies for screening in various patient populations. Some strategies may be beneficial more generally, not just for the population mentioned.

Table 3.2. Population-based challenges and strategies for screening

Population	Screening-related challenges	Strategies
Patients with behavioral health needs	• Patients may lack trust in the staff, providers, or health care system, and it may take longer to screen them.	• Train staff on communication strategies (for example, active listening and trauma-informed care) and draw on partnerships with peer supports, behavioral health providers, and community services to build trust and rapport with patients. • Ensure staff are prepared to spend extra time assisting patients with behavioral health needs.
Elderly patients	• Patients may refuse screening because of stigma, fear of losing independence, or privacy concerns.	• Train screeners on using empathic inquiry and active listening techniques to engage elderly patients. • Enlist student or elderly volunteers who may be able to spend more time with patients.
Patients with disabilities	• Staff may have unconscious biases or make assumptions based on patients' ability.	• Enlist the expertise of diversity and inclusion committees to train staff on respectfully engaging patients with disabilities. • Ensure that staff allow extra time to accommodate visual, hearing, or cognitive impairments.
Patients with low literacy	• Patients needing assistance may not feel comfortable asking for it.	• Train staff on how to identify patients with low literacy and offer assistance by reading questions.
Patients from racial or ethnic groups that differ from staff	• Staff may have unconscious biases or make assumptions based on patients' physical appearance or race/ethnicity.	• Enlist the expertise of diversity and inclusion committees to help staff recognize cultural differences, biases, and assumptions, and to promote cultural sensitivity.
Non-English speakers	• The screening tool is only publicly available in English.*	• Translate the AHC HRSN Screening Tool and any related materials to languages commonly spoken in the community. When developing translations, engage a native speaker in the process to ensure quality and be sure to consider the dialect. • Hire bilingual screeners who represent common languages in the population served, and use telephonic interpreting services.
Sexual and gender minorities (SGM)**	• Patients may not feel accepted at the screening site.	• Promote an inclusive and welcoming culture, train staff on SGM needs and hold staff accountable for creating a safe space. • Use signs, stickers, or flags to signal that the site is SGM friendly. • Note that the proxy and multiuse versions of the AHC HRSN Screening Tool include gender-neutral and inclusive language.

*Although the AHC HRSN Screening Tool is only publicly available in English, AHC Model awardees use translated screening tools to meet the needs of the populations they serve.

**Following the definition put forth by the Sexual and Gender Minority Research Office within the National Institutes of Health, SGM populations "include, but are not limited to, individuals who identify as lesbian, gay, bisexual, asexual, transgender, Two-Spirit, queer, and/or intersex. Individuals with same-sex or -gender attractions or behaviors and those with a difference in sex development are also included. These populations also encompass those who do not self-identify with one of these terms but whose sexual orientation, gender identity or expression, or reproductive development is characterized by non-binary constructs of sexual orientation, gender, and/or sex."

3.7. TRAIN STAFF TO MANAGE PRIVACY AND ADDRESS SAFETY CONCERNS

Patients may have concerns about how their information will be used, so it is important to train staff on how to discuss privacy concerns. When patients raise concerns, screeners should emphasize that personal information will be kept private and no names or identifying information will be released without the patient's permission (with the exception of instances requiring mandatory reporting). Develop protocols for ensuring privacy for patients who are accompanied to their visits. If possible, check to see if accompanied patients can see the provider alone, which enhances privacy for screening.

Considerations around privacy are crucial when screening for safety needs. Patients may be reluctant to disclose safety needs, especially if they are accompanied during their visit or being screened by phone. Providing information about resources to all patients can equip those experiencing violence with critical resources, whether they choose to disclose the danger or not, and can also enable them to help friends and family members in danger. This information may include what violence and abuse can look like, as well as helpful community resources.

All reports of physical harm should be assessed for urgency. Organizations should specify existing protocols to help patients in immediate danger and heed relevant state requirements for mandatory reporting of child or elder abuse or trafficking. More guidance on developing such protocols is available from Futures Without Violence.

Critical points for handling safety needs

- To enable patients to disclose potential safety needs, try to see patients without accompanying individuals.
- When screening patients with disabilities, develop protocols and scripts to allow screening staff to increase privacy before engaging in screening.
- If a safety need is identified, assess whether a patient is safe before probing.
- Immediately connect patients in danger with resources (for example, a hotline or advocate).
- Provide general safety information and resources to all patients, regardless of whether they identify a safety need.

3.8. INSTITUTE CONTINUOUS QUALITY IMPROVEMENT

Quality improvement (QI) involves systematic and continuous actions to produce measurable improvements in health care services.[13] QI is valuable for examining and improving screening by identifying areas for improvement, testing change activities, and using defined measures of success to assess outcomes. Continuous QI serves as a feedback loop for ongoing improvement. Consider the following tips, strategies, and resources for QI:

- When selecting an approach from the methods and tools available to guide QI, consider whether staff have experience with the approach or require training.
- Designate a coordinator to lead QI. While prior experience with QI is helpful, AHC Model awardees have reported success with coordinators without prior experience, as much of the work involves on-the-ground learning.
- Cultivate staff engagement in QI by embracing a "culture of QI" in which staff recognize the importance of identifying areas for improvement and testing changes. Celebrate successful QI initiatives, emphasizing the ensuing benefits for staff and patients. Identify QI coaches to lead individual projects among staff.

Common quality improvement approaches

Quality improvement methods

- Lean
- Six Sigma
- Model for Improvement

Models for process improvement

- Define, Measure, Analyze, Improve, Control (DMAIC)
- Plan-Do-Study-Act (PDSA)

Tools

- Process mapping and flow charts
- Pareto charts

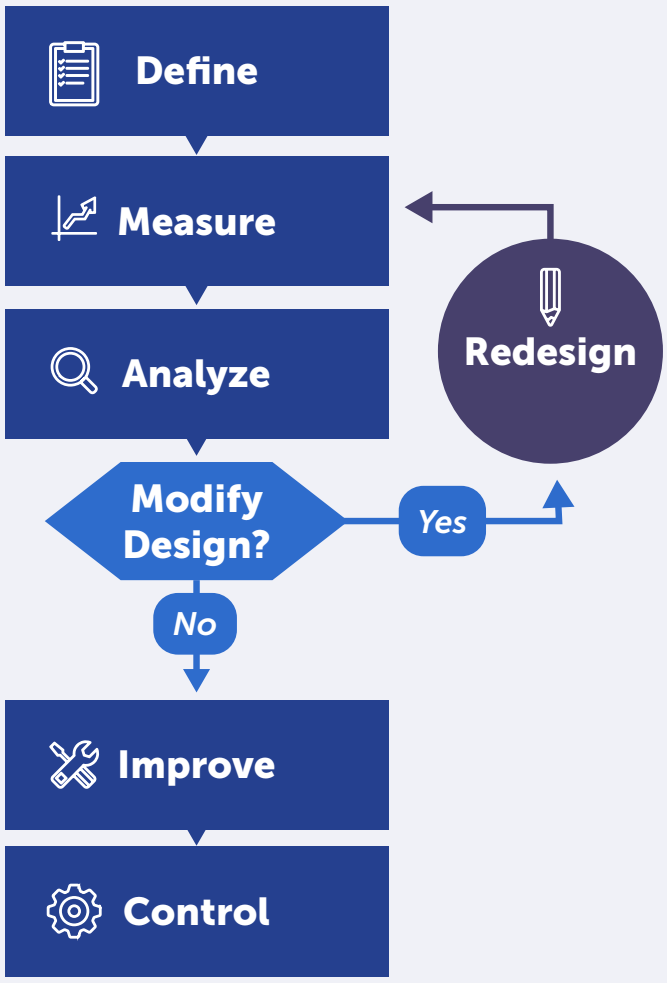
- To monitor staff performance and drive QI, develop reports comparing actual screening rates to targets and share these data with screening staff regularly.
- Because screeners have direct experience with the screening process and are well positioned to identify and address areas for improvement, solicit their feedback on screening to identify priorities for QI and respond promptly to issues they raise.
- For more guidance on designing and carrying out QI, review open source resources available online:
  - Institute for Healthcare Improvement (IHI) Quality Improvement Toolkit
  - IHI Open School: How to Improve with the Model for Improvement
  - AHRQ Practice Facilitation Guide with QI Guidance
  - American Society for Quality
  - American Academy of Family Physicians

Quality improvement in the field

The Define, Measure, Analyze, Improve, Control (DMAIC) is a data-driven process improvement model involving five phases:[14]

- **Define** the problem, improvement activity, opportunity for improvement,the project goals, and customer requirements.
- **Measure** process performance.
- **Analyze** the process to determine root causes of variation and poor performance.
- **Improve** process performance by addressing and eliminating the root causes.
- **Control** the improved process and future process performance.

An AHC Model awardee with several screening sites used DMAIC to improve screening. First, the team defined a problem: low offers to screen in one of its emergency department (ED) sites. To measure process performance, the team decided to focus on improving the percentage of patients eligible for screening who were offered screening. Through brainstorming to analyze the process and determine the causes of low offers to screen, the team found that the schedules of screeners did not align with the hours of highest patient volume in the ED. To improve, the AHC Model awardee shifted staff hours to increase staff coverage during the busiest ED times, resulting in an observable increase in offers to screen. Last, to control the process, the team developed visuals (such as control charts) to monitor, celebrate, and share the success of this change with staff.



3.9. PREPARE STAFF TO RESPOND TO COMMON QUESTIONS

It is important for screeners to be able to answer any questions about screening concisely and efficiently, without adding information that could be misunderstood or cause confusion. Prepare screeners to be able to address the most commonly asked questions. Responses should convey confidence in the screeners' understanding of the screening process. Below are some commonly asked questions and concerns about screening as well as suggested responses that can be adapted as needed:

- **What is the purpose of this program?** [Organization] developed [screening program] to connect patients to services that can help address their needs. The questions are designed to help us understand if people need help with areas of their lives outside the clinic. Your answers will be used only for this program, and we will keep them confidential. You don't need to answer, but you could be eligible for assistance if you do.
- **What is this tool about?** The screening tool asks about your nonmedical needs, such as living situation, food, transportation, paying utility bills, and interpersonal safety.
- **Is this screening mandatory?** No, your participation is voluntary. You don't have to complete the screening, but if you do, we may be able to connect you to free or low-cost services that may help you. You may also refuse to answer any specific question you do not want to answer.
- **Will I get paid for participating?** No. You will not be paid for completing the screening.
- **I don't have time.** The screening is short and only takes a few minutes to complete. If you do not have time today, you have the option of participating at your next visit. We hope you will consider participating as the screening may identify services that may help you.
- **Will my information be kept confidential?** All information you provide will be kept private. Your participation won't affect your care, insurance, other health or disability benefits, or premiums.
- **What do you mean by, "Your information will be kept confidential except where law requires mandatory reporting"?** [State] requires mandatory reporters who suspect the mistreatment of a child, dependent adult, or elderly person to report the case for investigation. Mandatory reporters tend to be social workers, physicians, nurses, counselors, and other mental health professionals.
- **How do you protect patients' personally identifiable health information (PHI)?** To protect patients' PHI, we [describe organization's confidentiality policies]. Strategies may include:
  - Creating unique identification numbers for each patient so they may be tracked in a data file over time without reliance on the individual's name, Social Security number, or other identifier.
  - Ensuring proper handling and storage of screenings and other documents containing PHI. Do not leave documents unattended and keep them out of sight and in locked storage or stored electronically on a password-protected computer with file access restricted to those who need it. Avoid including PHI in emails.
  - Ensuring unauthorized persons cannot see information displayed on computer or tablet screens (for example, by looking over the screener's shoulder from a hallway). Advise screeners to lock computers when not in use, keep passwords secure, and prevent others from using their computers.
  - Ensuring discussions about patients and their personal information take place in private and are kept confidential.

Appendices

APPENDIX A.1. STANDARD VERSION OF THE AHC HRSN SCREENING TOOL

Tool starts on next page

Information

1. Complete the following statement. I am answering this survey about ...

- ☐ Myself
- ☐ My child
- ☐ Another adult for whom I provide care
- ☐ Other (please describe your relationship to this person)

_____

2. How many times have you received care in an emergency room (ER) over the last 12 months? If you are in the ER now, please count your current visit. Please do not count urgent care visits.

- ☐ 0 times
- ☐ 1 time
- ☐ 2 or more times

3. Do you live in any of the following locations?

- ☐ I live in an assisted living facility (this is a long-term care option that provides personal care support services such as meals, bathing, dressing, or medications)
- ☐ I live in a nursing home (this is a long-term care option that provides 24 hours a day medical care that would not be possible in other housing)
- ☐ I live in a rehabilitation center or skilled nursing facility (these are centers that help a person heal after illness or injury by providing treatments like physical, occupational, or speech therapy)
- ☐ I live in an in-patient recovery program for a drug or alcohol problem
- ☐ I live in a psychiatric facility (this is a health care facility providing treatment to those with behavioral or emotional illnesses)
- ☐ I live in a correctional facility (such as a jail, prison, detention center, or penitentiary)
- ☐ None of the above

→ **Questionare Complete**

Before you continue, please make sure you have selected responses to the above questions and completed this section.

Living Situation

4. What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but **I am worried** about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily 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)

5. Think about the place you live. Do you have problems with any of the following?

CHOOSE ALL THAT APPLY

- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

6. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

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

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

Transportation

8. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?

- ☐ Yes
- ☐ No

Utilities

9. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ☐ Yes
- ☐ No
- ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions

10. How often does anyone, including family and friends, physically hurt you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

11. How often does anyone, including family and friends, insult or talk down to you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

12. How often does anyone, including family and friends, threaten you with harm?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

13. How often does anyone, including family and friends, scream or curse at you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

Financial Strain

14. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is...

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

Employment

15. Do you want help finding or keeping work or a job?

- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ I do not need or want help

Family and Community Support

16. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, caring for children or dependents, managing finances, etc., do you get the help you need?

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

17. How often do you feel lonely or isolated from those around you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Education

18. Do you speak a language other than English at home?

- ☐ Yes
- ☐ No

19. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

- ☐ Yes
- ☐ No

Physical Activity

20. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7

21. On average, how many minutes did you usually spend exercising at this level on one of those days?

- ☐ 0
- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60
- ☐ 90
- ☐ 120
- ☐ 150 or greater

Substance Use

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you.

22. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

23. How many times in the past 12 months, have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarette)?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

24. How many times in the past 12 months, have you used prescription drugs for non-medical reasons?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

25. How many times in the past 12 months, have you used illegal drugs?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Mental Health

26. Over the past 2 weeks, how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

b. Feeling down, depressed, or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

27. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

Disabilities

28. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

- ☐ Yes
- ☐ No

29. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)

- ☐ Yes
- ☐ No

Background

Now we would like to know a little more about you.

30. What is your sex?

- ☐ Male
- ☐ Female

31. Are you Hispanic, Latino/a, or of Spanish origin?
CHOOSE ALL THAT APPLY

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin

32. Which one or more of the following would you say is your race?
CHOOSE ALL THAT APPLY

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other (*specify*) _____

33. What is the highest grade or year of school you completed?

- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1 through 8 (Elementary)
- ☐ Grades 9 through 11 (Some high school)
- ☐ Grade 12 or GED (High school graduate, diploma, or alternative credential)
- ☐ College 1 year to 3 years (Some college, Associate's degree, trade, vocational, or technical school)
- ☐ College 4 years or more (College graduate)

34. How many people do you currently live with?
Please count yourself, your spouse or partner, your children, and any other dependents. If you live alone, put 1.

☐☐ NUMBER OF PEOPLE

35. What is your annual household income from all sources?
Please include your income as well as the income for everyone you counted above in your household.

- ☐ Less than $10,000
- ☐ $10,000 to less than $15,000
- ☐ $15,000 to less than $20,000
- ☐ $20,000 to less than $25,000
- ☐ $25,000 to less than $35,000
- ☐ $35,000 to less than $50,000
- ☐ $50,000 to less than $75,000
- ☐ $75,000 or more

THANK YOU!

Thank you very much for answering these questions.

APPENDIX A.2. PROXY VERSION OF THE AHC HRSN SCREENING TOOL

Tool starts on next page

Information

1. Complete the following statement. I am answering this survey about ...

- ☐ Myself
- ☐ My child
- ☐ Another adult for whom I provide care
- ☐ Other (please describe your relationship to this person)

_____

For the rest of the survey, please think about the person you selected in Question 1 when answering the questions. In an effort to incorporate diversity, equity, and inclusion, this proxy uses gender-inclusive singular pronouns (i.e. he/she/they or him/her/them) to refer to a beneficiary, as individuals may choose to refer to any of these pronouns when referring to themselves.

2. How many times has he/she/they received care in an emergency room (ER) over the last 12 months? If he/she/they is in the ER now, please count his/her/their current visit. Please do not count urgent care visits.

- ☐ 0 times
- ☐ 1 time
- ☐ 2 or more times

3. Do you live in any of the following locations?

- ☐ He/She/They lives in an assisted living facility (this is a long-term care option that provides personal care support services such as meals, bathing, dressing, or medications)
- ☐ He/She/They lives in a nursing home (this is a long-term care option that provides 24 hours a day medical care that would not be possible in other housing)
- ☐ He/She/They lives in a rehabilitation center or skilled nursing facility (these are centers that help a person heal after illness or injury by providing treatments like physical, occupational, or speech therapy)
- ☐ He/She/They lives in an in-patient recovery program for a drug or alcohol problem
- ☐ He/She/They lives in a psychiatric facility (this is a health care facility providing treatment to those with behavioral or emotional illnesses)
- ☐ He/She/They lives in a correctional facility (such as a jail, prison, detention center, or penitentiary)
- ☐ None of the above

→ **Questionare Complete**

Before you continue, please make sure you have selected responses to the above questions and completed this section.

Please think about the person you selected in Question 1 when answering the questions. Please select the option that best describes him or her.

Living Situation

4. What is his/her/their living situation today?

- ☐ He/She/They has a steady place to live
- ☐ He/She/They has a place to live today, but **he/she/they is worried** about losing it in the future
- ☐ He/she does not have a steady place to live (he/she/they is temporarily 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)

5. Think about the place he/she/they lives. Does this place have problems with any of the following?
CHOOSE ALL THAT APPLY

- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for him/her/them and his/her/their household in the last 12 months.

6. Within the past 12 months, he/she/they worried that his/her/their food would run out before they got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

7. Within the past 12 months, the food he/she/they bought just didn't last and he/she/they didn't have money to get more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

Transportation

8. In the past 12 months, has lack of reliable transportation kept him/her/they from medical appointments, meetings, work or from getting to things needed for daily living?

- ☐ Yes
- ☐ No

Utilities

9. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in his/her/their home?

- ☐ Yes
- ☐ No
- ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

10. How often does anyone, including family and friends, physically hurt him/her/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

11. How often does anyone, including family and friends, insult or talk down to him/her/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

12. How often does anyone, including family and friends, scream or curse at him/her/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

13. How often does anyone, including family and friends, scream or curse at him/her/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

Financial Strain

14. How hard is it for him/her/them to pay for the very basics like food, housing, medical care, and heating? Would you say it is...

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

Employment

15. Do he/shethey want help finding or keeping work or a job?

- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ I do not need or want help

Family and Community Support

16. If for any reason he/she/they needs help with day-to-day activities such as bathing, preparing meals, shopping, caring for children or dependents, managing finances, etc., does he/she/they get the help they need?

- ☐ He/She/They doesn't need any help
- ☐ He/She/They gets all the help they need
- ☐ He/She/They could use a little more help
- ☐ He/She/They needs a lot more help

17. How often does he/she/they feel lonely or isolated from those around him/her/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Education

18. Do he/she/they speak a language other than English at home?

- ☐ Yes
- ☐ No

19. Doea he/she/they want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

- ☐ Yes
- ☐ No

Physical Activity

20. In the last 30 days, other than the activities he/she/they did for work, on average, how many days per week did he/she/they engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7

21. On average, how many minutes did he/she/they usually spend exercising at this level on one of those days?

- ☐ 0
- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60
- ☐ 90
- ☐ 120
- ☐ 150 or greater

Substance Use

The next questions relate to his/her/their experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if he/she/they has taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help him/her.

22. How many times in the past 12 months has he/she/they had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

23. How many times in the past 12 months, has he/she/they used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarette)?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

24. How many times in the past 12 months, has he/she/they used prescription drugs for non-medical reasons?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

25. How many times in the past 12 months, has he/she/they used illegal drugs?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Mental Health

26. Over the past 2 weeks, how often has he/she/they been bothered by any of the following problems?

a. Little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

b. Feeling down, depressed, or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

27. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his/her/their mind is troubled all the time. Does he/she/their feel this kind of stress these days?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

Disabilities

28. Because of a physical, mental, or emotional condition, does he/she/they have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

- ☐ Yes
- ☐ No

29. Because of a physical, mental, or emotional condition, does he/she/they have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)

- ☐ Yes
- ☐ No

Background

Now we would like to know a little more about him/her/them. Please select the option that best describes him/her/them.

30. What is his/her/their sex?

- ☐ Male
- ☐ Female

31. Is he/she/they Hispanic, Latino/a, or of Spanish origin?
CHOOSE ALL THAT APPLY

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin

32. Which one or more of the following would you say is his/her/their race?
CHOOSE ALL THAT APPLY

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other (*specify*) _____

33. What is the highest grade or year of school he/she/they has completed?
If you are answering this survey for a child under the age of 18, please answer this question about his/her/their parent or legal guardian.

- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1 through 8 (Elementary)
- ☐ Grades 9 through 11 (Some high school)
- ☐ Grade 12 or GED (High school graduate, diploma, or alternative credential)
- ☐ College 1 year to 3 years (Some college, Associate's degree, trade, vocational, or technical school)
- ☐ College 4 years or more (College graduate)

34. How many people does he/she/they currently live with?
Please count yourself, your spouse or partner, your children, and any other dependents. If you live alone, put 1.

|_|_| NUMBER OF PEOPLE

35. What is the annual income of his/her/their household from all sources?
Please include his/her/their income as well as the income for everyone you counted above in his/her/their household.

- ☐ Less than $10,000
- ☐ $10,000 to less than $15,000
- ☐ $15,000 to less than $20,000
- ☐ $20,000 to less than $25,000
- ☐ $25,000 to less than $35,000
- ☐ $35,000 to less than $50,000
- ☐ $50,000 to less than $75,000
- ☐ $75,000 or more

THANK YOU!

Thank you very much for answering these questions.

APPENDIX A.3. MULTIUSE VERSION OF THE AHC HRSN SCREENING TOOL

Tool starts on next page

Information

1. Complete the following statement. I am answering this survey about ...

- ☐ Myself
- ☐ My child
- ☐ Another adult for whom I provide care
- ☐ Other (please describe your relationship to this person)

_____

For the rest of the survey, please think about the person you selected in Question 1 when answering the questions. Please select the option that best describes this person. In an effort to incorporate diversity, equity, and inclusion, if using this this multi-use tool as a proxy, it uses gender-inclusive singular pronouns (i.e they or them) to refer to a beneficiary, as persons may use various pronouns when singularly referring to themselves.

2. How many times have you/they received care in an emergency room (ER) over the last 12 months? If you/they are in the ER now, please count your/their current visit. Please do not count urgent care visits.

- ☐ 0 times
- ☐ 1 time
- ☐ 2 or more times

3. Do you live in any of the following locations?

- ☐ I/They live in an assisted living facility (this is a long-term care option that provides personal care support services such as meals, bathing, dressing, or medications)
- ☐ I/They live in a nursing home (this is a long-term care option that provides 24 hours a day medical care that would not be possible in other housing)
- ☐ I/They live in a rehabilitation center or skilled nursing facility (these are centers that help a person heal after illness or injury by providing treatments like physical, occupational, or speech therapy)
- ☐ I/They live in an in-patient recovery program for a drug or alcohol problem
- ☐ I/They live in a psychiatric facility (this is a health care facility providing treatment to those with behavioral or emotional illnesses)
- ☐ I/They live in a correctional facility (such as a jail, prison, detention center, or penitentiary)
- ☐ None of the above

→ **Questionare Complete**

Before you continue, please make sure you have selected responses to the above questions and completed this section.

Please think about the person you selected in Question 1 (either yourself or another) when answering the questions. Please select the option that best describes this person.

Living Situation

4. What is your/their living situation today?

- ☐ I/They have a steady place to live
- ☐ I/They have a place to live today, but I/they **am/are worried** about losing it in the future
- ☐ I/They do not have a steady place to live (I/They am/are temporarily 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)

5. Think about the place you/they live. Do you/they have problems with any of the following?
CHOOSE ALL THAT APPLY

- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

Food

Somepeople have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you/them and your/their household in the last 12 months.

6. Within the past 12 months, you/they worried that your/their food would run out before you/they got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

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

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

Transportation

8. In the past 12 months, has lack of reliable transportation kept you/they from medical appointments, meetings, work or from getting to things needed for daily living?

- ☐ Yes
- ☐ No

Utilities

9. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your/their home?

- ☐ Yes
- ☐ No
- ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

10. How often does anyone, including family and friends, insult or talk down to you/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

11. How often does anyone, including family and friends, insult or talk down to you/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

12. How often does anyone, including family and friends, threaten you/them with harm?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

13. How often does anyone, including family and friends, scream or curse at you/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

Please think about the person you selected in Question 1 (either yourself or another) when answering the questions. Please select the option that best describes this person.

Financial Strain

14. How hard is it for you/them to pay for the very basics like food, housing, medical care, and heating? Would you/they say it is...

- ☐ Very hard
- ☐ Somewhat hard
- ☐ Not hard at all

Employment

15. Do you/they want help finding or keeping work or a job?

- ☐ Yes, help finding work
- ☐ Yes, help keeping work
- ☐ I/They do not need or want help

Family and Community Support

16. If for any reason you/they need help with day-to-day activities such as bathing, preparing meals, shopping, caring for children or dependents, managing finances, etc., do you/they get the help you/they need?

- ☐ I/They don't need any help
- ☐ I/They get all the help I need
- ☐ I/They could use a little more help
- ☐ I/They need a lot more help

17. How often do you/they feel lonely or isolated from those around you/them?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Education

18. Doyou/they speak a language other than English at home?

- ☐ Yes
- ☐ No

19. Do you/they want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.

- ☐ Yes
- ☐ No

Physical Activity

20. In the last 30 days, other than the activities you/they did for work, on average, how many days per week did you/they engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7

21. On average, how many minutes did you/they usually spend exercising at this level on one of those days?

- ☐ 0
- ☐ 10
- ☐ 20
- ☐ 30
- ☐ 40
- ☐ 50
- ☐ 60
- ☐ 90
- ☐ 120
- ☐ 150 or greater

Substance Use

The next questions relate to your/their experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you/they have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you/them.

22. How many times in the past 12 months have you/they had 5 or more drinks in a day (male sex at birth) or 4 or more drinks in a day (female sex at birth)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

23. How many times in the past 12 months, has he/she/they used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarette)?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

24. How many times in the past 12 months, have you/they used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarette)?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

25. How many times in the past 12 months, have you/they used illegal drugs?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Mental Health

26. Over the past 2 weeks, how often have you/they been bothered by any of the following problems?

a. Little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

b. Feeling down, depressed, or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

27. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because your/their mind is troubled all the time. Do you/they feel this kind of stress these days?

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much

Disabilities

28. Because of a physical, mental, or emotional condition, do you/they have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

- ☐ Yes
- ☐ No

29. Because of a physical, mental, or emotional condition, do you/they have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)

- ☐ Yes
- ☐ No

Background

Please think about the person you selected in the first question (either yourself or another) when answering the following. If you are answering for someone else, please select the option that best describes this person.

30. What is your/their sex at birth?

- ☐ Male
- ☐ Female

31. Is you/they Hispanic, Latino/a, or of Spanish origin?
CHOOSE ALL THAT APPLY

- ☐ No, not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin

32. Which one or more of the following would you/they say your/their race?
CHOOSE ALL THAT APPLY

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other (*specify*) _____

33. What is the highest grade or year of school you/they completed?
If you are answering this survey for a child under the age of 18, please answer this question their parent or legal guardian.

- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1 through 8 (Elementary)
- ☐ Grades 9 through 11 (Some high school)
- ☐ Grade 12 or GED (High school graduate, diploma, or alternative credential)
- ☐ College 1 year to 3 years (Some college, Associate's degree, trade, vocational, or technical school)
- ☐ College 4 years or more (College graduate)

34. How many people do you/they currently live with?
Please count yourself, your spouse or partner, your children, and any other dependents. If you live alone, put 1.

|__|__| NUMBER OF PEOPLE

35. What is your/their annual household income from all sources?
Please include your/their income as well as the income for everyone you/they counted above in your/their household.

- ☐ Less than $10,000
- ☐ $10,000 to less than $15,000
- ☐ $15,000 to less than $20,000
- ☐ $20,000 to less than $25,000
- ☐ $25,000 to less than $35,000
- ☐ $35,000 to less than $50,000
- ☐ $50,000 to less than $75,000
- ☐ $75,000 or more

THANK YOU!

Thank you very much for answering these questions.

APPENDIX B. AHC MODEL BACKGROUND

The AHC Model addresses a critical gap between clinical care and community services in the current health care delivery system. It does so by testing whether systematically identifying and addressing the HRSNs of community-dwelling Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will affect health care costs and reduce health care utilization. As part of the AHC Model, the bridge organizations or clinical delivery sites (CDSs) rely on a screening tool to identify the HRSNs of community-dwelling Medicare and Medicaid beneficiaries and then help address those needs by linking these beneficiaries to community service providers.[1]

The AHC Model is based on emerging evidence that unmet HRSNs, such as interpersonal safety, food insecurity, and unstable housing, are linked to an increased risk of developing chronic conditions, a reduction in an individual's ability to manage health conditions, an increase in health care costs, and avoidable health care utilization.[15] Addressing HRSNs through community services can improve health outcomes, reduce health care costs, and limit inpatient and outpatient health care utilization.

In the AHC Model, bridge organizations and their partnering CDSs link community-dwelling beneficiaries with unmet HRSNs to community services through two intervention approaches, referred to as "tracks":

1. **Assistance Track.** Bridge organizations participating in the Assistance Track use the HRSN Screening Tool to identify community-dwelling beneficiaries with HRSNs. Such beneficiaries with an identified HRSN and who are considered ***high-risk*** beneficiaries—defined as having two or more emergency department (ED) visits during the previous 12 months—are randomized into either a ***control group*** or an ***intervention group***.
    - High-risk community-dwelling beneficiaries in ***both the control and intervention groups*** receive, in addition to usual care, a community referral summary—a tailored summary that contains a list of community service providers that may help address the HRSNs identified through the screening.
    - High-risk community-dwelling beneficiaries randomized to the ***intervention group*** also receive, in addition to usual care, community service navigation to ***assist*** with accessing community services.
    - Community-dwelling beneficiaries with an identified HRSN who are considered low risk—defined as having one or no ED visits during the previous 12 months—receive, in addition to usual care, a community referral summary.
    - Community-dwelling beneficiaries without an identified HRSN are not eligible for the AHC intervention and receive the usual care from their clinical providers.
2. **Alignment Track.** Bridge organizations participating in the Alignment Track follow the same procedures described above, but with some important differences:
    - First, community-dwelling beneficiaries determined to be ***high risk*** are not randomized into an intervention or control group. Instead, all high-risk beneficiaries receive a community referral summary and community service navigation.
    - Second, bridge organizations in the Alignment Track focus on partner ***alignment***; that is, they ensure community services are available and responsive to the needs of the community-dwelling beneficiaries of interest.

APPENDIX C. DEVELOPMENT OF THE AHC HRSN SCREENING TOOL

In July 2016, CMS convened a technical expert panel (TEP) to develop the HRSN Screening Tool that participating bridge organizations and their CDSs would use to identify community-dwelling beneficiaries' HRSNs. The purpose of the TEP was as follows:

- Identify effective social need screening questions by developing an evidence or consensus base
- Recommend reliable screening questions for CMS to consider for inclusion in the HRSN Screening Tool
- Identify best practices in screening for HRSNs
- Identify current barriers and challenges associated with screening for HRSNs
- Identify specific population challenges, such as language barriers and low literacy
- Recommend solutions to address these challenges

The TEP recommended commonly used or evidence-based questions from a range of sources. Many questions in the HRSN Screening Tool were modified or adapted from other surveys. The collection of questions included in the HRSN Screening Tool has not been tested as a whole, which may impact the validity (the extent to which the questions measure what they are intended to measure) and reliability (the consistency or reliability of the questions). More information on the construction of the HRSN Screening Tool appears in the National Academy of Medicine discussion paper "The Standardized Screening Tool for Health-Related Social Needs in Clinical Settings."[4]

CORE DOMAINS

CMS developed the HRSN Screening Tool, based on recommendations from the TEP, to identify patient needs that may be addressed through community services. The questions in the HRSN Screening Tool identify individuals with unmet HRSNs in five core domains: (1) living situation, (2) food, (3) transportation, (4) utilities, and (5) safety. These domains reflect evidence linking the HRSNs to poor health or increased health care costs; the ability of community service providers to address such needs; and the reality that such needs are not currently being systemically addressed.

- **Living situation.** The first question under this core domain was adapted from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment tool, developed to identify individuals who are homeless or at risk of losing their housing for any reason.[16] The second question was adapted from a question developed by Nuruzzaman and colleagues[17] and is intended to identify individuals living in substandard housing.
- **Food.** The two questions under this core domain were modified from the validated Hunger Vital Sign and are intended to identify food insecurity.[18]
- **Transportation.** The one question under this core domain was adapted from the PRAPARE assessment tool and modified to distinguish between medical and nonmedical transportation.[16] For the HRSN Screening Tool, "beyond medical transportation" means including but not limited to medical transportation.
- **Utilities.** The one question under this core domain was adapted from the validated Children's Sentinel Nutritional Assessment Program (C-SNAP) survey. Input from a review of common questions was used to list the specific utilities in the answer choices for this question.[19]
- **Safety.** The four questions under this core domain are related to exposure to intimate partner violence, elder abuse, and child abuse, and were adapted from the validated Hurt, Insult, Threaten, and Scream instrument.[20] The questions were broadened to include family and friends.

SUPPLEMENTAL DOMAINS

To accompany the core domains, CMS, in collaboration with the TEP, developed eight optional domains that bridge organizations could use to tailor the HRSN Screening Tool to their communities. The questions in the supplemental domains include (1) financial strain, (2) employment, (3) family and community support, (4) education, (5) physical activity, (6) substance use, (7) mental health, and (8) disabilities.

- **Financial strain.** The one question under this supplemental domain was adapted from the validated SWAN Sleep Study[21] and recommended by the Institute of Medicine (IOM) in 2015.[22]
- **Employment.** The one question under this supplemental domain is geared to determining whether the individual has a job or is looking for employment. The question was developed by the TEP hosted by CMS in July 2016 to identify and recommend screening questions for the AHC Model.
- **Family and community support.** The two questions under this supplemental domain were adapted from the Kaiser Permanente Medicare Total Health Assessment Questionnaire[23] and the AARP.[24]
- **Education.** The two questions under this supplemental domain aim to understand whether the individual speaks another language at home and/or whether that person wants help with school or training. The language question was adapted from the U.S. Census Bureau's American Community Survey;[25] CMS developed the training question.
- **Physical activity.** The two questions under this supplemental domain first were validated in the Vital Sign study[26] and recommended by the IOM in 2015.[22]
- **Substance use.** The four questions under this supplemental domain were adapted from the National Institute on Drug Abuse's (NIDA) Quick Screen[27] and the National Institute on Alcohol Abuse and Alcoholism's clinician guide.[28]
- **Mental health.** The three questions under this supplemental domain address depression and anxiety. The two depression questions were validated in the PHQ-2,[29] the anxiety question was validated as a single-item measure,[30] and both were recommended by IOM.[22]
- **Disabilities.** The two questions under this supplemental domain were drawn from U.S. Department of Health and Human Services standards.[31]

PRE-TESTING OF THE HRSN SCREENING TOOL

In July 2017, CMS and its contractor conducted two rounds of cognitive interviews to pre-test the HRSN Screening Tool. The pre-test assessed effective administration of the tool and gathered feedback on comprehension of instructions and questions, respondent burden, and question flow. The first round of pre-testing took place in Baltimore, Maryland, on July 10–12, 2017, and included interviews with 40 respondents. The second round took place in Bethesda, Maryland, on July 24–25, 2017, and included interviews with 26 respondents.

Pre-test respondents represented the diversity of the Medicare and Medicaid populations intended to be served by the AHC Model. During pre-testing, all versions (standard, proxy, and multiuse) of the HRSN Screening Tool were tested on paper as both beneficiary- and interviewer-administered screenings. The lessons learned from the pre-test guided development of the final tool and the content presented in this screening guide.

APPENDIX D. OTHER HRSN SCREENING TOOLS

In addition to the AHC HRSN Screening Tool, there are a number of screening tools that are used to identify HRSNs in patients across various health care settings. Table D.1 below describes some of the most commonly used tools. For organizations that plan to use the AHC HRSN Screening Tool, please refer to the Accountable Health Communities Health-Related Social Needs Screening Tool Citation and Notification Information available on the AHC Model website for guidance on including appropriate citations and for certain items, notifying the original question authors of their plans.

Table D.1. Overview of other HRSN screening tools

Screening Tool	Description	Reference
PRAPARE	The Protocol for Responding to and Assessing Patients' Risks and Experiences (PRAPARE) Tool is designed for use across health care settings to screen patients for HRSNs.	National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. "PRAPARE." 2017. Available at. http://www.nachc.org/research-and-data/prapare/
Well Rx	This questionnaire is meant for use at every patient visit and covers the domains of food insecurity, housing, utilities, income, employment, transportation, education, substance abuse, childcare, safety, and abuse	Page-Reeves, J., W. Kaufman, M. Bleecker, J. Norris, K. McCalmont, V. Ianakieva, D. Ianakieva, et al. "Addressing Social Determinants of Health in a Clinic Setting: The Wellrx Pilot in Albuquerque, New Mexico." Journal of the American Board of Family Medicine, vol. 29, no. 3, 2016, pp. 414–418. https://doi.org/10.3122/jabfm.2016.03.150272.
AAFP Social Needs Screening Tool	Developed by the American Academy of Family Physicians (AAFP), this tool is geared toward primary care settings and aims to help primary care physicians address the social determinants of health within their community.	American Academy of Family Physicians. "Social Needs Screening Tool." 2018. Available at https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf
Health Leads	This screening tool is part of a larger toolkit. Similar to the AHC HRSN Screening Tool, this tool is split into recommended and optional domains. The recommended domains are food insecurity, housing instability, utility needs, financial resource strain, transportation, exposure to violence, and socio-demographic information. The optional domains include childcare, education, employment, health behaviors, social isolation and supports, and behavioral health.	Social Interventions Research and Evaluations Network (SIREN). "Social Need Screening Tools Comparison Table." 2020. Available at https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison
Health Begins Upstream Risk Screening Tool	This tool includes recommendations on the frequency of screening as well as a method to calculate an overall upstream risk score. The tool includes questions on education, employment, social support, immigration, financial strain, housing insecurity and quality, food insecurity, transportation, violence exposure, stress, and civic engagement.	Social Interventions Research and Evaluations Network (SIREN). "Social Need Screening Tools Comparison Table." 2020. Available at Research on Integrating Social & Medical Care | SIREN | HealthBegins Upstream Risk Screening Tool (ucsf.edu)
Your Current Life Situation Survey	This tool, developed by Kaiser Permanente, screens for a variety of HRSNs including, living situation, housing, food, utilities, childcare, debts, medical needs, transportation, stress, and social isolation.	Social Interventions Research and Evaluations Network (SIREN). "Social Need Screening Tools Comparison Table." 2020. Available at Research on Integrating Social & Medical Care | SIREN | Kaiser Permanente's Your Current Life Situation Survey (ucsf.edu)

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