Achieving the Triple Aim for Children with Medical Complexity

Christopher J. Stille, MD, MPH
Sara E. Martin RN, BSN
# Local Problem:
## Children With Medical Complexity (CMC)

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>National Level</th>
<th>Children’s Hospital Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of children</td>
<td>% of children</td>
</tr>
<tr>
<td>Healthy/ episodic/ chronic (CRG 0-5a)</td>
<td>31 million</td>
<td>94%</td>
</tr>
<tr>
<td>Medically complex (CRG 5b-9)</td>
<td>2 million</td>
<td>6%</td>
</tr>
<tr>
<td>CARE Enrolled Population</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Total</td>
<td>33 million</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: “Percent of spend” includes <1 year olds with < 6 months continuous enrollment.
Source: Extrapolated from Truven Marketscan Medicaid claims dataset, 2011.
The CARE Award: A Grant Funded Initiative

**Coordinating All Resources Effectively**

**Project Goals:**
- Improved health outcomes for kids with Medical Complexity
- Improved family satisfaction with access to care
- Decreased cost of care

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Medical Complexity</th>
<th>Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMMI Health Care Innovation Award (Centers for Medicare and Medicaid Innovation)</td>
<td>CRG Groups 5B-9 (Clinical Risk Grouper)</td>
<td>3yr Learning Collaborative 10 partner Hospitals $23 Million Award</td>
</tr>
</tbody>
</table>
Governance structure

Care Coordination Steering (Executive Leadership)

CARE Award Team

Community PCP Partners
- Local PCP’s
- Behavioral Health
- Family Navigators
- RN Care Coordinators

Grant Funded
- Physician Leaders
- Care Coordinator
- Research Data Analyst
- Process Improvement
- Social Worker / Family Liaison

CHCO Staff
- Process Improvement
- Project Management
- Health Literacy
- Case Management
- CHCO Social Work
- Primary Care leadership
- EHR Analysts
The Change Package

Goals
• Integrated
• Accessible
• Transparent

Patient Registry
• All enrolled children
• Integrated within EHR
• Accessible and transparent

Dynamic Care Team
• Accessible by parents and PCP
• Integrated
• Easily revised

Access Plan
• Who and when to call for what symptoms
• Contact info for all team members.

Shared Care Plan
• Patient and family’s specific needs
• Short and long term goals
• “Who am I??”
Voice of the Customer

Parent: “I never know who knows what about my child.”

Care Coordinator: “I can’t find important information.”

Parent: “I’m doing Care Coordination for my own child.”

Care Coordinator: “I don’t know who to focus on first.”

Community PCP: “We don’t know who to call when we need help.”
Baseline Data

Family Experience
• CAHPS- Patient Access Module
  (Consumer Assessment of Healthcare Providers and Systems)

Utilization
• ED visits
• Hospitalization (Inpatient days)

Direct Cost
• Total cost of care

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Baseline Jan-Dec 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHPS Patient Access Module Score</td>
<td>N=111</td>
<td>69.3</td>
</tr>
<tr>
<td>IP Days 1000pts/month</td>
<td>N=1467</td>
<td>297 days</td>
</tr>
<tr>
<td>ED visits 1000pts/month</td>
<td>N=1467</td>
<td>80 visits</td>
</tr>
<tr>
<td>Total Direct Cost (aggregate population)</td>
<td>N=1481</td>
<td>$23,405,724 ($15,804 per pt)</td>
</tr>
</tbody>
</table>

Note: N number for CAHPS reflect number of enrolled families able to be reached by phone to successfully complete both pre and post survey.
Our Approach

**WHAT:**
1. Define our population
2. Define their needs
3. Define / Draft Technology requirements
4. Integration within the EHR
5. Prioritize and deploy care

**HOW:**
- Patient Registry
- Complexity Score
- Kaizens
- Develop complexity algorithm
- HIT Integration
- Transparency
- Medical and social Complexity
- "One place"
- Clinical Tools
- Streamlined processes
- Tools in Practice
Population Defined

- 4 tiers
- Both Medical and Social complexity
- Interventions escalate with complexity
- Change package only for tiers 3 and 4
Integrated Complexity Scoring Algorithm Process
What we needed
- Patient Registry and metrics
- Complexity Score
  - 3M CRG
  - SDOH
  - Homecare Needs
  - ED visits
- Change Package Elements:
  - Care Team
  - Access Plan
  - Care Plan
- And one place to store it all…

What we had
- Patient Registry and metrics
- Complexity Score
  - 3M CRG
  - Social Determinants
    - Homecare Needs
    - ED visits
  - Change package elements:
    - Care Team
    - Access Plan
    - Care Plan
- And one place to store it all
Clinical Risk Grouper Implementation

- Tier 1: CRG 1
- Tier 2: CRG 2-5a
- Tier 3: CRG 5b-7
- Tier 4: CRG 8 and 9

Complexity increases as CRG increases.

View for clinicians in patient lists.
Social Determinants of Health Integration

- 13 domain Psychosocial Screen
- Standardized screens also incorporated
- Complexity increases for positive screens

Standard Screening Tools Included

- ASQ (Ask Suicide-Screening Questions)
- CRAFFT (Screening tool for Adolescent Substance Abuse)
- PHQ-9 (Patient Health Questionnaire-9)
- EPDS (Edinburgh Postnatal Depression Scale)

Psychosocial Screen: Social Needs Domains

- Finding a Medical Home
- Barriers to Keeping Appointments
- Barriers to Purchasing Medications
- Financial Resource Strain
- Food Insecurity
- Access to Benefits
- Education
- Housing Instability
- Guardianship
- Social Isolation
- Substance Abuse in Caregiver
- Family Violence
- Depression/Anxiety in Caregiver
Social Determinants of Health: Clinical Processes

1. MA hands paper screen to family
2. Family completes independently to promote honesty
3. Provider reviews with family during visit
4. MA enters clinical information into the EHR
5. CDS tools alert additional clinicians once information entered by MA
Social Determinants: Clinical Decision Support

- Clinical decision support tools integrated into clinical workflows
- Clinicians notified real time of positive screens needing follow up
- All data reportable and tracked
Wellness Registry and Complexity score elements

- All children seen last 3 years included
- CRG applied to all patients
- Score increases with additional elements
- Once score assigned, tier 3 and 4 children selected for change package interventions ~1600 kids
## Ambulatory View: Longitudinal Plan of Care

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
<th>Time</th>
<th>Provider</th>
<th>COMPLEXITY-AMB</th>
<th>CRG</th>
<th>+ Psychosocial Screen?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>16y</td>
<td>8:20 AM</td>
<td>Dempsey, Amanda Frisch, M.D.</td>
<td>2</td>
<td>37541</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>13y</td>
<td>8:30 AM</td>
<td>Devoogd, Ruth Susan, CPNP-AC/PC</td>
<td>4</td>
<td>91101</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>12y</td>
<td>8:30 AM</td>
<td>Miyazawa, Naomi, PA-C</td>
<td>3</td>
<td>51381</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>10y</td>
<td>8:30 AM</td>
<td>Fox, David, M.D.</td>
<td>3</td>
<td>55852</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>15y</td>
<td>8:30 AM</td>
<td>Crane, Susan M, Psy D.</td>
<td>3</td>
<td>55851</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>15y</td>
<td>8:30 AM</td>
<td>Brown, Mark Allen, M.D.</td>
<td>3</td>
<td>51382</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>20y</td>
<td>8:40 AM</td>
<td>Washington, Kimberly A, CPNP-PC</td>
<td>4</td>
<td>90701</td>
<td>No</td>
</tr>
</tbody>
</table>

### Patient Complexity Score
- **3 Points: Rising Risk**
- **4 Points: Highest Risk**

### Psychosocial Screen (since 1/31/2018)
- **Screen positive?** Yes
- **Trouble with Dr. Appts?** Yes

### Problem List
- **Vitamin D deficiency**
  - Codes: ICD-9-CM: 268.9
  - ICD-10-CM: E55.9
  - Noted - Resolved: 7/24/2018 - Present
- **Moderate obstructive sleep apnea**
  - Codes: ICD-9-CM: 337.9

### Upcoming Health Maintenance
- Date Due

Ambulatory View: Longitudinal Plan of Care

Longitudinal Plan of Care available below provider schedule

1) Clinicians can choose columns to add
2) Complexity Score elements clearly visible
3) Psychosocial screen accessible from report

Patient Complexity Score

- 1 point: Healthy
- 2 - 3 Points: Rising Risk
- 4 Points: Highest Risk

Details:
- Patient complexity score. Displays most recent data in last 2 years.
- CRG Score: 53182
- PT/OT/Speech last 12 mos: Yes
- Moderate Risk social determinants: 7/25/2018
- ASQ suicide screen: 7/30/2018
- CRAFFT: 7/30/2018
- ED Visits: 0

Psychosocial Screen (since 1/31/2018)

- Screen positive? Yes
- Trouble with Dr. Appts? Yes

Problem List

- Vitamin D deficiency
  - Codes: ICD-9: CM: 268.9
  - ICD-10: CM: E55.9
  - Noted - Resolved: 7/24/2018 - Present
- Moderate obstructive sleep apnea
  - Codes: ICD-9: CM: 377.23

Asthma Action Plan Reviewed

- Date of Review: 7/24/2018 10:23 AM

Upcoming Health Maintenance

- Date Due
### Inpatient View: Patient Complexity Score

- “Hover to discover”
- Real-time Updates
- All elements integrated within EHR

<table>
<thead>
<tr>
<th>Name</th>
<th>Patient Age</th>
<th>MRN</th>
<th>Admit Date</th>
<th>Patient Complexity Score</th>
<th>CRG</th>
<th>+ Psychosocial Screen?</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>15 yr</td>
<td>2002411</td>
<td>07/27/18</td>
<td>2</td>
<td>10000</td>
<td>Yes</td>
</tr>
<tr>
<td>Alex</td>
<td>12 yr</td>
<td>1081536</td>
<td>07/30/18</td>
<td>4</td>
<td>10000</td>
<td>No</td>
</tr>
<tr>
<td>Mia</td>
<td>8 yr</td>
<td>1278105</td>
<td>07/30/18</td>
<td>3</td>
<td>62706</td>
<td>No</td>
</tr>
</tbody>
</table>

### Patient Complexity Score

- **CRG Score:** 90903
  - Chronic Ventilation: Yes
  - PT/OT/Speech last 12 mos: Yes
  - Homecare: Yes
  - Moderate Risk social determinants: 8/3/2018
  - High Risk social determinants: 8/3/2018
  - ASQ suicide screen: 8/3/2018
  - ED Visits: 1

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*Children’s Hospital Colorado*

*Affiliated with University of Colorado Anschutz Medical Campus*
Care Team, Care Plan and Access Plan: Integration

- Snapshot of “Who am I?”
- “Who to call for what”
- Patient / family specific
- Available to community providers, homecare companies and school through web portal
- Family accessible through patient portal
# Parent View: Longitudinal Plan of Care

## Care Team

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jelinek-Berens, Christine T, M.D.</td>
<td>PCP - General, Hospital Medicine</td>
<td>303-338-4545</td>
</tr>
<tr>
<td>Ivey, David Dunbar, M.D.</td>
<td>Cardiology</td>
<td>720-777-6820</td>
</tr>
<tr>
<td>Bakel, Leigh Anne, M.D.</td>
<td></td>
<td>720-777-3070</td>
</tr>
<tr>
<td>Boggus, Kristin J, B.S.N.</td>
<td>Care Coordinator, Nursing</td>
<td>720-777-2060</td>
</tr>
<tr>
<td>Abromowitz, Minnie, M.D.</td>
<td>Unknown</td>
<td>402-955-3950</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stille, Christopher J, M.D.</td>
<td>Consulting Provider, General Pediatrics</td>
<td>720-777-2740</td>
</tr>
</tbody>
</table>

## Goals

**Diet**

- Action: Set a timer in morning to remind me to eat breakfast in the morning
- Person Responsible: ZZTest
- Time Frame: 3 months

## Preferred Pharmacy

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walgreens Drug Store 12855</td>
<td>BROOKLYN, NY - 1511 86TH ST AT 15TH AVE &amp; 86TH ST</td>
<td>347-856-5679 Fax: 347-856-5685</td>
</tr>
<tr>
<td>Walgreens Drug Store 10739</td>
<td>AURORA, CO - 15310 E COLFAX AVE AT SEC of Chambers &amp; Colfax</td>
<td>720-262-4015 Fax: 720-262-4621</td>
</tr>
</tbody>
</table>

## Action Plan

**Access Plan**

**Child Health Clinic:**

- Call 911 if it's an emergency
- Office Hours: Monday-Thursday – 8am – 7pm
- Friday – 8am – 5pm
- Main Phone Number: 720-777-2740
- Fax: 720-777-7149

There is a nurse and provider on call 24 hours a day. They are here to help you and can save you a trip to the doctor if your child is sick. During business hours, they may be able to schedule an appointment for the same day.

**Option #1: Scheduling**

- Our Patient Schedulers can help you with your scheduling needs.

**Option #2: Speak with a Nurse**

- Experienced, caring pediatric nurses are available 24/7 to help answer your health questions.

**Option #4: Prescription refills and Assistance with Referrals**

**Option #9: For Spanish Speakers**

If the clinic is closed:

- Call 720-777-2740 to speak to an afterhours nurse

## Preferred Home/External/Community Providers

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Home Health, Pueblo</td>
<td>(719-543-2700, fax 709-543-2704)</td>
</tr>
<tr>
<td>Continuum Pediatric Nursing</td>
<td>(303-997-7411, fax 866-495-2577)</td>
</tr>
<tr>
<td>Amrita</td>
<td>(303-355-4745, fax 303-322-7022)</td>
</tr>
<tr>
<td>Coram, a division of Apria Healthcare</td>
<td>(303-799-0093, fax 303-790-7627)</td>
</tr>
<tr>
<td>Preferred Homecare</td>
<td>(303-783-1700, fax 303-607-5488)</td>
</tr>
<tr>
<td>Edgepark Medical Supplies</td>
<td>(850-321-0591, fax 330-425-4355)</td>
</tr>
<tr>
<td>Apria HealthCare</td>
<td>(720-922-4600, fax: 720-922-0405)</td>
</tr>
<tr>
<td>APS – Adult and Pediatric Specialist</td>
<td>(303-368-4556, fax 303-368-4606)</td>
</tr>
<tr>
<td>Community Center Board</td>
<td>(see comment)</td>
</tr>
<tr>
<td>Behavioral Health (see comment)</td>
<td></td>
</tr>
<tr>
<td>San Juan</td>
<td></td>
</tr>
<tr>
<td>Anapahoe County</td>
<td></td>
</tr>
<tr>
<td>Mary Jones</td>
<td>(303-692-4315)</td>
</tr>
<tr>
<td>Abe Herrera</td>
<td>(719-888-9999)</td>
</tr>
</tbody>
</table>

## Additional Information

- **Care Team:** Jelinek-Berens, Christine T, M.D.
- **Diet:** Action: Set a timer in morning to remind me to eat breakfast in the morning
- **Preferred Pharmacy:** Walgreens Drug Store 12855 - BROOKLYN, NY - 1511 86TH ST AT 15TH AVE & 86TH ST
- **Preferred Pharmacy:** Walgreens Drug Store 10739 - AURORA, CO - 15310 E COLFAX AVE AT SEC of Chambers & Colfax
Results
# High level outcomes

<table>
<thead>
<tr>
<th>Measure</th>
<th>n</th>
<th>Baseline Jan-Dec 2014</th>
<th>n</th>
<th>Post Implementation Jan-Dec 2017</th>
<th>% change</th>
</tr>
</thead>
</table>
| **CAHPS**  
Patient Access Module Score             | n=111 | 69.3                 | n=111  
Fall-Spring 2016-2017 | 81.0 | ↑16%  
p<0.05 |
| **IP Days**  
1000pts/month                              | n=1467 | 297 days             | n=1588 | 123 days                        | ↓58.6%   |
| **ED visits**  
1000pts/month                                | n=1467 | 80 visits            | n=1588 | 54 visits                       | ↓32.5%   |
| **Direct Cost per Adjusted Volumes/year**   | n=1481 | $23,405,852           | n=1529 | $14,221,683                     | ↓39.4%   |

*Note:* Patients were enrolled during the first full year of the collaborative. Pre-implementation N reflects # patients enrolled in June 2015. Post implementation N reflects total number enrolled at end or collaborative, accounting for new enrollees during first year and deaths.
Process Measures: Care Team, Access Plan, and Care Plan

- Care team and Access plan automated in EMR
- Care plan required 1:1 intervention with families resulting in longer implementation times.

Change Package Implementation

- Enrolled Patients
- Care Team
- Access Plan
- Care Plan

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Voice of the Customer

Parent: “The Care Plan is easy to understand, I know exactly where to go”

Care Coordinator: “I can easily see my Tier 3 and 4 patients for today’s clinic”.

Care Coordinator: “All the important information is in one place”

Parent: “I know exactly who to call for what”

Community PCP: “The updated Care team and access plan have been a huge help”.

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25
CAHPS Survey: Access Scores

Patient Access: Results by Site

Children’s Colorado ONLY site with a statistically significant improvement!
Relationship: ED visits and Change Package elements

As more change package elements are implemented, ED rate drops.

Note: Graphic obtained from Children’s Hospital Association
Direct Costs: Did we change anything?

55% decrease in the cost of Inpatient care per enrolled patient (2015-2017)

7.1% increase in the cost of Ambulatory Care per enrolled patient (2015-2017, ED costs are included in ambulatory setting)

33% decrease in total direct cost per patient per year (2015-2017)
Cost Assessment

Eliminating the age progression factor

- Due to resources, not all patients were able to receive a care plan during the 3 year project.
- Tier 4 patients that **did** receive a care plan appeared to have a faster decline in costs than those that did not receive a care plan.
- More data should be evaluated on larger population to determine if trend continues with expansion.

**Enrolled Tier 4 patients:**

*Total Direct Cost per unique patient*

- Graph represents 391 Tier 4 patients enrolled in the collaborative.
- **Blue line:** 125 tier 4 patients with a completed care plan by end of collaborative.
- **Red line:** 266 tier 4 patients without completed care plans by end of collaborative.
Project Goals and Overall Outcomes:

1. Improved health outcomes for kids with Medical Complexity
   ↓ 32% ED visits/1000 enrolled patients

2. Improved family satisfaction with access to care
   ↑ 16% Increase in family satisfaction with access to care

3. Decreased cost of care
   ↓ 33% total direct cost per patient per year (2015-2017)
Lessons Learned:

1. Get interdisciplinary team and parent feedback frequently during build process.
2. Technical build requires multiple iterations... Validate often!
3. Social determinants of health integration critical to successful tiering of medically complex kids.

Designing effective care coordination solutions for children with medical complexity is very difficult…

But not impossible
Conclusions

- IP hospital days, ED visits, and total direct cost were decreased in a population of medically complex kids after targeted care coordination interventions

- Satisfaction increased for both families and providers
Moving Forward

• Expand implementation in all ambulatory clinics
• Expand Social Determinants to community practices
• Collaborate with local health systems for shared care across the continuum
• Share EHR based solutions with other children’s health systems across the country
Thanks to the team

Abe Herrera (TCHP)
Allison Caldwell (CHCO)
Amy Root (CHCO)
Amy Sun (CHCO)
Andrea Loasby (CHCO)
Anissa Jones (CHCO)
Anita Rich (CHCO)
Annie Lee (CHCO)
Antonia Sainez (CHCO-SCC)
Audra Bailey (APA)
Ayelet Talmi (CHCO)
Aza Fahed (MCPN)
Bryan Wallace (CHCO)
Cathy Del Santo (CHCO)
Chris Stille (CHCO)
Christine Jelinek-Berents (Kaiser)
Cindy Leckman (APA)
David Keller (CHCO)
Douglas Novins (CHCO)
Dr. Dubynsky (TCHP)
Elizabeth Nowak (CHCO)
Ellen Elias (CHCO-SCC)
Ellen Servetar (CHCO)
Gretchen McGinnis (CO Access)
Heidi Baskfield (CHCO)
Jamie Haney (MCPN)
Jen Thomson (CHCO)
John Bear (CHCO)
Josh Williamson (MCPN)
Julie Degenstein (CHCO)
Karen Kelminson (CHCO)
Kelly Galloway (CHCO)
Kevin Wilson (CHCO)
Kim Evertse (Kaiser)
Kris Boggus (CHCO-CHC)
Kristen Hounsel (CHCO)
Lindy Ruiz (TCHP)
Lisa Davis (CHCO)
Lynn Bakken (MCPN)
Maryam El-Bakry (CHCO)
Maya Bunik (CHCO-CHC)
Regan Hall (Parent)
Rudy Lindsey (CHCO)
Sandra Whisler (CHCO)
Sarah E. Martin (CHCO)
Sarah McGrath (APA)
Scott Bates (CHCO)
Shauna Kelly-Moore (APA)
Stephanie Stevens (APA)
Suzy Jaeger (CHCO)
Judy White (CHCO)
Thank you
Appendix
U Chart: Hospital days per 1000 enrolled patients

- Year: 2018
- Month: Apr, Jan, Oct, Jul
- IP days/1000 enrolled patients:
  - U = 302.5
  - UCL = 344.2
  - LCL = 260.8

- Enrollment Begins
- Interventions Begun
- Collaborative Concludes

Enrollment Begins:
- Summer 2014

Interventions Begun:
- Summer 2015

Collaborative Concludes:
- Summer 2016

- Year: 2017
- Month: Apr, Jan, Oct, Jul
- IP days/1000 enrolled patients:
  - U = 219.3
  - UCL = 254.6
  - LCL = 184.1

- Year: 2016
- Month: Apr, Jan, Oct, Jul
- IP days/1000 enrolled patients:
  - U = 130.9
  - UCL = 158.2
  - LCL = 103.7

- Year: 2015
- Month: Apr, Jan, Oct, Jul
- IP days/1000 enrolled patients:
  - U = 302.5
  - UCL = 344.2
  - LCL = 260.8

- Year: 2014
- Month: Apr, Jan, Oct, Jul
- IP days/1000 enrolled patients:
  - U = 302.5
  - UCL = 344.2
  - LCL = 260.8
U Chart: ED Discharges per 1000 enrolled patients

- Visits/1000 patients
- U = 36.78
- UCL = 51.22
- LCL = 22.34

March 2017: Enrollment Begins
April 2017: Interventions Begun
Summer 2017: Collaborative Concludes

Year 2014-2018
Social Determinants of Health Integration

<table>
<thead>
<tr>
<th>Psychosocial Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Psychosocial Screen?</td>
</tr>
<tr>
<td>Do you need help finding a doctor or clinic for yourself?</td>
</tr>
<tr>
<td>Concerns/problems that make it hard to keep your child’s Dr. appointments or manage their health care?</td>
</tr>
<tr>
<td>In the last 3 months, have you felt stressed about making ends meet?</td>
</tr>
<tr>
<td>In the last 3 months, have you worried that your food would run out before you had money to buy more?</td>
</tr>
<tr>
<td>In the last 3 months, did your food ever not last and you didn’t have money to get more?</td>
</tr>
<tr>
<td>Are you worried about benefits right now?</td>
</tr>
<tr>
<td>Do you have concerns about your child’s education needs?</td>
</tr>
<tr>
<td>Do have concerns about your housing or becoming homeless?</td>
</tr>
<tr>
<td>Do you need help with guardianship of a minor child or disabled adult?</td>
</tr>
<tr>
<td>Do you want to talk to someone about feeling alone or needing someone to rely on when you have problems?</td>
</tr>
<tr>
<td>Do you or anyone else in your home have a problem with alcohol or marijuana?</td>
</tr>
<tr>
<td>Do you, or anyone else in your home use medicine not prescribed to you, or any other type of drugs (such as</td>
</tr>
<tr>
<td>In the past year, has anyone threatened, hit, slapped or touched you or your child in an unwanted way?</td>
</tr>
<tr>
<td>Do you feel sad, hopeless, or anxious a lot of the time?</td>
</tr>
</tbody>
</table>

Psychosocial Screen Comments