CPC+ FAQ Sheet

Name: Addressing Social Needs in Primary Care

Date: 8/11/2017

Link to Recording

What?

- Who in you practice needs screening for social determents?
- Which screening tool will your practice use?
- Who will screen the patients?
- How will data be used for practice improvement?

How?

- Identify your focus
  - Food
  - Housing
  - Transportation
  - Prescription medications
- Which screening tool will you use?
  - Health Leads Screening Toolkit
  - Institute of Medicine
  - We Care
- What resources are available to your patients?
  - Healthify
  - Needmymeds.com
  - Soup kitchens
  - Food stamp assistance
  - Housing assistance

When?

- Designate a team member
  - Collects resources
  - Monitors effectiveness
- Decide when/where the screening will happen
- Start with a focus group of patients
- Align with current CPC+ work
  - Hospital transition patients
  - Medicaid patients
  - Complex chronic patients
- Monitor your progress for a designated period
- Make changes as necessary

Small or rural practice tip:

Network with local organizations like soup kitchens, free clinics, and/or your local Medicaid office to learn more about resources available in your community. Don't forget your care team members may have some great insight into your community.

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