Camden Coalition

The National Center for Complex Health & Social Needs
An initiative of the Camden Coalition

Complex Care Startup Toolkit

nationalcomplex.care/startup-toolkit | August 2022

Program operations**: Intake**

This document is part of the Complex Care Startup Toolkit, a practical collection of guides, templates, and other tools to launch and grow a new complex care program. Find the full toolkit at **www.nationalcomplex.care/startup-toolkit.**

Intake in a complex care program serves two purposes: engagement of individuals and collecting information. Individuals are generally chosen for programs based on provider and/or data-driven referrals that are informed by inclusion and exclusion criteria. After initial selection, individuals must be engaged to assess their interest in participating in a program. If they decide to proceed in the program, staff must assess the participants' holistic needs and strengths and work together to create a mutually agreed upon plan of care and action.

Key considerations

1. Does your staff take time to introduce themselves, build rapport, and assess readiness/ interest before they begin their comprehensive assessments?
2. Taking an inventory of the individual's needs, as well as existing resources and community linkages, is essential in understanding the whole picture and building better ways to coordinate and collaborate.
3. Being person-centered means listening to individual perspectives and incorporating their goals into the care plan, which may conflict with those of the program or providers.

Below, find resources you can use as you work through each of these key considerations.

Resources

Key consideration #1: Does your staff take time to introduce themselves, build rapport, and assess readiness/interest before they begin their comprehensive assessments?

- More information about that can be found in **Participant outreach and engagement**.
- **Greetings self-check** New!
  This checklist from the Integrated Behavioral Health Network provides guidance on how healthcare providers can greet patients and families during care interactions.

Key consideration #2: Taking an inventory of the individual's needs, as well as existing resources and community linkages, is essential in understanding the whole picture and building better ways to coordinate and collaborate.

- **Systematic review of social risk screening tools**
  In 2018, a group of researchers from Kaiser Permanente Washington Health Research Institute (KWPHRI) and the Social Interventions Research and Evaluation Network (SIREN) collaborated on a systematic review of social risk screening tools. This **study** was published in the American Journal of Preventive Medicine and also built into an interactive website. Please keep in mind that this team does not currently plan to update the systematic review or website results to align with the rapidly developing literature in this space. This review can be used to identify screening tools appropriate for your program.
- **Social needs screening tools comparison table** New!
  This table helps you to gain familiarity with several of the most widely used social health screening tools that are compared across population, setting, and social domains.
- **Screening for social determinants of health in populations with complex needs: Implementation considerations**
  This brief helps you to understand how organizations are assessing and addressing social determinants of health (SDOH) for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting individual-level information related to SDOH; (3) creating workflows to track and address individual needs; and (4) identifying community resources and tracking referrals.
- **Social risk screening and referral-making** New!
  This resource provides stepped guidance on how to implement social risk screening at your organization.

- **Behavioral health and addiction screening tools**
  This collection of validated behavioral health and substance use assessments helps you to inform your assessments.

- **Patient support questionnaire**
  This needs survey with a Spanish version included helps you to better understand individual needs.

- **Eco-map template**
  This template helps you to document participants' relationships with friends, family, and community members/resources.

- **Project Restoration enrollment intake**
  This example helps to inform your intake form with questions about medical needs, behavioral health, suicide, food and nutrition, support, housing and environment, education and employment, legal, identification, transportation, and medication and medical supplies.

- **Sample patient consent**
  This example helps you to create your own consent form that will allow you to share information with other providers.

Key consideration #3: Being person-centered means listening to individual perspectives and incorporating their goals into the care plan, which may conflict with those of the program or providers.

- **Patient passport encourages better engagement with providers**
  This tool helps you to increase engagement and drive system-level change by helping individuals start a conversation with providers in order to express their needs and preferences.

- **Utilization & enrollment summary template**
  This template helps you to complete utilization review, enrollment summary, and initial planning with individuals in complex care programs.

- **Root cause evaluation tool**
  This template helps you to assess medical, behavioral, social, and systems factors impacting outcomes for individuals with complex needs.

- **Self-management and complex care planning: Workbook**
  This person-centered care planning tool, which includes sample interview questions, helps you to enhance the collaborative nature of the care planning process and evoke and enhance the participant's intrinsic motivation to change health behaviors.

- **Shared care plan template**
  This template helps you to care plan with the participant and other providers.

- **Case management case conference form**
  This template helps you to support case communication and collaboration from multiple participants and agencies.

- **Complex care case conferencing script - 4 quadrants of complexity**
  This template helps you to identify the needs and resources of participants.

- **Complex care case conferencing script - 4 quadrants of complexity example**
  This example helps you to identify the needs and resources of participants.

About the Camden Coalition

We are a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. The Camden Coalition works to advance the field of **complex care** by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being. Supported by a robust data infrastructure, cross-sector convening, and shared learning, our community-based pro-grams deliver better care to the most vulnerable individuals **in Camden** and **regionally**.

The **National Center for Complex Health and Social Needs** (National Center), an initiative of the Camden Coalition, connects complex care practitioners with each other and supports the field with tools and resources that move complex care forward. The National Center's founding sponsors are the Atlantic Philanthropies, the Robert Wood Johnson Foundation, and AARP.