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## **Learning Session #4**

# **Best Practices for Assessing and Addressing Social Needs**

**April 23, 2025  
1pm – 2pm**

# Call Agenda

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- Welcome

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- Housekeeping

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- Presentation

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- Close-Out & Next Steps

# Housekeeping



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**transcribed.**

By staying in the  
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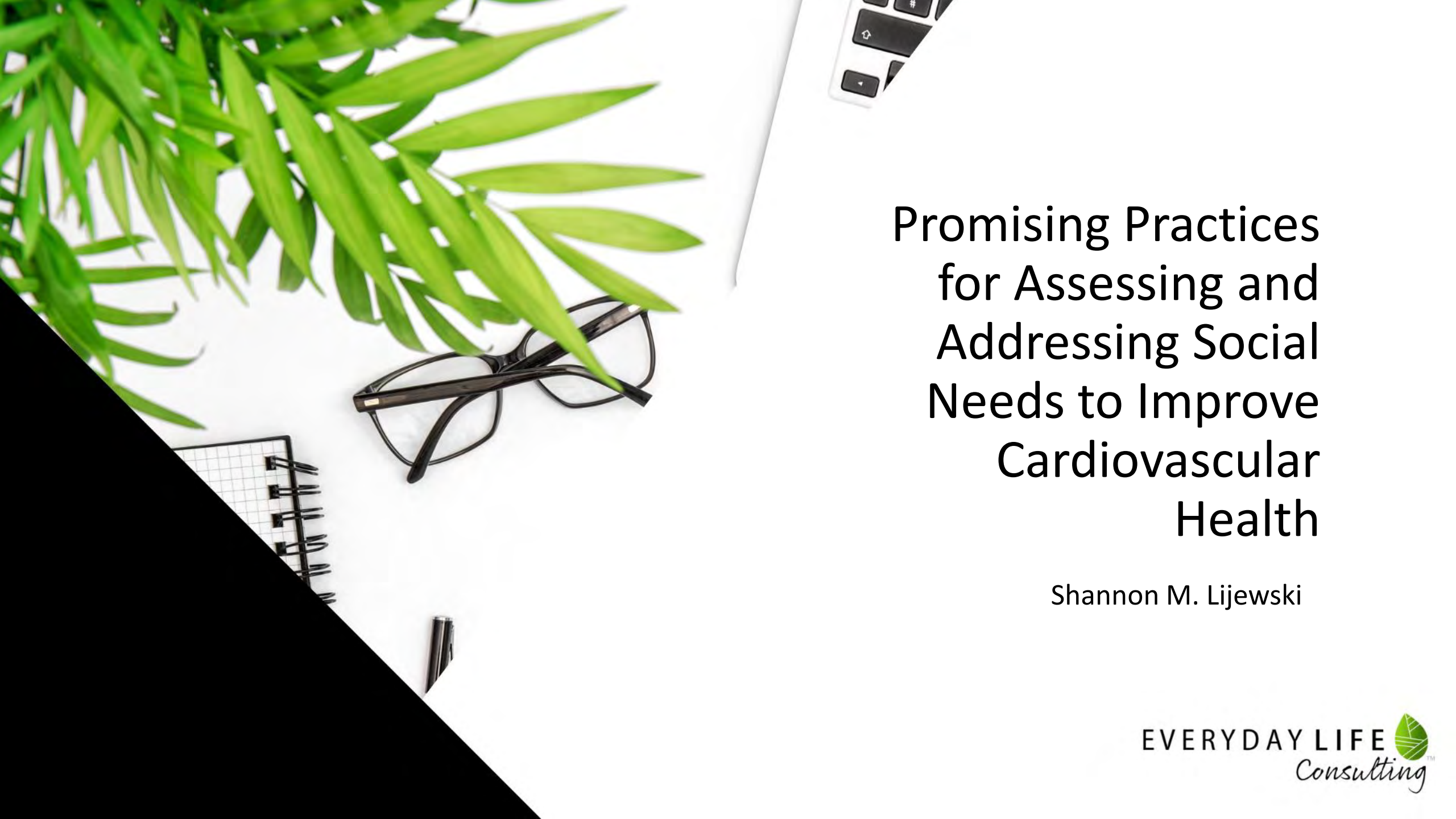
We  
encourage  
you to  
submit  
questions  
and  
comments  
at any time  
via Teams  
chat.

# Disclaimer

- Funding for this Learning Session was made possible (in part) by the Centers for Disease Control and Prevention.
- The views expressed in materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.




- Shannon Lijewski, NCHW, MBA, CHCEF
  - Chief Executive Officer - Everyday Life Consulting



# Promising Practices for Assessing and Addressing Social Needs to Improve Cardiovascular Health

Shannon M. Lijewski





# Our story

With a focus on building individual, organization and community capacity, our team is committed to working alongside our clients, distilling the most complex issues and providing a clear path forward. Everyday Life has had the unique opportunity to work nationally with health and human service organizations which has allowed us to gain insight and build on promising practices. Areas of expertise include but are not limited to; Community Health Workers (CHW), practice transformation, tri-sector partnerships, social determinants of health, change management, community systems integration and Clinical Community Linkages (CCL).

# About your presenter

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Shannon is a wife, mother and entrepreneur with a passion for helping people. Shannon has more than two decades of experience in public and community health, and it is her personal mission to make health accessible for all through addressing social determinants and health barriers.



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# Learning objectives

By the end of this presentation, participants will be able to:

- Explain the connection between social determinants of health and cardiovascular outcomes, including how unmet social needs contribute to heart disease and stroke risk.
- Identify common social barriers—such as food insecurity, transportation challenges, housing instability, and financial strain—that impact cardiovascular health.
- Describe at least two validated screening tools (e.g., PRAPARE, AHC HRSN) used to assess social needs in healthcare and community settings.
- Recognize the critical role of Community Health Workers (CHWs) in screening, resource navigation, and ongoing support for individuals with cardiovascular risk factors.



"Community Health Workers are the bridge to health and well-being,  
connecting communities one relationship at a time."



# Introduction

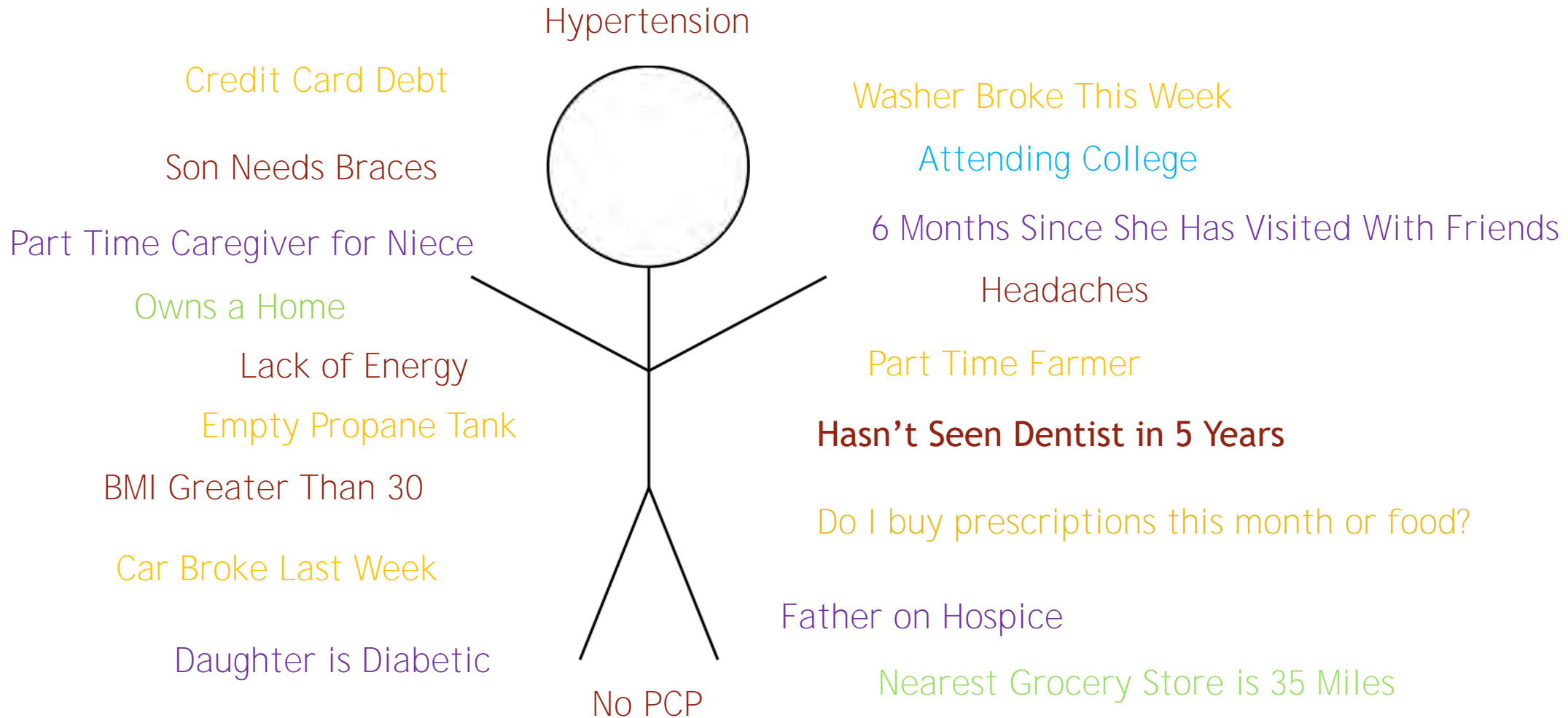
Understanding the role of Community Health Workers (CHWs) in assessing and addressing social needs is essential for improving cardiovascular health outcomes. This presentation will explore best practices for identifying social risk factors, connecting individuals to resources, and leveraging CHW-led interventions to support heart health in clinical and community settings.



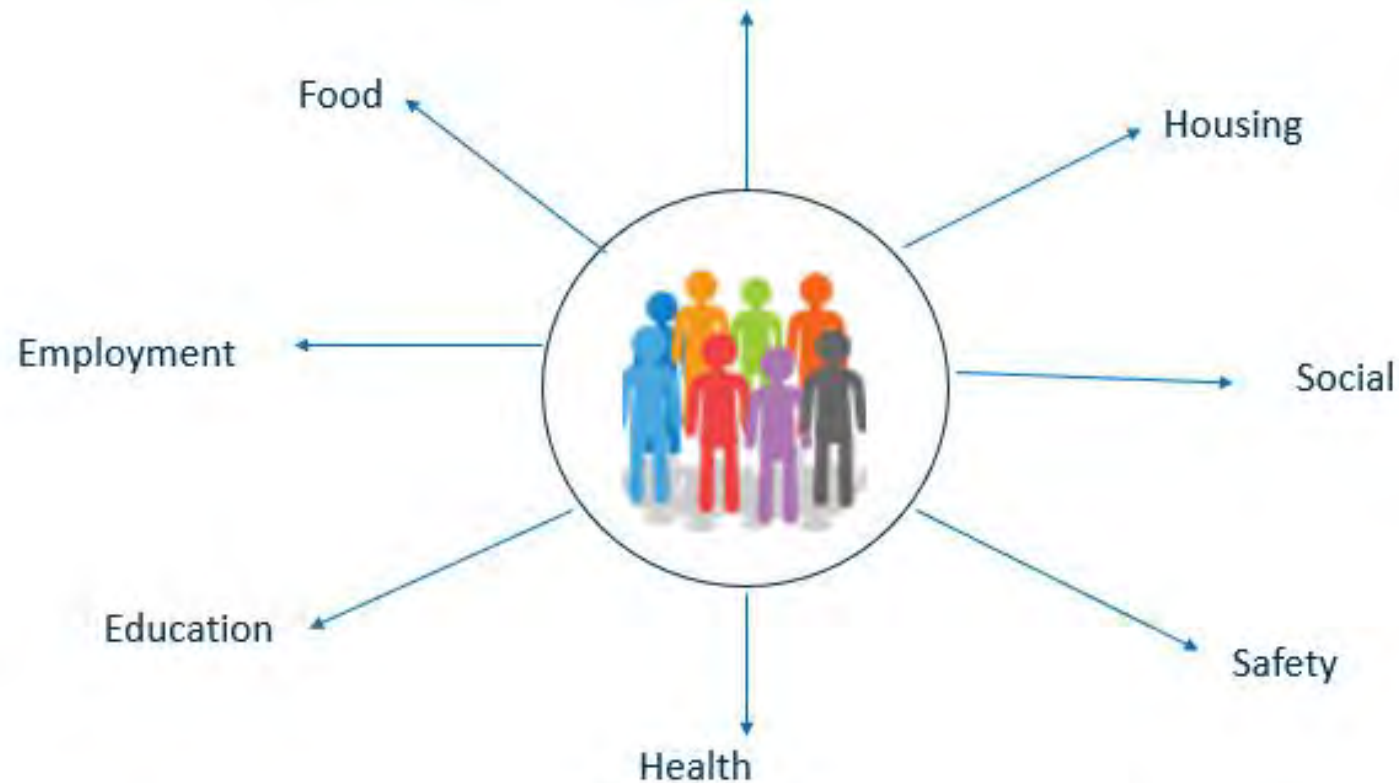
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# Meet Mrs. Smith 5<sup>th</sup> Grade Teacher



# Conditions in the places where people live, learn, work, and play





# Social determinants of health in Michigan

**Significant barriers and challenges can exist in communities, including:**

- Income, employment, and poverty
- Educational attainment and literacy
- Health literacy
- Adequate community infrastructure
- Environmental health
- Access to safe and healthy homes
- Access to safe and affordable transportation
- Access to healthy and affordable food
- Access to healthcare services



# Change agents



## Meeting Individuals Where They're At

### Who are CHWs?

A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusted relationship enables the CHW to serve as a liaison between health/social services and the community to facilitate access, improve the quality and cultural competence of service delivery.

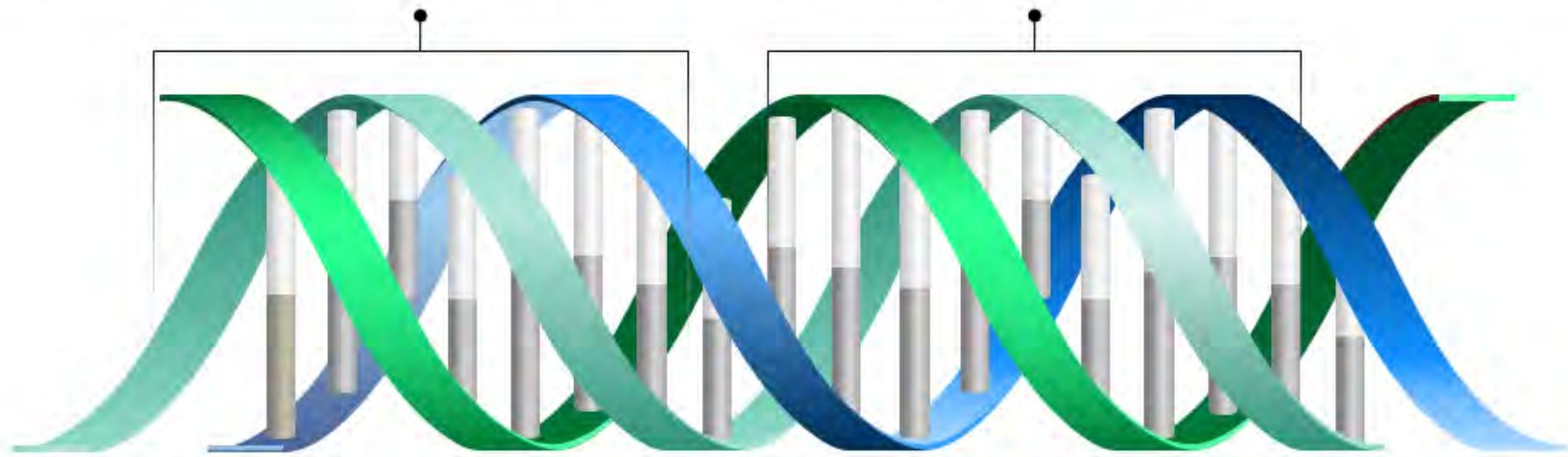
### Why CHWs are Valuable?

- Skilled at Outreach & Engagement
- Provide culturally and linguistically appropriate screening and linkage to community resources
- Experts at resource and community sector navigation
- Ability to build self-efficacy in individuals

# Improving community response system & population health

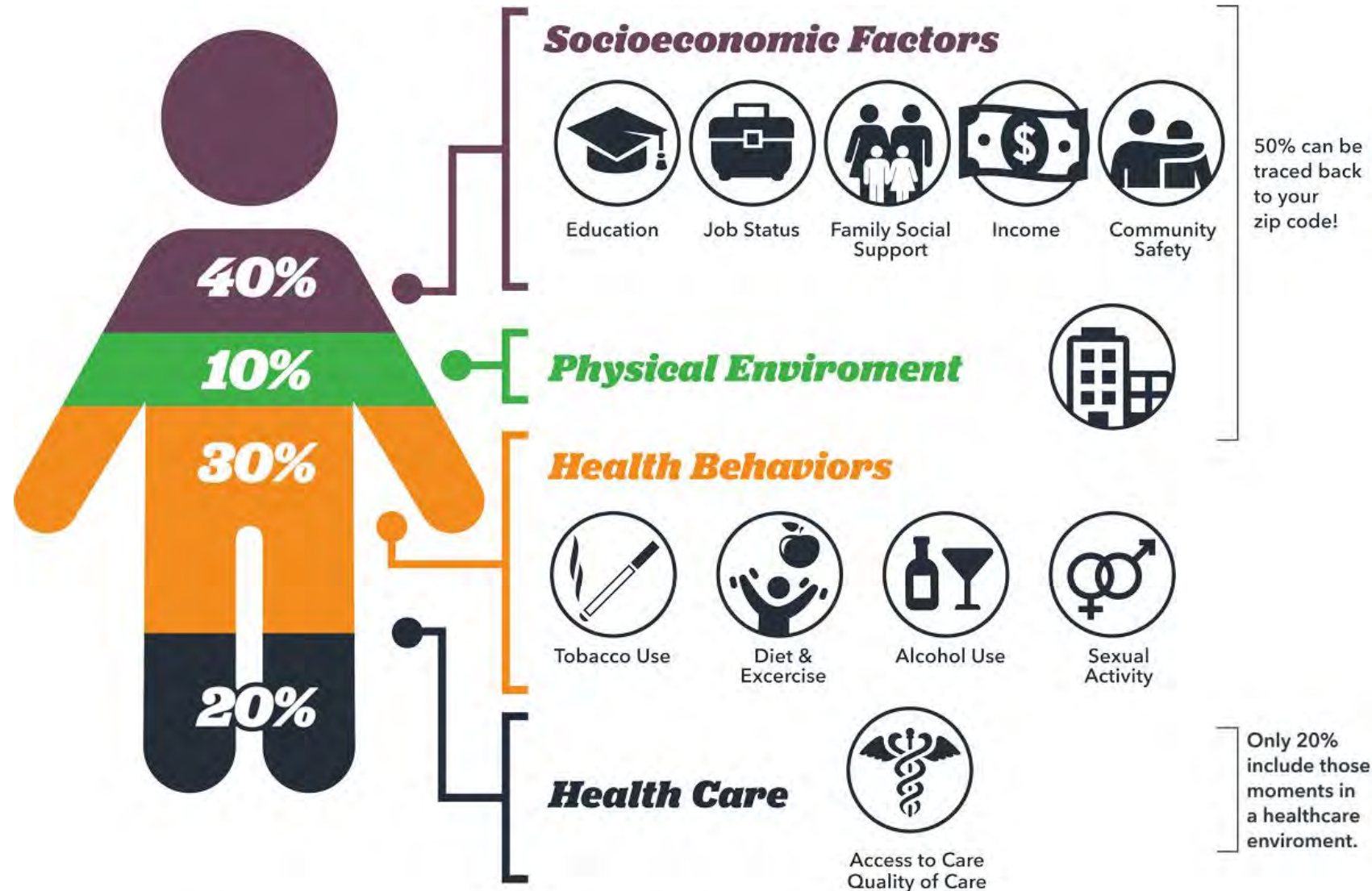
Clinical-Community Linkages (CCLs)

Transformative Change



Continuous Feedback Loop





Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)



# What does coordinating care mean?

- Integrating health care and social services
- Bridging gaps between care sources and services

# Actions in care coordination



Monitoring individual's health regularly



Assisting individuals as they transition to different facilities or care



Providing educational materials and resources for individual to use



Referring individuals to additional services and resources



Supporting individuals as they navigate appointments and treatments



Encouraging personal goals through motivational interviewing

# Examples of coordinating care



A patient leaves a medical facility and has strict orders to stay at home, but they don't have any groceries, so a CHW delivers a food pantry donation



A client in active recovery sees a pharmacist and psychiatrist for MAT, and their social worker connects them to community support groups



A nurse contacts a patient each week between appointments to screen their health

# Importance of building meaningful relationships

- Positive health outcomes

- Increased trust and collaboration

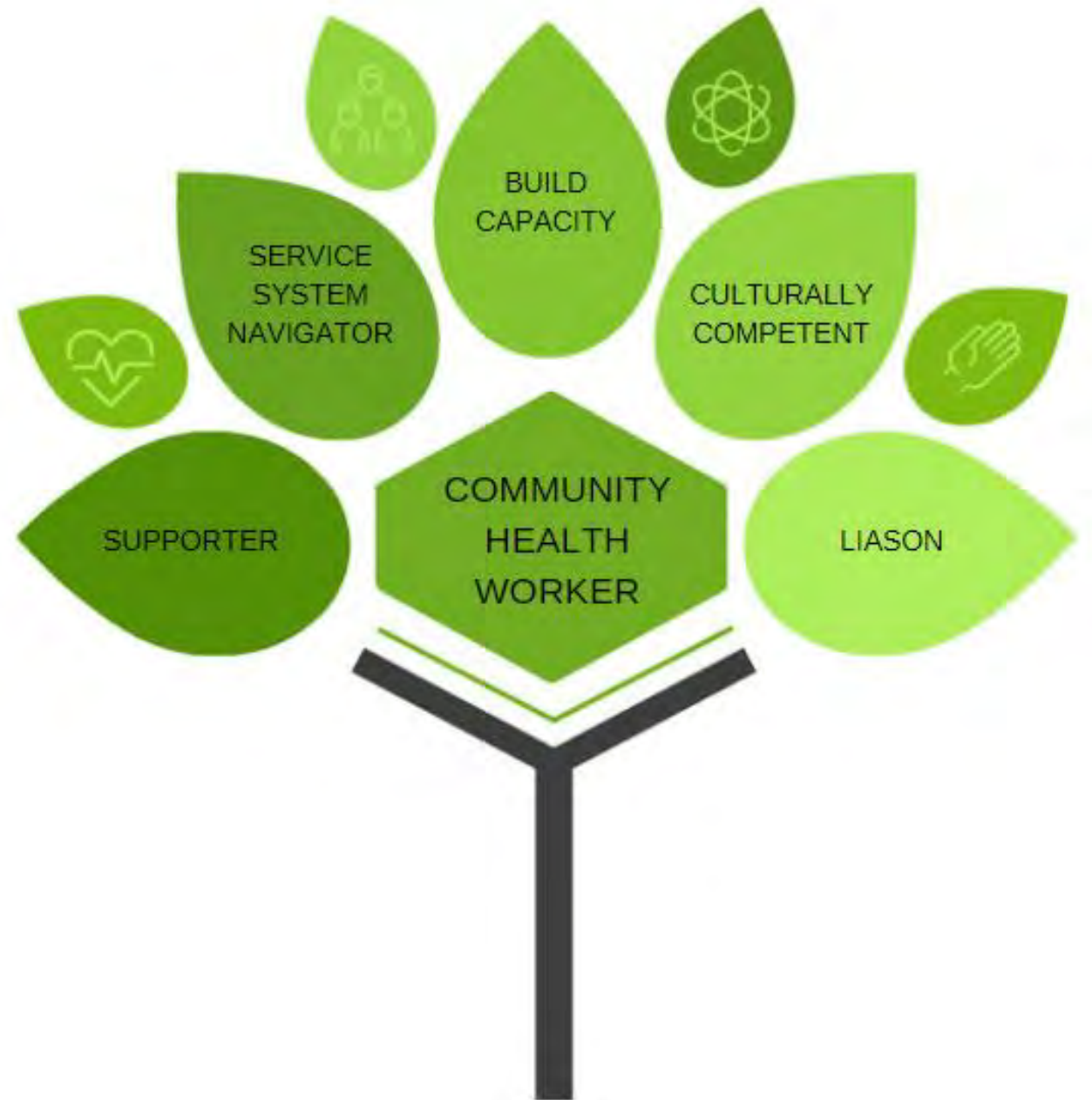
- Enhanced cultural competency

- Sustained engagement

- Refined service delivery



# CHWs





# Roles

10 nationally  
recognized roles  
and 25+ sub-  
roles

- Community resource expert
- Cultural liaison
- Translation services
- Health promotion
- Health coaching
- Care coordination/system navigation
- Coaching and social support
- Advocating for individuals and communities
- Providing direct services
- Home-based supports
- Implementing individual and community assessments
- Conducting outreach

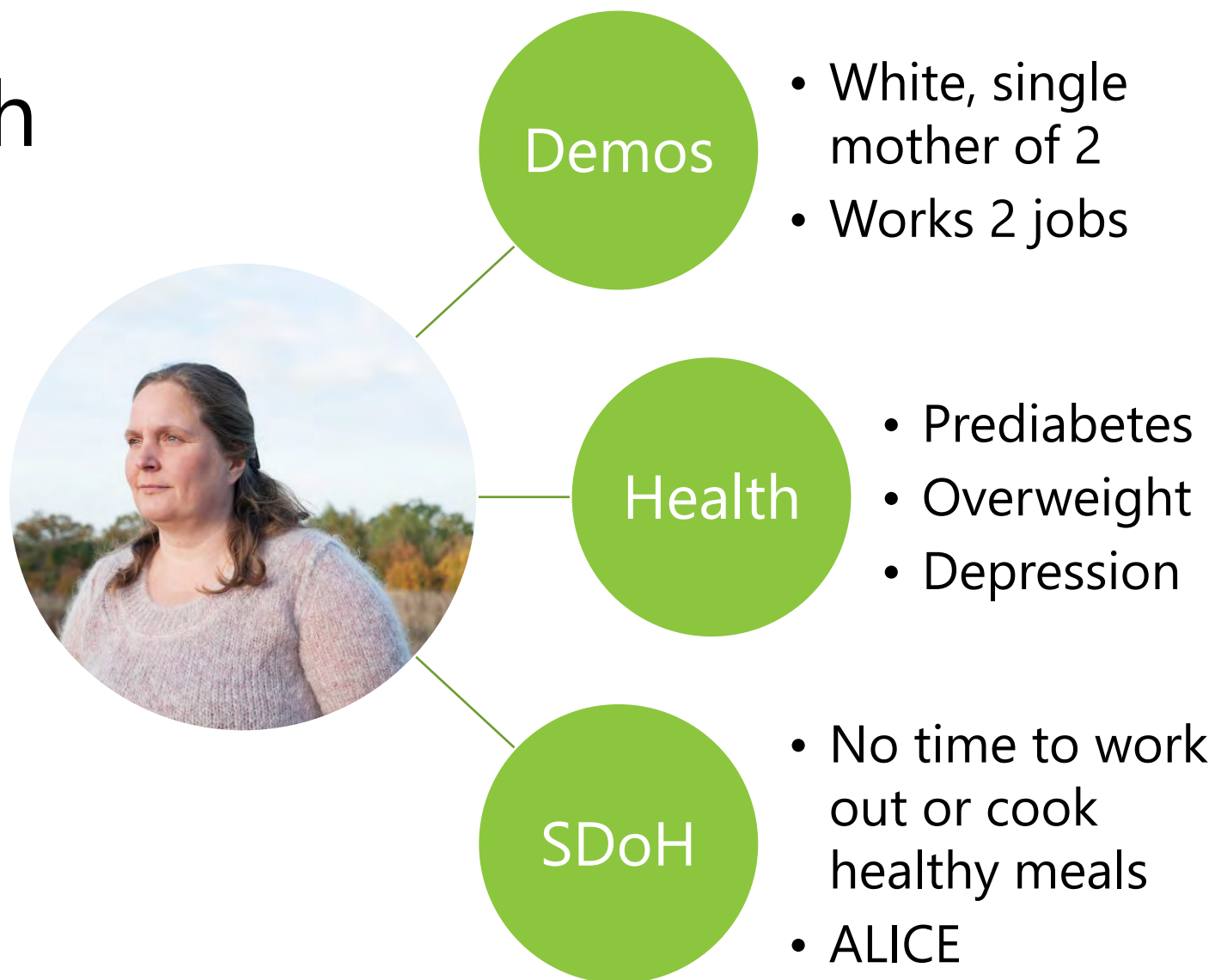


# Importance of CHWs

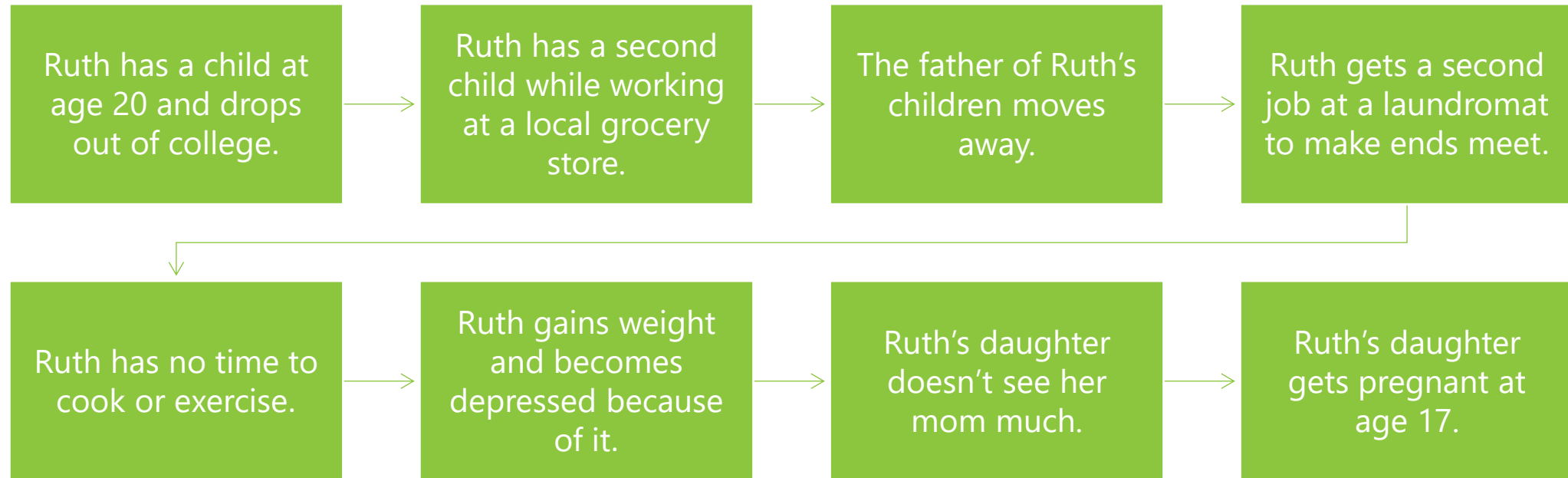
- **\$2.47:1 ROI** for Medicaid patients
- **Reduced** number of **days in hospital by 34%** (NIHCM, 2021)
- CHW intervention **reduced hospital readmission by 50%** (McKeon, 2021)



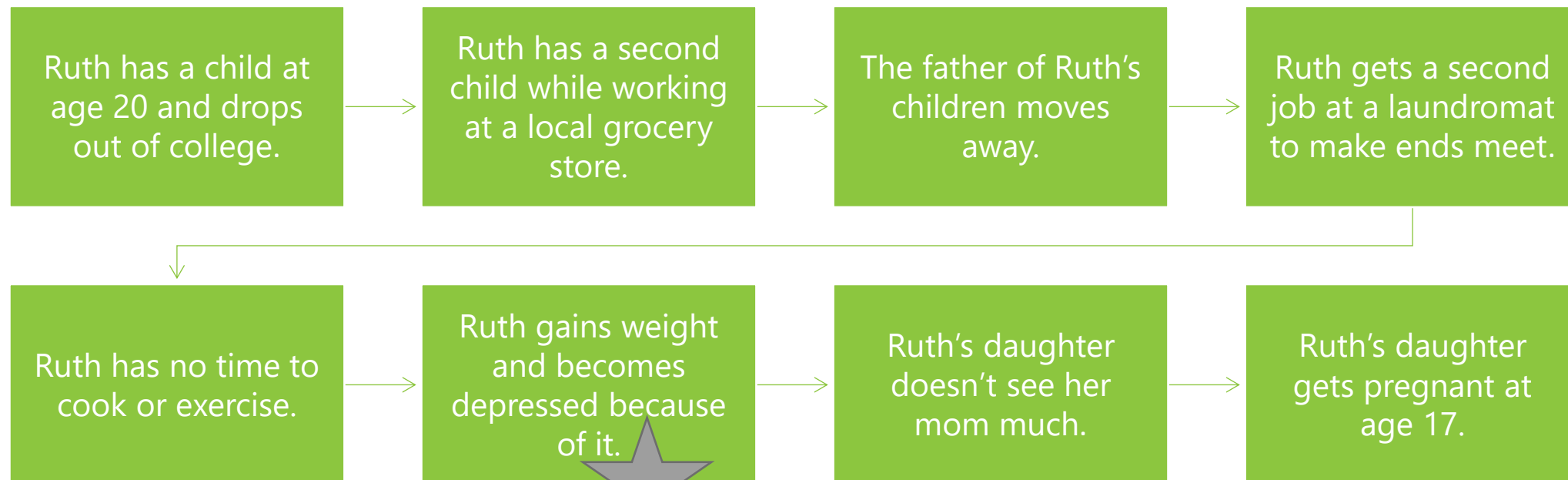
# Community member: Ruth



# Ruth's journey



# Ruth's journey: Interventions



This is where we typically see interventions. Intervening here won't have long-term impacts because the **root causes** of Ruth's health issues don't start here.

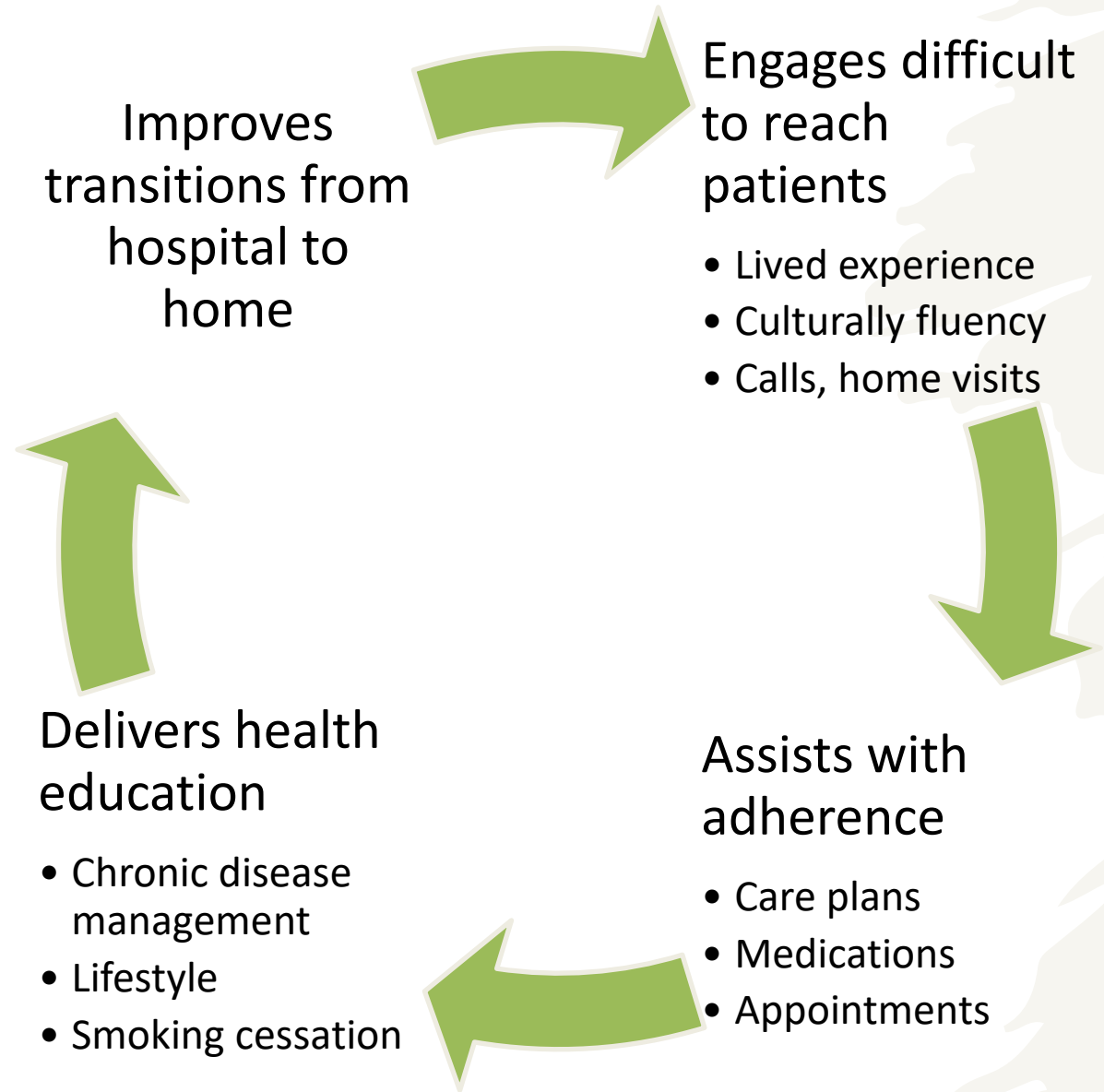


# Root causes

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# CHW role in chronic disease management



# Concept of clinical integration

## Help with transitions

- From hospital to short term rehab
- From rehab to home
- From care facility to home
- Home to care facility

## Connect patients to appropriate resources

- Clinical
- Community based



# SDOH vs. HRSN

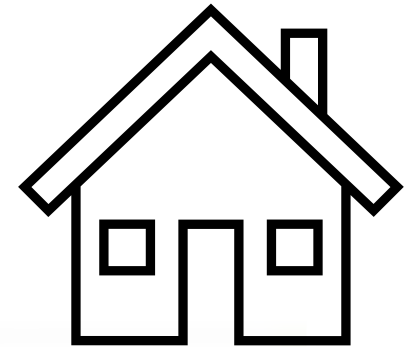
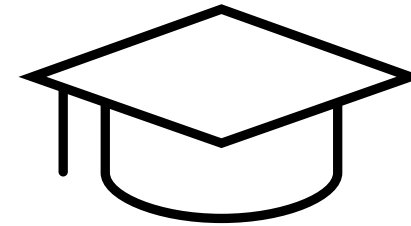
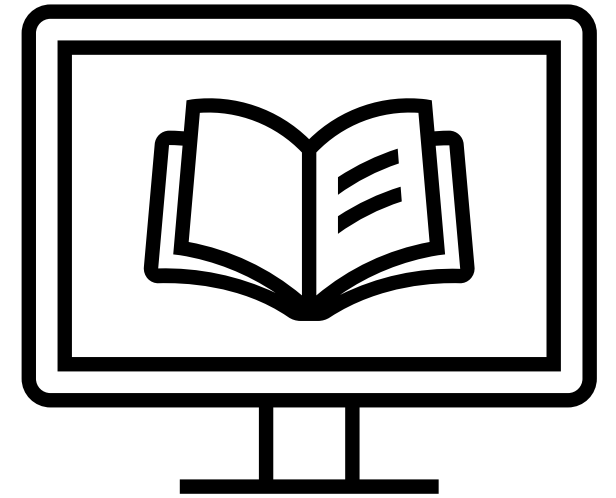
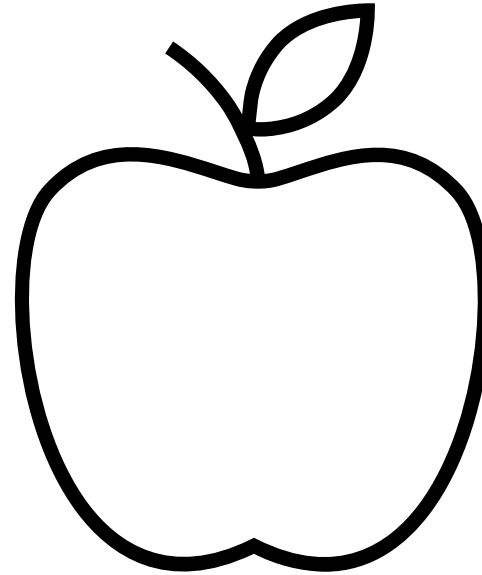
Health-related social needs and social determinants of health are terms often used interchangeably, but they hold distinct meanings.

# Addressing health related social needs in clinical setting

- Screen for social needs
- Administer PRAPARE or AHC tool
- Positive screen → Referral CHW or case manager steps in → Referral to services
- Use resource directory or electronic referral system
- Follow-up & documentation
- Confirm connection, track outcomes

# Common screening

- Safe housing, transportation, and neighborhoods
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills





# Evidenced based screening tools

## PRAPARE

- Developed by the National Association of Community Health Centers (NACHC)
- Aligns with national initiatives and value-based care models.
- Includes 21+ core and optional measures (e.g., housing, income, stress, transportation) Integrates with major EHRs (Epic, eClinicalWorks, etc.).
- Designed for use by CHWs, care teams, and clinics serving underserved.

The image shows a PRAPARE form, which is a standardized tool for screening patients for social determinants of health. It includes sections for patient information, screening questions, and checkboxes for various social determinants of health.

The image shows a CMS form titled "The Accountable Health Communities Health-Related Social Needs Screening Tool". It includes a header with the CMS logo and a title. The form contains several sections with headings and bullet points, providing information about the tool and its use.

## AHC

- Developed by CMS for the Accountable Health Communities model.
- Focuses on 5 core domains: housing, food, transportation, utilities, and interpersonal safety.
- Short and standardized – ideal for high-volume clinical workflows.
- Evidence-informed and free to use.
- Promotes early identification of social risks in Medicare/Medicaid populations

# Journal prompt 1

What types of health-related social needs do you see within your community?

What resources are available to help address these needs?

1. How do you think addressing SDOH/HRSN can improve long-term health outcomes for your clients and communities? How does understanding this distinction impact your approach to providing care?
2. Take time to explore these questions and think about how your knowledge of SDOH/HRSN will shape your work as a CHW, both now and in the future.

# CHW Documentation

How are you currently documenting?

# CHW documentation

How do you ensure CHWs documentation is accurate, timely and high quality?

Types of documenting	Where to document	How to document	Why document
<ul style="list-style-type: none"><li>• SOAP notes</li><li>• Use quotes and proper words, avoid derogatory words or phrases</li></ul>	<ul style="list-style-type: none"><li>• Written or electronic</li></ul>	<ul style="list-style-type: none"><li>• What to include</li></ul>	<ul style="list-style-type: none"><li>• If it's not documented, it didn't happen</li><li>• He said/She said</li></ul>

# Setting expectations

- Having a clear timeline for documenting work
- Case conferencing with CHWs
- How to case conference with effectiveness

# Am I doing this right?

- Get feedback from participants
- What are you currently doing?
- Is it working?
- Do you have a documentation procedure?
- What tools do you need for success

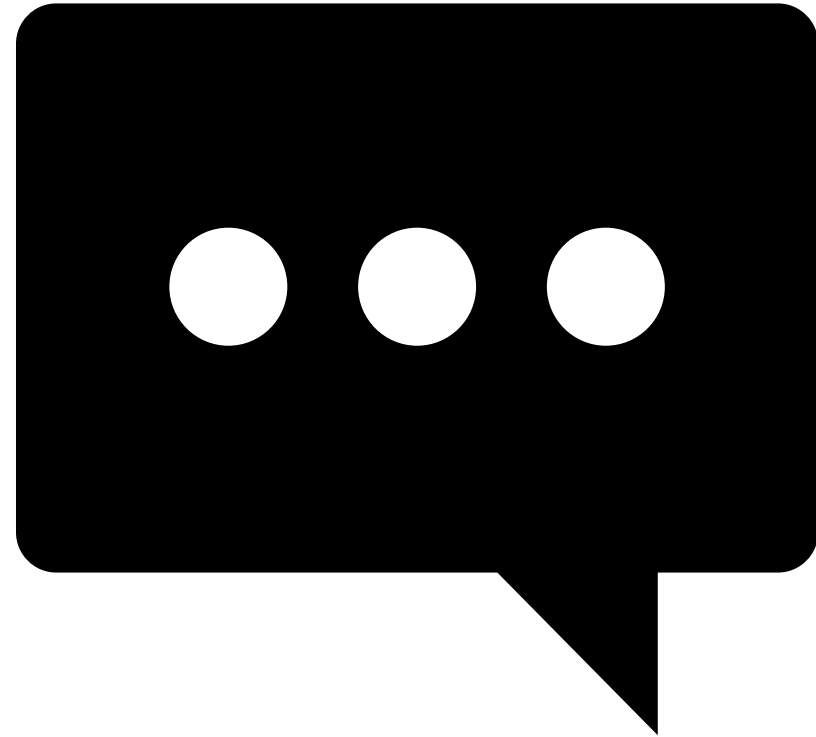


# Take a pulse

- Giving assistance when needed to help create best possible outcomes. How to take the pulse of your team?

How do you  
currently receive  
referrals?

Type your response in the chat!



# Follow-up best practices



Establish a practice-wide documentation system and follow-up schedule



Work one-on-one with clients to establish their preferred contact method



Include follow-up procedures with clinical providers



Document all meetings and client preferences!

# Why closing referral loops matters

## The Problem

- Referrals made, but no feedback to the provider
- Delayed or incomplete follow-up with patients
- Lack of documentation or care coordination

## The Impact

- Missed opportunities for preventive care
- Patient distrust or disengagement
- Gaps in communication between care team members

# Promising practices for CHWs supporting



Culturally appropriate  
communication and real  
time documentation



Patient education



Integrate update into clinical  
huddle



Build bi-directional  
communication with clinical  
and community teams



# Making a roadmap

What is your organization currently doing ? What's working? What's not?

# Roadmap

- Ongoing process
- Audit of what's going on, what's going well, what needs improvement
- Followed with strategy on how to improve

Thank you

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Website: [www.everydaylifechw.com](http://www.everydaylifechw.com)

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Courses



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Training  
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# Questions & Discussion

# Close-Out & Next Steps

- Let us know what you thought about today's session!
- Learning Session #5 will be held June 11, 2025.
  - Topic: Community Engaged Design & Implementation of Health Promotion and Awareness Campaigns
  - Registration link will be provided in a follow-up email



For additional questions about MICH Learning Sessions, contact:

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[MDHHS-MICHLearningCollab@michigan.gov](mailto:MDHHS-MICHLearningCollab@michigan.gov)

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