WOMEN'S HEALTH INITIATIVE

VERMONT BLUEPRINT FOR HEALTH | OCTOBER 2017

TABLE OF CONTENTS

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VERMONT BLUEPRINT FOR HEALTH | OCTOBER 2017

PROGRAM OVERVIEW

The Women's Health Initiative helps ensure that women's health providers, primary care practices, and community partners have the resources they need to help women be well by supporting healthy pregnancies, avoiding unintended pregnancies, and building thriving families through enhanced screenings, brief in-office interventions, comprehensive family planning counseling and referrals to services for mental health and substance use disorders, interpersonal violence, food insecurity, housing instability and trauma once identified.

WHY: HEALTHIER WOMEN, CHILDREN, AND FAMILIES

Currently in Vermont, an estimated 50% of all pregnancies are unintended. Unintended pregnancies are associated with an increased risk of poor health outcomes for mothers and babies and long-term negative consequences for the health and wellbeing of the children and adults those babies become. By helping to ensure that more pregnancies are intentional, health care providers and community partners can support women and their families to have healthier lives.

WHAT: WOMEN EXPERIENCE ENHANCED SCREENING, CONNECTIONS, OPTIONS

The Women's Health Initiative is focused on strengthening relationships between medical practices and community organizations to provide seamless care. Women who visit participating medical providers – OB-GYN offices, midwifery practices, family planning clinics, and primary care practices – engage in comprehensive family planning counseling and psychosocial screening to assess mental health, substance use, interpersonal safety, and access to food and housing. Women identified by screening at participating providers are immediately connected to an initiative-funded social worker and/or are referred for more intensive treatment or services in the community as needed. Participating community organizations, essential for ensuring seamless care, also provide screening and comprehensive family planning counseling and connect identified women to primary care and women's health providers. Women who wish to become pregnant receive pre-conception counseling and services. Those who tell their providers they do not want to have a baby in the coming year have access to all contraception options, including immediate access to LARC. Newly developed referral relationships, protocols, and workflows support more timely access to care.

HOW: MULTI-DISCIPLINARY EXPERT SUPPORT, COMMUNITY IMPLEMENTATION

Learning Collaboratives (practice and community) offered providers and staff from practices and community organizations training in the screening model, referral processes, LARC insertion, and more. Each participating community builds a coalition including the participating medical practices and community organizations; local coalitions develop formal referral relationships that allow access to necessary services in order to improve health outcomes for women in their community.

FOR MORE INFORMATION: CONTACT THE BLUEPRINT FOR HEALTH

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WOMEN'S HEALTH INITIATIVE

VERMONT BLUEPRINT FOR HEALTH | OCTOBER 2017

WHAT PRACTICES AGREE TO DO: PRACTICE ATTESTATION

Participating practices sign and submit a Women's Health Initiative attestation form. The attestation form clearly describes the expectations for participating practices and the expected time frames for adoption and implementation. A participating practice attests to:

- Within **one month** of receiving payment, the participating practice shall stock the full spectrum of long acting reversible contraceptive devices at a level adequate for the practice size. This expectation is established in order to ensure the availability of same-day insertions, when clinically appropriate, for women who choose a long acting reversible contraceptive as their preferred method of birth control.
- Within **three months** of receiving payment, the participating practice shall:
  - develop and implement policies and procedures for providing evidence-based, comprehensive family planning counseling through a patient-centered, shared-decision making framework, including implementing One Key Question® (OKQ) and;
  - develop and implement policies and procedures for providing screening, brief intervention, brief treatment and referrals to more intensive treatment or advocacy services for **depression, substance use disorder, and interpersonal violence**.
- Within **six months** of receiving payment, the participating practice shall have developed and implemented policies and procedures to provide same-day insertion, when clinically appropriate, of long acting reversible contraceptives for women who chose that as their preferred method of contraception.
- Within **twelve months** of receiving payment, formal referral protocols should be developed and executed between the participating practice and **at least 3 community-based organizations** (to ensure patients are able to be seen by the participating practice for comprehensive family planning services within 1 week of being referred and same-day insertion of long-acting reversible contraception is available when clinically appropriate and chosen by the patient) and with **at least 1 Patient Centered Medical Home** (this could be the attesting PCMH) to accept patients who are identified as being without a primary care provider.
- Within **eighteen months** of payments beginning, the participating practice shall have developed and implemented policies and procedures for screening and referral to support services for **access to primary care** (a patient-centered medical home for participating practices that are not PCMHs), **housing instability** and **food insecurity**.
- The participating practice shall incorporate the local Community Health Team into the practice.
- The participating practice, when available through the State-appropriated vendor, shall connect the practice's electronic medical record to the Vermont Health Information Exchange and the Vermont Clinical Registry to allow clinical data to be collected, analyzed, and utilized in performance measurement and performance payment calculations.

PROPOSED PERFORMANCE PAYMENTS

Contraceptive care measures used for calculation of performance payments include NQF #2903, the percentage of women aged 15-44 years at risk of unintended pregnancy that were provided a most effective or moderately effective (FDA-approved) contraceptive method, NQF #2902, the percentage of women aged 15-44 years who had a live birth that were provided a most or moderately effective (FDA-approved) contraceptive method within 3 and 60 days of delivery, and the rate of pregnancy among women aged 15-19 years.

WOMEN'S HEALTH INITIATIVE

VERMONT BLUEPRINT FOR HEALTH | OCTOBER 2017

SCREENING OVERVIEW

The Women's Health Initiative helps ensure that communities have the resources and relationships that they need to help women be well by offering enhanced screenings for pregnancy intention, mental health and substance use, interpersonal safety, food security, housing stability, and trauma. Enhanced screenings, connection to an initiative-funded social worker and referrals to treatment or advocacy services in the community through formalized referral relationships support identification and intervention for many factors that impact the health of Vermont women, children and families. Implementing a screening tool requires a plan for who will be screened (e.g. universal), how often the screenings will occur (e.g. annually), when the screening will occur (e.g. in the waiting room or examination room), the method by which screenings will occur (e.g. self-administration versus oral interview), and what the process will be for addressing the results of the screenings (e.g. by whom will the brief intervention, brief treatment or referral to treatment occur).

PREGNANCY INTENTION

The One Key Question® (OKQ) was developed by the Oregon Foundation for Reproductive Health to embed pregnancy intention screening within primary care practices and ensure that women, aged 18-50, were routinely offered essential reproductive health services as indicated by the patient's response to the question: yes or ok, either way (preconception care), unsure (comprehensive family planning counseling), or no (comprehensive contraceptive counseling). Improved use of LARC among women aged 15-44 may generate health-care cost savings by reducing inconsistent contraceptive use; if 10% of women aged 20-29 years began using a LARC instead of oral contraception, it is estimated that the total costs of unintended pregnancy in the United States could be reduced by $288 million per year.

Bellanca H and Stranger Hunter M. One Key Question® - Oregon Foundation for Reproductive Health; ARHP: December 2013. The Oregon Foundation for Reproductive Health, in partnership with The National Campaign to Prevent Teen and Unplanned Pregnancy. One Key Question® is trademarked and a signed MOU is required before implementation to ensure fidelity of the program. Blueprint for Health, Department of Vermont Health Access, State of Vermont, confirmed with OFRH that all prior agreements with OFRH are being honored by TNC and utilization of the One Key Question within the Women's Health Initiative is still acceptable. Contact: OneKeyQuestion@TheNC.org for implementation of the OKQ outside of the State of Oregon; implementation within the State of Oregon, Contact: info@ORfrh.org Trussell J et al. 2013. Burden of Unintended pregnancy in the United States: Potential savings with increased use of long-acting reversible contraception. Contraception; 87: 154-161 and CDC, the 6|18 Initiative: Prevent Unintended Pregnancy.

The One Key Question® (OKQ) may be adapted to incorporate inclusive language that allows for its use with "men, non-binary, and LGBT individuals" while avoiding assumptions and opening conversations about pregnancy. The adapted question becomes, "Would you, **or your partner**, like to become pregnant in the next year?"

Phanthavong S. 2017. Family Planning Program: Rhode Island Department of Health. ATTC Network One Key Question Presentation.

MENTAL HEALTH AND SUBSTANCE USE

The Patient Health Questionnaire-2 item (PHQ-2), comprised of the first two items of the 9-item Patient Health Questionnaire (PHQ-9), is intended to screen for the frequency of depressed mood and anhedonia over the past 2 weeks, and has been validated in multiple settings, including primary care and obstetrics-gynecology clinics, with sensitivity and specificity established for scores of greater than or equal to 3. The purpose of the PHQ-2 is to establish a brief, initial approach to screening for depression in busy clinical settings; patients who screen positive should be evaluated with the PHQ-9. A cut-off score of 3 is the optimal point for identifying patients who should be evaluated with the PHQ-9. The validity of the PHQ-2 has been evaluated in the adolescent

population; a PHQ-2 score of greater than or equal to 3 demonstrated sensitivity and specificity for detecting depression in adolescents.

Kroenke K et al. 2003. The Patient Health Questionnaire-2: Validity of a two-item depression screener. Med Care; 41: 1284-1292. Richardson LP et al. 2010. Evaluation of the PHQ-2 as a brief screen for detecting major depression among adolescents. Pediatrics; 125: 1097-1103. Patient Health Questionnaire-2 adapted from phqscreeners.com; terms for the PHQ Screeners indicate the content is expressly exempted from Pfizer's general copyright restrictions and that content on the PHQ Screeners site is free for download and use as stated within the site.

The USAUDIT is a brief screening questionnaire used by health care and human service practitioners in clinical settings to identify individuals using alcohol in a harmful way and may be administered as a self-report questionnaire, an oral interview, or a computer-administered survey. Based upon the 10 question-Alcohol Use Disorders Identification Test (AUDIT) developed by the World Health Organization, the first 3 questions are adjusted for the standard U.S. drink (Centers for Disease Control and Prevention, 2014), recommended drinking limits (National Institute on Alcohol Abuse and Alcoholism, 2007), and definitions of alcohol use disorder (AUD), according to the International Classification of Diseases, 10th Revision, and the Diagnostic and Statistical Manual, 5th Edition.

Administering the USAUDIT-C (the first 3 questions of the USAUDIT) to all patients will identify those patients whose alcohol consumption exceeds low-risk levels for healthy adults (70-90 percent of primary care patients have negative results to these questions and require no additional time or follow-up) by measuring patients' weekly consumption and occasions of excessive alcohol consumption. Patients who score positive on the USAUDIT-C should complete the remaining 7 questions (completed most efficiently by having the patient use a paper form) for full USAUDIT completion, and the total USAUDIT score calculated and used to guide the practitioner in discussing the patient-reported alcohol use with the patient. For the USAUDIT-C, a total score of 7 or more for women and men over the age of 65, and a total score of 8 or more for males (under the age of 65) is a positive risk indicator.

Despite the guide focus on primary care settings, the authors note that "practitioners in other medical and human service settings, such as obstetrics-gynecology clinics … may find the content useful as well." Screening for alcohol use allows practitioners to engage in conversations with patients regarding alcohol-related health problems and the adverse effect of alcohol on conditions such as high blood pressure, diabetes, obesity, depression, sleep disorders, etc. In conversations with patients about alcohol-related health problems, providers can discuss the irreversible, lifelong birth and development effects of fetal alcohol spectrum disorders.

A team of academic researchers reviewed the literature and concluded that the AUDIT and its abbreviated versions have demonstrated effectiveness in different populations and alcohol consumption ranges, but that little research has focused on detection among adolescents. Cortes-Tomas et al. published a journal article in Drug and Alcohol Dependence (2016) that indicated the AUDIT and AUDIT-C were adequate to identify binge drinking, and discussed the optimal cutoff scores for the AUDIT and AUDIT-C when used, in an adolescent population, and differences in sensitivity when the sample was divided by gender. For the AUDIT-C, the optimal cutoff score for identification in the adolescent population was the score indicating a positive result for adult women.

Babor T et al. 2016. USAUDIT. The Alcohol Use Disorders Identification Test, adapted for use in the United States: A guide for primary care practitioners. Guide prepared by JBS International, Inc. under contract no. HHSS2832012000021/HHss28342003T (SAMHSA/CSAT) and grant no. 5P60AA003510-36 (NIAAA). USAUDIT and USAUDIT-C may be reproduced and used without permission or cost by medical and human service practitioners in clinical settings. Cortes-Tomas MT et al. 2016. Different versions of the Alcohol Use Disorders Identification Test (AUDIT) as screening instruments for underage binge drinking. Drug Alcohol Depend; 158: 52-59.

The Patient Health Questionnaire-9 item was modified for adolescents and is available as the Patient Health Questionnaire for Adolescents (PHQ-A), a self-administered tool, validated for assessing mood disorders in the adolescent population. The Center for Adolescent Substance Abuse Research (© Children's Hospital Boston, 2009) developed the CRAFFT, a 6-question, self-administered screening tool developed to screen adolescents

for high risk alcohol and other substance use. The National Institute on Drug Abuse recently launched 2 evidence-based online screening tools for providers to use to assess substance use disorder risk amongst adolescents aged 12-17, the Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD) and the Screening to Brief Intervention (S2BI). These tools may be self-administered or completed by a clinician in under 2 minutes.

National Institute on Drug Abuse, Accessed October 2017: https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults and https://www.drugabuse.gov/news-events/news-releases/2017/11/nida-launches-two-adolescent-substance-use-screening-tools. Johnson JG et al. 2002. The Patient Health Questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health; 30: 196-204.

The Drug Abuse Screening Test (DAST-10) is a 10-item, screening tool that can be self-administered or administered by a clinician and may be completed in less than 8 minutes. The DAST-10 assesses substance use (including cannabis and prescribed or over-the-counter medications, excluding alcohol or tobacco) in the past 12 months. A total score for all the questions indicates a degree of problems related to drug use, and a suggested action of "further investigation" is indicated when the total score is 3-5.

National Institute on Drug Abuse, Accessed October 2017: https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults and https://www.drugabuse.gov/sites/default/files/dast-10.pdf. Skinner HA. 1982. The Drug Abuse Screening Test. Addict Behav; 7: 363-71.

For older adults, there are several tools available to help health care providers identify older adults who have symptoms of depression or are at-risk of alcohol use disorder. The Geriatric Depression Scale (GDS), a 15-item screening tool for depression in older adults, and the Short Michigan Alcoholism Screening Test, Geriatric Version (S-MAST-G), a 10-item screening tool for assessing alcohol use, have been validated in the older adult population.

Substance Abuse and Mental Health Services Administration and Administration on Aging. 2013. Older Americans Behavioral Health. Issue Brief 6: Depression and Anxiety. https://www.ncoa.org/resources/issue-brief-6-depression-and-anxiety-screening-and-intervention/ and Substance Abuse and Mental Health Services Administration and Administration on Aging. 2012. Older Americans Behavioral Health. Issue Brief 3: Screening and Preventive Brief Interventions for Alcohol and Psychoactive Medication Misuse/Abuse. https://www.ncoa.org/resources/issue-brief-3-screening-and-preventive-brief-interventions-for-alcohol-and-psychoactive-medication-misuseabuse/ Conigliaro J et al. 2000. Screening and identification of older adults with alcohol problems in primary care. J Geriatr Psychiatry Neurol; 13: 106-114.

STANDARDIZED SCREENING FOR HEALTH-RELATED SOCIAL NEEDS

A team from the Centers for Medicare and Medicaid Services published a discussion paper emphasizing the importance of standardized screening for health-related social needs in clinical settings to address the critical gaps existing between clinical care and community services. Moreover, the published discussion paper provided access to the Accountable Health Communities Health-Related Social Needs (AHC HRSN) screening tool that was developed by a technical expert panel following review of 50 screening tools, comprising over 200 questions and offering the opportunity for standardization in the screening for health-related social needs. The tool was designed to be readily understandable to the broadest audience, across a variety of settings, and allow for inclusion of routine screening in a busy clinical workflow. Medicare and Medicaid beneficiaries represent a diverse subset of the population; all ages, backgrounds and environments (urban and rural) are represented. As such, the tool had to be accessible to beneficiaries regardless of language, literacy level, or disability status. Self-administration of the screening tool was considered during the development of the tool by the Technical Expert Panel (TEP); the final recommended screening tool was designed to reduce the need for outside assistance. The tool was intended to be completed by the individual respondent or by a parent / caregiver on the individual's behalf.

INTERPERSONAL SAFETY

The Hurt, Insult, Threaten, and Scream (HITS) assessment tool, validated in multiple settings around the world for use as a self-report or clinician-administered tool to identify intimate partner violence among women and

men, was adapted by the technical expert panel to broaden the scope of the assessment for interpersonal safety beyond intimate partner violence by editing the answer options to say "anyone, including family" instead of "your partner." A total score of greater than 10 indicates the individual is experiencing, or at risk of experiencing, interpersonal violence.

Billioux A et al. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Perspectives; National Academy of Medicine: 1-9.

HOUSING STABILITY

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) assessment tool (developed by the National Association of Community Health Centers) includes questions designed to assess housing insecurity. The technical expert panel adapted the question from the PRAPARE assessment to modify the first answer option, that identifies individuals who are homeless, to be consistent with the federal definition of homeless. The second answer option is intended to identify individuals who are at risk of losing their housing, including inability to afford a mortgage of rent; as a result, selecting either answer option 1 or option 2 would indicate the individual is experiencing, or at risk of experiencing, a housing need (housing insecurity).

Billioux A et al. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Perspectives; National Academy of Medicine: 1-9.

FOOD SECURITY

The Hunger Vital Sign™, 2-question screening tool, with established sensitivity, specificity, and validity amongst low-income families with young children and recommended for universal screening by the American Academy of Pediatrics and contained within the 18-question USDA U.S. Household Food Security Survey, was only adapted by the technical expert panel to match the voice of the other questions included within the screening tool. Selection of "often true" or "sometimes true" for either of the 2 questions would indicate the individual is experiencing, or at risk of experiencing, a food need (food insecurity).

Billioux A et al. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Perspectives; National Academy of Medicine: 1-9.

PRAPARE TOOL

The Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) assessment tool was designed by the National Association of Community Health Centers and partners (© 2016) to collect data on the social determinants of health in order to support providers in identifying upstream factors that hold the potential to negatively impact health outcomes and health care expenditures. The PRAPARE tool, version 1.0 (2016), is an 8-page, 21-question tool; for the purposes of the Women's Health Initiative, the PRAPARE tool's housing questions would count for the housing instability screening component of the WHI, but it is recommended for the food insecurity and interpersonal violence domains that the AHC HRSN tools referenced above are used. The PRAPARE tool does not include questions for the screening of mental health and substance use disorders that are consistent with the intent of the WHI.

http://www.nachc.org/wp-content/uploads/2016/09/PRAPARE_Paper_Form_Sept_2016.pdf; the PRAPARE tool and its resources are proprietary information and may not be published, copied or distributed, in part or in whole, without prior written consent.

ASSESSING TRAUMA

The Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol (TIP 57) indicates that exposure to trauma is common, rates of exposure to trauma are higher among clients with mental or substance use disorders, and mental and substance use disorders are often more difficult to treat if trauma-related symptoms are not detected and treated effectively. Screening, early identification, and intervention serves as a prevention strategy as undetected trauma histories and related symptoms may negatively affect factors that impact health outcomes, such as engagement in treatment and relapse rate. As a result, the Women's Health Initiative has incorporated assessment for trauma into the initiative when an initial screen indicates a positive result for any of the domains identified above, excluding pregnancy intention. Treatment Improvement Protocol (TIP) 57 and SAMHSA provide general guidance for trauma-informed screening and assessment processes in primary care. The guidance includes general rules and methods for introducing trauma-informed screening and assessments, and describes the overall process, including screening, assessment, treatment / referral to more intensive services, and follow-up. There are numerous tools (ACES, PC-PTSD) that screen for trauma; the purpose of screening and the population to be assessed are essential for determining the appropriate tool to use.

SAMHSA. 2014. Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series; No. 57. Prins A et al. The Primary Care PTSD Screen (PC-PTSD): Development and operating characteristics. Primary Care Psychiatry. 2004; 9:9–14, van Dam D et al. 2010. Validation of the Primary Care Posttraumatic Stress Disorder screening questionnaire (PC-PTSD) in civilian substance use disorder patients. J Subst Abuse Treat; 39: 105-113. Felitti VJ et al. 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) study. Am J Prev Med; 14: 245-258. Clinical assessment tools for children and adolescents available at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Clinical-Assessment-Tools.aspx

ASSESSING SUICIDALITY

The Patient Health Questionnaire-9 item is a frequently utilized tool for screening patients in a primary care setting. Of the 9 items, one question, item 9, may be used to screen for suicide risk. The question asks, "Over the past two weeks, have you been bothered by … thoughts that you would be better off dead or of hurting yourself in some way." The response given to item 9 of the PHQ-9 has been shown to be a moderate predictor of subsequent suicide death and may be used to identify individuals at increased risk of suicide attempt or death, with cumulative risk continuing to increase over a period of time. When the Patient Health Questionnaire-2 item is used exclusively, a patient could answer "no" to both questions but still be experiencing suicidality. Simon et al. examined the association between thoughts of death or self harm, as reported by responses to item 9 of the Patient Health Questionnaire, and the risk of suicide attempt or suicide death in the following 2 years. Rates of suicide attempt and suicide death increased with escalating responses to item 9; however, over 1/3 of suicide attempts and deaths occurred among those responding, "not at all." The Zero Suicide in Health and Behavioral Health Care toolkit states the wording of item 9 is "somewhat indirect" and advises organizations to consider adding a more direct question about suicide to the PHQ-2 and substituting the more direct question for item 9 in the PHQ-9. The toolkit provides the example of: "Over the past two weeks, have you been bothered by … thoughts that you want to kill yourself, or have you attempted suicide?" Zero Suicide in Health and Behavioral Health Care provides general guidance for screening and assessment processes in primary care. Under the screening section, additional screening tools, such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the SAFE-T are discussed in depth. Additionally, the toolkit includes guidance for introducing a Zero Suicide approach into an organization and describes the overall framework, including the core components of training staff in suicide care, identifying individuals with suicide risk through comprehensive screenings, engaging at-risk individuals in a suicide care management plan, treating individuals with suicidal thoughts or behavior through evidence-based interventions, transitioning individuals through levels of care with warm hand offs and support, and using continuous quality improvement to improve organizational policies and procedures. A full assessment of suicide risk involves gathering complete information regarding past, recent and present suicidal ideation and behavior, gathering information about a

patient's history and context, and using this information to create a prevention-oriented suicide risk formulation, anchored in the patient's life. These components are essential for providing the foundation for treatment planning. Evidence-based interventions, designed for targeting suicide risk directly, with demonstrated effectiveness for reducing suicidal thoughts and behaviors are: non-demand "caring contacts," structured, problem-solving therapies, and collaborative assessment and treatment planning. Whichever model is chosen, the intervention should be person-centered, collaborative, and acknowledge the ambivalence often cited by individuals contemplating suicide.

Simon GE et al. 2016. Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice. J Clin Psychiatry; 77: 221-227. Simon GE et al. 2013. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? Psychiatr Serv; 64: 1195-1202. Patient Health Questionnaire-9 adapted from phqscreeners.com; terms for the PHQ Screeners indicate the content is expressly exempted from Pfizer's general copyright restrictions and that content on the PHQ Screeners site is free for download and use as stated within the site. Zero Suicide in Health and Behavioral Health Care toolkit: Screening for and Assessing Suicide Risk. https://zerosuicide.sprc.org/toolkit

Women's Health Initiative

Adapted from One Key Question®, Vermont SBIRT, Alcohol Use Disorders Identification Test (USAUDIT-C), Patient Health Questionnaire (PHQ-2), & Accountable Health Communities Health-Related Social Needs Screening Tools

Name:	**DOB:**	**Today's Date:**

Once a year, all of our patients are asked to complete this form, and answer questions about medications currently being taken, because these factors can all affect health. Please help us provide you with the best medical care by answering the questions below.

One Key Question®

Would you like to become pregnant in the next year?	**Yes** or **Ok, Either Way**		**Unsure**	**No**		

Patient Health Questionnaire-2

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

Little interest or pleasure in doing things	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**		
Feeling down, depressed or hopeless	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**		

VT SBIRT

Do you use tobacco products?	**Yes**		**Sometimes**	**No**		

USAUDIT-C Questionnaire

Think about your drinking in the past year. A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

How often do you have a drink containing alcohol?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**2-3 times a week**	**4-6 times a week**	**Daily**
How many drinks containing alcohol do you have on a typical day you are drinking?	**1 drink**	**2 drinks**	**3 drinks**	**4 drinks**	**5-6 drinks**	**7-9 drinks**	**10 or more drinks**
How often do you have 4 or more drinks on one occasion?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**2-3 times a week**	**4-6 times a week**	**Daily**

VT SBIRT

How often have you used marijuana in the past year? (including smoking, vaping, dabbing, or edibles)	**Never**	**Monthly or less**	**Several days per month**	**Weekly**	**Several days per week (2-4 days/wk)**	**Daily Almost Daily (5-7 days/wk)**
How often in the past year have you used prescription medications that were not prescribed to you?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**
How often in the past year have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**
How often in the past year have you used other drugs (for example, heroin, cocaine, salvia, inhalants)?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**

AHC HRSN					
How often does anyone, including family, physically hurt you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
How often does anyone, including family, insult or talk down to you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
How often does anyone, including family, threaten you with harm?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
How often does anyone, including family, scream or curse at you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
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**
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**
What is your housing situation today? □ **I do not have housing (I am 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.** □ **I have housing today, but I am worried about losing housing in the future.** □ **I have housing.**					
Do you have any urgent issues you would like to discuss today?	**Yes**		**Unsure**		**No**

Women's Health Initiative

Adapted from One Key Question®, Vermont SBIRT, Alcohol Use Disorders Identification Test (USAUDIT-C), Patient Health Questionnaire (PHQ-2), & Accountable Health Communities Health-Related Social Needs Screening Tools

Name:	**DOB:**	**Today's Date:**

Once a year, all of our patients are asked to complete this form, and answer questions about medications currently being taken, because these factors can all affect health. Please help us provide you with the best medical care by answering the questions below.

One Key Question®

Would you like to become pregnant in the next year?	**Yes** or **Ok, Either Way**	**Unsure**	**No**	

Patient Health Questionnaire-2 and 9

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

Little interest or pleasure in doing things	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling down, depressed or hopeless	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Thoughts that you would be better off dead or of hurting yourself in some way	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**

VT SBIRT

Do you use tobacco products?	**Yes**	**Sometimes**	**No**

USAUDIT-C Questionnaire

Think about your drinking in the past year. A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

How often do you have a drink containing alcohol?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**2-3 times a week**	**4-6 times a week**	**Daily**
How many drinks containing alcohol do you have on a typical day you are drinking?	**1 drink**	**2 drinks**	**3 drinks**	**4 drinks**	**5-6 drinks**	**7-9 drinks**	**10 or more drinks**
How often do you have 4 or more drinks on one occasion?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**2-3 times a week**	**4-6 times a week**	**Daily**

VT SBIRT

How often have you used marijuana in the past year? (including smoking, vaping, dabbing, or edibles)	**Never**	**Monthly or less**	**Several days per month**	**Weekly**	**Several days per week (2-4 days/wk)**	**Daily Almost Daily (5-7 days/wk)**
How often in the past year have you used prescription medications that were not prescribed to you?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**
How often in the past year have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**
How often in the past year have you used other drugs (for example, heroin, cocaine, salvia, inhalants)?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**

AHC HRSN					
How often does anyone, including family, physically hurt you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
How often does anyone, including family, insult or talk down to you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
How often does anyone, including family, threaten you with harm?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
How often does anyone, including family, scream or curse at you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**
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**
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**
What is your housing situation today? □ **I do not have housing (I am 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.** □ **I have housing today, but I am worried about losing housing in the future.** □ **I have housing.**					
Do you have any urgent issues you would like to discuss today?	**Yes**		**Unsure**		**No**

Women's Health Initiative

Adapted from One Key Question®, Vermont SBIRT, Alcohol Use Disorders Identification Test (USAUDIT-C),
Patient Health Questionnaire (PHQ-2), & Accountable Health Communities Health-Related Social Needs Screening Tools

Name: **DOB:** **Today's Date:**

Once a year, all of our patients are asked to complete this form, and answer questions about medications currently being taken, because these factors can all affect health. Please help us provide you with the best medical care by answering the questions below.

One Key Question®

Would you like to become pregnant in the next year?	**Yes or Ok, Either Way**	**Unsure**	**No**
	Preconception Care	Both	CFPC

Patient Health Questionnaire-2 and 9

Over the past 2 weeks, how often have you been bothered by any of the following problems?	0	1	2	3
Little interest or pleasure in doing things	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling down, depressed or hopeless	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	A total score of 3 or more: PHQ-9			
Thoughts that you would be better off dead or of hurting yourself in some way	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	Full assessment of suicide risk			

VT SBIRT

Do you use tobacco products?	**Yes**	**Sometimes**	**No**
	Yes or Sometimes: Refer to Tobacco Cessation		

USAUDIT-C Questionnaire

Think about your drinking in the past year. A drink means one beer, one small glass of wine (5 oz.), or one mixed drink containing one shot (1.5 oz.) of spirits.

	0	1	2	3	4	5	6
How often do you have a drink containing alcohol?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**2-3 times a week**	**4-6 times a week**	**Daily**
How many drinks containing alcohol do you have on a typical day you are drinking?	**1 drink**	**2 drinks**	**3 drinks**	**4 drinks**	**5-6 drinks**	**7-9 drinks**	**10 or more drinks**
How often do you have 4 or more drinks on one occasion?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**2-3 times a week**	**4-6 times a week**	**Daily**
	A total score of 7 or more: USAUDIT Questionnaire (10 item)						

VT SBIRT						
How often have you used marijuana in the past year? (including smoking, vaping, dabbing, or edibles)	**Never**	**Monthly or less**	**Several days per month**	**Weekly**	**Several days per week (2-4 days/wk)**	**Daily Almost Daily (5-7 days/wk)**
	"Weekly," or more frequently, clinician's discretion: DAST-10					
How often in the past year have you used prescription medications that were not prescribed to you?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**
How often in the past year have you taken your own prescription medication more than the way it was prescribed or for different reasons than its intended purpose?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**
How often in the past year have you used other drugs (for example, heroin, cocaine, salvia, inhalants)?	**Never**	**Monthly or less**	**2-4 times per month**		**2-3 times per week**	**4 or more times per week**
	"Monthly or less," or more frequently: DAST-10					
AHC HRSN	1	2	3	4	5	
How often does anyone, including family, physically hurt you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**	
How often does anyone, including family, insult or talk down to you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**	
How often does anyone, including family, threaten you with harm?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**	
How often does anyone, including family, scream or curse at you?	**Never**	**Rarely**	**Sometimes**	**Fairly often**	**Frequently**	
	A total score of greater than 10: CHT and/or Advocacy Services					
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
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
	Often True or Sometimes True for either question: CHT for Food Need					
What is your housing situation today? □ **I do not have housing (I am 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.** □ **I have housing today, but I am worried about losing housing in the future.** □ **I have housing.**						
	Selection of Option 1 or 2: CHT for Housing Need					
Do you have any urgent issues you would like to discuss today?	**Yes**		**Unsure**		**No**	