NEXT STEPS

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2016

Complete Implementation & Action Toolkit

Spread

Phase II

Including:
* Free EHR Templates—by May
* Training Materials—by this summer
* Model Interventions to Address the SDH—by this summer

Including:
* Standardized data on Interventions
• National PRAPARE Learning Network
• State Based Action groups
* Validation
* Translation
* Pediatric PRAPARE Tool

RESOURCES AVAILABLE TO YOU

PRAPARE resources: www.nachc.com/research
- PRAPARE Tool
- Implementation steps and timeline
- Data Documentation

AAPCHO's ESAP technical and other resources at http://enablingservices.aapcho.org.

PRAPARE info and listserv signup: Michelle Jester, mjester@nachc.org

AAPCHO ESAP technical assistance: Heather Skrabak, hskrabak@aapcho.org

PRAPARE EHR-SPECIFIC WEBINARS

- eClinical Works: June 15th
- Epic: June 23rd
- NextGen: June 28th
- GE Centricity: June 29th
- Email Michelle mjester@nachc.org if interested

- Will cover the following:
  - Steps to implement EHR template in another clinic's EHR system
  - The particulars of using the PRAPARE template
  - A health center's experience in redesigning or modifying workflow to collect and respond to the data on social determinants
  - How the PRAPARE template can expedite the reporting and aggregation of data and be used for patient and population-level interventions

THANK YOU!

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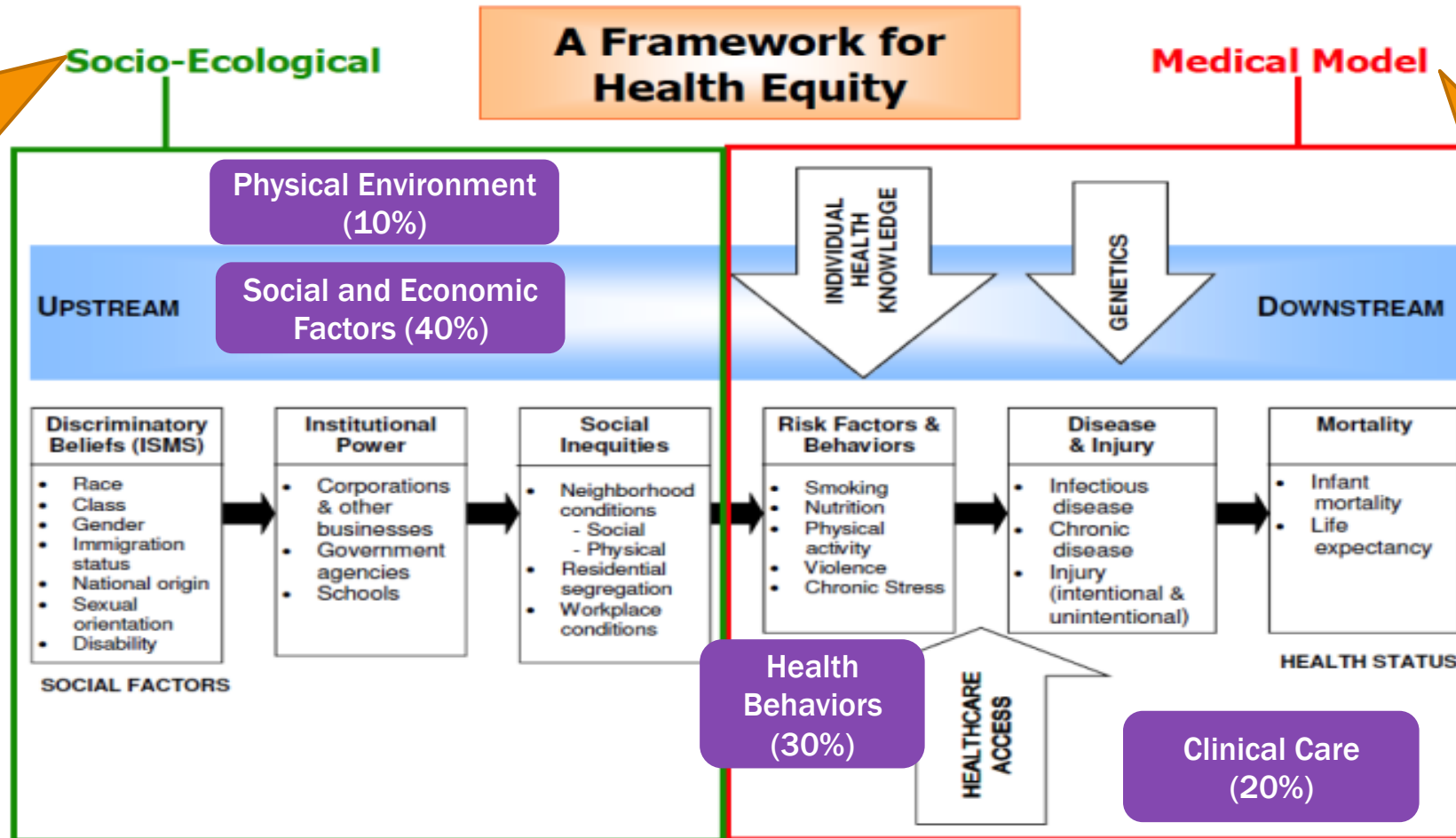
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QUESTIONS AND DISCUSSION

- **End of presentation**

WHAT IS DRIVING THE NEED TO COLLECT DATA ON THE SOCIAL DETERMINANTS OF HEALTH (SDH)?

Figure 1

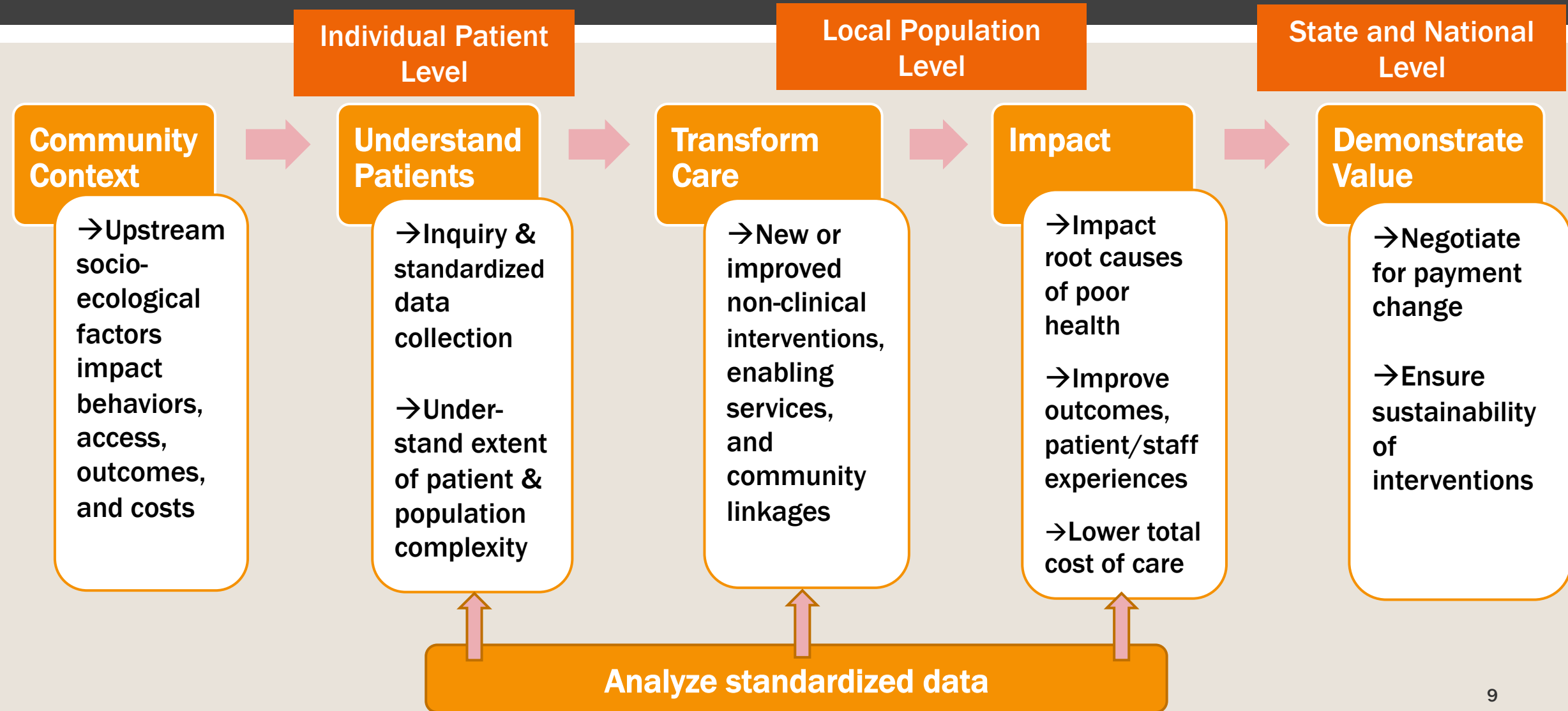**A Framework for Health Equity**

Socio-Ecological

Medical Model

How well do we know our patients?

Are services addressing SDH incentivized and sustainable?

Are community partnerships adequate and integrated?

Physical Environment (10%)

Social and Economic Factors (40%)

UPSTREAM

DOWNSTREAM

INDIVIDUAL HEALTH KNOWLEDGE

GENETICS

Discriminatory Beliefs (ISMS)	Institutional Power	Social Inequities	Risk Factors & Behaviors	Disease & Injury	Mortality

• Race
• Class
• Gender
• Immigration status
• National origin
• Sexual orientation
• Disability
	• Corporations & other businesses
	• Government agencies
	• Schools
		• Neighborhood conditions
		  - Social
		  - Physical
		• Residential segregation
		• Workplace conditions
			• Smoking
			• Nutrition
			• Physical activity
			• Violence
			• Chronic Stress
				• Infectious disease
				• Chronic disease
				• Injury (intentional & unintentional)
					• Infant mortality
					• Life expectancy

SOCIAL FACTORS

HEALTH STATUS

Health Behaviors (30%)

HEALTHCARE ACCESS

Clinical Care (20%)

Bay Area regional Health Inequities Initiative (BARHII). 2008. "Health Inequities in the Bay Area", accessed November 28, 2012 from http://barhii.org/resources/index.html.

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FROM DATA TO PAYMENT: CONNECTING THE DOTS

Individual Patient Level

Local Population Level

State and National Level

Community Context
→Upstream socio-ecological factors impact behaviors, access, outcomes, and costs

Understand Patients
→Inquiry & standardized data collection

→Under-stand extent of patient & population complexity

Transform Care
→New or improved non-clinical interventions, enabling services, and community linkages

Impact
→Impact root causes of poor health

→Improve outcomes, patient/staff experiences

→Lower total cost of care

Demonstrate Value
→Negotiate for payment change

→Ensure sustainability of interventions

Analyze standardized data

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VALIDATING THE TOOL

Selected questions to measure SDH domains

- Pulled from existing validated questions when possible (few validated questions exist)

Questions Reviewed by Health Literacy Expert

- To ensure language matched common reading levels

Performed Cognitive Testing on Questions

- Each pilot site performed cognitive testing with at least 10 patients

Pilot Tested Questions

- Revised as necessary after pilot testing

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE for Implementation As of March 14, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	Other (please write)		I choose not to answer this question

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

	English
	Language other than English (please write)
	I choose not to answer this question

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?

Street:_____

City, State, Zipcode: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

For more information about this tool, please contact Michelle Jester at miester@nachc.org or visit the "Social

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THE KRESGE FOUNDATION   KAISER PERMANENTE.   blue of california foundation

NATIONAL ASSOCIATION OF Community Health Centers   AAPCHO   OPCA Oregon Primary Care Association   Institute for Alternative Futures

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

	I choose not to answer this question

14. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
		I choose not to answer this question			

Social and Emotional Health

15. How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week		1 or 2 times a week
	3 to 5 times a week		5 or more times a week
	I choose not to answer this question		

16. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

17. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this question

18. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

19. Are you a refugee?

	Yes		No		I choose not to answer this question

20. What country are you from?

	United States	Country other than the United States (please write):

21. Do you feel physically and emotionally safe where you currently live?

	Yes		Unsure
	No		I choose not to answer this question

22. In the past year, have you been afraid of your partner or ex-partner?

	Yes		Unsure
	No		I have not had a partner in the past year
	I choose not to answer this question		

EXAMPLES OF NEXTGEN TEMPLATES

SDOH Survey Template

`F` [Refresh]

Personal Characteristics

1. Are you Hispanic or Latino?
   Declined to specify — *EPM Demographics - Ethnicity*

2. Which race(s) are you?
   Hawaiian Part-Hawaiian — *EPM Demographics - Race*
Race
Hawaiian Part-Hawaiian

3. At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?
   Enter data in EPM Patient Information Screen

4. Have you been discharged from the armed forces of the United States?
   `U` *EPM UDS - Veteran Status*

5. What language are you most comfortable speaking?
   Filipino-Tagalog — *EPM Demographics - Preferred Language*

Family & Home

6. How many family members, including yourself, do you currently live with?
   Enter data in EPM Patient Information Screen

7. What is your housing situation today?
   Enter data in EPM Patient Information Screen

8. What address do you live at? (include street and zipcode)
   IPA ST — *EPM Demographics - Line 1 - Billing Address 1*
   Line 2 - Sec Street Address1
   City, Zip
   WAIANAE 96792

Money and Resources

9. What is the highest level of school that you have finished?
   High School/GED
   PRAPARE Survey Responses — *Social Hx template field auto populates based on PRAPARE response*

10. What is your current work situation?
    employed

    How many hours per week do you work?

    How many jobs do you work?

11. What is your main insurance?
    QUEST OHANA — *EPM - Primary Insurance (listed 1st in insurance list)*

    Do you have insurance through your job? ○ Yes ○ No

12. During the past year, what was the total combined income for you and the family members you live with?
    Enter data in EPM Patient Information Screen

13. In the past year, have you or any family members you live with been <u>unable</u> to get any of the following when it was <u>really needed</u>? Check all that apply.

☐ Check "No" To All

○ Yes	○ No	Food	○ Yes	○ No	Clothing
○ Yes	○ No	Utilities	○ Yes	○ No	Rent/Mortgage payment
○ Yes	○ No	Transportation	○ Yes	○ No	Child care
○ Yes	○ No	Medicine or medical care	○ Yes	○ No	Phone
○ Yes	○ No	Health Insurance	○ Yes	○ No	Other (please specify) [ ]

Social and Emotional Health

14. How often do you see or talk to people that you care about and feel close to?
Ex. Talking to friends on the phone, visiting, attending church or meetings.

[   ]

15. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

[   ]

Who are the people or groups you usually see or talk to during stressful times?

[   ] (ex. family, friends, church group, etc...)

Optional Questions

16. In the past year have you spent more than 2 nights in jail, prison, detention center or juvenile correctional facility?

○ Yes   ○ No   ○ Choose not to answer

If yes, what was your release date?

[/ /]

17. Has lack of transportation kept you from medical appointments or from getting your medications?

○ Yes   ○ No

Omitting Q17 - refugee & Q18 - country

20. Do you feel physically and emotionally safe where you currently live?

○ Yes   ○ No   ○ Unsure

21. In the past year, have you been afraid of your partner or ex-partner?

[   ]

Summary: «

Interactions: ⚠️ ✎

📋 Forms   📄 Text

Forms   Add...

📰 PRAPARE

Attachments   Add...

➕ Order ➕ Medication ➕ Problem

| Sociodemographic/Socioeconomic | **Money and Resources** | Psychosocial Assets |

PRAPARE   DOB: 07/30/1957   Patient Age: 58 Years Old

Money and Resources

Add to Note ☑

Previous

9th-12th grade (07/08/2014)

What is the highest level of school that you have finished? 9th-12th grade ▼

Add Underachievement in School (Z55.3) to Prob List

Employed? ⦿ Yes ○ No   Your current work situation? ⦿ FT ○ PT

Insurance: Alohacare

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

○ I choose not to answer

Detailed Insecurities:

Food:	○ Yes ⦿ No		Clothing	○ Yes ⦿ No
Utilities:	⦿ Yes ○ No		Rent/Mortgage payment	⦿ Yes ○ No
Transportation:	○ Yes ⦿ No		Child care:	⦿ Yes ○ No
Medicine or medical care:	○ Yes ⦿ No		Phone:	○ Yes ⦿ No
Health insurance:	○ Yes ⦿ No		Other:	○ Yes ⦿ No

Add Inadequate housing (Z59.1) to Prob List

Add Other prob rel. to housing and econ. circ. (Z59.8) to Prob List

Orders   **Care Management Plan**   **Care Coordination**

Prev Form (Ctrl+PgUp)   Next Form (Ctrl+PgDn)

ALLIANCE OF CHICAGO
Community Health Services, L3C

USING DATA ON THE SOCIAL DETERMINANTS OF HEALTH

COMMON CHALLENGES ENCOUNTERED WHEN USING PRAPARE AND SOLUTIONS

Challenge: Staff and Patients Don't Understand Why Doing PRAPARE

Solution: Use short script to explain to staff & patients why health center is collecting this information. Message around better understand patient and patient's needs to provide better care

Challenge: Have too much going on now to add another project

Solution: Don't market PRAPARE as new big initiative but as project that aligns with other work already doing (care management, ACO, enabling services, etc)

Challenge: How do we implement this without increasing visit time?

Solution: Find "Value-Added" time, whether in waiting room, during rooming process, or after clinic visit

Challenge: Fitting PRAPARE into Workflow

Solution: Incorporate into other assessments to encourage completion (Health Risk Assessment, Depression Screening, Patient Activation Measure, etc)

Challenge: Inability to Address SDH

Solution: Message "Have to start somewhere and do the best we can with what we have. Collecting information will help us figure out what services to provide."

HOW CAN PRAPARE BE USED AT YOUR ORGANIZATION?

IMPLEMENTING PRAPARE:
USING THE FIVE RIGHTS FRAMEWORK

Right Information

- How will tool be administered to the patient to ensure that it accurately identifies the SDH the patient may have?

Right Person

- Who will collect the data and who will address the social determinants identified?

Right Intervention Format

- How will resource information be organized so that it is readily available and standardized for all?

Right Channel

- How is the appropriate care team member notified to address the SDH identified?

Right Time in Workflow

- When in the patient visit does it make sense to administer the tool and when is the best time to address identified SDH?

SAMPLE WORKFLOWS

Health Center	Who	Where	When	How	Rationale
CHC #1	Non-clinical staff (enrollment assistance)	In exam room	Before provider visit	Administered PRAPARE with patients who would be waiting 30+ mins for provider	Provided enough time to discuss SDH needs
CHCs #2	Nursing staff and/ or MAs	In exam room	Before provider enters exam room	Administered it after vitals and reason for visit. Provider reviews PRAPARE data and refers to case manager	Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info
CHC #3	Non-clinical staff (patient navigators, patient advocates, and community health workers)	In patient advocate's office	After clinical visit when provider refers patient to patient navigator	Patient advocates administer it and then can relay to provider in office next door.	Wanted same person to ask question and address need. Often administer PRAPARE with other data collection effort (Patient Activation Measure) to assess patent's ability and motivation to respond to their situation.
CHC #4	Medical Assistants	In exam room	Before provider	MAs administer PRAPARE while patient is roomed but before provider.	Want to get patient in to exam room as quickly as possible. However, often don't finish because provider comes in to exam room.
CHC #5	Care Coordinators	No wrong door approach	No wrong door approach, but mostly as care coordinators complete chart review and HRA		Allows staff to address similar issues in real time that may arise from both PRAPARE and HRA

HOW PRAPARE DATA HAS BEEN USED TO IMPROVE CARE DELIVERY AND HEALTH OUTCOMES

Better Understand INDIVIDUAL Patient's Socioeconomic Situation

- Ensure prescriptions and treatment plan match patient's socioeconomic situation
- Refer patients to needed social services, whether in-house or through community partnership
- Build services in-house for same-day use as clinic visit (children's book corner, food banks, clothing closets, wellness center, transportation shuttle, etc)

Better Understand Needs of Patient POPULATION

- Build partnerships with local community based organizations to offer bi-directional referrals and discounts on services (ex: Iowa transportation)
- Streamline and expand care management plans to better allocate resources to areas most in need
- Improve Community Resource Guide to ensure accuracy and appropriateness
- Guide work of local foundations to pay for non-clinical services and partnerships
- Inform advocacy efforts related to local policies around SDH

Drive STATE and NATIONAL Care Transformation

- Inform both Medicaid and Medicare ACO discussions and care management policies
- Inform payment reform and APM discussions with state agencies (e.g., Medicaid) on caring for complex patients
- Create risk score to inform risk adjustment
- Guide policies to incentivize integrated care with social services

Education

Why Is Education Important?

Education is a widely used measure of socio-economic status and is a significant contributor to health and prosperity. Higher education is associated with longer life-span and fewer chronic conditions. Parental education is a determinant of child health outcomes.

	Sample Needs Related to Education*		
Clinical Related Needs	• Illiteracy and low-level literacy (ICD-10: Z55.0)	• Educational maladjustment and discord with teachers and classmates (ICD-10: Z55.4)	
Non-Clinical Related Needs	• Underachievement in School (ICD-10: Z55.3)	• Failed School Examinations (ICD-10: Z55.2)	• Need skills for job
	• Have skills needed for job but need U.S. certification/ accreditation	• Schedule Problems (can't go to school due to work schedule or lack of child care)	• Other problems related to education and literacy (ICD-10: Z55.8)
Community Related Needs	• Schooling unavailable or unattainable (ICD-10: Z55.1)	• Poor quality schools	• Poor quality teachers
	* Please note that this list is not exhaustive but only includes common examples of needs.		

Ways to Address Education Risk in a CLINICAL Setting

- Ensure prescriptions match patient's literacy level
- Check truancy issues in clinic; encourage youth to stay in school
- Provide books after pediatric check-ups and encourage caregivers or older siblings to read to/with younger members of the family

Simple, Low-Cost Ways to Ameliorate Education Risk in a NON-CLINICAL Setting

- Offer or refer patient to courses for language, math, reading, financial literacy, computer skills, and art

APPENDIX A – RESOURCES

IDENTIFYING AND CONNECTING PEOPLE TO COMMUNITY RESOURCES AND SERVICES

2-1-1

Developed By: United Way

Free and confidential service that helps people across the U.S. find the local resources they need related to health, food, disaster assistance, housing, jobs, reentry, human trafficking, crisis and emergency, and veterans. It is accessible 24 hours a day, 7 days a week in all languages through phone or web.

Geographic Availability: U.S.

Cost: Free

http://www.211.org/

COMMUNITY HEALTH CORPS

Developed By: Community Health Corps

National Americorps program that funds members in full-time positions at health centers to perform a variety of activities associated with health services and programs for patients and the community, often by functioning as community health workers.

Geographic Availability: In 17 states and Washington, DC

Cost: Application to begin program but members funded by Community HealthCorps

http://www.communityhealthcorps.org/ToolsforProgram%20Staff.cfm

HEALTHIFY

Developed By: Healthify

Leading software solution for healthcare and community services addressing the social determinants of health. Provides extensive database that allows user to easily identify and access community resources available within certain radius and service's eligibility requirements

ASSESS WHERE YOU ARE IN TERMS OF RESOURCES (PEOPLE, PROCESSES, TECHNOLOGY)
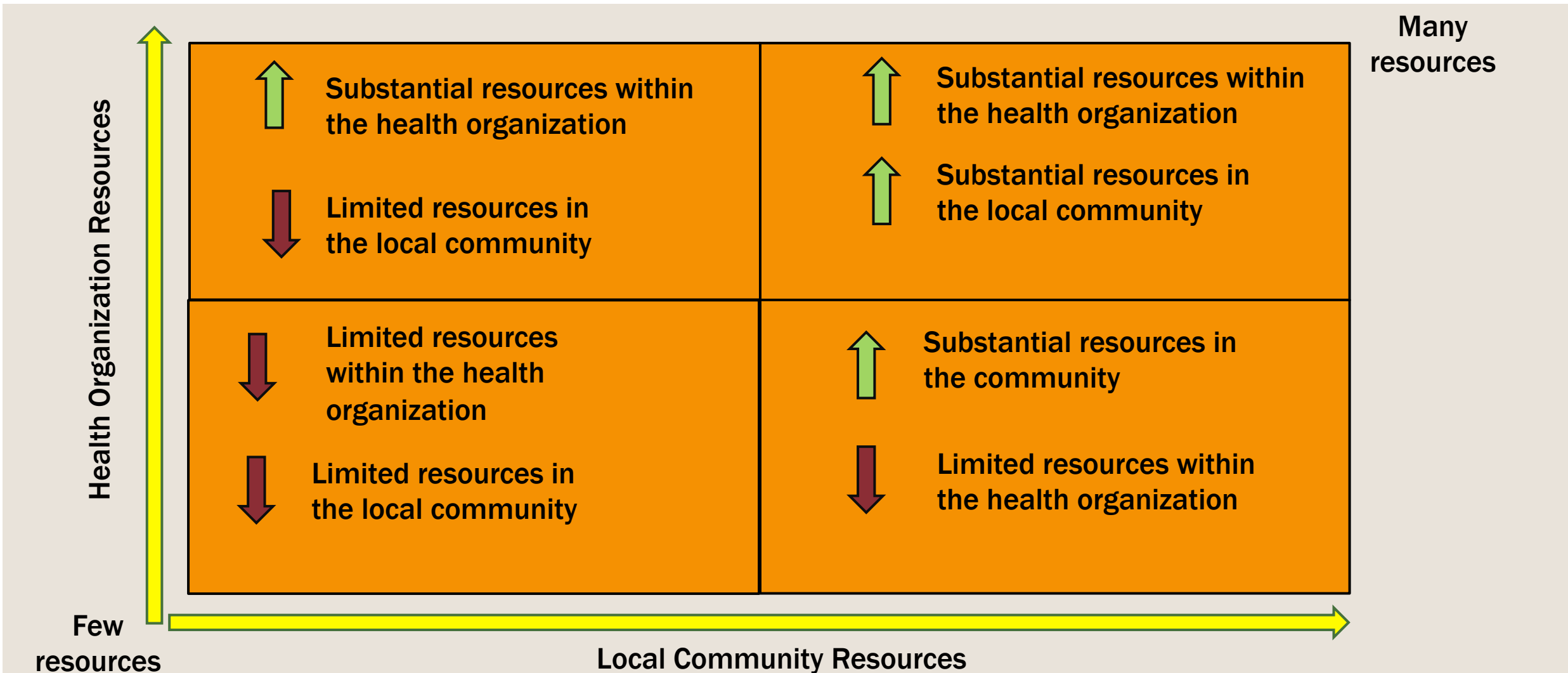
HOW DID WE CREATE PRAPARE?

Literature reviews of SDH associations with cost and health outcomes

Monitored and/or aligned with national initiatives

- *HP2020*
- *RWJF County Health Rankings*
- *ICD-10*
- *IOM on SDH in MU Stage 3*
- *NQF on SDH Risk Adjustment*

Collected existing protocols from the field

- *Collected 50 protocols (many not validated)*
- *Interviewed 20 protocols*
- *Identified top 5 protocols*

Engaged stakeholders for feedback

- *Braintrust (advisory board) discussion*
- *Surveyed stakeholders*
- *Distributed worksheet to potential users for feedback*

Used evidence to apply domain criteria → Identified 15 Core Domains

Critiera:
1) **Actionability**
2) **Alignment with National Initiatives**
3) **Evidence in Research**
4) **Burden of Data Collection**
5) **Sensitivity**
6) **Stakeholder Feedback**

WHAT IS THE STATUS OF PRAPARE?

USING DATA ON THE SOCIAL DETERMINANTS OF HEALTH

CONCEPTUAL FRAMEWORK

Social Determinants of Health
(PRAPARE Domains: Race/ethnicity, poverty employment, English proficiency, etc..)

Appropriate Care
(For health condition in question, for example, # of doctor visits, exams/tests levels...)

Health Outcomes
(For example, ideal outcomes, reduced complications, ED visits, etc..)

Enabling Services & other non-clinical interventions