Documenting Your Impact:
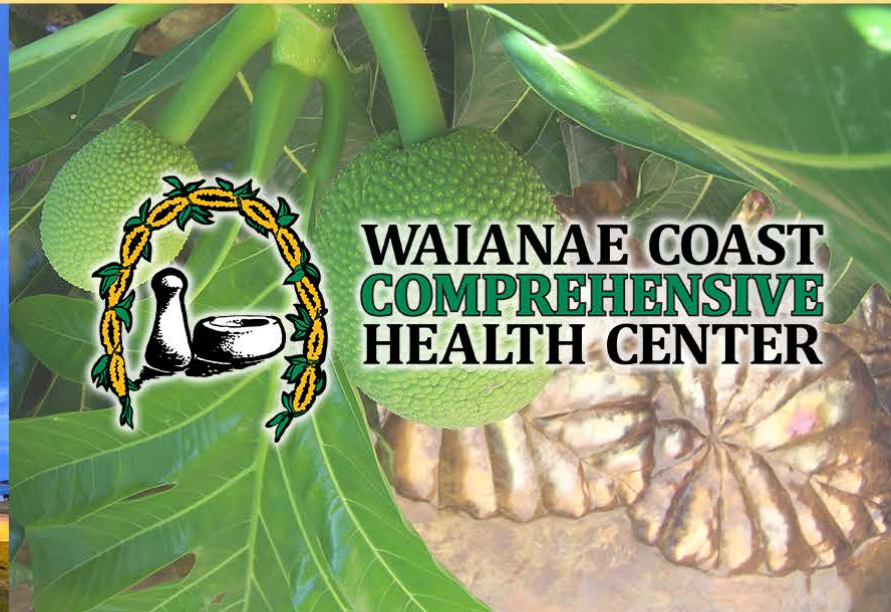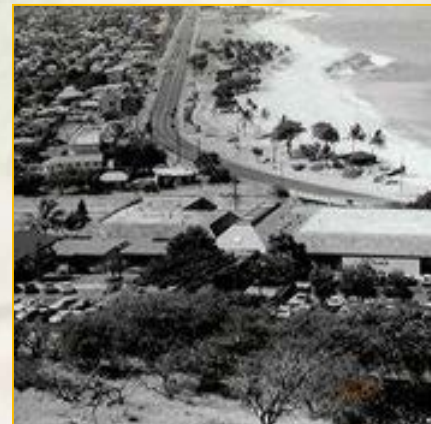# Tools For Addressing Social Determinants Of Health And Demonstrating Value

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AANHPI Summit
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Waianae Coast Comprehensive Health Center

- Established 1972 as a community-driven response to the lack of health care providers available on the Waianae coast.

- The largest and oldest of Hawaii's 14 community health centers.

- In 2016, served over 36,000 patients through over 200,000 encounters from the main clinic and its satellite sites in Nanakuli, Kapolei and Waipahu.

- Largest employer on the Waianae coast with nearly 650 employees – most of them residents of the community.

Waianae Coast Primary Service Area

- Highest number of households in the state receiving financial aid and food stamps

- Highest percent of individuals on Oahu living below the Federal Poverty Level

- Highest number of obese adults, adults with diabetes, and adult smokers.

2016 State of Hawaii Primary Care Needs Assessment Data Book (Hawaii State Department of Health, May 2016)

Long History Of Addressing Sdoh

- 1991 developed a Perinatal program to address poor birth outcomes from high risk pregnancies in the Waianae community.

- Homeless outreach program.

- Implemented Service Coordinators in Primary Care setting to address social complexities

- "No wrong door" approach of referring complex patients to case management.

- Over 200 enabling codes developed and tracked.

Pilot Project With AlohaCare

- Patient Centered Healthcare Home pilot project with Medicaid payer, AlohaCare.

- Purpose was to identify complex patients and develop cost-saving methods while maintaining or improving quality of care.

- Recognized that SDoH played a significant role in defining the complexity of these patients.

Partnership with Altruista Health

- A population management, predictive modeling and care management program

- Stratifies patients into various risk levels based on:
  - Probability of complications
  - Cost

- Uses a combination of:
  - Payer claims data
  - EHR data
  - Pharmacy claims

Altruista Health Guiding Care

- Has the capacity to incorporate SDoH and psychosocial factors to produce a holistic risk score.

- These more holistic risk scores would then dictate the level of intervention needed.

- Intention is for those with moderate to high risk scores to be referred to a care coordinator for more thorough assessment and care plan development

PRAPARE:
Protocol For Responding To & Assessing Patients' Assets, Risks, & Experiences

- **PRAPARE** is a national effort to help health centers and other partners to collect data needed to better understand their patients SDoH.

- **PRAPARE** assessment tool was
  - informed by research on SDH domains that predict poor outcomes and high cost.
  - consists of a set of national core measures as well as optional measures.

- **Core Measures Include:**
  - Race & Ethnicity
  - Housing Status
  - Insurance Status
  - Language Preference
  - Education
  - Employment
  - Transportation
  - Safety
  - Neighborhood
  - Stress
  - Material Security
  - Domestic Violence

WCCHC Experiences In Implementing PRAPARE

- Initial plans were to expand our 'no wrong door' approach to data collection.
- Every 'door' a patient enters contributes to the understanding of who we serve.
- This includes: receptionists, medical assistants and providers.
- However, resulted in incomplete data.
- Recognized need to develop a standardized method of data collection.

WCCHC Experiences In Implementing PRAPARE

- Trained RN care coordinators to administer the survey.

- Survey administered to a cohort of 500 Medicaid non-pregnant adults with either diabetes or cardiovascular disease.

- Time it took to administer the survey varied from 15 minutes to an hour.

- Care coordinators were trained to address concerns raised during the course of administering survey.

Relationships, Connections & Trust

- Relationships Are Key To Establishing Mutual Respect And Positive Outcomes

- Seek Out Common Interests

- Cultural Diversity

- Encourage Patients To Be Their Own Change Agents

- Patients Perspective

- Active Listening And Positive Body Language

PRAPARE Video

Implementation

- Initially implemented survey into care coordinators' workflow.
- Found to be too time consuming.
- Adapted process to create a 'talk story' environment.
- This process allowed care coordinators a 'foot in the door'.
- Encouraged us to build community resource data base.

PRAPARE Survey Experiences

- Resistance noted on some questions, especially regarding household income and incarceration.

- Care coordinators needed to provide reassurance that this data was not going to be shared.

- Surveyors felt flow of survey as written did not flow smoothly, they therefore modified the order in which they asked specific questions.

Suggestions For PRAPARE Modifications

Expand Certain Categories To Include Assessing:

- Stability Of Housing Situation.
- Access To Health Care.
- Work Situation.
- Legal Concerns And Rights.
- Social And Emotional Health To Include Screening For Depression And Domestic Violence.

Example Of Our Expansion Of PRAPARE

15. What are your current legal concerns (Check all that apply)

	Parole		Probation
	Supervised release		Formerly in system, completed requirements
	Drug Court		None
	I choose not to answer this question		

16. Do you have other concerns regarding your legal rights, the law and the courts such as the following (Check all that apply)

	Divorce/Custody/Guardianship/Visitation		Bankruptcy
	Eviction/Housing concerns with landlord		Public benefits
	Immigration		Tax issues
	Life Planning		I choose not to answer this question

Today's PRAPARE, Tomorrow's Solutions

- Developed a patient mode of PRAPARE to allow patients the ability to self administer the survey.

- Created workflow conducive to clinic practices

- Collaboration with support staff

- PRAPARE administered in three clinics (Adult Medicine, Behavioral Health & Women's Health)

- Average time to complete survey - 5-7 minutes

- Positive responses on trigger question produces an automatic referral to Community Health Services

- Triage patients to appropriate workforce for social support

Lessons Learned & Future Plans

- Strong leadership in disseminating the tool

- Accountability of staff

- Stronger network of community partners

- Future dissemination to all clinics

- Use of patient portal to disseminate the tool prior to the appointment

- Ultimately develop a holistic risk score, incorporating SDoH with claims based data, to better define the complex patients we serve.

Future Plans

- Developing a risk score that predicts poor outcomes is outside the scope of the PRAPARE project but an important next step. It cannot be done until non-clinical patient risk data are collected in a standardized way.

- However…with Altruista's Predictive Modeling, we are already on our way in calculating a risk score which incorporates SDoH.

  - ✓ Interface has been built
  - ✓ PRAPARE data being transferred
  - ✓ Validation stage

How Can PRAPARE Help You?

- **PRAPARE** propels providers who serve underserved populations towards transformed, integrated care and the demonstration of value.

- By understanding patients' SDoH, this allows providers to:
  - o Define & document the complexity of patients.
  - o Better target clinical care, enabling services and community partnerships.
  - o Enables providers to demonstrate the value they bring to patients, communities and payers.
  - o Advocate for change at the community and national levels.

PRAPARE resources

PRAPARE toolkit & tool

www.nachc.org/prapare

Summary

- CHCs well positioned to address SDoH
- CHCs have long sought solutions to providing care enabling services with limited resources – used to doing "more with less".
- When budget is tight – care enabling services lose resources.
- Need to accurately define and measure SDoH

Summary

- CHCs need to be appropriately compensated for the medically, psychologically and socially complex patients they serve.

- With appropriate compensation, targeted intensive care enabling services can be provided.