ASSESSING AND ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH USING PRAPARE:

PROTOCOL FOR RESPONDING TO AND ASSESSING PATIENTS’ ASSETS, RISKS, AND EXPERIENCES

This project was made possible with funding from:

THE KRESGE FOUNDATION

KAISER PERMANENTE
WEBINAR OBJECTIVES

- Strategize the PRAPARE implementation process
- Introduce EHR template for data collection/patient engagement
- Describe health center implementation experience, including workflow
- Previous webinars located in the “Social Determinants of Health Resources” folder at http://www.healthcarecommunities.org/ResourceCenter.aspx
## IN DEVELOPMENT: IMPLEMENTATION AND ACTION TOOLKIT

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples of Potential Resources to Include</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Understand the Project</td>
<td>Project overview, project framework, defining risk, case studies, FAQs</td>
</tr>
<tr>
<td>Step 2: Engage Key Stakeholders</td>
<td>Messaging materials, change management guidance</td>
</tr>
<tr>
<td>Step 3: Strategize the Implementation Plan</td>
<td>Readiness assessment, PDSA materials, 5 Rights Framework, Implementation timeline, progress reports, legal documents</td>
</tr>
<tr>
<td>Step 4: Technical Implementation</td>
<td>PRAPARE paper assessment, data documentation, EHR templates, sample data dictionaries, data specifications, data warehouse and retrieval strategies, guidelines for using design and requirements documents</td>
</tr>
<tr>
<td>Step 5: Workflow Implementation</td>
<td>Workflow diagrams, data collection training curriculum, lessons learned and best practices</td>
</tr>
<tr>
<td>Step 6: Understand and Report Your Data</td>
<td>Reporting requirements, sample database, sample data outputs, sample data analyses and reports, cross-tabulating data, evaluation protocol, population-level planning, guidelines for data integration</td>
</tr>
<tr>
<td>Step 7: Act on Your Data</td>
<td>Strategy for detecting risk, report on best practices and processes for using SDH data, examples of SDH interventions, SDH response codes, linking to enabling services codes</td>
</tr>
<tr>
<td>Step 8: Use Your Data to Drive Payment and Policy Transformation</td>
<td>Strategy to engage payers, funding SDH efforts, data visualization templates</td>
</tr>
</tbody>
</table>
### IN DEVELOPMENT: IMPLEMENTATION AND ACTION TOOLKIT

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples of Potential Resources to Include</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1: Understand the Project</strong></td>
<td>Project overview, project framework, defining risk, case studies, FAQs</td>
</tr>
<tr>
<td><strong>Step 2: Engage Key Stakeholders</strong></td>
<td>Messaging materials, change management guidance</td>
</tr>
<tr>
<td><strong>Step 3: Strategize the Implementation Plan</strong></td>
<td>Readiness assessment, PDSA materials, 5 Rights Framework, Implementation timeline, progress reports, legal documents</td>
</tr>
<tr>
<td><strong>Step 4: Technical Implementation</strong></td>
<td>PRAPARE paper assessment, data documentation, EHR templates, sample data dictionaries, data specifications, data warehouse and retrieval strategies, guidelines for using design and requirements documents</td>
</tr>
<tr>
<td><strong>Step 5: Workflow Implementation</strong></td>
<td>Workflow diagrams, data collection training curriculum, lessons learned and best practices</td>
</tr>
<tr>
<td><strong>Step 6: Understand and Report Your Data</strong></td>
<td>Reporting requirements, sample outputs, sample data analyses and cross-tabulating data, population-level planning</td>
</tr>
<tr>
<td><strong>Step 7: Act on Your Data</strong></td>
<td>Strategy for using SDH data, examples of SDH interventions, SDH response codes, linking to enabling services codes</td>
</tr>
<tr>
<td><strong>Step 8: Use Your Data to Drive Payment and Policy Transformation</strong></td>
<td>Strategy to engage payers, funding SDH efforts, data visualization templates</td>
</tr>
</tbody>
</table>

Available in August through an End User License Agreement
The chat feature is available to ask questions or make comments anytime throughout today’s webinar.

We will answer as many questions as possible.

Submit to “All Panelists” and click the send button.
PRAPARE in GE Centricity Webinar

Dave Faldmo (Siouxland Community Health Center)
Christina Kim (Alliance of Chicago)
Kyle Pedersen (Iowa Primary Care Association)
PRAPARE

Why do CHCs need to document and address SDH?

Research demonstrates SDH:
• Contribute to poorer health outcomes
• Lead to health disparities

Impact on health centers and population served:
• Increasingly difficult to improve health outcomes for complex patients
• Possible negative impacts under:
  - Value-based pay, such as incentive payments, shared shavings, and pay for performance
  - Public Reporting
• Insufficient funds to provide comprehensive care
• HRSA’s goal is to have providers screen for and address SDH within the EMR
PRAPARE
Social Determinants of Health
PRAPARE
Social Determinants of Health

Implementation
Teams use 4 common EHRs that are used by 58% of all community health centers.
PRAPARE

Social Determinants of Health

Why We Participated:

• Provide better care to patients
  – Collect more robust data about other factors impacting health
  – Begin to match identified issues with solutions with the health center

• Use data to establish or grow partnerships with other community resources

• Leverage data and accompanying interventions to provide evidence to payors and policymakers about the needs of patients, a broader definition of patient risk, and to ensure adequate reimbursement for safety net providers
Overall Project Goals

- To create, implement/test, and promote a national standardized patient risk assessment protocol to assess and address patients’ social determinants of health (SDH).
- Document the extent to which each patient and total patient populations are complex.
- Use that data to:
  - improve patient health,
  - affect change at the community/population level
  - sustain resources and create community partnerships necessary to improve health.
Timeline of the project
We have just finished year 2 and are now in year 3 of the 3 year project.

Year 1 • Develop paper based tool

Year 2 • Develop EMR template and test tool in health center workflow with CHCs and HCCNs

Year 3 • Disseminate tool widely and release final report
PRAPARE was designed specifically to aid health centers in gathering data that informs and addresses individual patient care and population health management, while capturing what makes health center populations unique.
PRAPARE

SDH Impact the Ability to Achieve Triple Aim
Complex patients must be treated in new and innovative ways to achieve the Triple Aim

- Complex patients usually have multiple needs that must be addressed to produce the desired clinical results.
- Health centers are held accountable for patient health and cost outcomes.
- Complexity results when multiple risks converge to interfere with the Triple Aim of improving patient health and experience of care, while lowering cost.
- In order to assess and address patient complexity, care teams need data on patient SDH assets, risks, and experiences to inform care.

Complex patients require complex solutions
PRAPARE
Social Determinants of Health

Our journey with PRAPARE…

Siouxland Community Health Center
Sioux City, IA and South Sioux City, NE
PRAPARE
Social Determinants of Health

Steps needed to develop readiness:

1. Educate staff and leadership of the value of PRAPARE
   - Educate everyone in the organization at a high level.
   - Educate key players at a detailed level
   - Get the right people on the bus!
Social Determinants of Health

Steps needed to develop readiness:

2. Be prepared to address concerns and questions from staff and administration
   - We have too much going on right now to add another project.
   - We already screen for and address social determinants of health.
   - Once we identify a social determinant of health, are we accountable to provide help to overcome the determinant?
   - Who is going to be responsible for addressing the need?
Steps needed to develop readiness:

3. Be prepared to address questions and concerns of patients.
   - Why are you asking me these questions?
   - Who will have access to this information?
   - Will providing this information impact my ability to receive care?
Steps needed to develop readiness:

4. Catalog current countermeasure/resources available, both in-house and in the community, for each social determinants of health surveyed on the tool.
   - Identify resources that need to be developed or improved.
   - Identify community partnerships that need to be initiated or strengthened.
PRAPARE

Social Determinants of Health

Steps needed to develop readiness:

5. Use “5 Rights” and PDSA cycle to develop workflow for administering and responding to PRAPARE tool.

The “5 Rights” include:

- the right information,
- to the right person,
- in the right intervention format,
- through the right channel,
- at the right time in workflow.
PRAPARE

Social Determinants of Health

Steps needed to develop readiness:

5. Use “5 Rights” and PDSA cycle to develop workflow for administering and responding to PRAPARE tool.

- How will tool be administered to the patient to ensure that it accurately identifies the SDH the patient may have? (obtain right information)
- Who will address social determinants identified? (right person)
- How will resource information be organized so that it is readily available and standardized for all? (right intervention format)
- How is the appropriate care team member notified to address the SDH identified? (right channel)
- When in the patient visit does it make sense to administer the tool and when is the best time to address identified SDH? (right workflow)
PRAPARE

Social Determinants of Health

Implementation at SCHC:

*How we prepared for this change?*

- Invitation to all employees to join the project.
- Planning meeting which included employees from various departments at all levels.
- Determined initial teams to try out survey with patients and identify workflow issues before it is rolled out to all the provider teams.
PRAPARE

Social Determinants of Health

Implementation at SCHC:

Who would survey the patients?

- PDSA 1 – Behavioral Health/Social Services and PCMH Case Managers complete face to face interview with patients.
- PDSA 2 – Paper copies were developed in 4 languages for provider teams to handout to the patients while waiting in the exam room.
  - Questions were added to identify if the patient would like to visit with behavioral health staff.
PRAPARE

Social Determinants of Health

Implementation at SCHC:

How did we roll out to all the provider teams?

- Educating all provider teams one on one.
- Developed instructions in writing for employees to refer back to and to educate new employees.
  - purpose of the survey
  - how to locate appropriate community resource
  - what to do with difficult questions
PRAPARE

Social Determinants of Health
# Social Determinants of Health

<table>
<thead>
<tr>
<th>Survey Question &amp; Category Link</th>
<th>Location &amp; Resource</th>
<th>English Handout</th>
<th>Spanish Handout</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>Food Bank of Southeast</td>
<td>1 - Food Resources/Food Bank of Southeast English Updated 8-2015.pdf</td>
<td>1 - Food Resources/Food Bank of Southeast Spanish Updated 8-2015.docx</td>
</tr>
<tr>
<td></td>
<td>Food Bank of Southeast - Rural Communities</td>
<td>1 - Food Resources/Food Bank of Southeast Rural Community English Updated 8-2015.docx</td>
<td>1 - Food Resources/Food Bank of Southeast Rural Community Spanish Updated 8-2015.docx</td>
</tr>
<tr>
<td></td>
<td>Southeast Soup Kitchen</td>
<td>1 - Food Resources/Southeast Soup Kitchen English/Spanish Updated 8-2015.docx</td>
<td>1 - Food Resources/Southeast Soup Kitchen English/Spanish Updated 8-2015.docx</td>
</tr>
<tr>
<td></td>
<td>SHARE</td>
<td>1 - Food Resources/SHARE English Updated 8-2015.docx</td>
<td>1 - Food Resources/SHARE Spanish Updated 8-2015.docx</td>
</tr>
<tr>
<td></td>
<td>Plymouth Co (IA) - Mid Iowa</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social Determinants of Health

Siouxland Area Food Pantries

Call first to determine requirements and set appointments per information below.

Central/North/West Side Sioux City

Gospel Mission
500 Bluff St
Sioux City
25?1769
Mon-Fri 9:30-10 am

Midtown Fam. Comm. Center
524 14th St
Sioux City
258-2470
Second Fri 5-6 pm
Last Thurs 10-12 pm

First Evangelical Free Church
401 9th St
Sioux City
255-7239
Last Tues 1-3 pm
4th Wed 10-12 Noon

St. Thomas Episcopal Church
406 12th St
Sioux City
258-0141
Mon & Wed 10-12 Noon

Calvary Lutheran
4400 Central
Sioux City
258-2397
M-Th 12:30 pm-4:30 pm
Friday 7:30-12:30 pm

Radiant Life Church
423 George St Sioux City IA
259-3090
3rd Wednesday
5:30-6:30 pm
Please call first.

East Side Sioux City

First Lutheran Church
3939 Cheyenne Blvd
Sioux City
239-3942
Wed 10-12 Noon
PRAPARE

Social Determinants of Health

Implementation at SCHC:

How does this help medical providers, behavioral health, and nurse case managers work with patients?

- Survey allows for behavioral health to have an initial meeting with patients and build rapport.
- We don’t know what we don’t ask.
- Opportunity to engage the patient in their psychosocial health and discuss how these things could affect their overall health.
Challenges/Impacts

• Need to account for data collection overload among staff and share how the data will be used and why it is valuable
  – ROI when this adds time to the patient visit
  – Don’t treat as a project, but instead part of providing care

• The data captured as part of the pilot project has multiple uses – endless number of case statements possible
  – More discussion about how the data will be used, i.e. is it most important to impact point of care or policy or something else?
  – Where can the easiest customization and marrying of data occur?

• Need to consider what interventions are internal versus require community partnerships
PRAPARE Template
Unique Features:

- 3 Tabs:
  - 1. Sociodemographic/Socioeconomic
  - 2. Money & Resources
  - 3. Psychosocial Assets
- User friendly look & feel
- Pulls fields from registration
- ICD-10 codes populate depending on how the patient responds
- Blue jump buttons > brings you to additional forms/assessments
- Ability to show previously captured information
- Remove from note option for patient sensitive information
How to Implement PRAPARE:

How to Install into CPS:
1. Save the PRAPARE zip folder to your computer
2. Log in to CPS
3. Administration Module
4. System Folder > Import Clinical Kits
5. Click “Import Clinical Kit”
6. If the file is saved to the local PC, chose the location & double click on the source drive
7. Double click on the PRAPARE folder > Double click on the text file
   1. Select YES TO ALL if a pop up display appears
8. Return to Chart Documents > Start a new encounter > Select “Add” > Locate the PRAPARE form to add
Greyed out fields will pull from PM if documented
Homeless Patient = Patient who lacks housing (without regard to whether the individual is a member of a family), including individuals whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and individuals who reside in transitional housing.

The definition of homeless for UDS reporting purposes includes the following:

- Shelter: Shelters for homeless persons are seen as temporary and generally provide for meals as well as a place to sleep for a limited number of days and hours of the day that a resident may stay at the shelter.
- Transitional Housing: Transitional housing units are generally small units (5 persons is common) where persons who leave a shelter are provided extended housing stays—generally between 6 months and 2 years—in a service-rich environment. Transitional housing provides for a greater level of independence than traditional shelters, and may require that the resident pay some or all of the rent, participate in the maintenance of the facility and/or cook their own meals. Count only those persons who are transitioning from a homeless environment. Do not include those who are transitioning from jail, an institutional treatment program, or the military, schools or other institutions.
- Double Up: Patients who are living with others; the arrangement is generally considered to be temporary and unstable, though a patient may live in a succession of such arrangements over a protected period of time.
- Street: This category includes patients who are living outdoors, in a car, in an encampment, in a makeshift housing/shelter, or in other places generally not deemed safe or fit for human occupancy.
- Other: This category may be used to report previously homeless patients who were housed when first seen, but who were still eligible for the Health Care for the Homeless program. Patients who reside in SRO (single room occupancy) hotels or motels, other day-to-day paid housing, as well as residents of permanent supportive housing or other housing programs that are targeted to homeless populations should also be classified as “other.”
Sociodemographic/Socioeconomic

Money and Resources

Psychosocial Assets

**PREPARE**

**DOB:** 09/15/1946   **Patient Age:** 69 Years Old

Social and Emotional Health

- How often do you see or talk to people that you care about and feel close to?
  - 1 or 2 times a week

Add Problem to Primary Support Group, Unspecified (Z63.3) to Problem List

Additional Optional Domains

- In the past 3 months, have you spent much time on the phone with
  a jail, prison, detention center or other locked facility?
- Has lack of transportation kept you from attending church or
  meetings, work, or from getting there on time?
- In the past year, have you had trouble paying for
  medications, doctors, or other health care?
Reporting / Future Plans
PRAPARE
Social Determinants of Health

PRAPARE Data

• Over 25,000 patients
• 3,842 surveys completed
• 13% do not have housing (483)
• 18% indicate they only have social interactions 1 – 2 per week (696)
• 38% indicate quite a bit, somewhat, very much stress (1,463)

* Data report pulled 6/9/2016
PRAPARE

Social Determinants of Health

Unmet Materials Needs

- Child care (104)
- Clothing (328)
- Food (463)
- Medicine/Medical Care (538)
- Phone (316)
- Rent/Mortgage (369)
- Transportation (443)
- Utilities (369)

* Data report pulled 6/9/2016
Insights from Data

• Staff not surprised by the issues identified through the tool
• Data changed the way the care teams communicated with patients (education question)
• Lots of discussion about possible interventions if incarceration identified as an issue
• Changed the way Siouxland approached community partners – transportation example
PRAPARE

Social Determinants of Health

Reporting:

• Alliance of Chicago is working on enhancing the reporting capabilities
  – Health Center friendly
  – Data Warehouse
  – Adding obs terms behind each question response
  – to enabling services to document interventions

*Work in progress
Future plans:

- **Risk coding/stratification** as a hot topic
  - Need for consideration of non-clinical factors to be included
  - Payors need providers to come to the table with data
  - Providers need payors to recognize these factors
  - Together we need to develop new models

- Documenting **Enabling Services** to validate to payers and policy makers need for CHC funding and for internal justification

- **Identifying most common determinants** and **determining best ways to address**
  - Bolster or create in-house services
  - Develop or strengthen and external partnerships
  - Partner with others to create
  - Coordinate with policymakers and community stakeholders to address social and environmental conditions
More future plans

• Cross tab survey results with clinical indicators such as chronic diseases

• Think about staffing needs at the health center and further community partnerships needed to connect patients to necessary interventions

• Build these necessary interventions into the overall care coordination approach at health centers

• Using the data as part of PCMH re-recognition process
Opportunities with Payors in Iowa

• Some alignment with largest commercial payor and Medicaid around a 3M product and overall approach through CMS SIM Model Testing funding
  – Interest in better understanding SDOH data at patient level, community level, and state level
• Exploration of interest in different payment methodologies with new managed care plans
• Likely need more health centers to implement the tool to reach critical mass, but believe providers need to collect this data
Final Thoughts

• Matthew Nagato, HI PCA – “Data is the currency of advocacy. Trust is the currency of medicine.”
  – This project brings both of these issues to the forefront

• We believe this project is the first step in a long journey to figure out how the marrying of health care and social determinant data can lead to better individual health (via more individualized and higher quality care) and community health (via advocacy and policy change)
Questions & Thoughts

David Faldmo PA-C, MPAS
Siouxland Community Health Center
Sioux City, Iowa
dfaldmo@slandchc.com