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
CHAT FEATURE

- All participants have been muted upon entry.
- 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.
WEBINAR OBJECTIVES

- Strategize the PRAPARE implementation process
- Introduce EHR template for data collection/patient engagement
- Describe health center implementation experience, including workflow
## 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 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><strong>Step 7: Act on Your Data</strong></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><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>
### Categories

<table>
<thead>
<tr>
<th>Step 1: Understand the Project</th>
<th>Examples of Potential Resources to Include</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Project overview, project framework, defining risk, case studies, FAQs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Engage Key Stakeholders</th>
<th>Messaging materials, change management guidance</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Step 3: Strategize the Implementation Plan</th>
<th>Readiness assessment, PDSA materials, 5 Rights Framework, Implementation timeline, progress reports, legal documents</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Step 4: Technical Implementation</th>
<th>PRAPARE paper assessment, data documentation, EHR templates, sample data dictionaries, data specifications, data warehouse and retrieval strategies, guidelines for using design and requirements documents</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Step 5: Workflow Implementation</th>
<th>Workflow diagrams, data collection training curriculum, lessons learned and best practices</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Step 6: Understand and Report Your Data</th>
<th>Reporting requirements, sample data analyses and reporting, sample data outputs, cross-tabulating data, evaluation protocol, population-level planning, guidelines for data integration</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Step 7: Act on Your Data</th>
<th>Strategy for detecting risk, processes for using SDH data, examples of SDH interventions, response codes, linking to enabling services codes</th>
</tr>
</thead>
</table>

| Step 8: Use Your Data to Drive Payment and Policy Transformation | Strategy to engage payers, funding SDH efforts, data visualization templates |

Available in August through an End User License Agreement.
Collecting Social Determinants of Health Using PRAPARE in eClinicalWorks

This project was made possible with funding from:
Presenters

**Stephanie Rose**  
Project Director  
Health Center Network of New York

**Liana Fixell**  
Director of Care Coordination Programs  
Open Door Family Medical Centers

**Andrew Lehto**  
Director of Community Outreach and Engagement of Special Populations  
HRHCare
Agenda

1. Overview of PRAPARE

2. Health Center Case Studies
   ◦ Open Door Family Medical Center
   ◦ HRHCare
   ◦ Q&A

3. eClinicalWorks PRAPARE Configuration
   ◦ Q&A
PREPARE

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

The objective of the PRAPARE Tool is to help providers assess and address the social determinants of health (SDH) by creating, implementing, and promoting the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE).

Identify patient risks related to the SDH:
- Greater understanding of the patient population
- Improve ability to manage patient populations
- Inform development of new programs/partnerships
- Improve health outcomes
- Control/Reduce health care spending
Literature reviews of SDH associations with cost and health outcomes

Monitored and aligned with national initiatives
- HP2020
- RWJF County Health Rankings
- IOM on SDH in MU Stage 3
- NQF on SDH Risk Adjustment
- SBM & NIH

Collected existing protocols from the field
- Collected 50 protocols
- Interviewed 20 protocols
- Identified top 5 protocols

Used evidence to apply domain criteria

Identified 15 Core Domains

Criteria:
1. Actionable
2. Alignment with National Initiatives
3. Evidence in Research
4. Burden of Data Collection
5. Sensitivity
6. Stakeholder Feedback
Project Goal

To create, implement/pilot test, and promote a *national standardized patient risk assessment protocol* to assess and address patients’ social determinants of health (SDH).

**Assessment Tool to Identify Needs**
- Paper Tool
- EHR Templates
- List of Granular Needs
- ICD10 Z Codes
- Workflow Diagrams
- Staff Training Curriculum

**Protocol to Respond to Needs**
- Implementation and Action Toolkit
- Examples of Interventions
- Guidance on how to build capacity
- Appendix of Resources
- Guidance on informing policy and payment
PRAPARE eCW Pilot

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE)

- eClinicalWorks Pilot
  - HCNNY
  - HRHCare
  - Open Door Family Medical Center
  - Over 1,100 patients completed PRAPARE

- PRAPARE Tool modifications

- eClinicalWorks PRAPARE Implementation Guide and Training Material developed
## PRAPARE DOMAINS

### UDS SDH Domains
- Race
- Ethnicity
- Veteran Status
- Farmworker Status
- English Proficiency
- Income
- Insurance
- Neighborhood
- Housing

### Non-UDS SDH Domains
- Education
- Employment
- Material Security
- Social Integration
- Stress
- Transportation

### Non-UDS Optional SDH Domains
- Incarceration History
- Refugee Status
- Country of Origin
- Safety
- Domestic Violence
ODFMC Experience with PRAPARE

Liana Fixell
Director of Care Coordination Programs
Open Door Family Medical Centers
Open Door is the region’s experts in all aspects of health, with a broad focus on building healthier communities. From prevention and wellness programs, to the treatment of diseases, Open Door sees our primary mission as keeping the people of Westchester and Putnam Counties healthy and strong, regardless of their ability to pay.

At Open Door, we believe that quality health care is a right, not a privilege.
Open Door’s Target Population

• Low income (200% or Below Poverty Level)

Note: According to the new 2016 Federal Poverty Guidelines, income of $24,300/household of 4 is considered at 100% poverty level.

• Uninsured and/or Underinsured Population
  • Underserved minorities
  • High Risk Population
• Women of Child Bearing Age & Children
Where do our patients come from?

About 89% of Open Door patients fall into 200% or below poverty level.

Note: According to the 2016 Federal Poverty Guidelines, income of $24,300/household of 4 is considered at 100% poverty level.

Income as a Percent of Poverty Level

- 69% Income of $24,300/household of 4
- 15% Income of $48,600/household of 4
- 10% 101-150%
- 5% 151-200%
- 2% Over 200%
- 0% Unknown

Note: According to the 2016 Federal Poverty Guidelines, income of $24,300/household of 4 is considered at 100% poverty level.
Socioeconomic Characteristics of our Patients

Open Door Patients by Insurance
2015

- **Uninsured**: 43%
- **Medicaid**: 39%
- **CHIP**: 5%
- **Medicare**: 4%
- **Private**: 10%

*Source: Open Door Family Medical Centers*
Open Door’s Experience with PRAPARE

Care Coordination Program – Patient Advocates

• Patient Advocates enhance:
  • Access (identify needs, health insurance, Wellness Program)
  • Health literacy (Chronic Disease Management Education)
  • Medication compliance (Pharmacy Assistance Programs, review visit summaries, etc.)
  • Treatment/appointment adherence
  • Care coordination (CSP, referrals, appointment preparation counseling)

• Typical workflow
  • Patients see medical providers and then meet with PA for an identified need
  • PA seeks out patient because of an anticipated need
  • Patients request appt with PA for assistance
Behavioral Health Integration Specialist (BHIS)

• MSW
• Perform BH assessments and link patients to BH care
• Typical workflow
  • Meet with patients in exam rooms before or after provider enters
  • BHIS seeks out patient because of a previously documented BH concern
  • Provider identifies a BH concern and calls in BHIS

New Role - Patient Navigator

• Workflow closer to a BHIS, but not MSW – former Medical Assistant (could be considered a Community Health Worker)
• Enters exam room while patient is waiting for provider
• Makes referrals to BHIS, Patient Advocate, or enabling services, depending on the need(s) identified
## Enabling Services “Dummy” CPT Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Desc</th>
<th>CPT</th>
<th>Desc</th>
<th>CPT</th>
<th>Desc</th>
<th>CPT</th>
<th>Desc</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVOC</td>
<td>Advocacy general</td>
<td>CSPE</td>
<td>CSP Enrollment</td>
<td>NFLEN</td>
<td>NFL Breast Screening Edu/Ref</td>
<td>TRAN</td>
<td>Transportation Assistance</td>
</tr>
<tr>
<td>AFLAN</td>
<td>Asthma Action Plan</td>
<td>CSPF</td>
<td>CSP Follow Up</td>
<td>PAM</td>
<td>PAM Survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTBH</td>
<td>Behavioral Health Appt</td>
<td>DNEDU</td>
<td>Diabetes Education</td>
<td>PAP</td>
<td>Pharmacy Assistance Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTBI</td>
<td>Breast Imaging Appt</td>
<td>DSS</td>
<td>Assistance with DSS</td>
<td>PCAP</td>
<td>PCAP Application Prental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTHC</td>
<td>Home Health Care Appt</td>
<td>FIT</td>
<td>FIT Test and Education</td>
<td>PEDU</td>
<td>Prenatal Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTNU</td>
<td>Nutritionist Appt</td>
<td>FPBP</td>
<td>FPBP Application</td>
<td>REFDU</td>
<td>Domestic Violence Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTQ1</td>
<td>Other Imaging Appt</td>
<td>FPEP</td>
<td>FPEP Assistance</td>
<td>REFEM</td>
<td>ER Medicaid Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTOP</td>
<td>Optometry Appt</td>
<td>HEDU</td>
<td>Health Education</td>
<td>REFFP</td>
<td>Food Pantry Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTPI</td>
<td>Prenatal Intake Appt</td>
<td>HCCA</td>
<td>Charity Care Assistance</td>
<td>REFHA</td>
<td>Housing Assistance Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTPO</td>
<td>Pediatric Appt</td>
<td>HEAP</td>
<td>HEAP Assistance</td>
<td>REFIN</td>
<td>Insurance Marketplace Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTPP</td>
<td>TOP Appt</td>
<td>MTNED</td>
<td>Hypertension Education</td>
<td>REFLE</td>
<td>Local Services Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTS</td>
<td>Specialty Medical Appt</td>
<td>INS</td>
<td>Insurance Issues</td>
<td>REFMC</td>
<td>MCTP Enroller Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASEDU</td>
<td>Asthma Education</td>
<td>MCAID</td>
<td>Medicard application</td>
<td>REFSH</td>
<td>Shelter Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHR</td>
<td>Behavioral Health Warm Hand</td>
<td>MCRD</td>
<td>Medicaid Recertification</td>
<td>SCE</td>
<td>Smoking Cessation Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIL</td>
<td>Billing Issues</td>
<td>MCTP</td>
<td>MCTP Application</td>
<td>SDH</td>
<td>Social Detox, Health PRAPARE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTPR</td>
<td>Child Insurance Enroll/Recert</td>
<td>MED</td>
<td>Medication Assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Open Door Family Medical Centers*
# RESOURCE GUIDE

## Ossining Community Resources

### Resources

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOUSING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Westchester Residential Opportunities, Inc</td>
<td>470 Mamaroneck Ave, White Plains, NY 10605</td>
<td>Tel: (914)428-4567</td>
</tr>
<tr>
<td>Fax: (914) 428-9455</td>
<td>Website: <a href="http://www.wroinc.org">www.wroinc.org</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HCA Housing Network</strong></td>
<td>130 Spring St, P.O. Box 790, Ossining, NY 10562</td>
<td>Tel: (914)941-5252</td>
</tr>
<tr>
<td>Fax: (914)941-7392</td>
<td>Email: <a href="mailto:info@hfcany.org">info@hfcany.org</a></td>
<td>Website: <a href="http://frany.org">http://frany.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Westhab</strong></td>
<td>8 Ruskfeldt St, Yonkers, NY 10701</td>
<td>Tel: (914)345-2800</td>
</tr>
<tr>
<td>Fax: (914)345-5014</td>
<td>Email: <a href="mailto:mail@westhab.org">mail@westhab.org</a></td>
<td></td>
</tr>
<tr>
<td>Additional Info: For affordable housing development, call for fax Ken Belfer at numbers above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For housing vacancies, call (914) 345-2800 ext. 801</td>
<td>For Youth Services, call Giselle Ayala (914)345-2800 ext. 140</td>
<td></td>
</tr>
<tr>
<td>For Employment Services programs, call Jim Coughlin (914)345-2800 ext. 114</td>
<td>For Apartment Finding Initiative, call Reagan Fetter (914)345-2800 ext. 307</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Contact Information

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westchester Coalition for the Hungry and Homeless Emergency Shelters</td>
<td>48 Mamaroneck Ave, White Plains, NY 10603</td>
<td>Tel: (914)622-2727</td>
</tr>
<tr>
<td>Website: Westchestercoalition.org</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TRANSPORTATION

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.C. Line Bus</td>
<td>To talk to a live person to help with bus directions in Westchester, call (914) 813-7777 &amp; hit 0.</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://transportation.westchestervp.com/index.php?option=com_content&amp;view=article&amp;id=514&amp;Itemid=190">http://transportation.westchestervp.com/index.php?option=com_content&amp;view=article&amp;id=514&amp;Itemid=190</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIP/Medicaid Transportation</td>
<td>1-866-883-7965</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RideConnect of Westchester County (for older adults, the disabled, and home health care professionals commuting into Westchester county for employment)</td>
<td>116 Radio Circle, Suite 205, Mount Kisco, NY 10549</td>
<td></td>
</tr>
<tr>
<td>Tel: (914) 242-7423</td>
<td>Contact: Marietta Manconi-Mobility Coordinator</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://rideconnectwestchester.org/content.aspx?aboutus">http://rideconnectwestchester.org/content.aspx?aboutus</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### FOOD & OTHER SERVICES

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port Chester Food Pantry (located in Carver Center)</td>
<td>Carver Center: 400 Port Chester Ave, Port Chester, NY 10573</td>
<td></td>
</tr>
<tr>
<td>Tel: (914) 505-6010</td>
<td>Fax: (914) 539-3961</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HOME HEALTH SERVICES

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crickitt Care of Westchester</td>
<td>144 S. Highland Ave, Ossining, NY 10562</td>
<td></td>
</tr>
<tr>
<td>Tel: (914)941-7775</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**PRAPARE DATA**

- 1,951 surveys done from 7/1/15 – present
  - 60% done by BHIS
  - 30% done by PA
  - 10% primary care/clinical social work/OB-GYN

- 86% born outside of U.S.

- 98% have housing, but this doesn’t reflect new question, “Are you worried about losing your housing?”

- 35% quite a bit, somewhat, or very much stressed

- Highest level of education completed
  - 32% high school or GED
  - 50% less than high school or no formal schooling

- 90% say lack of transportation has NOT kept them from appointments or other obligations
Challenges, Findings, and Next Steps

- Resource Guide is only as good as the resources available → with more data, hope to work on developing/advocating for more resources

- Questionnaire can become a lengthy conversation
  - Difficult to complete for staff who are doing other concrete tasks (scheduling appts, filling out forms, insurance issues, etc.)
  - Works well with BHIS model because their role already consists of doing assessments
  - This was partially the motivator for creating the Navigator position

- On the other hand, as much as we try to administer survey conversationally, some respondents only give short answers and may not completely open up about issues or struggles

- Can be difficult to capture nuances
  - Majority say lack of transportation isn’t an issue, which makes sense because our communities have many taxi companies – but how do we capture that relying on taxis means scheduling all appointments on the same day? Or that the expense of taxis leaves less for other necessities?
  - “Are you worried about losing your housing?” hopefully captures more nuance of housing insecurity, but still may not address over-crowding and poor housing conditions
Thank you!

Liana Fixell
Director of Care Coordination Programs
(914) 502-1347
Lfixell@odfmc.org
HRHCare Experience with PRAPARE

Andrew Lehto
Director of Community Outreach and Engagement of Special Populations
HRHCare

June 15, 2016
In the early 1970's a group of local residents and religious leaders addressed the lack of appropriate health services in their community. In particular, a group of four women, fondly referred to as our founding mothers, spearheaded the efforts and have remained committed to the organization since its inception. Our CEO completes this picture having served in her position since 1977.
HRHCare Overview

- Federally Qualified Health Center Network
- NYS DOH licensed Article 28 Diagnostic & Treatment Center
- Joint Commission Accredited
- Primary Care Medical Home Level 3 Recognized
- 51% of our Board of Directors are patients of the Health Centers
Commitment to Access: Patients Served

Number of Patients

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>500</td>
</tr>
<tr>
<td>1980</td>
<td>3,500</td>
</tr>
<tr>
<td>1985</td>
<td>7,000</td>
</tr>
<tr>
<td>1990</td>
<td>13,000</td>
</tr>
<tr>
<td>1995</td>
<td>18,000</td>
</tr>
<tr>
<td>2000</td>
<td>22,000</td>
</tr>
<tr>
<td>2005</td>
<td>42,000</td>
</tr>
<tr>
<td>2010</td>
<td>64,000</td>
</tr>
<tr>
<td>2014</td>
<td>112,000</td>
</tr>
<tr>
<td>2015</td>
<td>135,000</td>
</tr>
</tbody>
</table>
• Implemented at 3 sites in 3 different counties
  ▪ Hudson, Poughkeepsie Partnership, and Southampton chosen based on service to special populations
    ▪ Migratory and Seasonal Agricultural Workers (MSAW) – Hudson and Southampton
    ▪ Homeless – all three but primarily Poughkeepsie Partnership
    ▪ Residents of Public Housing – all three
  ▪ Hudson was selected because it serves MSAWs and is a relatively new site
    ▪ Able to reach nearly all patients who are seen at the Hudson health center
PRAPARE Workflows

• An MA and LPN complete PRAPARE at Hudson and Poughkeepsie Partnership in exam room before provider visit

• In Southampton, some time from an outreach worker was available to supplement efforts by MAs, especially for patients for whom the outreach worker is performing interpretation
  ▪ Doing the survey in a semi-private area in the waiting room worked better in Southampton

• Once results are in, the surveying staff refers patients on for needed services

• Provider has access to PRAPARE for review
• More than 1,100 surveys completed from May 2015 – May 2016
• 81% of surveys were completed at the Hudson site – 10% Southampton – 9% Poughkeepsie Partnership
• Overall:
  ▪ 26% MSAW by PRAPARE definition and survey administration
  ▪ 23% MSAW by UDS definition (more broad) and registration form administration
  ▪ 2% Homeless by PRAPARE definition (8% by UDS definition)
  ▪ 6% Public housing residents (no specific question about this within PRAPARE)
• 22% of surveys expressed at least one actionable social determinant of health, many more than one

  ▪ Referrals were provided for those with actionable social determinants of health when available

  ▪ Outside referrals and any additional enabling services provided directly are captured with the HRHCare electronic “brief encounter form” which is entered into the patient’s medical record
• HRHCare chose to ask a detailed medical transportation question
  ▪ Expected result would be slightly lower than overall transportation deficit
  ▪ Actual results:
    ▪ 3% responded “yes” to laundry list question about transportation difficulty
    ▪ **22% answered yes to specific question about lacking medical transportation**
    ▪ As previously stated, 22% of all patients replied having one or more potentially actionable social determinants of health such as lack of medical transportation
Data analysis has been most fruitful in Hudson where we have a large number of completed surveys, more than 900, especially compared to the town population of around 6,500.

- 50% of MSAWs reported that they missed appointments or medications because of a lack of transportation
- HRHCare is one of two agencies in the County to provide free medical transportation to MSAWs
- Data presented to collaborating agencies in Hudson
- Joint medical transportation marketing effort underway
- Data is expected to inform future grant getting and advocacy efforts around additional needed services
THANK YOU!

Andrew Lehto
Director of Community Outreach

HRHCare
6 Henry St
Beacon, NY 12508
T (845) 831-0400 x76033
F (845) 838-6105
alehto@hrhcare.org
eClinicalWorks Configuration
Demographics

Follow the eCW UDS Reference Guide for Collection of Demographic Data for UDS Reports that overlap with PRAPARE.

- Race
- Ethnicity
- Language
- Sliding Fee
- Migrant
- Seasonal
- Homeless
- Veteran
Social History Structured Data

CONFIGURING THE PROGRESS NOTE QUESTIONS
Create Item in Social History

- Click on Custom drop down and select New Item
- Add Social Determinants of Health
- Check the Structured Data Box
- Click OK
Click on “Details” to open Social Determinants of Health Structured Data Window.

Click on Custom

Then Click “Add” to enter each Question as Structured Data one at a time
NOTE: Use Copy (Control C) and Paste (Control V) from the eCW Configuration Guide to save time
Add Responses for Questions with Structured Text Using the Customize Structured Text Button
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.

Check Multi Select for this question. This allows you to select all that apply.
Create a PRAPARE Template using placeholders that will allow users to enter data in a pop up box on the Progress Note.

Add place holder in Notes for each question.
Merge Template

Click on the placeholder (...) and use the pop up box to complete PRAPARE.
# Recommended Enabling Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management Assessment First Visit</td>
<td>CM001</td>
</tr>
<tr>
<td>Case Management Follow-up</td>
<td>CM002</td>
</tr>
<tr>
<td>Case Management Home Visit</td>
<td>CM003</td>
</tr>
<tr>
<td>Emergency Intervention/Phone Non-Medical</td>
<td>CM004</td>
</tr>
<tr>
<td>Emergency Intervention/Encounter Non-Medical</td>
<td>CM005</td>
</tr>
<tr>
<td>Phone and Walk-in Triage</td>
<td>CM006</td>
</tr>
<tr>
<td>Pharmaceutical Case Management</td>
<td>CM007</td>
</tr>
<tr>
<td>Case Management Appointment Made</td>
<td>CM008</td>
</tr>
<tr>
<td>Case Management Chronic Disease Management</td>
<td>CM009</td>
</tr>
<tr>
<td>Follow-up for Compliance/Phone</td>
<td>CM010</td>
</tr>
<tr>
<td>Case Management Field Visit</td>
<td>CM011</td>
</tr>
<tr>
<td>Referral for Food Services</td>
<td>CM012</td>
</tr>
<tr>
<td>Referral for Housing Services</td>
<td>CM013</td>
</tr>
<tr>
<td>Financial Counseling/Eligibility Assistance</td>
<td>FC001</td>
</tr>
<tr>
<td>Health Education/Supportive Counseling</td>
<td>HE001</td>
</tr>
<tr>
<td>Interpretation Services</td>
<td>IN001</td>
</tr>
<tr>
<td>Language Assistance in Completing Forms</td>
<td>IN002</td>
</tr>
<tr>
<td>Outreach Services</td>
<td>OR001</td>
</tr>
<tr>
<td>Transportation to/from Health Center</td>
<td>TR001</td>
</tr>
<tr>
<td>Transportation to/from Referral Appointment</td>
<td>TR002</td>
</tr>
<tr>
<td>Other Services</td>
<td>OT001</td>
</tr>
</tbody>
</table>
PRAPARE Smart Form

 Provides a view of the PRAPARE information captured in demographics
 Clinical Questions displayed in an easy to read form view
 Recommendations for social determinants of health related assessments based on the response
 Basic scoring
 Mechanism to document enabling services provided that codes (dummy codes) to the progress note billing window for tracking
Smart Form
Mock Up
**Patient Name:** Tom, Sam  
**Address:** 123 Happy Lane, Overtherainbow, NY, 12345  
**Race:** White  
**Ethnicity:** Hispanic  
**Language:** Spanish  
**Insurance:** Self Pay  
**Insurance Class:** None  
**Income Level:** 40%  
**Income Level ICD:** Z59.5 or Z59.6 · ([if value = 0-100% ICD Z59.5, if 101%-200% ICD Z59.6])  
**Migrant:** Yes  
**Seasonal:** No  
**Veteran:** No

### Money & Resources

**What is your current housing situation?**

- [ ] I have housing
- [ ] I do not have housing (staying with others, in a hotel, on the street, in a shelter, living outside on the street, on a beach, or in a park) - **ICD Z59.0**
- [ ] I choose not to answer this question

**Are you worried about losing your housing?**

- [ ] Yes
- [ ] No
- [ ] I choose not to answer this question

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

- [ ] Less than a high school degree - **ICD Z55.3**
- [ ] High school diploma or GED
- [ ] More than high school
- [ ] I choose not to answer this question
Enabling Services Provided? [ ] (If checked, show list below)

- Case Management Assessment First Visit
  - Case Management Follow-up
  - Case Management Home Visit
  - Emergency Intervention/Phone Non-Medical
  - Emergency Intervention/Encounter Non-Medical
  - Phone and Walk-in Triage
  - Pharmaceutical Case Management
  - Case Management Appointment Made
  - Case Management Chronic Disease Management
  - Follow-up for Compliance/Phone
  - Case Management Field Visit
  - Referral for Food Services
  - Referral for Housing Services
  - Financial Counseling/Eligibility Assistance
  - Health Education/Supportive Counseling
  - Interpretation Services
  - Language Assistance in Completing forms
  - Outreach Services
  - Transportation to/from Health Center
    - Transportation to/from Referral Appointment
    - Other Services
Community Mapping

Once the SMART form is available, you can use eCW Community Mapping to map your existing structured data or add the items as needed.

eCW will configure the CPT Code Mapping on the Enabling Services in the Smart form and link it to the dummy codes you are using so they appear on the Progress Note Billing Window.
Resources Available to you

NACHC Healthcare Communities
www.healthcarecommunities.org/ResourceCenter.aspx

Social Determinants of Health Folder
- Implementation steps and timeline
- PRAPARE Tool
- Data Documentation
- Educational materials about PRAPARE and other health center SDH projects

AAPCHO’s Enabling Services Accountability Project (ESAP) Resources
http://enablingservices.aapcho.org
**CONTACT INFO:**

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

**HCNNY** technical assistance
Stephanie Rose, srose@hcnny.org

**AAPCHO ESAP** technical assistance
Tuyen Tran, ttran@aapcho.org
Workflow

Front Desk Staff check in patient for their appointment
- Staff enter/update demographics fields

Front Desk Staff enter/update the following in eCW demographics and additional information fields at each visit:

- Name
- Address
- Gender
- Race
- Ethnicity
- Language
- Insurance
- Income/Poverty Level
- Migrant/Seasonal
- Veteran
Clinical Workflow – Part of visit

Nurse/MA rooms patient

Health Care Worker completes the PRAPARE tool
- Document patient response in eCW Structured Data
- Direct patients to appropriate enabling services/resources as needed

Provider begins exam
- Review progress note and PRAPARE responses
- Discuss clinical and Social Determinant issues
- Complete clinical visit
Workflow – Patient Navigator

**Clinical Visit** - Provider identifies patients to refer
- Patients needing Enabling Services
- Chronic Disease patients
- Referrals
- Pregnancy
- Behavioral Health patients

**Patient Navigator/Behavioral Health Integration Specialist Visit**
- Complete PRAPARE
- Refer patients to enabling services based on responses