COLLECTING SOCIAL DETERMINANTS OF HEALTH DATA USING PRAPARE TO REDUCE DISPARITIES, IMPROVE OUTCOMES, AND TRANSFORM CARE
BACKGROUND ON PRAPARE
Under value-based pay environment, providers are held accountable for costs and outcomes.

Difficult to improve health & wellbeing and deliver value unless we address barriers.

Current payment systems do not incentivize approaching health holistically and in an integrated fashion.

- Providers serving complex patients often penalized without risk adjustment.
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).
TIMELINE OF THE PROJECT

**Year 1 2014**
- Develop PRAPARE tool

**Year 2 2015**
- Pilot PRAPARE implementation in EHR and explore data utility

**Year 3 2016**
- PRAPARE Implementation & Action Toolkit
DEVELOPING PRAPARE

Aligned with National Initiatives:
* Healthy People 2020
* ICD-10
* Meaningful Use Stage 3
* NQF on Risk Adjustment

Identified 15 Core Social Determinants of Health

Experience of Existing Protocols
Stakeholder Feedback
Literature Review

Criteria:
- Action-ability
- Sensitivity
- Burden of Data Collection
# PRAPARE DOMAINS

## Core

<table>
<thead>
<tr>
<th>UDS SDH Domains</th>
<th>Non-UDS SDH Domains (MU-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Race</td>
<td>10. Education</td>
</tr>
<tr>
<td>2. Ethnicity</td>
<td>11. Employment</td>
</tr>
<tr>
<td>6. Income</td>
<td>15. Transportation</td>
</tr>
<tr>
<td>7. Insurance</td>
<td></td>
</tr>
<tr>
<td>8. Neighborhood</td>
<td></td>
</tr>
<tr>
<td>9. Housing Status and Stability</td>
<td></td>
</tr>
</tbody>
</table>

## Optional

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incarceration History</td>
<td>3. Domestic Violence</td>
</tr>
<tr>
<td>2. Safety</td>
<td>4. Refugee Status</td>
</tr>
</tbody>
</table>

Older version in Spanish

Find the tool at:
[www.nachc.org/prapare](http://www.nachc.org/prapare)
**UNIQUE ADVANTAGES OF PRAPARE TOOL**

- **Design**
  - All measures align with more than one national initiative (UDS, ICD-10, Meaningful Use, HP2020)
  - Data can be captured in the Electronic Health Record for NextGen, GE Centricity, eClinicalWorks, and Epic
  - Conversation starter and patient-centered
  - Able to make more granular / align with existing data collection efforts
  - Focus on standardizing the need, not the question
WHAT WE’VE LEARNED FROM IMPLEMENTATION
PRAPARE PILOT TESTING IMPLEMENTATION TEAMS AND ELECTRONIC HEALTH RECORDS

Team 1
- OCHIN, Inc.
- La Clinica del Valle Family Health Center (OR)

Team 2
- Waianae Coast Comprehensive Health Center (HI)
- AlohaCare
- Altruista Health

Team 3
- Health Center Network of New York
- Open Door Family Medical Centers (NY)
- Hudson River Healthcare (NY)

Team 4
- Alliance of Chicago
- InConcertCare
- Iowa Primary Care Association
- Waikiki Health (HI)
- Peoples Community Health (IA)
- Siouxland Community Health Center (IA)

Other EHRs in Development or Interested:
- Greenway
- Allscripts
- Athena
- Cerner
WHAT WE’VE LEARNED FROM PILOT TESTING

- Easy to use: On average, takes ~9 minutes to complete form
- Staff find value in the tool: Helps them better understand patients and build better relationships with patients
- Identifies New Needs, Often Leading to New Community Partnerships
- Patients appreciate being asked and feel comfortable answering questions
- Emotional Toll on Staff
<table>
<thead>
<tr>
<th>Health Center</th>
<th>Who</th>
<th>Where</th>
<th>When</th>
<th>How</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC #1</td>
<td>Non-clinical staff (enrollment assistance, community health workers)</td>
<td>In waiting room</td>
<td>Before provider visit</td>
<td>Administered PRAPARE with patients who would be waiting 30+ mins for provider</td>
<td>Provided enough time to discuss SDH needs</td>
</tr>
<tr>
<td>CHCs #2</td>
<td>Nursing staff and/or MAs</td>
<td>In exam room</td>
<td>Before provider enters exam room</td>
<td>Administered it after vitals and reason for visit. Provider reviews PRAPARE data and refers to case manager</td>
<td>Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info</td>
</tr>
<tr>
<td>CHC #3</td>
<td>Non-clinical staff (patient navigators, patient advocates)</td>
<td>In patient advocate’s office</td>
<td>After clinical visit when provider refers patient to patient navigator</td>
<td>Patient advocates administer it and then can relay to provider in office next door.</td>
<td>Wanted same person to ask question and address need. Often administer PRAPARE with other data collection effort (Patient Activation Measure) to assess patient’s ability and motivation to respond to their situation.</td>
</tr>
<tr>
<td>CHC #4</td>
<td>Care Coordinators</td>
<td>In office of care coordinator</td>
<td>When Completing chart reviews and administering Health Risk Assessments</td>
<td>Administered PRAPARE in conjunction with Health Risk Assessments</td>
<td>Allows care coordinators to address similar issues in real time that may arise from both PRAPARE and HRA</td>
</tr>
<tr>
<td>CHC #5</td>
<td>Any staff (from Front Desk Staff to Providers)</td>
<td>No wrong door approach</td>
<td>No wrong door approach</td>
<td></td>
<td>Allows everyone to be part of larger process of “painting a fuller picture of the patient” and taking part in helping the patient</td>
</tr>
</tbody>
</table>
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.”
PERCENT OF PATIENTS WITH NUMBER OF SDH “TALLIES”

N = 2,694 patients for all teams
CORRELATION BETWEEN SDH FACTORS AND HYPERTENSION: ALL TEAMS

$r = 0.61$
HOW PREPARE DATA HAS BEEN USED TO IMPROVE CARE DELIVERY AND HEALTH OUTCOMES

Better Understand INDIVIDUAL Patient’s Socioeconomic Situation

- 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)

Drive STATE and NATIONAL Care Transformation

- Inform both Medicaid and Medicare ACO discussions (ex: Iowa, New York)

- Create risk score to inform risk adjustment (ex: Hawaii)

- Ensure prescriptions and treatment plan match patient’s socioeconomic situation

- Guide work of local foundations (ex: New York housing)

- Streamline care management plans for better resource allocation (ex: Hawaii)

- Inform payment reform and APM discussions with state agencies (e.g., Medicaid) on caring for complex patients (ex: Oregon, Hawaii)
Chapter 1: Understand the PRAPARE Project
Chapter 2: Engage Key Stakeholders
Chapter 3: Strategize the Implementation Process

- Chapter 4: Technical Implementation with EHR Templates
- Chapter 5: Develop Workflow Models
- Chapter 6: Develop a Data Strategy
- Chapter 7: Understand and Evaluate Your Data

- Chapter 8: Build Capacity to Respond to SDH Data
- Chapter 9: Respond to SDH Data with Interventions
- Chapter 10: Track Enabling Services
HEALTH CENTER AND PCA EXPERIENCES WITH PRAPARE
Group of advanced clinics that are participating in an APM which allows them to create a patient-centric model of care to:

- Improve clinic population outcomes
- Improve patient and staff engagement
- Support open access
- Contain costs

APCM IN OREGON: USING PRAPARE TO EXPLORE PATIENT SEGMENTATION WITH OREGON CHCS

Five strategies of APCM

1. Teams use actionable, real-time information/data
2. Teams expand/enhance access
3. Teams proactively reach out and provide acute care
4. Teams engage patients and provide self-management support
5. Teams enhance appropriate care and work to reduce unnecessary utilization

GOAL

* Draft as of 10/24/14

SEGMENTATION TOOL to inform care needs
We invited clinics to pick a patient population and interview 10 consumers using 3 questions from PRAPARE

 Afterwards, clinics met face-to-face to share their experiences

- How did you and the patient discuss these questions?
- What did you observe about the process (your experience, patient’s reaction)?
- Did asking these questions lead to conversations about other topics?
APCM: THE BIG PICTURE

APCM Accountability Plan

Quality
Track 9 CCO measures, 5 UDS measures, and 1 utilization measure. Focus on two of the clinical measures. Sustain or improve patient satisfaction.

Cost
Maintain or reduce adjusted per capita costs. Match services and resources to complex care needs.

Access
Document visits and engagement; touches with 70% of established patients on an annual basis.

Population Management
Segment population to identify disparities. Interview, track, and intervene accordingly. Use psychosocial risk adjustment for payment and quality to promote health equity.

Care Transformation Strategies

Teams
Build care teams that are a reflection of patient needs.

Data
Use actionable and real time data

Appropriate Care
Enhance appropriate care and work to reduce unnecessary emergency department utilization and ambulatory care sensitive admissions

Access
Centered around patient’s schedule, mode of preference

Partner
Partner with patients to co-create and provide self-management services

© Oregon Primary Care Association
Population Segmentation: Our work NOW

10,000 PEOPLE POPULATION

Use analytics to piece together target population characteristics. May require multiple data sources and analytic processes.

SUB-POPULATION(S)

- 834 diabetics
- 223 with HbA1c >9

TARGET POPULATION

- 56 out of the 223 diabetics with HbA1c >9 who also:
  - Missed 2 appointments in the last 6 months
  - Live below 100% FPL
  - Are non-native English speaker
  - Have a co-occurring mental health diagnosis
  - Did not graduate from high school

Understanding Their Needs
- Empathic inquiry and community data (PREPARE)

Responding to Their Needs
- Redesigning care teams
- Developing strong
- Community partnerships
- Expanding social determinants of health/upstream interventions

Demonstrating Impact
- Metrics of success
- Understanding cost and ROI
FROM GATHERING DATA TO ASSESSMENT TO EMPATHIC INQUIRY

- Expand the medical mental model while enhancing the human connection
  - Trust and understanding is fostered bi-directionally by interviewing with empathy and incorporation of SDoH
  - This interaction, alone, can function as a healing intervention
- Deepen our understanding of the individuals and populations we serve while also releasing health care professionals from the entrenched cultural orientation of responsibility to fix other people’s lives
- Start from respect for patient autonomy and strength; collaborate to develop individual- and community-level solutions
- Develop the trauma-informed care skills to learn about people’s difficult experiences without causing re-traumatization
- Provide a setting where provider teams get to do the work they care about – linked to retention and joy at work
OPCA Demo:

- https://www.youtube.com/watch?v=9rfmfsMMeEU

Waianae Demo:

https://youtu.be/iQj_QsDvmI
TRACKING INTERVENTIONS
DATA ON SDH AND NON-CLINICAL INTERVENTIONS GO HAND IN HAND

**NEED**
- Standardized data on patient risk

**RESPONSE**
- Standardized data on interventions

**BOTH are necessary to demonstrate health center value**
RESPONSE- DATA ON INTERVENTIONS

TAKING THE FULL MEASURE OF HEALTH CENTER

Report by RCHN Foundation in NACHC Community Health Forum, HIT Connections, Fall/Winter 2014
## LACK OF COMPREHENSIVE ENABLING SERVICES DATA

### UDS TABLE 5 - STAFFING AND UTILIZATION

<table>
<thead>
<tr>
<th>Personnel by Major Service Category</th>
<th>FTEs (a)</th>
<th>Clinic Visits (b)</th>
<th>Patients (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient/Community Education Specialists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility Assistance Workers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpretation Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Enabling Services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Enabling Services Accountability Project (ESAP)

The ONLY standardized data system to track and document non-clinical enabling services that help patients access care.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CODE</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASE MANAGEMENT ASSESSMENT</td>
<td>CM001</td>
<td></td>
</tr>
<tr>
<td>CASE MANAGEMENT TREATMENT AND FACILITATION</td>
<td>CM002</td>
<td></td>
</tr>
<tr>
<td>CASE MANAGEMENT REFERRAL</td>
<td>CM003</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL COUNSELING/ELIGIBILITY ASSISTANCE</td>
<td>FC001</td>
<td></td>
</tr>
<tr>
<td>HEALTH EDUCATION/SUPPORTIVE COUNSELING</td>
<td>HE001</td>
<td></td>
</tr>
<tr>
<td>INTERPRETATION</td>
<td>IN001</td>
<td></td>
</tr>
<tr>
<td>OUTREACH</td>
<td>OR001</td>
<td></td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>TR001</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>OT001</td>
<td></td>
</tr>
</tbody>
</table>
SAMPLE ENABLING SERVICES EMR TEMPLATE
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
WHAT YOU CAN DO NOW
RESOURCES AVAILABLE NOW

- Visit www.nachc.org/prapare
  - PRAPARE Tool
  - PRAPARE Implementation and Action Toolkit
    - Electronic Health Record PRAPARE Templates
    - Readiness Assessment
  - Webinars
    - PRAPARE Overview
    - EHR and Workflow-specific
  - Frequently Asked Questions
- Contact: Michelle Jester at mjester@nachc.org

- Visit http://enablingservices.aapcho.org
  - AAPCHO’s Enabling Services Accountability Project
    - protocol for data collection of non-clinical enabling services
  - Enabling Services Data Collection Implementation Guide
  - White Papers, Best Practices, Studies
  - Contact Tuyen Tran at ttran@aapcho.org
PRAPARE Readiness Assessment Tool

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Use this tool to help identify your organization’s readiness to implement PRAPARE.

Instructions for Use
You can use this tool in several ways:
- Distribute it to members of your leadership team in advance of a meeting where you will discuss its results
- Bring it to a leadership team meeting to discuss readiness
- Have a facilitator use it to rate your leadership team’s meeting after a group discussion

The PRAPARE project is a major undertaking and significant leadership is needed to carry it out effectively. Be honest about the general state of affairs within your organization.

Tally the total number of checks made in each column. The more checks in the moderately prepared and highly prepared columns, the more ready your organization is ready for PRAPARE. If you find many checks in the not yet prepared column, look at the statements in the columns for moderately prepared or highly prepared. These will give you guidance on where your organization is to be and how to get there. The assessment may suggest the need for organizational development prior to undertaking the PRAPARE project.

<table>
<thead>
<tr>
<th>Readiness Area</th>
<th>Readiness Component</th>
<th>Not Yet Prepared</th>
<th>Moderately Prepared</th>
<th>Highly Prepared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture of Organization</td>
<td>PRAPARE is viewed...</td>
<td>□ Only a national standard.</td>
<td>□ Primarily a project to collect social determinants of health (SDH) data.</td>
<td>□ A component of clinical transformation to enable quality of care and patient health care improvement by identifying and addressing the SDH.</td>
</tr>
<tr>
<td>The PRAPARE project management process includes...</td>
<td>□ The administrator primarily driving the project.</td>
<td>□ A large group of individuals primarily for communication purposes.</td>
<td>□ An identified Project Manager working across clinical, IT, leadership, and data staff.</td>
<td></td>
</tr>
<tr>
<td>Health center stakeholder engagement</td>
<td>□ Is not feasible.</td>
<td>□ Primarily consists of executive leadership.</td>
<td>□ In action where all staff at all levels are engaged and understand the importance of the</td>
<td></td>
</tr>
</tbody>
</table>

Paper form: www.nachc.org/prapare

Online form: https://www.surveymonkey.com/r/PRAPARE_Readiness_Assessment
FUTURE OF PRAPARE
Use and Interest in PRAPARE as of October 2016

- States where health centers are already using PRAPARE (31 states)
- States where health centers or PCAs have expressed an interest in PRAPARE (19 states)
2016 – 2019: NATIONAL PREPARE LEARNING NETWORK (PLAN)
SPREAD, REFINE, & AUGMENT STANDARDIZED DATA COLLECTION FOR ACTION

PCA/HCCN
Train the Trainer Academy
& Live University
Promote & Spread

Validation and Aggregation
Document Impact and Risk

Enhancement
Track Interventions and Risks

Partnerships for Progress
Leverage Collective Impact for Population Health
Healthy Places for Healthy People is a new program to help communities partner with community health centers, nonprofit hospitals, and other health care facilities to create walkable, healthy, economically vibrant places.

Supported by Environmental Protection Agency and the Appalachian Regional Commission.

Communities receive planning assistance to develop action plans focusing on health as an economic driver and catalyst for downtown and neighborhood revitalization.

Learn how to apply for the Healthy Places for Healthy People Program: https://www.epa.gov/smartgrowth/healthy-places-healthy-people

Deadline: November 6th! Short application
To receive the latest updates on PRAPARE, join our listserv! Email Michelle Jester at mjester@nachc.org.
Take Home Activities

• Complete Evaluation

• Complete the PRAPARE Readiness Assessment:
  • Paper form available at: www.nachc.org/prapare
  • Online form available at: https://www.surveymonkey.com/r/PRAPARE_Readiness_Assessment

Readings/Resources for November 17th Housing Webinar

1. **ASK & CODE: Documenting Homelessness Throughout the Health Care System**

2. **Health and Housing Partnerships: Strategic Guidance for Health Centers and Supportive Housing Providers**

Next Webinar – November 17, 3:00 PM EST
Housing as a Social Determinant of Health

| Housing | Nov 17th 3:00 – 4:15 EST | • Understand relationship between health and housing (public, supportive, and lack of.) and role of health centers.  
• Learn how to identify and address barriers and challenges within your service area which adversely affecting your patient population.  
• Identify opportunities for health centers to partner with housing providers and stakeholders. | CSH, CHPFS, NHCHC |

1. Health and Housing Partnerships: Strategic Guidance for Health Centers and Supportive Housing Providers
3. Counting Residents of Public Housing on the 2015 UDS Report
Housing is a Social Determinant of Health Faculty

Kristine Gonnella
Community Health Partners for Sustainability
kristine@chpfs.org

Darlene M. Jenkins, DrPH, MPH, CHES
Senior Director of Programs
National Healthcare for the Homeless
THANK YOU!!