Assessing and Addressing the Social Determinants of Health Using PRAPARE: Experiences in California

December 7, 2017
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ACKNOWLEDGMENTS
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<td>Welcome and Setting the Stage</td>
<td>Rachel Wick, Blue Shield of California Foundation</td>
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<td>Overview of PRAPARE</td>
<td>Michelle Proser, NACHC</td>
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<td>PRAPARE Experiences and Impact in Two Health Center Settings</td>
<td>Celina Chan and Maria Reyes, La Clinica de la Raza Corinne Knutson, La Maestra</td>
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<td>Bringing PRAPARE to Scale in California</td>
<td>Val Sheehan, California Primary Care Association</td>
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Welcome and Setting the Stage
Welcome and Setting the Stage:
Blue Shield of California Foundation

Rachel Wick
Senior Program Officer
Health Care and Coverage
Overview of PRAPARE
Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences:

A *standardized protocol* designed to engage patients in assessing & addressing social determinants of health (SDH).

PRAPARE = SDH screening tool + implementation/action process

Health Organizations need tools to:
- Document patient complexity and demonstrate value
- Stratify patients by social risk to create interventions/partnerships, improve health, and control costs
In the EHR to facilitate assessment & interventions (free templates)

Implement in various workflows and staffing models

Actionable at patient and population levels
  - Build patient-provider relationship
  - Identified new needs, document extent of needs
  - Led to positive changes at the patient, health center, and community/population levels
  - Facilitate collaboration with community partners

Common core yet flexible:
  - Focus on standardizing the need, not question
  - Conversation starter and patient-centered
  - Able to make more granular and/or add questions, and can be used in combination with other tools

Designed to screen all patients but can be applied to specific populations
<table>
<thead>
<tr>
<th>Health Center</th>
<th>Who</th>
<th>Where</th>
<th>When</th>
<th>How</th>
<th>Rationale</th>
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<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>
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<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>
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<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>
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<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>
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patients experience multiple SDH risk factors (typically 4-7, excluding low income)

Percent of Patients with Number* of SDH “Tallies”

N = 2,694 patients for all teams

This health center pilot population had highest burden of chronic illness.

* Excludes low income
How PRAPARE Data Has been Used to Improve Care Delivery and Health Outcomes

**INDIVIDUAL Level**
- Build new or expand existing services in-house for same-day use as clinic visit (children’s book corner, food banks, clothing closets, wellness center, transportation shuttle, etc)
- Ensure prescriptions and treatment plan match patient’s socioeconomic situation (all)

**POPULATION Level**
- Build partnerships with local organizations (ex: Iowa and NY transportation)
- Use for Population Segmentation/Risk Stratification (HI, NY, OR)
- Guide work of local foundations (ex: New York housing)
- Streamline care management plans for better resource allocation (ex: Hawaii)

**System and Policy Level**
- Inform health delivery redesign (ex: Medicaid and Medicare ACO discussions in Iowa, New York)
- Use data for “seat at the table” with payers to discuss sustainable payment and APM (all)
PRAPARE EHR Templates include those commonly used by health centers

- Currently available:
  - NextGen
  - eClinical Works
  - GE Centricity
  - Epic

Available for free after signing EULA at www.nachc.org/prapare

- In development:
  - Greenway Success EHS
  - Greenway Intergy
  - Allscripts
  - Meditab
  - Athena
  - Cerner

60% of all health centers

Current 4 + New EHRs = 85-95% of all health centers
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
Goal: Better position California health centers for payment and delivery system reform and to accelerate community health improvement by developing a comprehensive roadmap for bringing PRAPARE to scale across California.

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<th>Organizations Involved</th>
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<td><strong>National Organizations</strong></td>
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<tr>
<td>Blue Shield of California Foundation</td>
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<tr>
<td>National Association of Community Health Centers</td>
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<tr>
<td>Association of Asian Pacific Community Health Organizations</td>
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<tr>
<td>Oregon Primary Care Association</td>
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A Tale of Two Settings:

PRAPARE Experiences and Impact in Two California Health Centers
PRAPARE Data Collection at La Clinica

December 7, 2017
Maria Reyes and Celina Chan
About La Clinica

Overview of La Clinica
- FQHC with 34 sites in 3 counties in the San Francisco Bay Area
- Patient demographics
  - Diverse: Latino (62%), Afr. Am. (11%), Asian (9%), White (10%)
  - Non-English speaking and immigrant populations
  - FPL: 75% live below 200% FPL ($24,600 for a family of 4)

About the Community Health Education (CHE) department
- Involved with a number of programs, such as healthy eating, tackling health disparities, and healthy and safe environments
Tackling Social Determinants of Health

- Since La Clinica’s inception, health equity and tackling SDH factors has been at the core of the organization’s work

- In 2016, social determinants of health (SDH) became the agency-wide Special Initiative for our Continuous Quality Improvement (CQI) Committee
  - Each year, the CQI committee works on a special initiative to promote QI methods & goals throughout the agency
  - In 2016, we began to meet as a subcommittee to identify SDH indicators to measure and a tracking system for indicators
  - SDH Subcommittee has diverse representation and leadership support

- SDH continued as CQI Special Initiative in 2017 and La Clinica participated in the NACHC PRAPARE pilot
Data Collection for PRAPARE Pilot

- Data collection timeframe: April 1, 2017 – September 31, 2017
- Number of surveys collected: 412
- Primarily administered by Community Health Education (CHE) staff in non-clinical settings
## PRAPARE Workflow for NACHC Pilot

<table>
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<tr>
<th>Who</th>
<th>Where</th>
<th>When</th>
<th>Population of Focus</th>
</tr>
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<tbody>
<tr>
<td>Community Health Educators</td>
<td>Medical sites where CHE staff have offices</td>
<td>During enrollment activities (such as Covered California)</td>
<td>General patient population</td>
</tr>
<tr>
<td>Patient navigator</td>
<td>Medical and dental waiting rooms</td>
<td>Front desk staff will check in patient and CHE staff will administer PRAPARE</td>
<td>General patient population</td>
</tr>
<tr>
<td></td>
<td>Sutter Emergency Dept.</td>
<td>• During 1-1 intake session</td>
<td>LC patients in ER</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For patients who don’t feel well, patient navigator will call patients after they’ve been discharged</td>
<td></td>
</tr>
<tr>
<td>Community Health Worker</td>
<td>Transitions Clinic</td>
<td>During 1-1 patient intake session</td>
<td>Re-entry population</td>
</tr>
<tr>
<td>Community Health Educator</td>
<td>Phone calls to Contra Costa CARES patients</td>
<td>Staff calls patients after 6pm and administers survey over the phone</td>
<td>Uninsured population</td>
</tr>
<tr>
<td>Joint Venture Health (JVH) nurses</td>
<td>Home visits</td>
<td>During the 2nd home visit with patient</td>
<td>Chronically-ill, intensive case management patients</td>
</tr>
</tbody>
</table>
Responding to Needs Identified

- **Community Resource Referrals**
  - Planning for use of Enabling Services: Documents Referral/Need Met
  - Development of Local Resource Directory: up-to-date, easy to use, able to be mapped, trusted contacts

- **Types of Referrals:**
  - Enrollment: CalFresh, Medi-Cal
  - Food
  - Mental health
  - Housing
  - Transportation
  - Immigration/ legal aid
  - Social services
Partner Organizations

- CPCA
- Local Consortia
- Funders

- Local Community Resources
- CBOs
- County Services
- EHSD
- Legal: Centro Legal and JCFS
- Food: Churches and Food Banks
- County Mental Health Services
- Transportation: Local Transit Co.
PRAPARE Data Findings (n=412)

**Gender**
- Female: 67%
- Male: 33%

**Preferred Language**
- English: 25%
- Language other than English: 75%

*Preferred languages: Spanish (n=303), Tagalog (n=2), Romanian (n=1), Other (n=2)*
What is your housing situation today?

- I have housing: 90.8%
- I do not have housing: 4.6%
- I choose not to answer this question: 1.0%
- Skipped question: 3.6%

Are you worried about losing your housing?

- Yes: 25.2%
- No: 68.0%
- I choose not to answer this question: 2.4%
- Skipped question: 4.4%
PRAPARE Data Findings (n=412)

What is the highest level of school you have completed?

- Less than high school degree: 31%
- High school diploma or GED: 43%
- More than high school: 16%
- I choose not to answer this question: 7%
- Skipped question: 4%

What is your current work situation?

- Unemployed and seeking work: 19%
- Part-time work: 16%
- Full-time work: 24%
- Otherwise unemployed but not seeking work: 25%
- I choose not to answer this question: 5%
- Skipped question: 8%
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.

- **Food**: 74
- **Clothing**: 47
- **Utilities**: 48
- **Child Care**: 16
- **Medicine or any health care**: 60
- **Phone**: 40
- **Other**: 2
- **No**: 242
- **I choose not to answer this question**: 51
- **Skipped question**: 19
Sharing Data – SDH Subcommittee

- Processes and PRAPARE data collection was discussed during monthly SDH subcommittee meetings

- Final PRAPARE data was shared among the following groups:
  - SDH subcommittee
  - CQI committee
  - Community Health Education monthly staff meeting

- We are hoping to work on a way to pull a report on PRAPARE data from NextGen so that we can review PRAPARE data more regularly
Lessons Learned

- Be flexible – modify workflows as needed
- Some staff may have more availability than others to administer PRAPARE due to their workloads and the setting in which they work
- Messaging PRAPARE to LC patients – developed a flyer in Spanish and English
- Identify provider champion to support the project and share importance of SDH with other staff
Impact of PRAPARE on La Clinica

- Allowed us to better quantify and understand the needs of our patient population
- Identified the need for an up-to-date, centralized resource directory
- Prepared La Clinica to implement the next phase of a project that will focus on collecting PRAPARE data on undocumented and uninsured patients in Contra Costa County
Future Plans for PRAPARE

- Will collect at least 500 PRAPARE surveys for another social determinants of health data project
  - At least 250 participants will be from Contra Costa CARES
  - The other 250 participants will be the general patient population in Contra Costa County
  - Share PRAPARE data with providers and other stakeholders in Contra Costa County

- Continue to build partnerships

- Finish developing an internal resource directory

- Track referrals through the use enabling services codes or another mechanism

- Identify funding sources to sustain SDH data collection
Thank you!

For questions, contact:
Maria Reyes: mreyes@laclinica.org
Celina Chan: cchan@laclinica.org
La Maestra Family Clinic, Inc.
PRAPARE

Presented by:
Corinne Knutson
Chief Development Officer
Workflow: Using PRAPARE during all Health Ed. visits. Template filled out by health ed. staff. Staff sit with patient and ask all questions and fill out in the patient’s EHR on the staff members computer. Positive results in having a staff member act as guide or patient concierge through the questions versus handing the patient a blank form.

In the process of moving to tablets so all patients will fill out PRAPARE as part of new patient registration and have one patient concierge staff manning the new patient registration and PRAPARE template at the main site and clinics second largest site in El Cajon.

Funding is needed for these additional PC staff members as well as time and resources for training the PCs.

Why this workflow/pilot group: Choose health ed. because of experience addressing and referring to onsite, upstream social services and the time allowed for CPSP initial assessment.
Better marketing of our onsite social services

(57%) of patients did not know we have on site services. Source: 2017 patient survey

food pantry, limited clothing and sundries in our HCH clinic, legal advocacy and immigration services, job training and transitional housing

Working to increase onsite housing

Improve housing referrals

Close the loop on referrals by participating in community information exchange (2-1-1), Catholic Charities, PATH, Scripps, etc.
Highlight of Interesting Results

Social Determinant of Health Needs
N=235

- Housing: 13%
- Utilities: 12%
- Health Insurance: 9%
- Food: 7%
- Medical Care: 6%
- Clothing: 6%

Employment Status
N=235

- Unemployed: 46%
- Skipped Question: 24%
- Working: 30%

16% of PRAPARE patients were veterans. Much larger percentage than our general patient population.
• LMFC staff in health ed. were the perfect group to pilot template they were experienced with asking similar questions for CPSP visits

• Having a staff member sit with patient helped. Thus, planning to have a patient concierge for tablets

• Downloading and analyzing PRAPARE data monthly as part of QI monthly meetings beginning Jan. 1, 2018

• Ensuring referrals are made to onsite services housing, food pantry, microcredit, afterschool care, community garden, etc.

• Closing the loop for both onsite and offsite social services with partner agencies

• Developing one-pager for PRAPARE to be included in all patient registration packets
• Providing SDOH onsite for decades, but no data

• PRAPARE data allowed us to identify patients needs and to create a new marketing plan to ensure that patients are being referred to onsite services

• Improved tracking and metrics for grants and individual fundraising

• Better track referrals and close the loop

• PRAPARE was a catalyst for partnership with a local CIE system

• Allowed staff to feel empowered, break down silos and work better across social service departments (health ed. and food pantry pictured, right)

• Staff are able to make referrals in EHR and to see SDOH data as additional resource for treatment plans
Plans for PRAPARE Data

• Use PRAPARE data for grants and additional partnerships with housing, additional food pantry sites, etc.

• Use data on a monthly basis as part of QI meetings starting Jan. 1

• Present data to Executive team at monthly Board meetings to guide org. in strategic planning efforts and new SDOH services, as needed
Questions?
Bringing PRAPARE to Scale in California
BOLD VISION
Advancing health equality for all people.

MISSION
The mission of the California Primary Care Association is to lead and position community clinics, health centers, and networks through advocacy, education and services as key players in the healthcare delivery system to improve the health status of their communities.
Bold Step 2 – Transform the Health System

TRANSFORM THE HEALTH SYSTEM

Advance health system transformation at the national, state, and local levels to promote health equity for all.

GOALS

1. Identify and facilitate learning around innovative approaches to delivering highly effective and efficient care.

2. Build and strengthen integrated delivery networks and bridge gaps across siloed delivery systems to advance the health outcomes of communities.

3. Increase advocacy around issues related to social determinants of health that affect the health outcomes of community health centers patients.
PROMOTE THE VALUE OF COMMUNITY HEALTH CENTERS

Identify and articulate a shared vision promoting the value of community health centers to California communities and the health system as a whole.

GOALS

1. Support community health centers’ ability to enhance internal cultures of quality and make strategic, data-informed decisions regarding operations and care delivery.
2. Create a shared community health centers’ “value vision” that underscores the important role of community health centers in affecting population health and social determinants of health.
3. Community health centers have the necessary skills and resources to influence and forge partnerships that impact community health.
QUESTIONS AND DISCUSSION

For more information and guiding resources, visit www.nachc.org/prapare