INTEGRATING CLINICAL AND NON-CLINICAL CARE TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

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April 24, 2018
Apply strategies to determine whether your organization has capacity to address social determinants in-house versus through community partnerships

Outline steps to build partnerships to integrate clinical care and community services

Compare and contrast different approaches to responding to socioeconomic needs
Why Is It Important for Us to Collect Data on the Social Determinants of Health?

**Individual level**
- Patient and Family
  - Empowered to improve health and wellbeing
- Care Team Members
  - Better manage patient and population needs

**Organizational level**
- Health Center
  - Design care teams and services to deliver patient/community-centered care

**System/Community level**
- Community/Local Health System
  - Integrate care through cross-sector partnerships, develop community-level redesign strategy for prevention, and advocate to change local policies

**Payer level**
- Payment
  - Execute payment models that sustain value-based care (incentivize the social risk interventions and partnerships, risk adjustment)

**Policy level**
- State and National Policies
  - Ensure capacity for serving complex patients, including uninsured patients
Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences:

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

PRAPARE = SDH screening tool + implementation/action process

**WHAT IS PRAPARE?**

[WWW.NACHC.ORG/PRAPARE](http://WWW.NACHC.ORG/PRAPARE)

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Customizable Implementation and Action Approach

- Assess Needs
- Respond to Needs

At the Patient and Population Level
Common Question: What If We Do Not Have the Resources or Services to Respond to Social Determinant Needs Identified? What Do We Do?

- Messaging Solution:
  - Explain that "the organization has to start somewhere"

- Data collection is that first step

- Collecting data on the social determinants of health will help the organization figure out which services it can provide in-house to improve outcomes by uncovering the root causes of health conditions and health behaviors

- For services that the organization cannot provide in-house, this data will help inform which community organizations with which it should partner to provide needed services

- Until then, the organization will do the best that it can to address the social determinants needs raised by PRAPARE with what it has.
Strategies to Integrate Clinical and Non-Clinical Care
BUILDING CAPACITY TO RESPOND: ASSESS YOUR SETTING

- **People**
  - Do you have staff time that can be dedicated to social determinants-focused initiatives at your clinic?
  - Are their specific roles (i.e. a Community Health Worker) focused on addressing a patient's social needs?

- **Processes**
  - Do you have referral workflows in place for connecting patients with resources to address their social determinant needs?
  - Have you formed partnerships with external organizations (i.e. your local chapter of the food bank, or an employment agency)?

- **Technology**
  - Does your EHR support or systematize patient referrals to social services?
  - Are you able to share data with external organizations?
# USING 5 RIGHTS/CDS TO PLAN FOR RESPONSES TO SOCIAL DETERMINANT NEEDS

<table>
<thead>
<tr>
<th>5 Rights</th>
<th>Responses/Interventions</th>
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</table>
| Right Information | What information and resources do you have to respond to social determinants data? Is it up to date?  
  - Update your community resource guide and referral list with accurate information  
  - Track referrals, interventions, and time spent |
| Right Format      | How will information be stored for use & presented to patients?  
  - Searchable database of resources (in-house or via partner);  
  - Printed resource for patients to take with them  
  - Warm hand-off for referrals |
| Right Person      | Who will respond to social determinants data?  
  - By a dedicated staff person? By any staff person who administers PRAPARE with patient? By the provider? |
| Right Time        | When will referrals take place?  
  - Immediately after need is identified?  
  - After patient sees provider? At end of visit? |
| Right Place       | Where will referral take place?  
  - In private office or exam room? |
IN-HOUSE OR PARTNERSHIPS?

Create Services In-house
- People: develop staffing models to respond to SDH
- Processes: Develop resources to support staff in addressing SDH needs at point of care

Form Coalitions w/ Community Partners; Advocate for Policy and Environmental Changes
- People: Build and staff a resource desk and community resource guides
- Process: Build and sustain effective community partnerships
- Technology: Track referrals to non-clinical services and measure intervention impact

Raise Awareness to Strengthen Staff, Patient, and Partner Knowledge of SDH
- People: Deliver skills training on how to discuss SDH (i.e. empathic inquiry)
- Process: Create opportunities for staff and leadership to message the value of addressing social determinants of health

Partner with Community-based Organizations & Leaders
- People: Set up volunteer programs at CHC for community volunteers
- Process: Focus public health/grant funds to support partnership development with local community organizations
- Technology: Develop an electronic referral system or resource guide
WAYS TO BUILD COMMUNITY PARTNERSHIPS
STEPS TO BUILDING COMMUNITY PARTNERSHIPS

1) Identify Key Partners
2) Form a Connection
3) Clarify A Common Agenda
4) Identify Clear Partnership Objectives
5) Secure Partner Commitment
6) Develop a Strategic Action Plan
7) Maintain Your Relationship
8) Evaluate Your Work Together

Key Ingredient: TIME!
1) STRATEGIES TO IDENTIFY KEY PARTNERS

- **Start with the Data**
  - Which social determinants were most prevalent in your population? Identifying community based organizations that focus on those is a good place to start.

- **Identify Strategic Opportunities**
  - Are there well-resourced organizations in your community that would be good partners, but may not have relationships or access points that your organization has?

- **Guided by Population Segmentation Needs**
  - If you are working to improve care management for a specific population, find other organizations who also focus on that population or who provide services that address needs of that population.
## Potential Community Partners to Engage

### Transportation:
- Local and Regional Transportation Authorities
- Ride Sharing Services (Uber, Lyft, etc.)

### Education:
- Head Start
- Community Colleges
- Local Schools

### Employment:
- Job Training Centers
- Employment Centers
- Temp Agencies

### Economic Development:
- Local Chamber of Commerce
- Local Funders

### Law Enforcement

### Food and Exercise:
- Farmers Markets
- Grocery Stores
- Meal Delivery Services
- YMCA
- Parks and Recreation Departments

### Ambulance, Fire, and EMS Services

### Housing:
- Housing Agencies
- Shelters
2) WAYS TO FORM A CONNECTION

- Attend organizational meetings to initially form a connection
  - Share data that you have! You are a witness as to what happens when socioeconomic need is not addressed.
    - Geomap needs to highlight geographic areas in need on common social determinant priority between your two organizations

- Invite community partner to your organization so that they can learn more about what you do, who you serve, etc. and vice versa

- Visiting can help identify each other’s strengths and opportunities for collaboration and partnership
  - Identify areas needing investment and resources

http://nrvrc.org/what-we-do/transportation/
3) CLARIFY A COMMON AGENDA AND
4) IDENTIFY CLEAR PARTNERSHIP OBJECTIVES

- Goals may be different at first so important to come to agreement on goals for partnership

- Logic Model to help identify common goals for guiding work—can lead to stronger plan
  - Resources, skills building experiences, & classes for patients (need for multi-lingual resources & services)
  - Identifying appropriate staff to be involved

- Discuss at onset how you will support the partnership
  - Get clarity on resource needs early-on because may determine feasibility of partnership & goals

- Take your time and start small if needed!
  - Share informational resources with each other
  - Refer patients to each other’s organizations

- Constant and clear communication is key!
  - Trust and respect each other because each has meaningful contribution to goals and partnership
5) SECURE PARTNER COMMITMENT AND 6) DEVELOP STRATEGIC ACTION PLAN

- Sample Memorandums of Understanding
  - Detail roles and responsibilities of partners
  - Chapter 8 in PRAPARE Implementation and Action Toolkit
    - www.nachc.org/prapare

- Logic Model and Workplan
7) MAINTAIN YOUR RELATIONSHIP AND 8) EVALUATE YOUR WORK TOGETHER

- Stick to Logic Model to maintain relationship and revisit goals frequently to ensure continued alignment

- Local academic institutions great option for evaluation
  - But ensure goals are the same!
  - Ensure community partners are authors of any published manuscripts and are compensated for their time
  - Share results back with community partners and patients for interpretation and validation
  - Hold meetings at community partner organization rather than university
  - Discuss next steps and priorities as a group (what worked well, what could be improved, etc.)

http://learningforsustainability.net/post/key-evaluation-questions/
THINGS TO CONSIDER

- **Do you have capability of sharing data with community partners?**
  - Sample Data Sharing Agreements
    - Chapter 8 of PRAPARE Implementation and Action Toolkit
    - [www.nachc.org/prapare](http://www.nachc.org/prapare)

- **Do you have capability of tracking referrals and “closing the loop” on referrals?**

- **Tools to Consider:**
  - EmpowOR
  - The Digital Bridge
  - State-based tools (CareConnect 360)
  - Health Information Exchanges and Community Information Exchanges
WAYS TO INTEGRATE CLINICAL AND NON-CLINICAL SERVICES
WAYS TO ADDRESS EDUCATION AND EMPLOYMENT NEEDS

In-House
- Ensure prescription and treatment plans match patient’s literacy levels and ensure patient understands plans
- Have book exchange
- Have clothing drives to collect professional clothes for patients’ job interviews, etc.
- Offer after-school and/or summer programs

Through Partnership
- Refer patients to employment centers for assistance with resume building, interview practice
- Refer patients to temp agencies for work
- Partner with community colleges to offer classes on computer skills, financial literacy, and job training (help with financial aid applications)
- Partner with Head Start programs to offer early education
- Organize Career and Job Fair with local and community-serving businesses
- Encourage community business development/local chamber of commerce to hire locally
WAYS TO ADDRESS FOOD AND PHYSICAL ACTIVITY NEEDS

- **In-House**
  - Organize food pantry and food donation drives
  - Build community gardens (in lot or on roof) and kitchens to offer nutrition cooking classes
  - Build walking paths around organization (if possible—can be indoor or outdoor)
  - Help patients with WIC and SNAP eligibility assistance
  - Offer grocery shopping tips and classes
  - Provide list of nearby parks or hiking trails

- **Through Partnership**
  - Work with Parent-Teacher Associations (PTAs) to advocate for free and reduced breakfasts and lunches at schools
  - Work with schools to have fruit and veggie gardens and nutrition and cooking classes at schools
  - Partner with local farmers to host farmers markets at clinics
  - Partner with food banks and/or food delivery services to have food delivered to clinic or patients home
WAYS TO ADDRESS TRANSPORTATION NEEDS

- **In-House**
  - Be strategic when scheduling so that patient can have everything during one visit (medical, dental, behavioral health, pharmacy, eligibility assistance) if know patient has transportation issues
    - Health fairs to provide multiple services in one-stop-shop
  - Provide bus tokens and taxi vouchers for patients
  - Mobile clinics can target areas experiencing transportation issues as a “Health Neighborhood”
  - Home visitation programs
  - Calculate $$ lost due to missed appointments due to transportation needs and potential ROI

- **Through Partnerships**
  - Uber or Lyft ride-share programs
  - Community carpools
  - Van or bus to take patients to major community organizations (health center, library, grocery store, YMCA, bank, etc.)
  - Advocate for new routes based on geomapped data
  - Advocate for needs-based pricing for transportation for students, seniors, low-income, veterans
WAYS TO ENHANCE COMMUNITY DEVELOPMENT AND INTERACTION

**In-House**
- Offer variety of group classes: cooking, Zumba, yoga, art, meditation and relaxation, wellness, etc.
- Organize Cultural Family Fair to stimulate engagement and interaction in community
- Organize Community Donation Days to collect shampoo, toothpaste, pillows, blankets, etc. for people in need

**Through Partnership**
- Organize neighborhood clean-up and beautification days to clean parks or beaches, pick up trash and recycling, paint over graffiti, etc.
- Partner with Habitat for Humanity, etc. to revitalize housing
OPPORTUNITIES TO LEVERAGE TO SUSTAIN CLINICAL AND NON-CLINICAL INTEGRATION

- Alternative Payment Methodologies
- Delivery System Transformation Initiatives
- Health Home Initiatives
- Local, State, & Private Funders
- Continuum of Care Funding from HUD Emergency Solutions Grants
- Community-Centered Health Homes
- State Funding Programs: Homeless Trust Funds
- Funding for Specific Social Determinant Work: Community Food Projects Food Insecurity Nutrition Initiative
**IMPORTANCE OF ENABLING SERVICES DATA**

**Data on NEEDS**
- Standardized data on patient social risk/barriers (PRAPARE)

**Data on RESPONSES**
- Standardized data on interventions (ES + others)

**BOTH are necessary to:**
- Demonstrate value of non-clinical services, social determinant interventions, and community partnerships to payers
- Seek adequate financing
- Better target and or improve services
- Together, both sets demonstrate how your organization is effectively meeting the needs of complex patients and benefiting the overall health care system.
RESPONDING TO NEEDS

- Asking of questions/empathic inquiry
- Care plan + treatment changes as result of needs identified
- Provide list of resources as result of needs identified
- Health center referrals and closing the loop of the referrals
- Health center enabling services
- Health center initiated community partnerships for interventions
- Health center advocacy for additional services

Capturing and documenting data on responses. ESAP chapter 10
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<td>CASE MANAGEMENT</td>
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Enabling Services Accountability Project (ESAP)

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

AAPCHO DATA COLLECTION PROTOCOL: THE ENABLING SERVICES ACCOUNTABILITY PROJECT

The Enabling Services Accountability Project (ESAP) is the ONLY standardized data system to track and document non-clinical enabling services that help patients access care.
GE CENTRICITY
PRAPARE + Enabling Services
RESOURCES AVAILABLE NOW
WWW.NACHC.ORG/PRAPARE

- PRAPARE Tool

- PRAPARE Implementation and Action Toolkit
  - Electronic Health Record PRAPARE Templates
  - Chapters on Building Partnerships, Interventions, and Enabling Services
  - Readiness Assessment

- Webinars
  - PRAPARE Overview
  - EHR and Workflow-specific

- Frequently Asked Questions

Contact: Michelle Jester at mjester@nachc.org
For more information, visit www.nachc.org/prapare
To receive the latest updates on PRAPARE, join our listserv!
Email Michelle Jester at mjester@nachc.org.
1) The webinar was helpful in supporting my social determinants of health learning and training efforts.
   a) Strongly Agree
   b) Somewhat Agree
   c) Neutral
   d) Somewhat Disagree
   e) Strongly Disagree

2) I gained new knowledge, understanding, or insights on integrating clinical and non-clinical care.
   a) Strongly Agree
   b) Somewhat Agree
   c) Neutral
   d) Somewhat Disagree
   e) Strongly Disagree

3) The speaker presented information well and answered questions clearly.
   a) Strongly Agree
   b) Somewhat Agree
   c) Neutral
   d) Somewhat Disagree
   e) Strongly Disagree