Adapting SDOH Data Collection Workflows during COVID-19

Yuriko de la Cruz, NACHC
Jessica Mussetter, Bighorn Valley Health Center

October 8, 2020
Acknowledgements

Support for this program was provided by a grant from the Robert Wood Johnson Foundation®
Housekeeping

• Webinar will be recorded
• Relevant resources and next steps will be emailed after
• Tips on Zoom and features for engaging with us and each other
• New realities: kiddos, furry friends, unstable internet, renovations, etc.
From AAPCHO T/TA to All panelists and other attendees:
Welcome to the webinar!

From Me to All panelists and other attendees:
I’m excited to be here!

Q&A

My Question 09:29 AM
How can I sign-up for more training opportunities?
Collapse all (2)

You 09:29 AM
I’m also interested in learning!

AAPCHO T/TA 09:30 AM
Feel free to email us at training@aapcho.org for more information or visit our website at www.aapcho.org.

My Question 10:01 AM
How can I sign-up for future webinars?
AAPCHO T/TA is going to answer this question live.

Type your question here...
Quick Polls

Get a sense of who is in the virtual room
<table>
<thead>
<tr>
<th>Topic</th>
<th>Timing in EST</th>
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</thead>
<tbody>
<tr>
<td>Opening and housekeeping</td>
<td>4:00pm</td>
</tr>
<tr>
<td>Overview of Social Risk Screening Workflow Models</td>
<td>4:05pm</td>
</tr>
<tr>
<td>SDOH Data Collection Strategy: SDOH Needs and Social Interventions</td>
<td>4:15pm</td>
</tr>
<tr>
<td>Health Center Spotlight: Bighorn Valley Health Center</td>
<td>4:25pm</td>
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<tr>
<td>Questions and Discussions</td>
<td>4:45pm</td>
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<tr>
<td>Closing and resources</td>
<td>4:55pm</td>
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</tbody>
</table>
Project Team at NACHC & AAPCHO

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NACHC

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AAPCHO

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Associate Director, T/TA
AAPCHO
The Value of Health Centers

• Health centers are on multiple frontlines
  ➢ COVID-19 pandemic response
  ➢ Strains on health care delivery
  ➢ Strains on community social services
  ➢ Attaining and maintaining health equity

• Health centers have had to rapidly adjust

• More important than ever to address social determinants of health
The goal of the series is to provide an overview, relevant updates, and promising practices on how community health centers are leveraging resources, including their workforce, technology, and external partners to assess and address their patients' SDOH needs.
Cross-Sector Alignment Theory of Change

Purpose: share a vision and a set of priority outcomes

Data: create a shared data and measurement system

Financing: establish sustainable financing with incentives and accountability

Governance: have strong governance with leadership, appropriate roles, and defined relationships

Sustainable progress toward improving health and well-being in communities, especially among populations most at risk of inequities

Strong Community Role and Engagement

Individual, organizational, and system-level enablers

Georgia Health Policy Center

Robert Wood Johnson Foundation
Learning objective #1

Provide an overview of strategies to determine which social risk screening workflow models work best for your organization’s setting.
Why collect SDOH data?

1. Define and document the increased complexity of patients

2. Better target clinical care, enabling services, and community partnerships to drive care transformation

3. Enable providers to demonstrate the value they bring to patients, communities, and payers

4. Advocate for change at the community and national levels
Why Health Centers Collect Standardized Data on SDOH

Individual level
- Patient and Family
  - Empowered to improve health and wellbeing
- Care Team Members
  - Better manage patient and population needs
- Health Center
  - Design care teams and services to deliver patient/community-centered care

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

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

Payer level
- State and National Policies
  - Ensure capacity for serving complex patients, including insured and uninsured patients

Policy level
Advancing Health Equity

• Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

• Health equity is achieved when every person has the opportunity to “attain full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

Source: CDC https://www.cdc.gov/chronicdisease/healthequity/index.htm
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?

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?)

Does your EHR support or systematize patient referrals to social services? Are you able to share data with external organizations?
<table>
<thead>
<tr>
<th>5 Rights</th>
<th>Workflow Considerations</th>
</tr>
</thead>
</table>
| Right Information--WHAT | What information in PRAPARE do you already routinely collect?  
• Part of registration  
• Part of other health assessments or initiatives                                                                                               |
| Right Format--HOW   | How are we collecting this information and in what manner are we collecting it?  
• Self-Assessment  
• In-person with staff                                                                                                                              |
| Right Person--WHO   | Who will collect the data? Who has access to the EHR to input the data? Who needs to see the information to inform care? Who will respond to needs identified?  
• Providers and other clinical staff  
• Non-Clinical Staff                                                                                                                                    |
| Right Time--WHEN    | When is the right time to collect this information so as to minimize disruption to clinic workflow?  
• Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.)  
• During visit?  
• After visit with provider?                                                                                                                                 |
| Right Place--WHERE  | Where are we collecting this information? Where do we need to share and display this information?  
• In waiting room? In private office?  
• Share during team huddles? Provide care team dashboards?                                                                                           |
Interactive Activity to Engage Staff and Patients: Example from Oregon

- Oregon PCA invited health centers to pick a patient population and interview 10 patients using 3 questions from PRAPARE.

- Afterwards, health centers 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?
  - Can you envision how you might apply this data to inform care?
WITHOUT DATA
YOU'RE JUST ANOTHER PERSON
WITH AN OPINION

W. EDWARDS DEMING
Learning objective #2

Review a SDOH data collection strategy for health centers to screen, collect, and crosswalk SDOH needs and intervention data.
Conceptual Framework: Linking Social Risk and Interventions Data

Social Determinants of Health
(PRAPARE Domains: Race/ethnicity, poverty, employment, English proficiency, etc.)

Appropriate Care
(Receipt of needed screens, tests, procedures, and other care)

Health Outcomes, Utilization, and Total Costs
(For example, ideal outcomes, reduced complications, ED visits, etc.)

Enabling services & other non-clinical, social interventions

Two Sides of the Same Coin: SDOH and ES Data are both essential in value-based care payment models

**Needs Data**
- Standardized data on patient social risk/barriers

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

**Both are necessary to:**
- Demonstrate health center value to payers
- Seek adequate financing
- Better target and/or improve services
- Achieve integrated, value-driven delivery system and reduce total cost of care
Crosswalking Your Data to Avoid Double Documentation

• Review your intake forms

• Are there areas where you already collect information that is also in PRAPARE?
  • Income verification forms
  • Self-management forms

• Many PRAPARE EHR templates automatically map to practice management system and/or demographics section and auto-populate that into PRAPARE template
## What questions are in PRAPARE?

<table>
<thead>
<tr>
<th>Core</th>
<th>Optional</th>
<th>Optional Granular</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Race*</td>
<td>10. Education</td>
<td>1. Employment: How many hours worked per week</td>
</tr>
<tr>
<td>2. Ethnicity*</td>
<td>11. Employment</td>
<td>3. Insurance: Do you get insurance through your job?</td>
</tr>
<tr>
<td>6. Income*</td>
<td>15. Transportation</td>
<td></td>
</tr>
<tr>
<td>7. Insurance*</td>
<td>16. Housing Stability</td>
<td></td>
</tr>
<tr>
<td>8. Neighborhood*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Housing Status*</td>
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</tbody>
</table>

| Optional Granular                          |                                        |                                        |
| 1. Incarceration History                  |                                        |                                        |
| 2. Safety                                 |                                        |                                        |
| 3. Domestic Violence                      |                                        |                                        |
| 4. Refugee Status                         |                                        |                                        |

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

Find the tool at [www.nachc.org/prapare](http://www.nachc.org/prapare)
• Crosswalks include ICD-10, LOINC, SNOMED

• Many PRAPARE EHR templates have used crosswalks to map PRAPARE measures to ICD-10 codes

• New proposed codes for PRAPARE in LOINC and ICD-10

• PRAPARE Data Documentation available in Toolkit
<table>
<thead>
<tr>
<th>COMMON CHALLENGES AND RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State or organization already committed to using other SDH tools (AHC, homegrown)</strong></td>
</tr>
<tr>
<td><strong>Competing Priorities</strong></td>
</tr>
<tr>
<td><strong>How do we implement this without increasing visit time?</strong></td>
</tr>
<tr>
<td><strong>Inability to Address SDH</strong></td>
</tr>
<tr>
<td><strong>Fitting PRAPARE into Workflow</strong></td>
</tr>
<tr>
<td><strong>Staff Turnover at both CHC and PCA and HCCN</strong></td>
</tr>
</tbody>
</table>

Learning objective #3

Share a health center’s approach to implementing social risk screening and tracking of social interventions during COVID-19.
Jessica Mussetter,
Optimal Performance Manager
Bighorn Valley Health Center
ASHLAND, CHINOOK, HARDIN, HARLEM, LEWISTOWN, MILES CITY, MONTANA
Why is PRAPARE important?

➢ Meet the SOD needs of patients
➢ Impact future development of resources
Athena workflow
### Athena workflow

#### Family History
- no current problems or disability
  - Father
  - Mother
- Unknown
- NOTE

#### Social History
- Alcohol intake: Occasional
  - Tobacco smoking status: Former smoker
  - Smoking - how much
  - Smokeless tobacco status
  - Tobacco-years of use
  - E-cigarette/vape

#### IHS
- Would you like to speak with a legal advocate about these or other civil legal issues?
  - Yes
  - No
- In the past year, have you or any family members live with been unable to get these resources when it was really needed?
- PRAPARE Screening Notes
  - Within the past 12 months we worried whether our food would run out before we got money to buy more.
  - Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.
- I choose not to answer PRAPARE questions today.
Referral to Community Health Advocate

- Referral “resourcesupport” bucket in Athena (see guide)
- Teams Channel message to the Resource Team
- Tytocare warm-hand off
- In person warm-hand off is able
Patient outcomes

- PRAPARE Dashboard
- Still developing ways to track patient outcomes
Data Visualization

1. Fully Screened Count, Partial Screened Count and IS Opportunities by Dept Display Name
   - Dept Display Name: Hurdin, Chinook, Miles City, Lewistown, Ashland

2. Fully Screened Count, Partial Screened Count and IS Opportunities by apptdate
   - apptdate: 09/21/2020 to 09/26/2020

3. Full or Partial Screened and IS Opportunities
   - Count of Unique ID:
     - Full Screening: 102
     - Previously Screened: 102
     - Not Screened on Date: 69
     - Partial Screening: 21
     - No Screening: 1
     - Total: 295

4. IS Opportunities by apptdate and Screening Completed on Date
   - Screening Completed on Date:
     - Full Screened
     - No Screened
     - Not Screened
     - Partial Screened

5. IS Opportunities by Dept Display Name
   - Dept Display Name: Hurdin, Chinook, Miles City, Lewistown, Ashland

PRAPARE
Pre-Screener

- Pre-screener developed
- Partnership with community-based organization

Patient Initials: _______________________
Date of Service: ______________________

Health starts—long before illness—in our homes, schools, and jobs. The more we know about you, the better health care we can provide. We want to support your health and wellness.

Please circle the areas you would like assistance with. We cannot guarantee assistance in all areas, but will do our best to respond to your priorities.

I am having a hard time getting access to and/or paying for:

<table>
<thead>
<tr>
<th>HOUSING</th>
<th>UTILITIES (electricity, phone, heat, etc.)</th>
<th>FOOD</th>
<th>PHYSICAL SAFETY</th>
<th>MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>![House Icon]</td>
<td>![Lightbulb Icon]</td>
<td>![Apple Icon]</td>
<td>![Shield Icon]</td>
<td>![Person Icon]</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>TRANSPORTATION</th>
<th>HEALTH INSURANCE</th>
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<tr>
<td>![Car Icon]</td>
<td>![Medication Icon]</td>
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<tr>
<th>EMPLOYMENT</th>
<th>LEGAL ASSISTANCE</th>
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<tr>
<td>![Job Search Icon]</td>
<td>![Law Icon]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MATERIAL GOODS (clothing, furniture, diapers, etc.)</th>
<th>HEALTH SUPPLIES (glasses, medicine, etc.)</th>
<th>EDUCATION</th>
<th>CHILD CARE</th>
<th>SOCIAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Shirt Icon]</td>
<td>![Medication Icon]</td>
<td>![Graduation Cap Icon]</td>
<td>![Baby Icon]</td>
<td>![Support Icon]</td>
</tr>
</tbody>
</table>

Would you like to be contacted by a member of our health care team about this survey?
Interview with Jessica

- What have been the lessons learned at BVHC about SDOH data collection?
- How did BVHC determine the workflow to collect and address SDOH?
- How is BVHC documenting social interventions?
- How has BVHC had to adjust during COVID-19 pandemic?
- What tips do you have for health centers to begin or enhance their strategy for collecting and addressing SDOH?
What's next?

- Webinar recording will be posted
- Office hours will be launched soon
- Please complete evaluation
- Share topics for future webinars
Webinar 2: Practical Strategies for Social Risk Screening during COVID-19
October 22, 2020 | 4-5 PM ET

Webinar 3: Emerging Strategies to Address SDOH Through Community Referrals & Cross-sector Partnerships
October 29, 2020 | 4-5 PM ET

*Registration links coming soon!*
Call for Innovative Practices in Health Equity

How is your health center innovating to improve health, well-being, and health equity?

Health centers have been trailblazers in providing high-quality, whole-person care for everyone. We want to hear how you’re leading the way in your community!

PRAPARE Related Resources
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
FREE EHR Templates Available:

- NextGen*
- eClinicalWorks
- athenaPractice (formerly GE Centricity*)
- Epic
- Cerner*
- Greenway Intergy
- Athena

Available for FREE after signing EULA at [www.nachc.org/prapare](http://www.nachc.org/prapare)

* Automatically map to ICD-10 Z codes so you can easily add relevant Z codes to problem or diagnostic list

In Development:

- Allscripts
- Meditech

70% of all health centers

Current 7 + New EHRs = 85-95% of all health centers

Recorded demos of each PRAPARE EHR template available at [www.nachc.org/prapare](http://www.nachc.org/prapare)

PRAPARE is Now in 26 Languages!

- Validated at community health centers for comprehension and cultural competence
- New additions include:

  - Khmer
  - Karen
  - Nepali
  - Chuukese
  - Marshallese
  - Swahili
  - Farsi
  - Lao
  - Tongan
  - Karenni
  - German
  - French
  - Hindi
  - Uzbek
  - Russian
  - Bengali
This fact sheet outlines how PRAPARE SDOH domains impact individuals’ risk of morbidity and mortality from COVID-19. Care team members and aligned social service partners can use this information to identify those who may be most vulnerable during the pandemic, prioritize patients in need of outreach and additional services, and develop plans for addressing social risks in the community.

Access now: [Printer-friendly version available here!](#)
The Protocol of Responding and Assessing Patient Assets, Risks, and Experiences (PRAPARE) team was recently published in the *Journal of Health Care for the Poor and Underserved*. The study revealed that nationally, health center patients face an average of 7.2 out of 22 social risks and demonstrate a high prevalence of social determinants of health (SDH) risks—key findings that can be critical for informing social interventions and upstream transformation to improve health equity for underserved populations.

Access now: available here
COVID-19 Related Resources
<table>
<thead>
<tr>
<th><strong>COVID-19 Resources: Found at nachc.org/coronavirus/</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Disease Control Coronavirus (COVID-19) resources page – includes strategies for optimizing the supply of PPE</td>
</tr>
<tr>
<td>Health Resources and Services Administration (HRSA) Health Center Program COVID-19 Frequently Asked Questions (FAQ) – includes Federal Torts Claim Act (FTCA) updates</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services (CMS) FAQs – includes information on diagnostic lab services and hospital services</td>
</tr>
<tr>
<td>NACHC’s Coronavirus webpage – information, event postings, and resources for health centers; NACHC also manages the resources below</td>
</tr>
</tbody>
</table>
| NACHC's Elevate learning forum – evidence-based practices, tools and protocols for the health center response to COVID-19  
PCAs, HCCNs, and NCAs sign up @ [bit.ly/2020ElevatePCA-HCCN-NCA](https://bit.ly/2020ElevatePCA-HCCN-NCA) |
| Health Center Resource Clearinghouse Priority Page COVID-19 – training events and tailored materials for serving special populations [healthcenterinfo.org](http://healthcenterinfo.org) |
| Consolidates information from many sources in an easily-searchable format; enables health centers, PCAs, and HCCNs to share info and questions  
To join, contact Susan Hansen at shansen@nachc.org. |
AAPCHO COVID-19 Resources

[Links]
coronavirus.aapcho.org
www.pi-copce.org
www.aapiern.org

[Images]
STAND UP FOR COMMUNITY HEALTH CENTERS.

Be an advocate.

#ValueCHCs
Long-term, stable funding!

WWW.HCADVOCACY.ORG/JOIN
@HCADVOCACY
GRASSROOTS@NACHC.ORG
We appreciate your time and commitment!

Have any questions or feedback?
E-mail: prepare@nachc.org
Website: www.nachc.org/prepare

Twitter: @prepare_sdoth
Join our Listserv