WACMHC

Washington Association of
Community & Migrant Health Centers

Social Determinants of Health: A Washington Roundtable for FQHCs

Wednesday, September 26th, 2018

Welcome!

- FQHC members
- Department of Health
- Healthcare Authority
- Coordinated Care
- The Oregon Primary Care Association
- Kaiser Permanente
- Governor's Interagency Council on Health Disparities
- Valley Medical Center/ICHS Board Member
- Molina Healthcare
- United Healthcare
- Community Health Plan of Washington
- Northwest Regional Primary Care Association
- OneHealthPort
- AmeriGroup
- UW School of Public Health

Housekeeping

Sign-in!

Agenda
Speaker Roster
WACMHC Contacts
Evaluation

PRAPARE Tool
Workflows
Study Invite

BCLS Guest
L@kew00d

Session Overview

Objectives

- Evaluate how identifying and addressing social risk is critical to improving patient outcomes
- Analyze readiness components and workflows to implement a SDoH screening program
- Describe state landscape of FQHC SDoH collection efforts and how they align with state or national initiatives

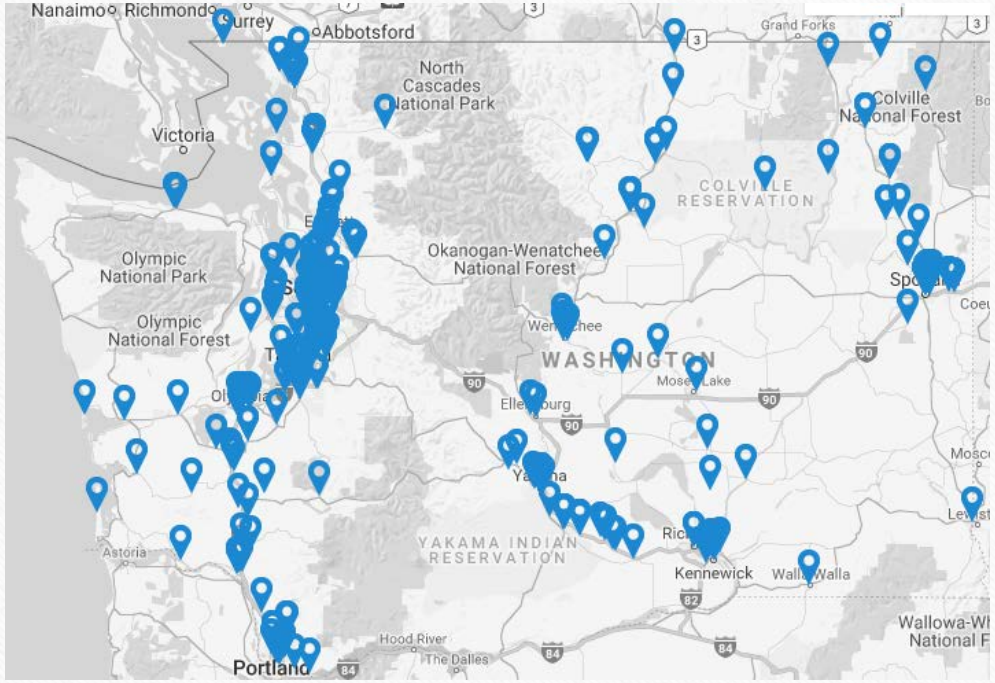
Agenda

- SDoH & PRAPARE
- FQHC Presentations
- Panel Discussions
- Breakouts

About WACMHC

- Washington State's Primary Care Association
  - Serve 27 Federally Qualified Health Centers (FQHCs) in WA
  - Governed by our Board of 26 health center member CEOs
- Our mission
  - *To strengthen and advocate for Washington's community health centers as they build healthcare access, innovation and value.*
- How?
  - Policy & advocacy and training & technical assistance. Some examples:
    - Apprenticeship Programs
    - PCMH and Colorectal Cancer Screening Program coaching
    - Group skill training – Lean Six Sigma, Motivational Interviewing
    - Workgroups

WA CHCs



- 27 FQHCs served **1,092,022** patients in 2017
- 260+ service delivery sites
- 59% of patients on Medicaid
- 60% of patients are 100% at or below the federal poverty guideline
- 473,347 patients served at a health center located in or immediately accessible to a public housing site
- 114,475 migrant or seasonal workers

Recognizing Quality

Addressing Health Disparities

11

Enhancing Access to Care

11

Achieving PCMH Recognition

24

Clinical Quality Improver

23

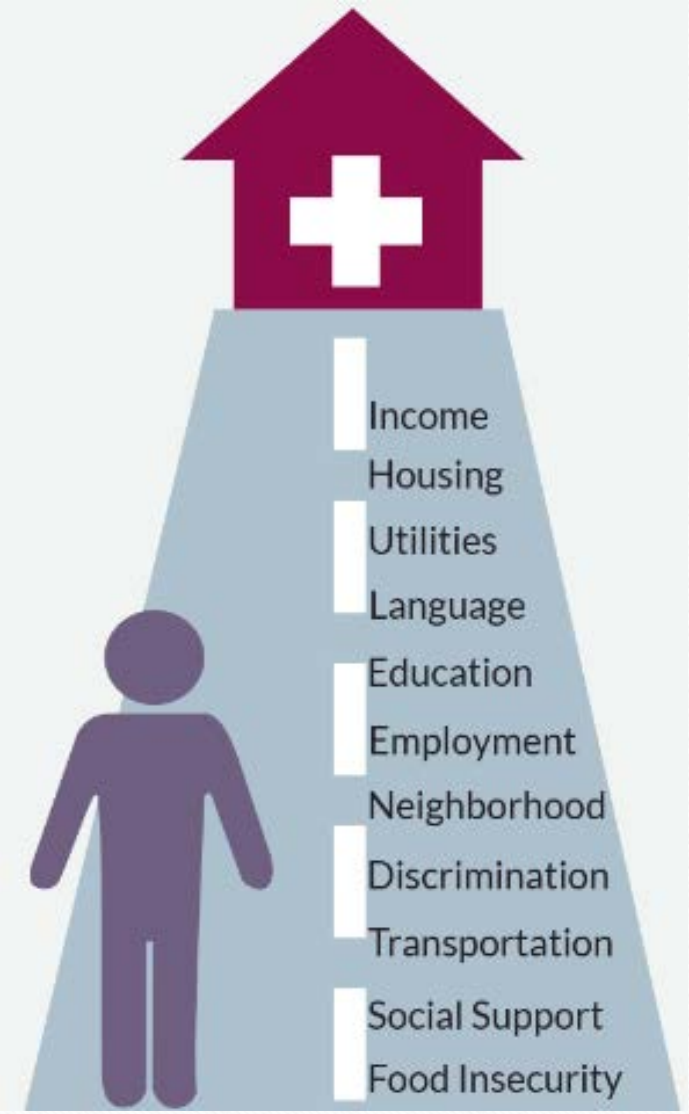
Congratulations National Quality Leaders!

Understanding and Addressing

Social Determinants of Health

Understanding and Addressing Social Determinants of Health

- Background and definition
- Overview of importance
- Potential FQHC impact
- WACMHC goals
- Peer discussion

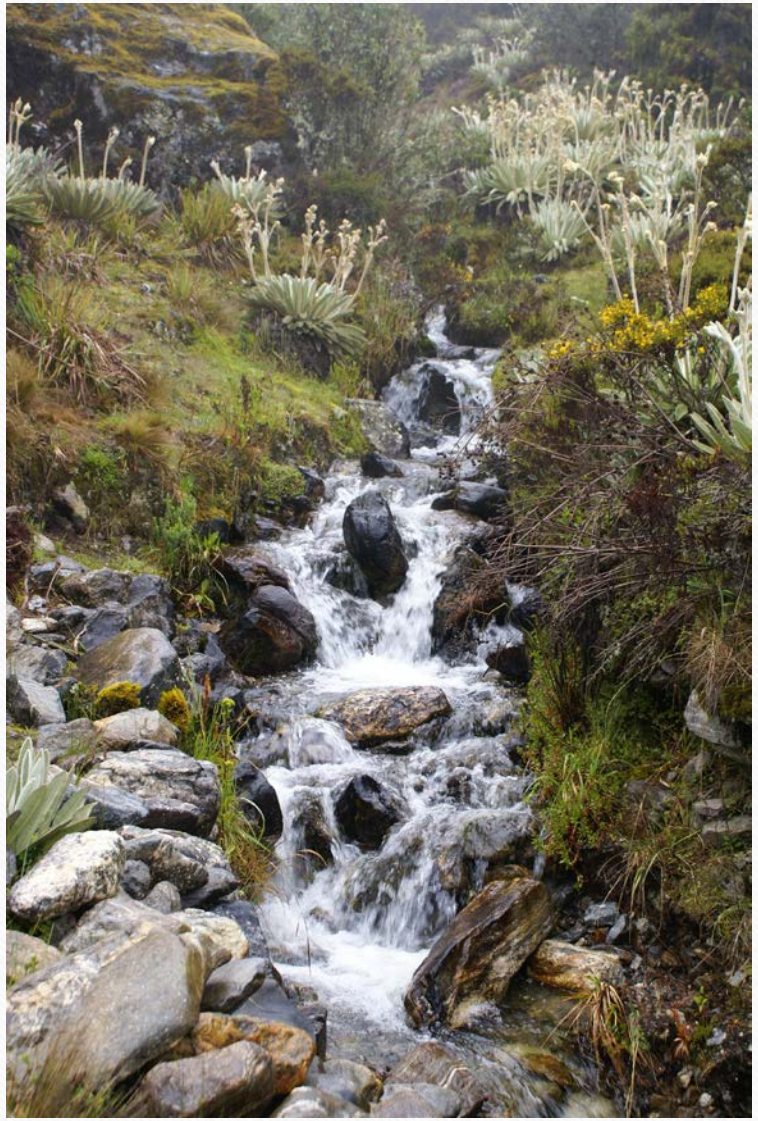


Social Determinants of Health: What are they?

- "The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."[1]
- "…access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships."[2]

Social Determinants of Health: **Why are they important?**

- Medical care accounts for only 10-20% of modifiable contributors to healthy outcomes for a population.[3]
- "Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."[4]
- "addressing the more upstream social determinants will improve health outcomes, reduce inequities, and lower costs."[3]



Improve Health Outcomes

Maximize impact on patient health by leveraging understanding of underlying social conditions

- "Engaging people and patients in the context of their lives maximizes the impact of healthcare on health outcomes."[5]
- Low social support associated with 50-100% increase in heart disease.[6]
- Food-insecure individuals are 20% more likely to report that they have hypertension.[7]
- Individual poverty = 133,000 deaths
  Low educational attainment = 245,000 deaths[7]

Reduce Health Disparities

Identify and address social inequalities to promote health equity

- "The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries."[8]
- "If the underlying causes of disease and ill health are not addressed, the risk of perpetuating a cycle of inequity, disparity, and inequality will remain for generations to come."[9]

Population Health

Work collaboratively to improve the health of all Washington FQHC patients

- "the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link these two."[10]
- Target and design effective interventions
- Create and strengthen community partnerships
- Describe your patient population
- "The leaders who can best address the root causes of disparities may be the decision makers outside of health care who are in a position to strengthen schools, reduce unemployment, stabilize the economy, and restore neighborhood infrastructure."[11]

Value Based Payment and Care

Support innovative, whole-person care by better understanding patient needs and risk factors

- Creates financial incentives for improved population-level health outcomes[12]
- Holds FQHCs indirectly accountable for addressing SDoH through quality metrics[13]
- Promotes flexibility in care teams
- Reduces cost of care while maintaining quality

WACMHC Board of Directors
Strategic Goals

- Strengthen CHC collective capacity to address the SDoH, identifying and spreading promising and best practices
- Capture effect and impact data that considers medical, social, and economic complexity of the patients we serve
- Build on social safety net partnerships to pursue "health in all policies"

Social Determinants of Health
Why do we need to know?

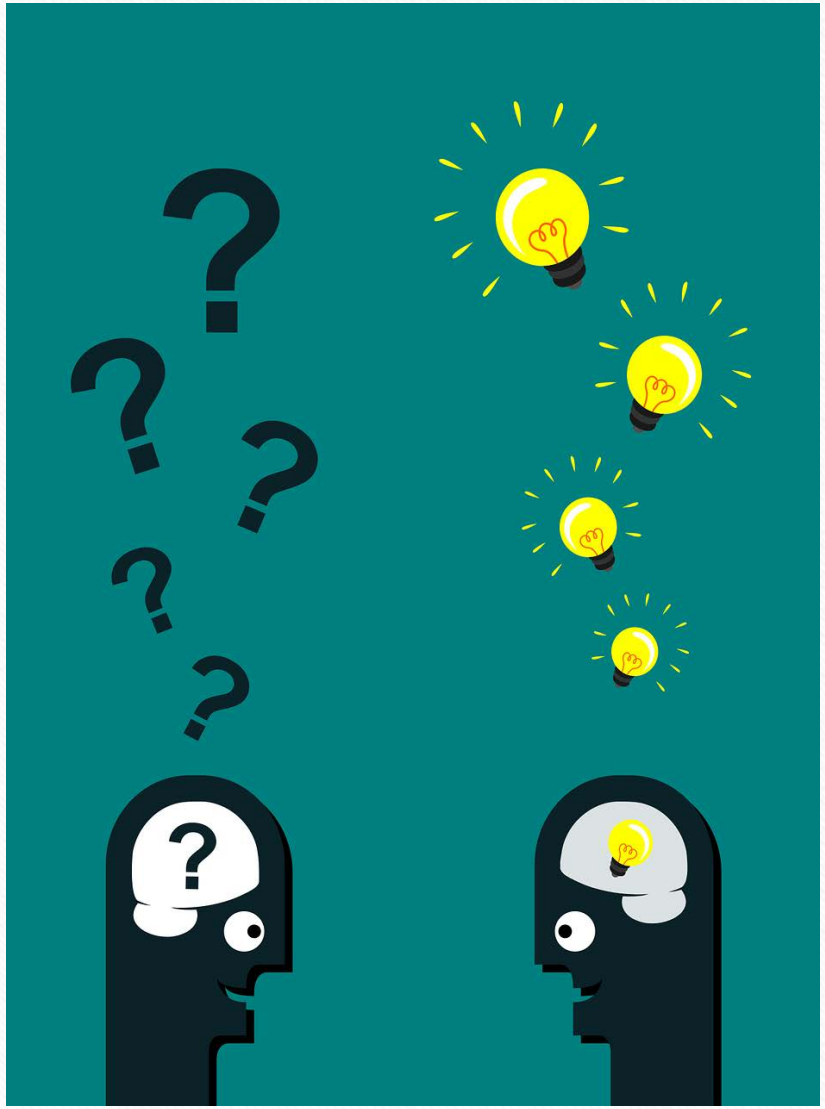
- Improve patient health outcomes
- Reduce health disparities
- Impact population health
- Thrive within a Value Based environment
- Develop a better understanding of our populations and community partnerships
- Strengthen the FQHC network by sharing our experiences and practices

The Mission of **Community Health Centers**

- *Access* – medically underserved and low-income populations
- *Comprehensive* – provide wraparound and enabling services
- *Patient centered* – understand the needs of patients and provide whole-person care
- *Community based* – empower communities and respond to needs

Peer Discussion

- Introduce yourself!
- What motivated you to attend today?
- What are your organization's goals in screening for Social Determinants of Health?
- How far along is your organization to reaching those goals?



References

1. "Social Determinants of Health." *World Health Organization*, World Health Organization, 31 May 2018, www.who.int/social_determinants/en/.
2. "Social Determinants of Health." Healthcare-Associated Infections | Healthy People 2020, www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.
3. Magnan, Sanne. "Social Determinants of Health 101 for Health Care: Five Plus Five." *National Academy of Medicine*, 17 Aug. 2018, nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/.
4. "Commission on Social Determinants of Health, 2005-2008." *World Health Organization*, World Health Organization, 25 Sept. 2017, www.who.int/social_determinants/thecommission/en/.
5. "Addressing the Social Determinants of Health: The Role of Health Professions Education." HRSA, Advisory Committee on Training in Primary Care Medicine and Dentistry, Dec. 2016, www.hrsa.gov/advisorycommittees/bhpradvisory/actpcmd/actpcmd_13th_report_sdh_final.pdf.
6. Shaya, Fadia T., et al. "Social Networks Help Control Hypertension." *Current Neurology and Neuroscience Reports.*, U.S. National Library of Medicine, Jan. 2013, www.ncbi.nlm.nih.gov/pmc/articles/PMC3580229/.
7. Bachrach, Deborah, et al. "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment." *The Commonwealth Fund*, The Commonwealth Fund, May 2014, www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.
8. "About Social Determinants of Health." *World Health Organization*, World Health Organization, 25 Sept. 2017, www.who.int/social_determinants/sdh_definition/en/.
9. Committee on Educating Health Professionals to Address the Social Determinants of Health. "A Framework for Educating Health Professionals to Address the Social Determinants of Health." *Current Neurology and Neuroscience Reports.*, U.S. National Library of Medicine, 14 Oct. 2016, www.ncbi.nlm.nih.gov/books/NBK395983/.
10. Kindig, David, and Greg Stoddart. "What Is Population Health?" *Current Neurology and Neuroscience Reports.*, U.S. National Library of Medicine, Mar. 2003, www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/.
11. Woolf, Steven H, and Paula Braveman. "Where Health Disparities Begin: The Role Of Social And Economic Determinants—And Why Current Policies May Make Matters Worse." *Health Affairs*, Project HOPE, Oct. 2011, www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.0685.
12. "Clinics Transition to New, Value-Based Payment Model." *HCA*, Washington State Health Care Authority, Sept. 2017, www.hca.wa.gov/assets/program/APM4-fact-sheet.pdf.
13. "Spotlight on Health Center Payment Reform: Washington State's FQHC Alternative Payment Methodology." *NACHC*, National Association of Community Health Centers, May 2018, www.nachc.org/wp-content/uploads/2018/05/NACHC-WA-APM-Case-Study-2018.pdf.

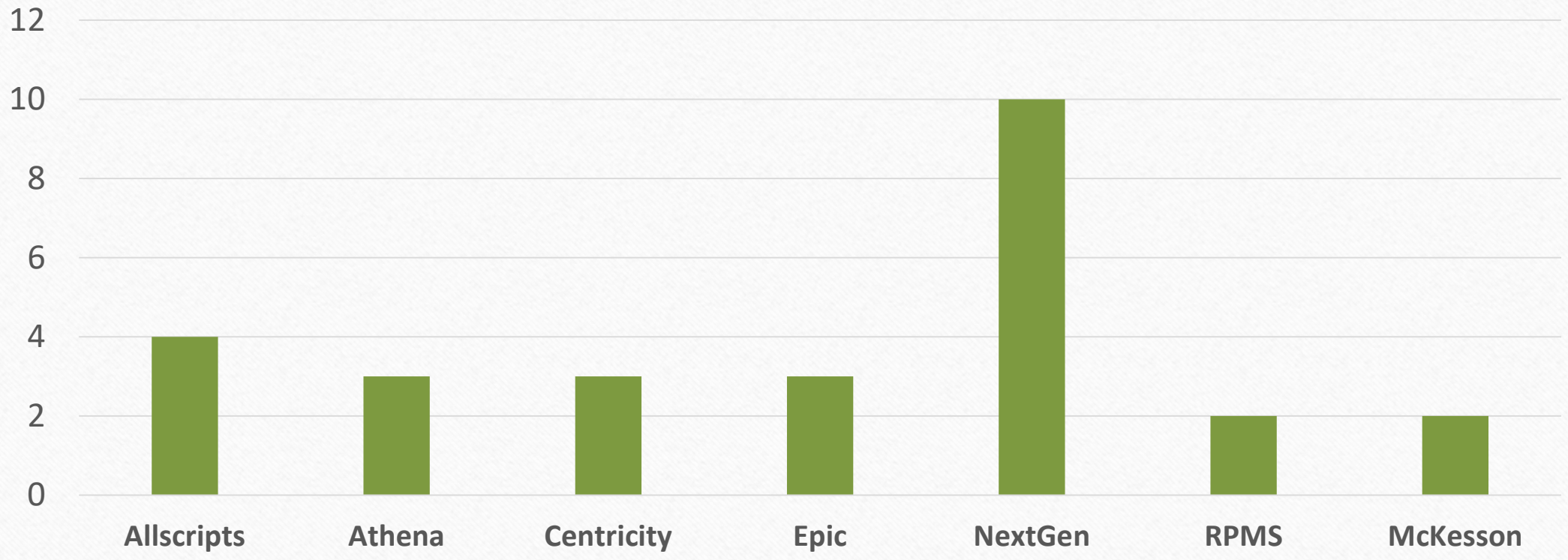
Environmental Scan

Understanding Washington's FQHC Capacity to Collect SDoH Data

Rationale for the Environmental Scan

- To help ALIGN SDoH data collection efforts
- To IDENTIFY tools, methods and gaps in technology
- To SUPPORT SDoH data collection efforts at FQHCs

EMR/EHRs


12
10
8
6
4
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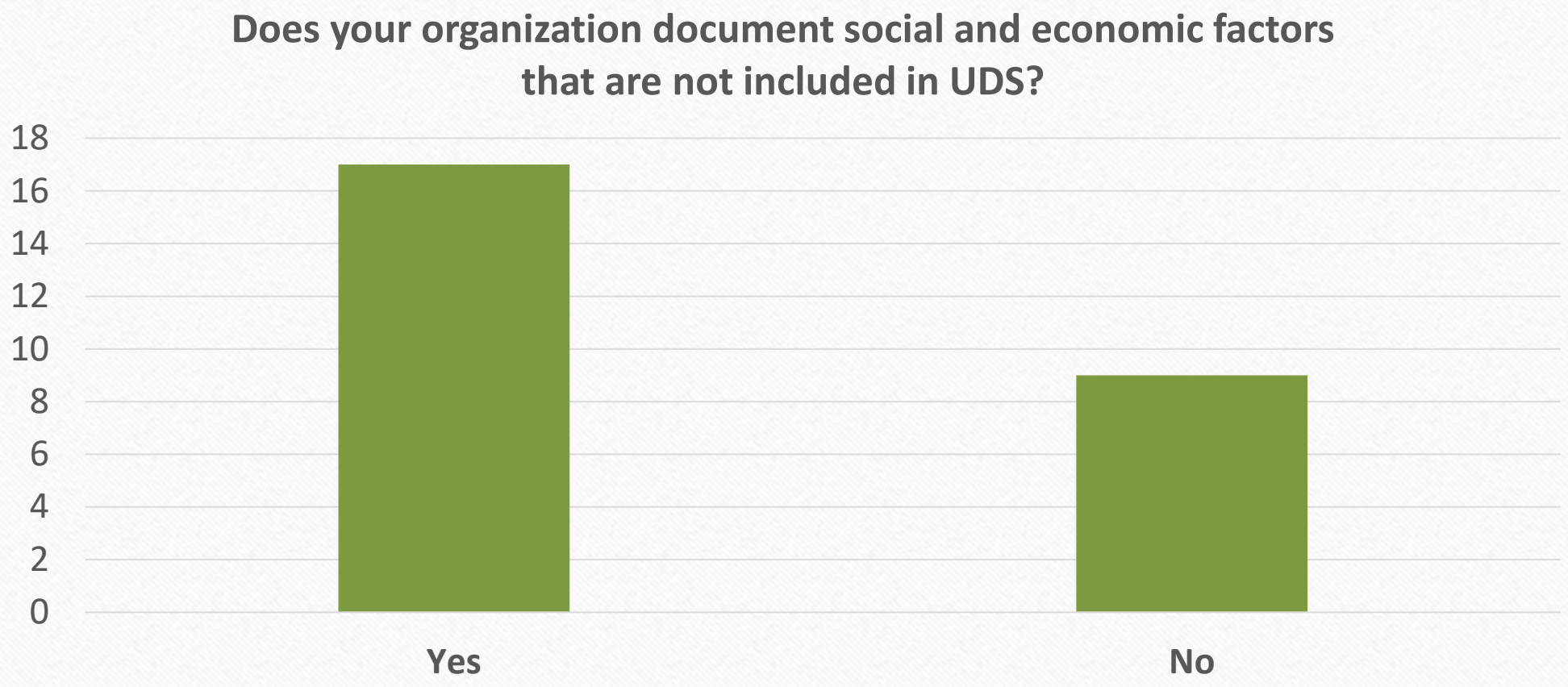
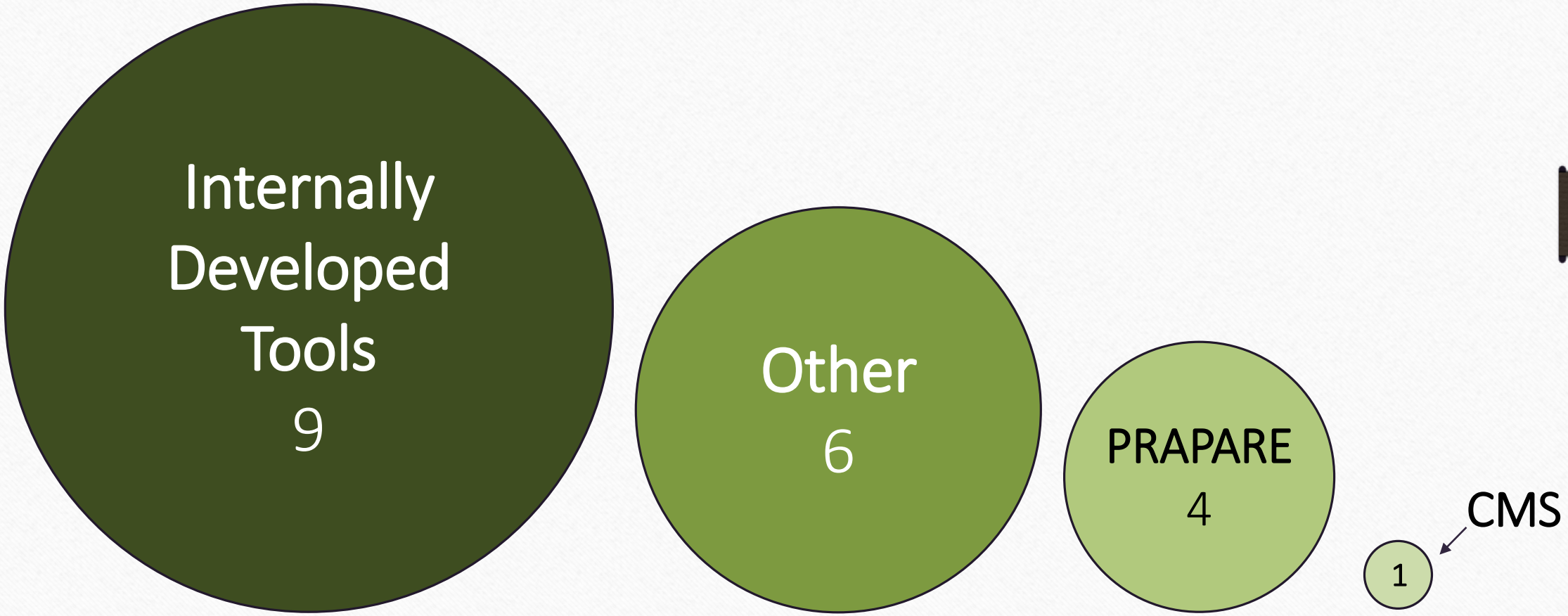
Allscripts
Athena
Centricity
Epic
NextGen
RPMS
McKesson

Documenting Social and Economic Factors



Collection Tools and Methods

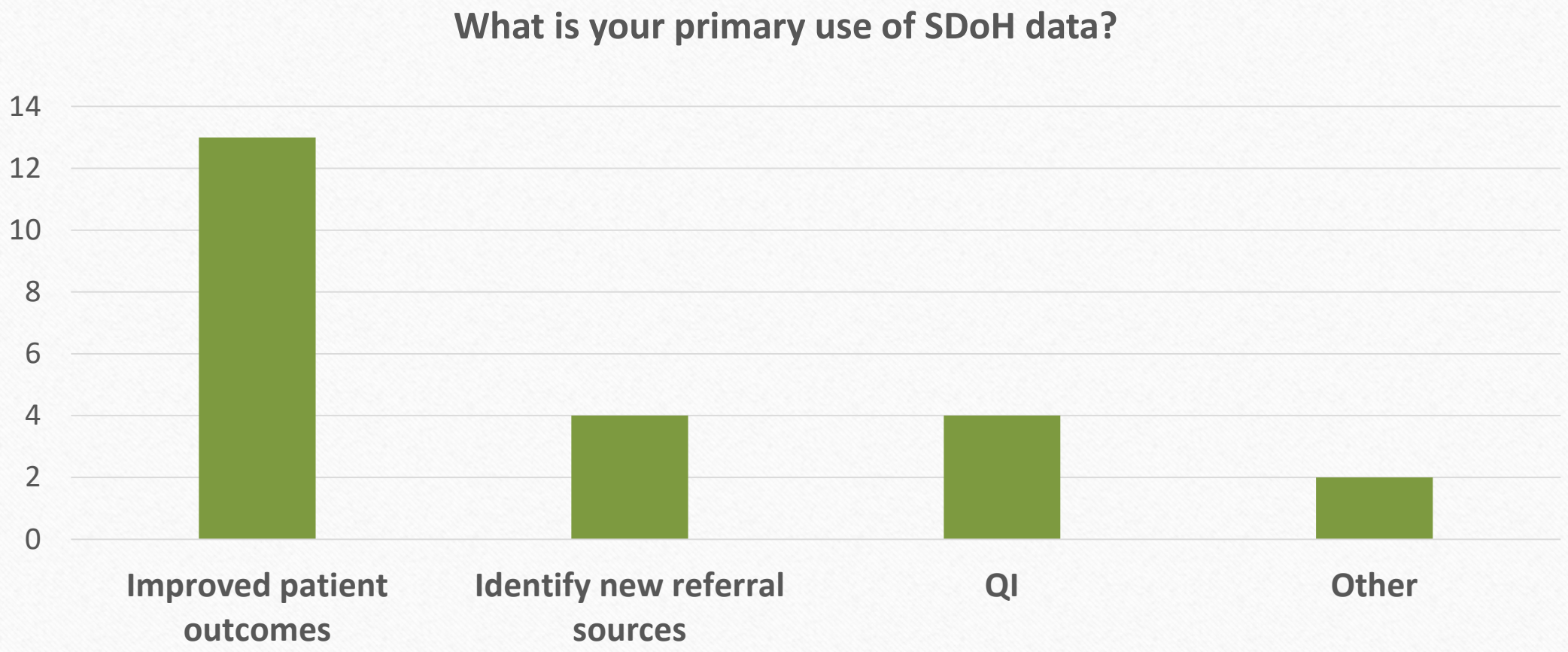
What tool(s) or method(s) do you use to collect SDoH?



Collection Tool Gaps

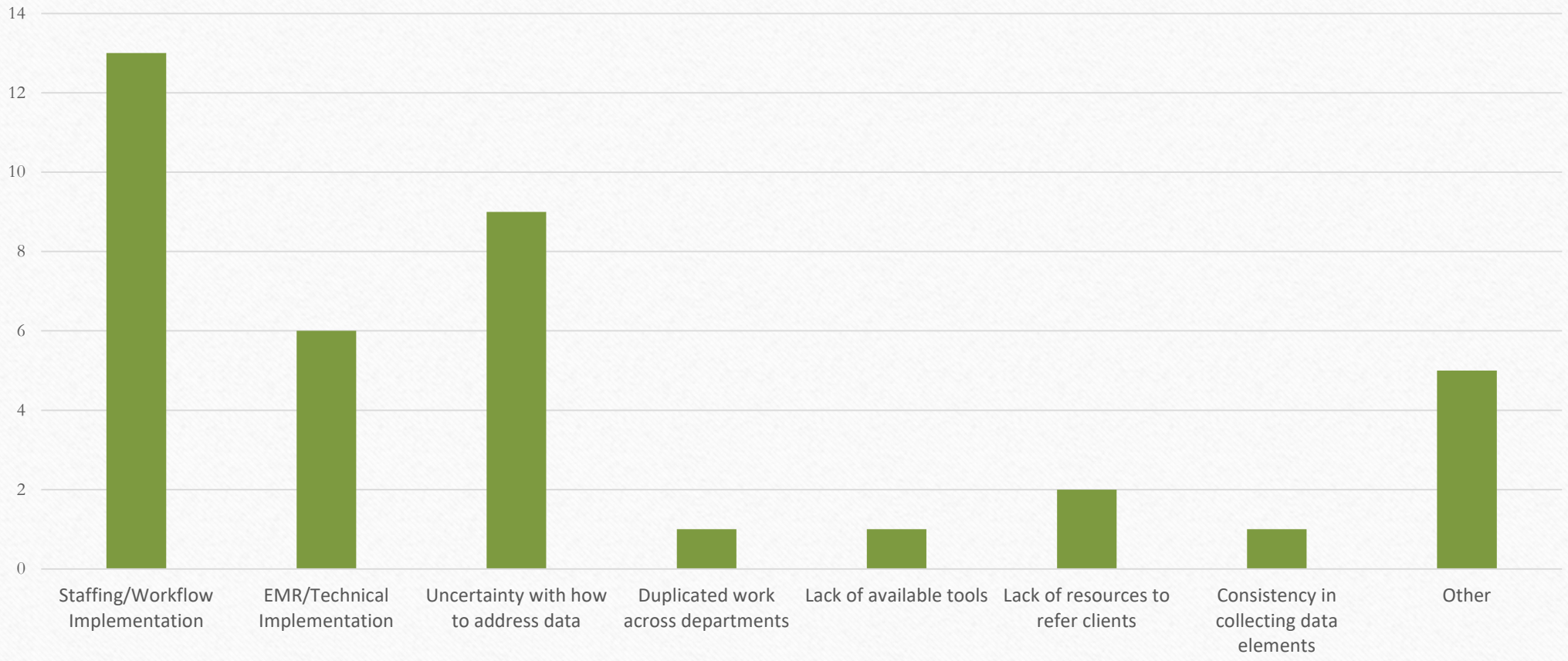
- Number of jobs individuals are working
- Housing conditions
- Insurance
- Incarceration
- Immigration
- Built environment

Use of Data

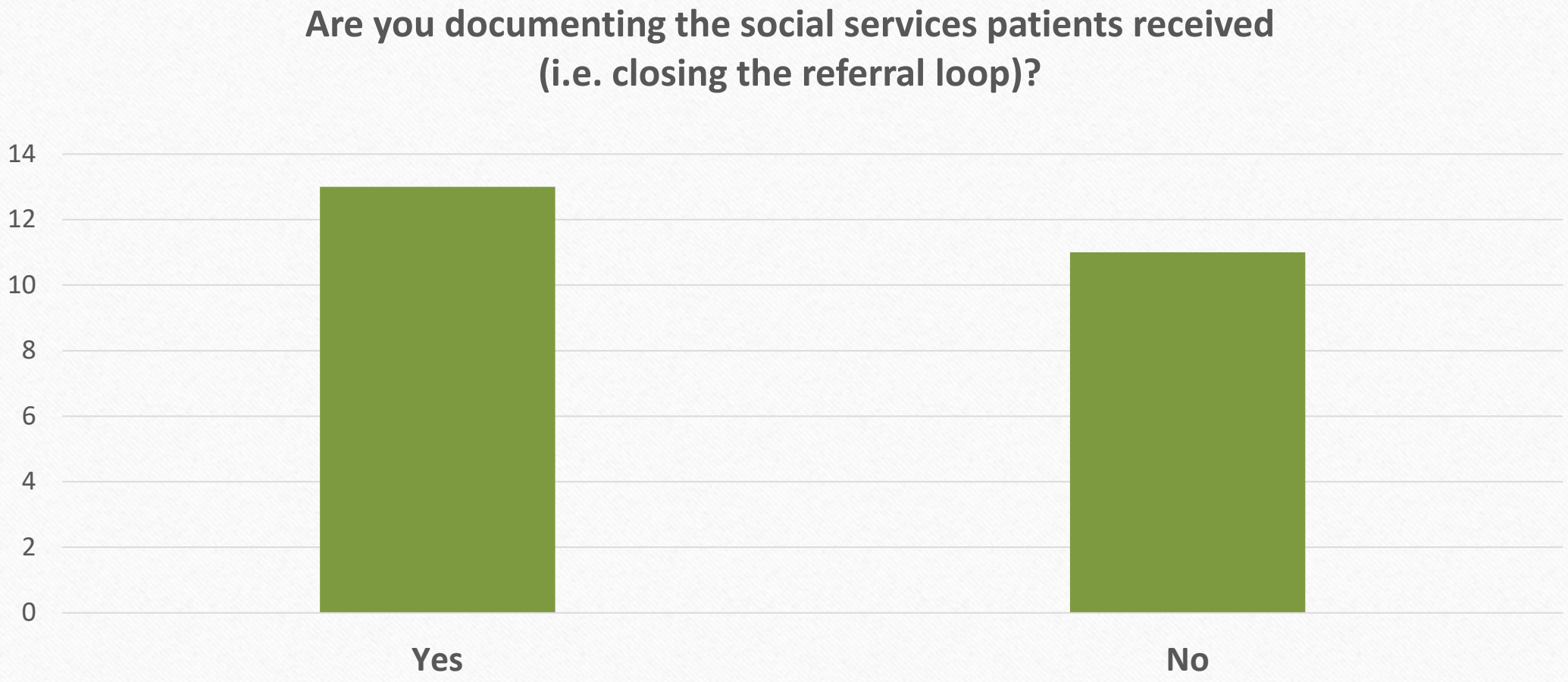

What is your primary use of SDoH data?
14
12
10
8
6
4
2
0
Improved patient outcomes
Identify new referral sources
QI
Other

Barriers to Screening

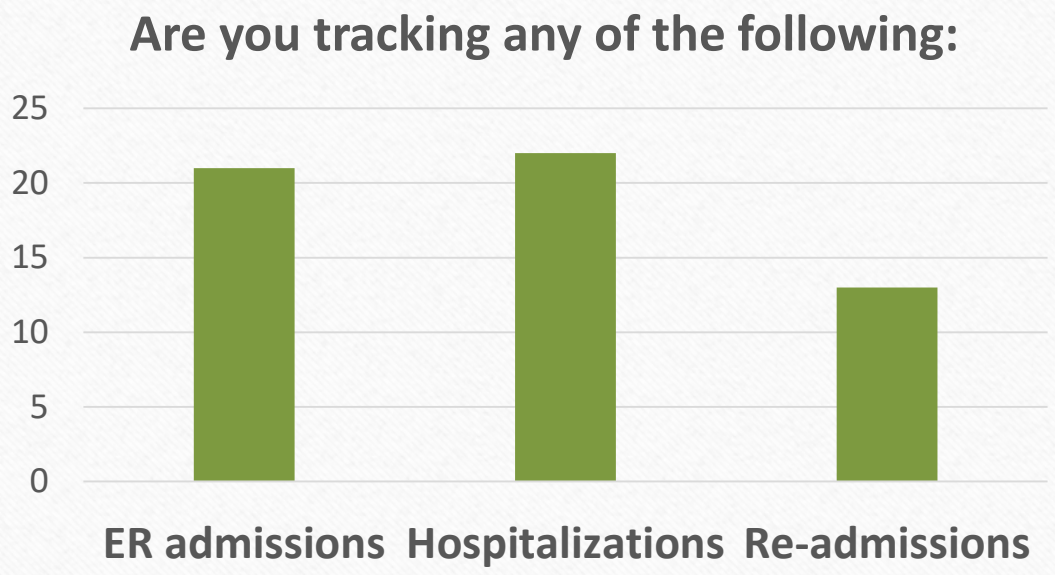
What are your Organizations leading barriers to screening patients for SDoH?

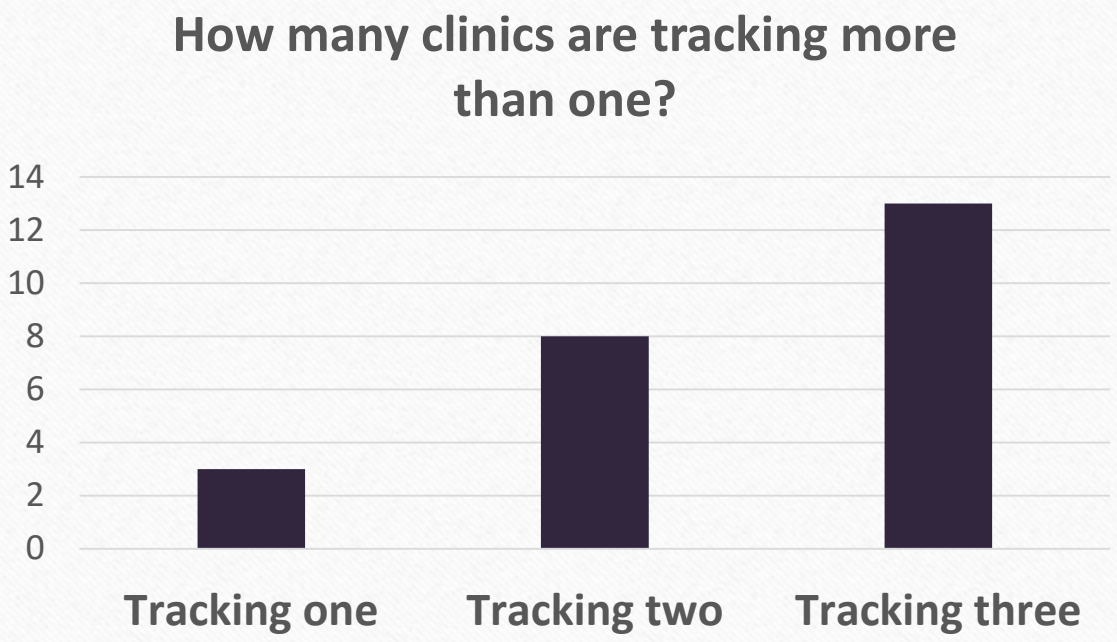


Closing the Loop



Hospital Admissions

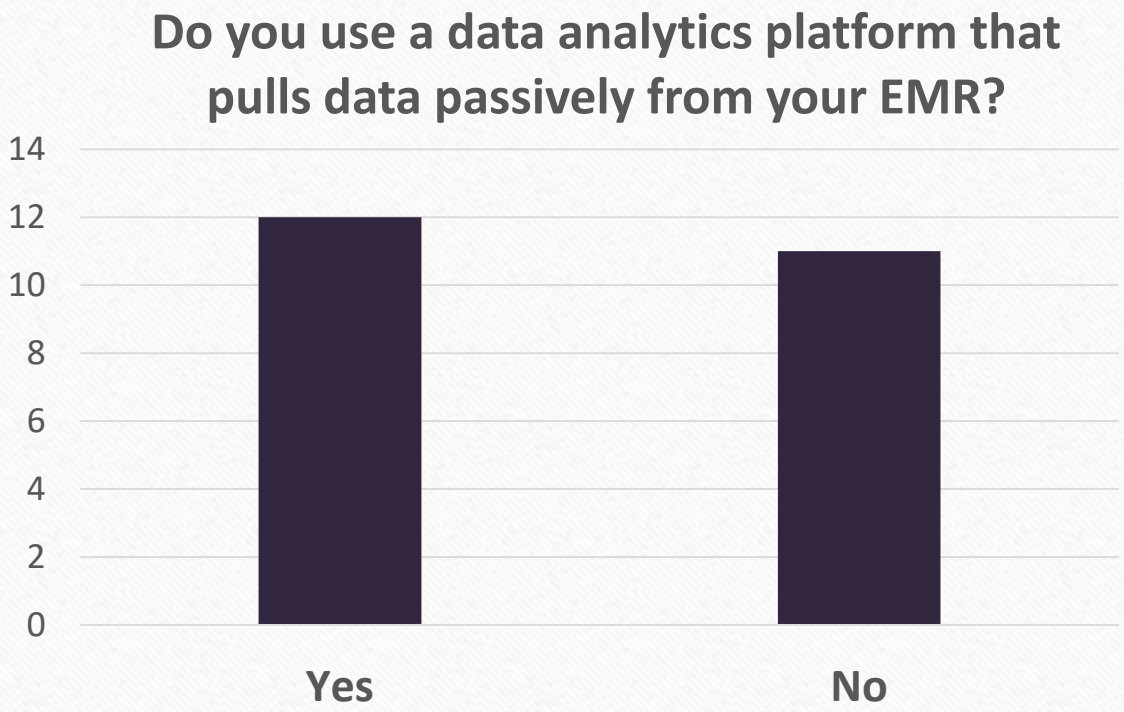


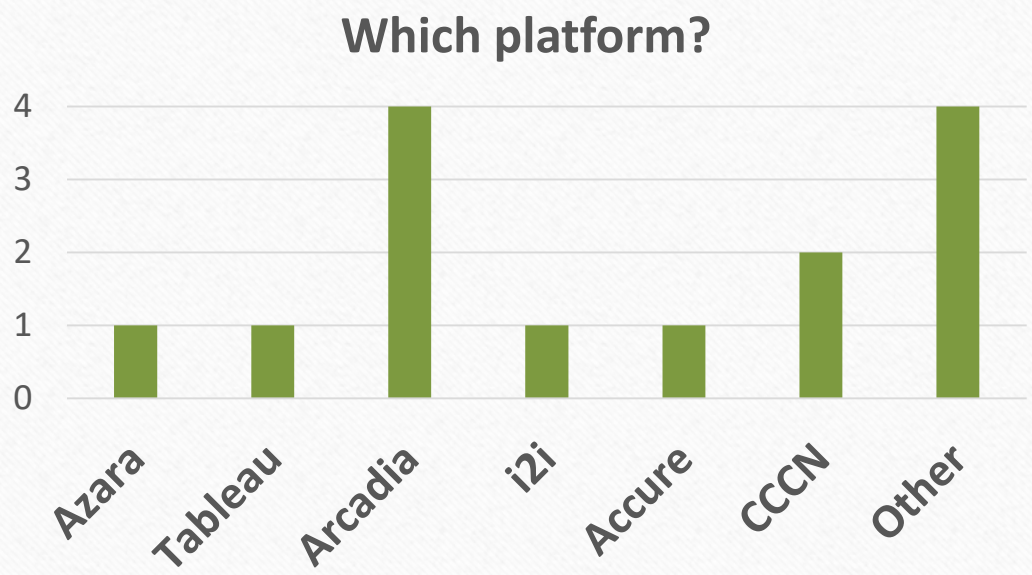


Supportive Services

- In-house behavioral health services (23)
- Dental services (23)
- In-house Pharmacy (22)
- Referral and resource navigation (21)
- Community Health Workers (15)

Data Analytics





What does knowing about our collective capacity help us do?

- Support policy and provide advocacy for needed referral resources
- Provide better T/TA to use this data for improving patient outcomes
- Assist clinics with how to address data both as a clinic and as a group
- Align measures for population health initiatives

Introducing PRAPARE

What is PRAPARE?

What is PRAPARE?

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

Customizable Implementation and Action Approach

Assess Needs → **Respond to Needs**

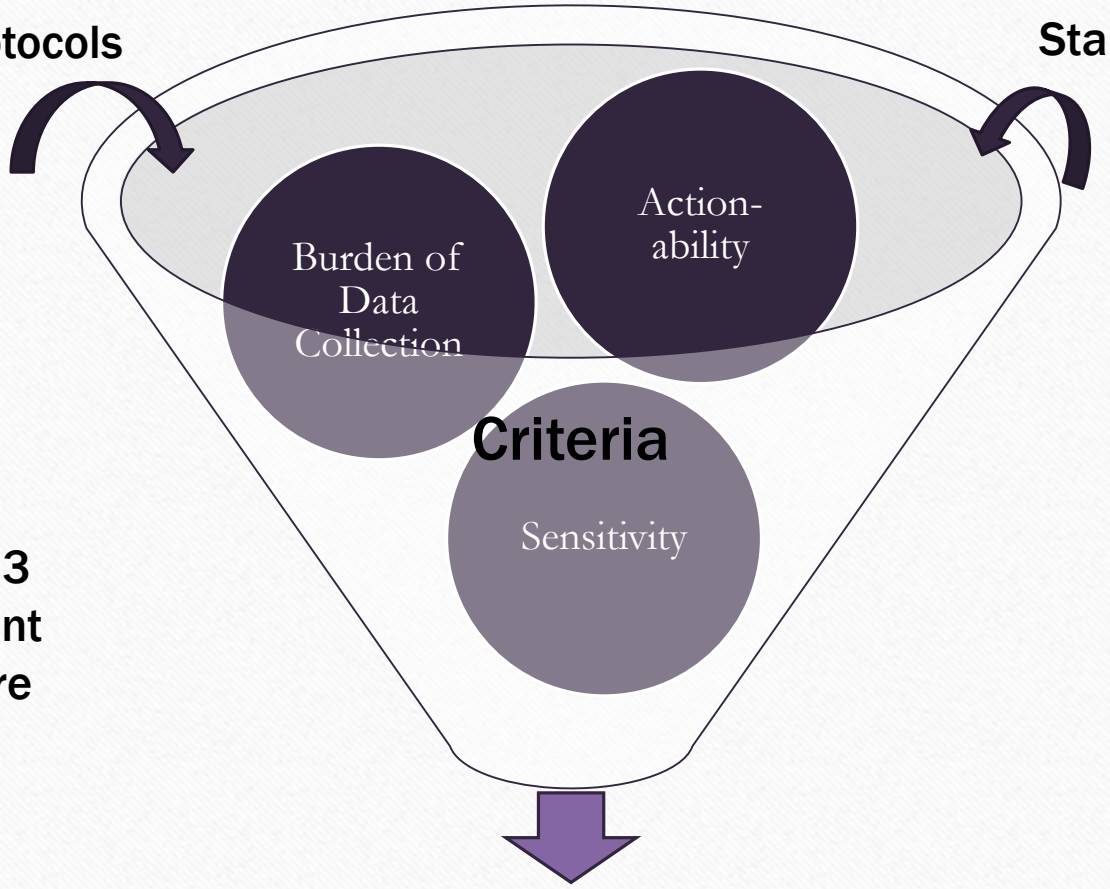
At the Patient and Population Level

How was PRAPARE developed?

Experience of Existing Protocols

Stakeholder Feedback

Literature Review



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

Identified 16 Social Determinants of Health Domains

What questions are in PRAPARE?
What questions should we focus on?

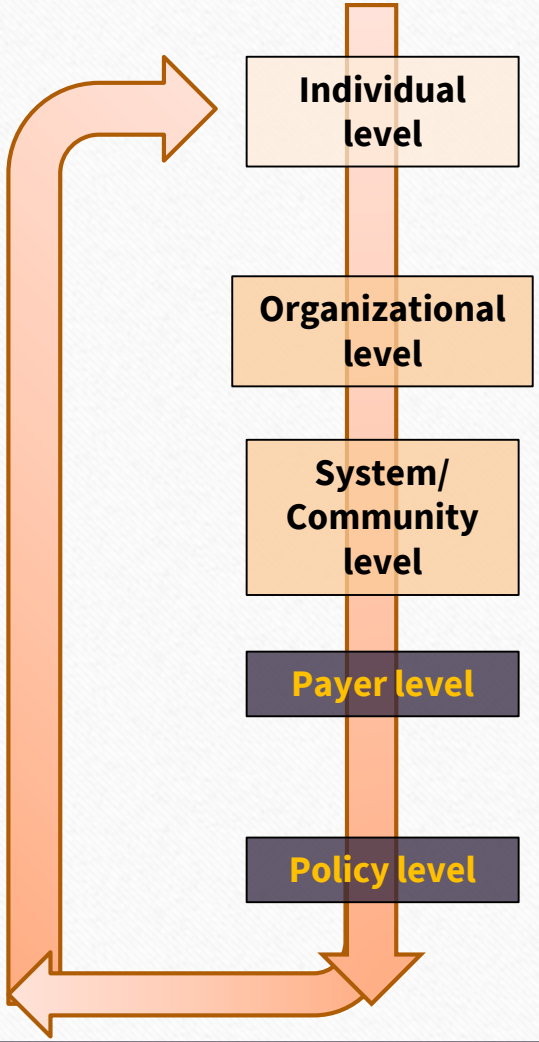
Core	
UDS SDH Domains	Non-UDS SDH Domains (MU-3)
1. Race	10. Education
2. Ethnicity	11. Employment
3. Veteran Status	12. Material Security
4. Farmworker Status	13. Social Isolation
5. English Proficiency	14. Stress
6. Income	15. Transportation
7. Insurance	16. Housing Stability
8. Neighborhood	
9. Housing Status	

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

Optional Granular	
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

Spanish and Chinese (Mandarin) translated versions

What will PRAPARE data allow us to do?



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
Community/Local Health System	Integrate care through cross-sector partnerships, develop community-level redesign strategy for prevention, and advocate to change local policies
Payment	Execute payment models that sustain value-based care (incentivize the social risk interventions and partnerships, risk adjustment)
State and National Policies	Ensure capacity for serving complex patients, including uninsured patients

What are the advantages of using PRAPARE?

- Standardized social determinant domains that align with national initiatives
  - (AHC, HP2020, UDS, IOM, MU, NQF, etc.)
- Vetted and tested by health center stakeholders
- Free EHR templates to capture and use data: eClinical Works, Epic, GE Centricity and Next Gen
- Builds relationships with patients
- Provides actionable data
- Common core yet flexible
  - Able to make more granular and/or add questions
  - Focus on standardizing the need, not the question
- Created with community health centers in mind and used nation-wide use by over 600 health centers, hospitals, health systems

Introducing PRAPARE

PRAPARE Academy

PRAPARE Academy Overview

NACHC, AAPCHO, and OPCA launched the first ever PRAPARE Train the Trainer Academy from Aug. 2017 – May 2018. WACMHC was chosen and recruited Neighborcare Health and HealthPoint to participate.

The goals of the PRAPARE Train the Trainer Academy:

- Build the capacity of PCAs and HCCNs to assist CHCs in PRAPARE implementation, spread it throughout states, and use it to affect change at the patient, organization, and community levels
- Build capacity of CHCs to use PRAPARE data to accelerate policy, payment, and delivery system changes
- Cultivate leaders in implementation that can accelerate spread and serve as a resource for PCAs and HCCNs

PRAPARE Academy Overview

Key capacity areas covered in Academy:

- Strategies to Support CHCs in PRAPARE Implementation
- HIT Functionalities for PRAPARE Data
- Supporting CHCs in Responding to Needs Identified
- Using Data for Policy, Delivery System Redesign, Broadly-Based Integration, and Care Transformation
- Tracking best practices to create resources to help other PCAs and HCCNs and support spread within participant states.

WACMHC's Participation Goals

- Low-level: be equipped with the knowledge and capacity to effectively support health centers to implement a standardized tool and intervention(s) to address social determinants of health
  - Help develop workflow best practices, team design, etc.
  - Help health centers learn the needs of their patient population to effectively act
  - Value-based payment and population risk assessment
  - Support UDS metrics – quality improvement award dollars
- High-level:
  - Learn effective implementation models and scale to other health centers in WA
  - Standardize efforts – compare apples to apples
  - Inform policy efforts

Academy Curriculum

Curriculum Emphasized:

- Data:
  - Collection strategies
  - Reporting
  - Aggregation
  - Analyzing
  - Acting
- EHR functionalities/HIT
- Shared learning

PRAPARE Implementation & Action Toolkit

www.nachc.org/prapare

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

How did WACMHC partner with CHCs during the Academy?

- In-person Kick Off Meeting held with the Health Centers to discuss expectations for the Academy, learn about their readiness, share Academy and WACMHC resources, and meet staff
- Monthly Check-In Calls with Health Centers:
  - WACMHC shared what was learned from the Academy's monthly Train-The-Trainer calls and office hours
  - Health Centers discussed their progress, identified issues requiring follow up and shared helpful information with each other

How did WACMHC partner with CHCs during the Academy?

- In-person visit to Health Center to observe PRAPARE pilot and map workflow
- In-person Wrap Up Meeting held with the Health Centers to gather feedback on their participation in Academy, best practices, and next steps
- Prepared report on PRAPARE data submitted by Health Centers

Lessons Learned from the Academy

- Completing a readiness assessment was essential for CHCs
- Peer networking was one of the best tools for CHCs
- Opportunity to close the gap between screening tools and other state initiatives

Moving Along Together

WACMHC Support

Services Offered

- Coaching & facilitation
- Survey implementation tool kit
- Peer-to-peer network facilitation
- Data Validation & Survey Implementation Training
- Pilot Data Analysis

Coaching and Facilitation

- Guidance through WACMHC's SDoH toolkit
- Coaching calls
- Email support
- Access to NACHC and other resources
- Assistance developing workflows
- Project management assistance

Data validation & survey implementation training

Data Training Modules

Field Survey Training

Assistance with online trainings

Peer-to-peer network facilitation

Pilot Data Analysis

Trends

Areas of need

Associations

Survey implementation tool kit

- Used with a variety of SDoH data collection tools
- Emphasizes readiness planning
- Includes templates, resources and training modules.

Literature Review on Bias

Name of the paper	Highlights of the paper
A catalog of biases in questionnaires	Identifies and categorizes 48 kinds of biases, with examples, and how to avoid these biases
Choosing a method to reduce selection bias: A tool for researchers	What is selection bias and methods to reduce selection bias
Information bias in health research: definition, pitfalls, and adjustment methods	Focuses on information bias and strategies to overcome it in observation and experimental studies
A primer on the validity of assessment instruments	What is reliability and validity and how are they measured and determined
Principles and methods of validity and reliability testing of questionnaires used in social and health science researches	Understand the principles and methods of validity and reliability measurement tools
Collecting and applying data on social determinants of health in health care setting	Describes ways to collect data and target interventions at patient, institution, and broader population level.

Invitation to Participate

Study on the Association between SDoH Screening and Hypertension and Diabetes Control

We invite you to participate in a one-year, analytical cross-sectional study. Participating clinics will receive training on data collection, progress reports and data support through the duration of the project.

Break

PRAPARE Academy FQHC Experience

Neighborcare Health

HealthPoint

PRAPARE PILOT AT NEIGHBORCARE HEALTH

BOMY YUN, MSN, ARNP AND PAIGE L. GIBBENS, DNP, ARNP | SEPT 26, 2018

AGENDA FOR TODAY

- Who We Are
- Pilot Background and Objectives
- Pilot Process
- SDOH Resource List
- Pilot Outcomes
- Lessons Learned
- Recommendations for other CHCs

WHO WE ARE

- Large community health organization in King and Vashon counties
- 8 primary care clinics
- 14 school-based clinics
- 7 dental clinics
- Homeless patients served in long-term and supportive housing units
- Behavioral health and pharmacy services

75,000 patients served in over 313,000 visits in 2017

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PRAPARE PILOT BACKGROUND

People with the most social disadvantage experience poorer health and decreased life expectancy.[1,2,3]

CHCs provide medical care to more socially disadvantaged individuals at higher risk for poorer health outcomes.[4]

Healthcare organizations and practitioners rarely gather SDOH information.[1,5]

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PRAPARE PILOT BACKGROUND

- What is PRAPARE?
  - The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
  - PRAPARE is a national, standardized tool to assess patients' SDOH
- PRAPARE was selected as the SDOH screening tool for the pilot
- Consists of 21 questions to screen for SDOH in various domains
- PRAPARE template available for use through NextGen EHR

PRAPARE PILOT OBJECTIVES

To design a single provider pilot for PRAPARE and implement it at one site

- Where? Neighborcare Health at Rainier Beach Medical and Dental Clinic
- Provider: Bomy Yun, ARNP

Screening questions administered in-person

- Contribution to pilot served as part of capstone project for UW DNP student Paige L. Gibbens

Creation of comprehensive resource list

- Resource list to address patient needs based on SDOH domains referred to in PRAPARE

Use of pilot findings to inform next steps

- Understand opportunities and barriers to widespread implementation

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PRAPARE PROCESS – PRE-PILOT

Formed pilot team	Clinician survey	PRAPARE "crosswalk"	Introductory script	Clinic flow
1 ARNP 1 DNP student 1 Project manager	Brief clinician survey conducted to understand attitudes toward SDOH screening	Performed "crosswalk" to identify overlap between PRAPARE questions and those on existing organizational questionnaires	Drafted script to introduce patients to PRAPARE	Determined clinic flow for administering PRAPARE tool during pilot

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PRAPARE PROCESS – DURING PILOT

- Creation of 8 SDOH resource lists
- PRAPARE questionnaire administered in entirety to all participants
  - Patients18 years and older
  - Administered in-person
  - Responses completed on PRAPARE template in patients' charts
- Brief patient feedback survey also administered
  - To assess patient perception of usefulness and comfort level in completing PRAPARE

PRAPARE PROCESS – DURING PILOT

- Abnormal response follow-up
  - EHR task (message) sent to provider notifying of abnormal responses for which action was taken
    - Internal referrals to social worker and/or behavioral health consultant
    - External/community referrals – SDOH resource list(s) given as handouts
- Modifications to problem list
  - Abnormal PRAPARE responses lead to addition of certain diagnoses to the problem list
    - E.g. For housing question, response of "I do not have housing" leads to addition of 'homelessness' or 'inadequate housing' to patient's problem list

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HOUSING RESOURCES

Bread of Life Mission
Services: Emergency shelter for homeless men (18 years and older).
Phone: (206) 682-3579
Website: http://www.breadoflifemission.org/
Address: 97 S Main St, Seattle, WA, 98104

Compass Housing Alliance
Services: Transitional housing, emergency shelters, affordable permanent housing and veteran services for men and women.
Phone: (206) 474-1840
Website: http://www.compasshousingalliance.org/
Address: 77 S Washington St, Client Services Office, Seattle, WA, 98104

HousingSearchNW.org
Services: Free online database that provides individuals with a list of available affordable housing in their community.
Website: http://www.housingsearchnw.org/index.html

Not sure where to start?

King County 2-1-1 is an excellent resource for affordable housing, emergency shelters and transitional housing.

- **Call 211 or visit their website at www.crisisclinic.org**
- **You will be connected to the services that are right for you**

They can also help you with:

- **Legal assistance**
- **Employment**
- **Education**
- **Employment**
- **Family support programs and more!**

SDOH RESOURCE LIST:

HOUSING

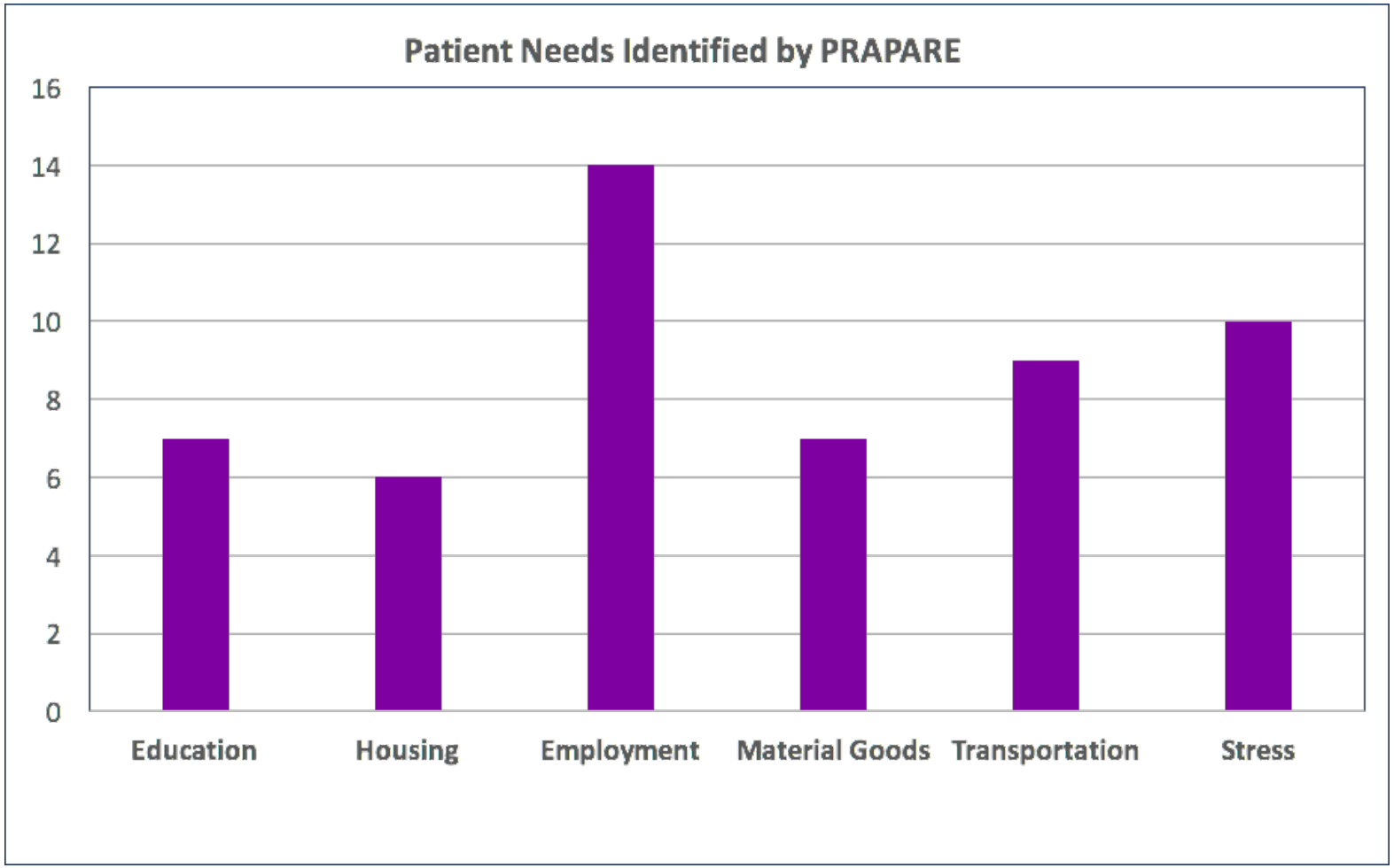
SDOH RESOURCE LIST

- Categories
  - Housing
  - Transportation
  - Nutrition and Food
  - Insurance
  - Education
  - Behavioral Health
    - Children and Adolescents
    - Adults
  - Domestic Violence Services

PILOT RESULTS

Patient Profile

- 40% male, 60% female
- Average age 48.75 years
- Interviews took 10 minutes on average
  - Ranged from 5 to 29 minutes
- Most common areas of need:
  - Transportation
  - Employment
  - Stress



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PRAPARE SURVEY #_____

1) **What do you think about the time it took to complete the PRAPARE survey?**
   A. I think the survey was too long
   B. I think the survey was too short
   C. I think it took the right amount of time
   D. Other (please write)
   _____

2) **Did you feel comfortable answering these questions?**
   A. Yes, I felt comfortable answering these questions
   B. I was comfortable answering some of these questions
   C. No, I was not comfortable answering any of these questions

   *If you were uncomfortable answering some of these questions, what information did you feel uncomfortable sharing?
   _____

3) **Do you think this survey will help your medical team better address your needs?**
   A. Yes, it will help address my needs
   B. No, it will not help address my needs
   C. Unsure if it will help address my needs.
   D. Other (please write) _____

4) **Do you feel that the questions included in this survey have been asked by Neighborcare Health before?**
   A. Yes, these questions have been asked before
   B. Yes, some of these questions have been asked before
   C. No, I have never answered these questions before

   *If you answered yes, what questions have you been asked before?
   _____

5) **If you have any other feedback, please write it below.**

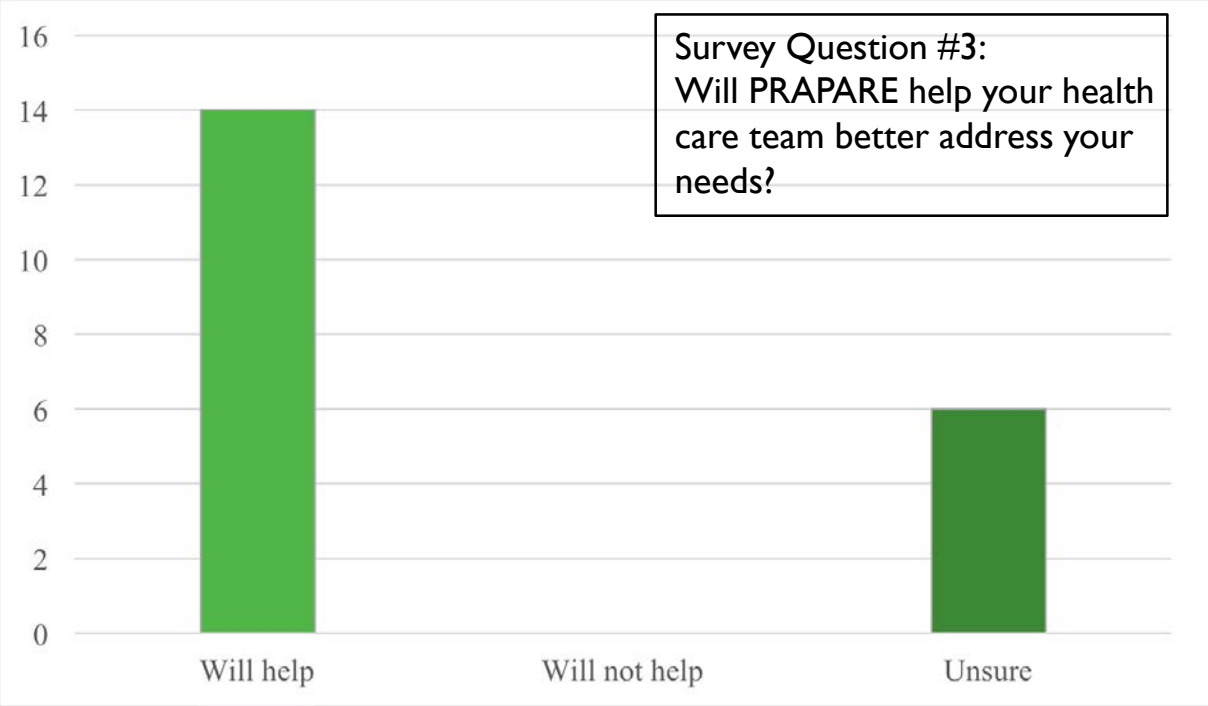
Thank you!

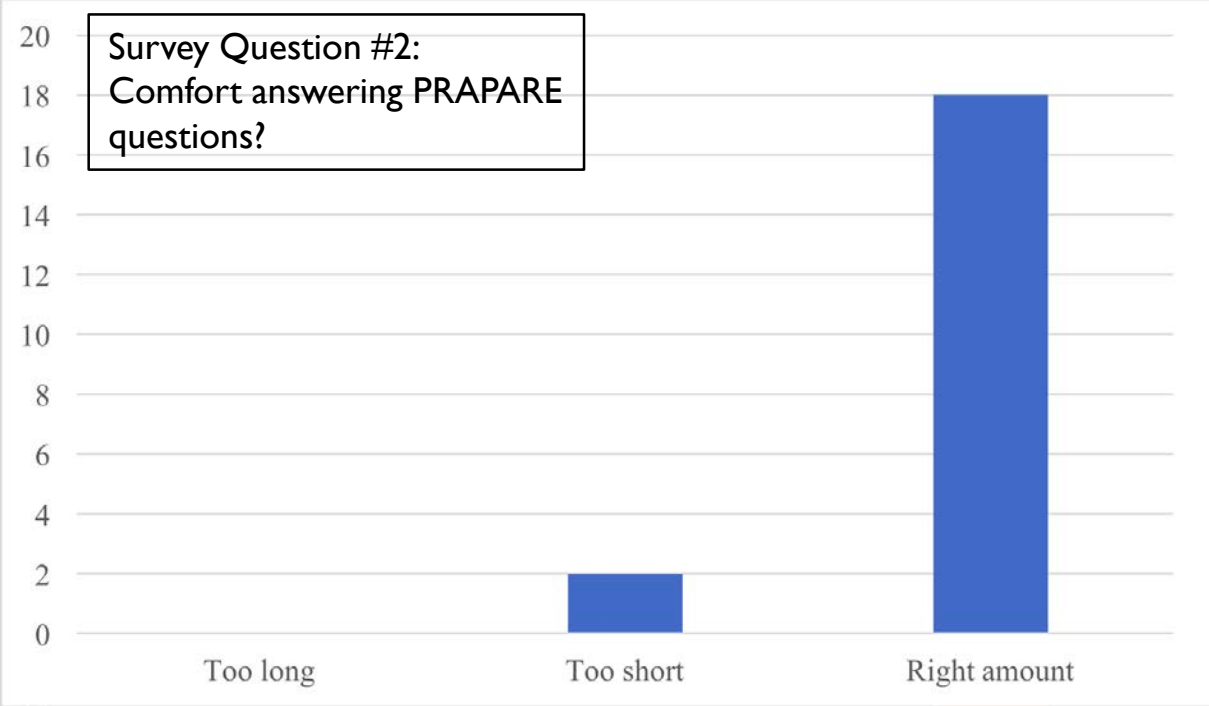
PATIENT FEEDBACK SURVEY

PILOT RESULTS

Patient Feedback Survey

- 90% thought the survey took the right amount of time.
- 85% were comfortable with all questions.
- 70% thought PRAPARE would help their medical team better address their needs.
- 60% felt that they had never answered similar questions at NCH in the past.





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PATIENT FEEDBACK EXAMPLES

Positive Feedback

"I think it has well-rounded questions. Most of the things people are concerned with are covered: financial problems, living, stress, transportation."

"If we asked questions like this, we could help the whole country."

"It was good. I had a lot to get off my chest."

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PATIENT FEEDBACK EXAMPLES

- Unfavorable Feedback
  - "Does anyone feel comfortable talking about this kind of thing? It's embarrassing to talk about…"
  - "The questions felt too broad. If you're trying to really match someone up well (to resources), the questions need to be more in-depth."
- One patient noted that "the housing and financial questions, stress factors and feeling safe…" questions have been asked in other screeners.

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LESSONS LEARNED

- In-person interviews not a sustainable method for administering PRAPARE due to excess time taken, despite delivering a good patient experience
- PRAPARE template use rather clunky
- Pilot was limited in scope to a few key staff; for greater effectiveness, should involve clinic social worker and behavioral health consultant
- Additionally, should inform billing department of start of pilot and what, if any, PRAPARE-related diagnosis codes they may see and what to do with them
- SDOH resource lists should be tailored to geographic region of clinic

RECOMMENDATIONS

- Start with a pilot!
- Conduct readiness assessment
- Develop SDOH resource lists and have plan to keep up-to-date
- Workflow/resource recommendations
  - Low resource/funding
    - Utilize paper questionnaires and data entry by existing staff
  - High resource/funding
    - Utilize additional technology or human resources

RECOMMENDATIONS

- Workflow/resource recommendations
  - Low resource/funding
    1) Administer PRAPARE on paper by having front desk staff hand abbreviated or whole questionnaire to patients at check-in
    2) Administer PRAPARE on paper by having medical assistant (MA) hand abbreviated or whole questionnaire to patients after rooming
    - In both scenarios above, MA could complete data entry
    - Provider makes appropriate referrals or otherwise addresses abnormal SDOH

RECOMMENDATIONS

- Workflow/resource recommendations
  - High resource/funding
    1) Purchase technology such as tablets or kiosks for PRAPARE administration
       - May need third-party vendor to provide an interface between device and EHR
       - Technology facilitates data gathering and documentation; interventions likely still need to be initiated by a staff person
    2) Hire staff such as community health workers, coordinators, or additional MAs to float around clinic assisting clinical teams to screen patients on laptops

RECOMMENDATIONS

- Workflow/resource recommendations
  - Population-specific approach
    1) Target select populations to screen for SDOH
    2) Select a few SDOH domains to focus screening on broader population
       - Consider rotating domains of focus
       - May be beneficial for risk stratification of patients with high complexity

PILOT CONCLUSIONS

- PRAPARE interviews resulted in referrals to internal (e.g. social worker) and community resources
- PRAPARE provides the opportunity to identify and document patients' SDOH needs
  - Addressing SDOH can be incorporated into patients' care plans by multiple members of the care team
  - More holistic patient care
  - Reportability
- Patient feedback was positive overall!

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REFERENCES

- Bravemen P, Egerter S, Wlliams DR. The social determinants of health: Coming of age. *Annu Rev Public Health*. 2011;32:381-398.
- Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: what the patterns tell us. *Am J Public Health*. 2010;100 Suppl 1:S186-196. doi: 10.2105/AJPH.2009.166082.
- Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies. *Health Aff*. 2002;21(2):60-76.
- Gold R, Cottrell E, Bunce A, et al. Developing electronic health record (EHR) strategies related to health care patients' social determinants of health. *J Am Board Fam Med*. 2017;30(4):428-447
- Institute of Medicine. *Capturing social and behavioral domains and measures in electronic health records: Phase 2*. Committee on the Recommended Social and Behavioral Domains and Measures for Electronic Health Records; Board on Population Health and Public Health Practice; Washington (DC): National Academies Press (US); 2015.

THANK YOU!




HealthPoint

Social Determinants of Health
Roundtable for FQHC's
September 26, 2018
Cindy Breed ND

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Deciding to Start Somewhere

- What we know
  - *The conditions in which people live, work, play and age have an effect on their health outcomes.*
  - *What we don't know is a barrier to making progress.*
- The availability of a social determinants assessment tool in our EMR NextGen opened the door for considering a first step.
- HealthPoint culture is accepting of testing new tools, pilot projects and small tests of change.

Initial pilot

- Tested the functionality of the Assessment tool in the EMR
- Discovery Session
  - *Anticipate the multiple areas impacted by this project*
  - *(IT) Information Technology, Billing, Clinical Care Teams*
- Training
  - *Supported by IT*

3 week initial pilot conducted in May 2018

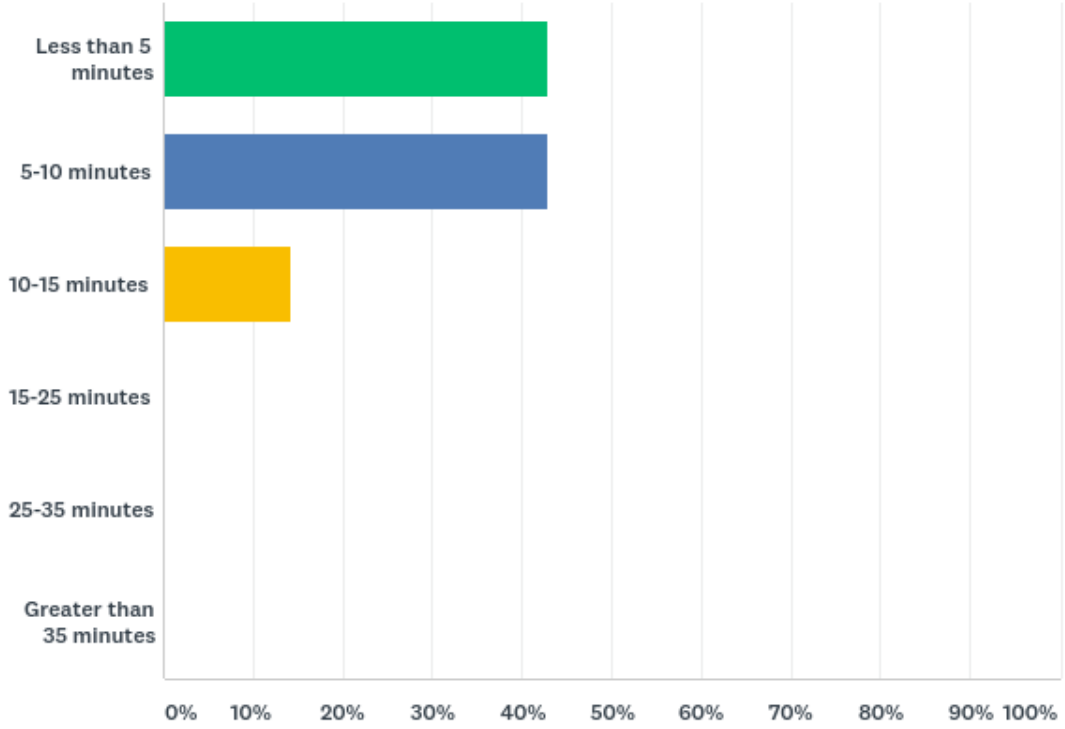
- HH Care Coordinators and BH Care Coordinators
  - *5 people*
- Goal: Use the assessment tool for 20 patients
- Complete Feedback Survey
- Track positive responses and what was done about them.

14 patients with positive responses

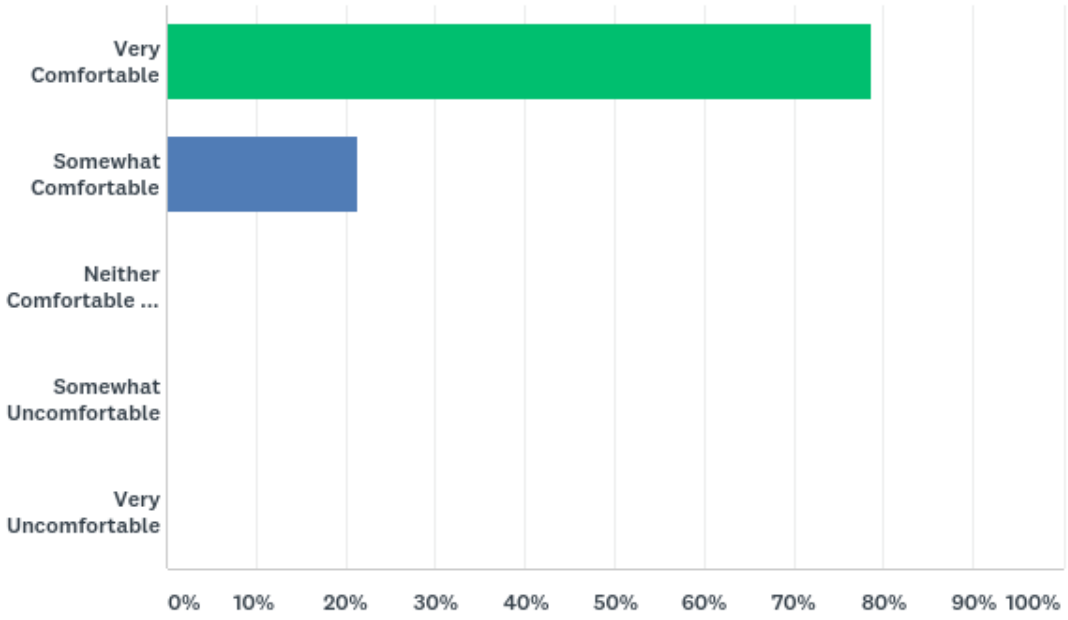
- Most Common
  - *2 positive responses*
    - Range 1-3 responses
    - NOTE: Data from NACHC toolkit: Most patients face 4-9 SDH and more complex patients can face upwards of 11 SDH
- Domains

Housing	Money and Resources	Barriers to Care	Social and Emotional Health
3	10	4	10

Q1 How long did it take to complete the PRAPARE Questionnaire?



Q3 How would you describe the response from your patients when they were asked these questions?



Q15 What did you like about the questions on the PRAPARE template?

Helpful Info Understand Patients

Lessons Learned

- Our initial pilot has demonstrated that using the tool is:
  - *Useful*
  - *Not overwhelming*
- Response Plan to positive answers needs development.
- Data Plan needs development.

Gradual Roll Out

- Gradual roll out to BH providers at 10 medical sites
  - *July-October 2018*
- Goal: Use the assessment tool for 2-3 patients per day that you see patients.
- Training
  - *Small groups through GoToMeeting*

What we learned

- 14 providers or care coordinators have used the PRAPARE assessment tool
- 56 patients have been assessed
- 55 patients have had at least one positive response

Percent of Patients with Positive Responses

Positive Responses	Percent
1	5%
2	14%
3	25%
4	21%
5 or more	32%

Percent of Positive Responses per Question

	Question	%PR
Unable to get resources	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.)	**100%**
Insurance	What is your main insurance?	**98%**
Insurance through work	Do you have insurance through your job?	**96%**
Work	What is your current work situation?	**82%**
Stress	Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?	**55%**

Percent of Positive Responses per Question

	Question	%PR
Work hours	How many hours a week do you work?	**41%**
Social contact	How often do you see or talk to people that you care about and feel close to? (Ex. talking to friends on phone, visiting friends or family, going to church or club meetings)	**27%**
Incarceration	History of Incarceration?	**24%**
Transportation	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? (Select All That Apply)	**22%**
Education level	What is the highest level of school that you have finished?	**20%**

Data Plan- How we plan to use this data

- Build programs to address the social issues of our patients who have poor health outcomes.
- Factor into risk stratification for our patients.
- Provide needed support for our medically complex patients.

Response Plan

- Survey conducted across the organization to learn what care coordinators, social workers, BH consultants use for resources currently
- Evaluated 211 resource
- Reviewed Global to Local resource database
- Reviewed Neighborcare's resource database
  - *Collaboration with WACMHC a participant in the NACHC Train the Trainer Academy*
- Goal: Create a database for reference that can be sorted by location or by area of need
  - *Design a process to keep the resource updated*

Resources that could help our response plan

- County or state wide systems for community linkages
  - *For bidirectional referrals for community organizations*
- Expanding programs like Health Homes
  - *Personal Care Coordination*

Thank You- for sharing what you learned

- WACMHC
- Neighborcare
- Family Health Center

Contact Information: Cindy Breed ND, HealthPoint Regional Director of Clinical Care cbreed@healthpointchc.org

Lunch

12:00 – 1:00 pm

Guest Panel

Coordinated Care

Oregon Primary Care Association

Yakima Neighborhood Health Services

Washington State Department of Health

Washington State Health Care Authority

Break

Breakout Sessions

Data & Population Health

Readiness, Workflows, & Implementation

State Landscape

Report Out

- What were interesting points of discussion?
- Any “AHA” moments?
- What action steps have been identified, if any?

Services Offered

- Coaching & facilitation
- Survey implementation tool kit
- Peer-to-peer network facilitation
- Data Validation & Survey Implementation Training
- Pilot Data Analysis

“

[The] Pioneering spirit should continue,
not to conquer the planet or space…
but rather to improve the quality of life.

”

Bertrand Piccard

Please complete your evaluations.

THANK YOU

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