COLLECTING SOCIAL DETERMINANTS OF HEALTH DATA USING PRAPARE

TO REDUCE DISPARITIES, IMPROVE OUTCOMES, AND TRANSFORM CARE
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BACKGROUND ON PRAPARE
Under value-based pay environment, providers are held accountable for costs and outcomes.

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

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

- Providers serving complex patients often penalized without risk adjustment.
WHAT IS DRIVING THE NEED TO COLLECT DATA ON THE SOCIAL DETERMINANTS OF HEALTH (SDH)?

Figure 1

A Framework for Health Equity

- **Socio-Ecological**
  - Physical Environment (10%)
  - Social and Economic Factors (40%)

- **Medical Model**
  - Health Behaviors (30%)
  - Clinical Care (20%)

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**What is driving the need to collect data on the Social Determinants of Health (SDH)?**

- How well do we know our patients?
- Are services addressing SDH incentivized and sustainable?
- Are community partnerships adequate and integrated?

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Project Goal: To create, implement/pilot test, and promote a national standardized patient risk assessment protocol to assess and address patients’ social determinants of health (SDH).
TIMELINE OF THE PROJECT

Year 1 2014
• Develop PRAPARE tool

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

Year 3 2016
• PRAPARE Implementation & Action Toolkit

Dissemination
DEVELOPING PRAPARE

Identified 15 Core Social Determinants of Health

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

Experience of Existing Protocols
Stakeholder Feedback
Literature Review

Criteria
- Burden of Data Collection
- Action-ability
- Sensitivity

Identified 15 Core Social Determinants of Health
**PREPARE DOMAINS**

<table>
<thead>
<tr>
<th>Core</th>
<th>Optional</th>
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<tbody>
<tr>
<td><strong>UDS SDH Domains</strong></td>
<td>1. Incarceration History</td>
</tr>
<tr>
<td><strong>Non-UDS SDH Domains (MU-3)</strong></td>
<td>3. Domestic Violence</td>
</tr>
<tr>
<td>1. Race</td>
<td>10. Education</td>
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<tr>
<td>2. Ethnicity</td>
<td>11. Employment</td>
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<tr>
<td>6. Income</td>
<td>15. Transportation</td>
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<td>7. Insurance</td>
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<td>8. Neighborhood</td>
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<td>9. Housing Status and Stability</td>
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**Older version in Spanish**

**Find the tool at:**
[www.nachc.org/prapare](http://www.nachc.org/prapare)
DOB: 07/30/1967  
Patient Age: 59 Years Old

Money and Resources

What is the highest level of school that you have finished? 9th-12th grade

Employed? Yes No  
Your current work situation? FT PT

Insurance: Allcare

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?

Detailed Insecurities:

- Food: Yes No
- Utilities: Yes No
- Transportation: Yes No
- Medicine or medical care: Yes No
- Health insurance: Yes No

Add Inadequate housing (259.1) to Prob List
Add Other prob rel to housing and econ. circ. (259.8) to Prob List
WHAT WE’VE LEARNED FROM IMPLEMENTATION
Other EHRs in Development or Interested:
- Greenway
- Allscripts
- Athena
- Cerner
**WHAT WE’VE LEARNED FROM PILOT TESTING**

- **Easy to use:** On average, takes ~9 minutes to complete form.
- **Staff find value in the tool:** Helps them better understand patients and build better relationships with patients.
- **Identifies New Needs:** Often Leading to New Community Partnerships.
- **Patients appreciate being asked and feel comfortable answering questions.**
- **Emotional Toll on Staff.**
**Challenge:** Staff and Patients Don’t Understand Why Doing PRAPARE

**Solution:** Use short script to explain to staff & patients why health center is collecting this information. Message around better understand patient and patient’s needs to provide better care.

**Challenge:** Have too much going on now to add another project

**Solution:** Don’t market PRAPARE as new big initiative but as project that aligns with other work already doing (care management, ACO, enabling services, etc)

**Challenge:** How do we implement this without increasing visit time?

**Solution:** Find “Value-Added” time, whether in waiting room, during rooming process, or after clinic visit

**Challenge:** Fitting PRAPARE into Workflow

**Solution:** Incorporate into other assessments to encourage completion (Health Risk Assessment, Depression Screening, Patient Activation Measure, etc)

**Challenge:** Inability to Address SDH

**Solution:** Message “Have to start somewhere and do the best we can with what we have. Collecting information will help us figure out what services to provide.”
PERCENT OF PATIENTS WITH NUMBER OF SDH “TALLIES”

Tally Score

Alliance/Iowa 3 CHCs
Waianae 1 CHC
New York 2 CHCs
Oregon 1 CHC
Total 7 CHCs

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

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

Better Understand INDIVIDUAL Patient’s Socioeconomic Situation

- Build services in-house for same-day use as clinic visit (children’s book corner, food banks, clothing closets, wellness center, transportation shuttle, etc)

Better Understand Needs of Patient POPULATION

- Build partnerships with local community based organizations to offer bi-directional referrals and discounts on services (ex: Iowa transportation)

Drive STATE and NATIONAL Care Transformation

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

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

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

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

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

- Inform payment reform and APM discussions with state agencies (e.g., Medicaid) on caring for complex patients (ex: Oregon, Hawaii)
TRACKING INTERVENTIONS
DATA ON SDH AND NONCLINICAL INTERVENTIONS GO HAND IN HAND

**NEED**
- Standardized data on patient risk

**RESPONSE**
- Standardized data on interventions

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

TAKING THE FULL MEASURE OF HEALTH CENTER

Report by RCHN Foundation in NACHC Community Health Forum, HIT Connections, Fall/Winter 2014
## AAPCHO DATA COLLECTION PROTOCOL: THE ENABLING SERVICES ACCOUNTABILITY PROJECT

### Enabling Services Accountability Project (ESAP)

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

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CODE</th>
<th>Minutes</th>
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<tbody>
<tr>
<td>CASE MANAGEMENT ASSESSMENT</td>
<td>CM001</td>
<td></td>
</tr>
<tr>
<td>CASE MANAGEMENT TREATMENT AND FACILITATION</td>
<td>CM002</td>
<td></td>
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<tr>
<td>CASE MANAGEMENT REFERRAL</td>
<td>CM003</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL COUNSELING/ELIGIBILITY ASSISTANCE</td>
<td>FC001</td>
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<tr>
<td>HEALTH EDUCATION/SUPPORTIVE COUNSELING</td>
<td>HE001</td>
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<tr>
<td>INTERPRETATION</td>
<td>IN001</td>
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<td>OUTREACH</td>
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<tr>
<td>TRANSPORTATION</td>
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<tr>
<td>OTHER</td>
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CONCEPTUAL FRAMEWORK

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

Appropriate Care
(For health condition in question, for example, # of doctor visits, exams/tests levels...)

Health Outcomes
(For example, ideal outcomes, reduced complications, ED visits, etc.)

Enabling Services & other non-clinical interventions
PRAPARE RESOURCES
RESOURCES AVAILABLE NOW

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

- Visit http://enablingservices.aapcho.org
  - AAPCHO’s Enabling Services Accountability Project
    - protocol for data collection of non-clinical enabling services
  - Enabling Services Data Collection Implementation Guide
  - White Papers, Best Practices, Studies

Contact Tuyen Tran at ttran@aapcho.org
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
PRAPARE IS A NATIONAL MOVEMENT!

Use and Interest in PRAPARE as of October 2016

- States where health centers are already using PRAPARE (31 states)
- States where health centers or PCAs have expressed an interest in PRAPARE (19 states)
THANK YOU!!

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