Adapting SDOH Data Collection Workflows during COVID-19

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

October 8, 2020

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association. PRAPARE and its resources are proprietary information of NACHC and its partners, intended for use by NACHC, its partners, and authorized recipients. Do not publish, copy, or distribute this information in part of whole without written consent from NACHC.

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.

Zoom Webinar Chat

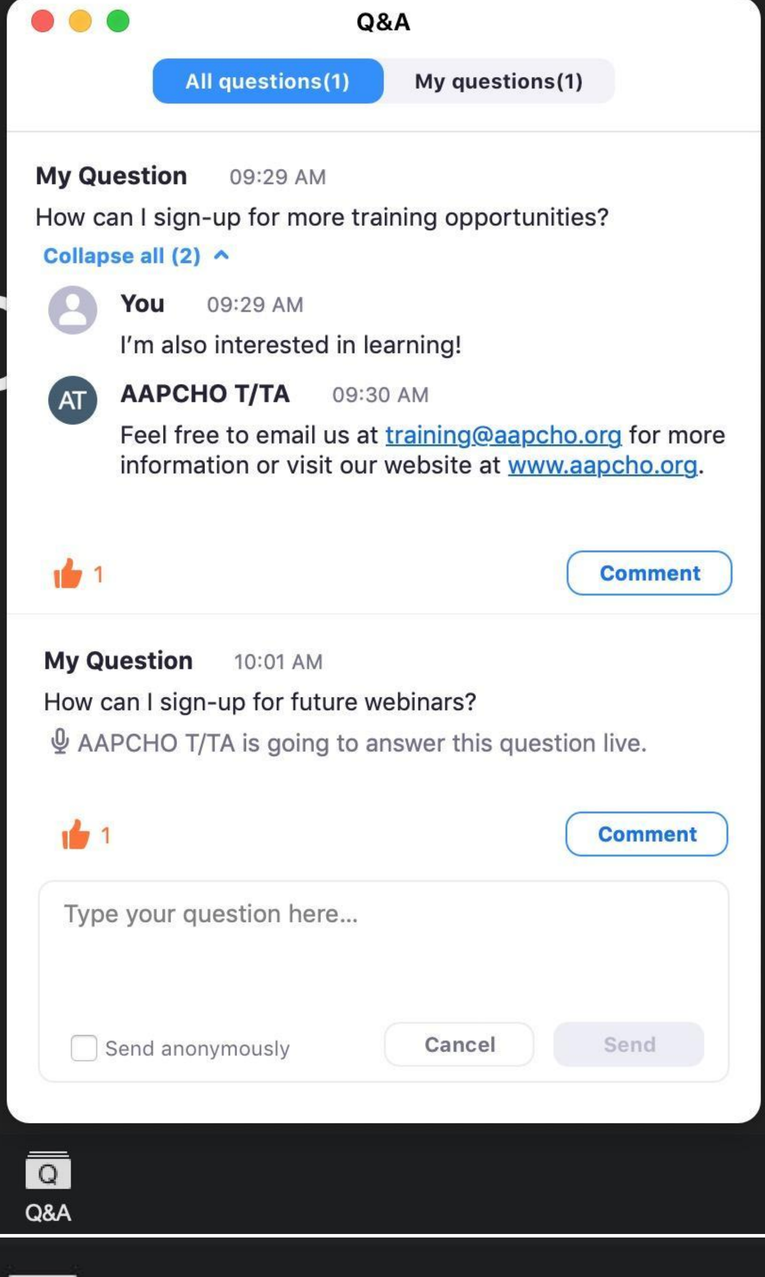
From AAPCHO T/TA to All panelists and other attendees:
Welcome to the webinar!

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

To: All panelists and attendees

Your text can be seen by panelists and other attendees

Chat



Unmute

Chat

Lower Hand

Q&A

Leave Meeting

Quick Polls

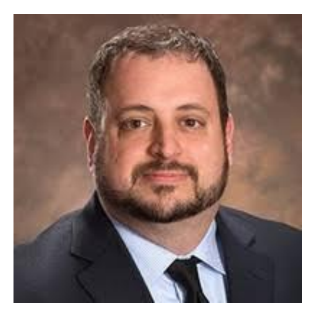
Get a sense of who is in the virtual room

Agenda

Topic	Timing in EST
Opening and housekeeping	4:00pm
Overview of Social Risk Screening Workflow Models	4:05pm
SDOH Data Collection Strategy: SDOH Needs and Social Interventions	4:15pm
Health Center Spotlight: Bighorn Valley Health Center	4:25pm
Questions and Discussions	4:45pm
Closing and resources	4:55pm

Project Team at NACHC & AAPCHO

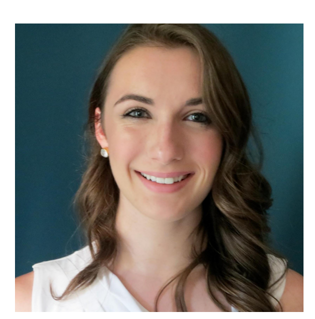
Michelle Proser
Director of Research
NACHC



Jason Patnosh
Associate VP, Partnership & Resource Development
NACHC

Rosy Chang Weir
Director of Research
AAPCHO

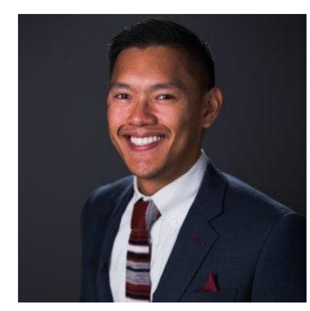
Joe Lee
Training and Technical Assistance Director
AAPCHO



Sarah Halpin
Program Associate
NACHC

Yuriko de la Cruz
SDOH Manager
NACHC

Vivian Li
Research Project Manager/Analyst
AAPCHO



Albert Ayson, Jr.
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**

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations

“Assessing and Addressing Social Determinants of Health During COVID-19” – Webinar Series

This Photo by Unknown Author is licensed under CC BY-SA

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.

Aligning Systems for Health
Health Care + Public Health + Social Services

Cross-Sector Alignment Theory of Change

Health Care

Public Health

Social Services

Internal Factors Affecting Capacity

External Factors Affecting Urgency

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

Individual, organizational, and system-level enablers

Factors Affecting Success

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

Strong Community Role and Engagement

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?

Define and document the increased complexity of patients

2

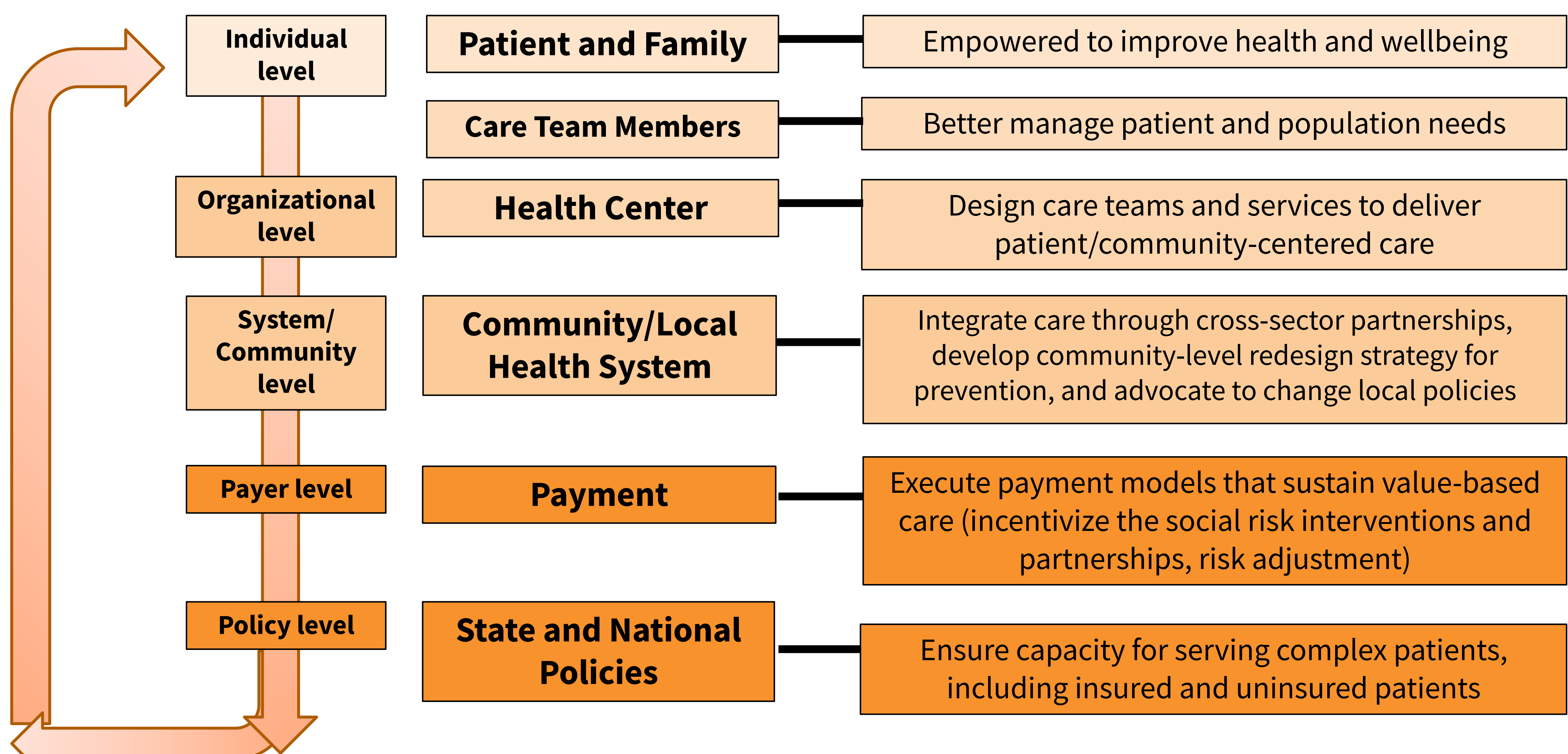
Better target clinical care, enabling services, and community partnerships to drive care transformation

3

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

Advocate for change at the community and national levels

Why Health Centers Collect Standardized Data on SDOH



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.”

This Photo by Unknown Author is licensed under CC BY-NC-ND

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

BUILDING CAPACITY TO RESPOND TO SDOH NEEDS

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?

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

WHAT WORKFLOW SHOULD WE USE TO IMPLEMENT PRAPARE?

5 Rights	Workflow Considerations
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?

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

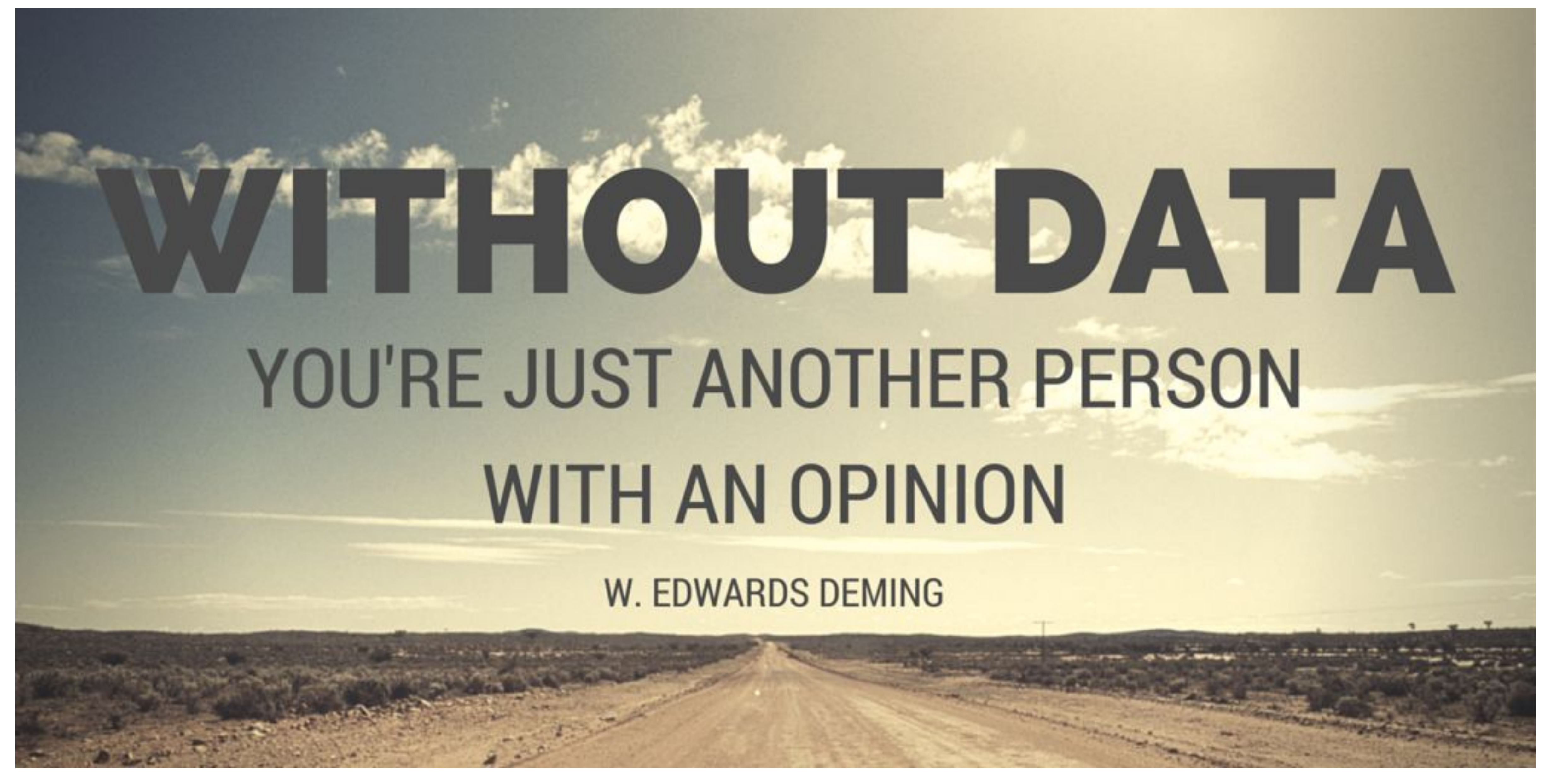
PRAPARE

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?

© 2019. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

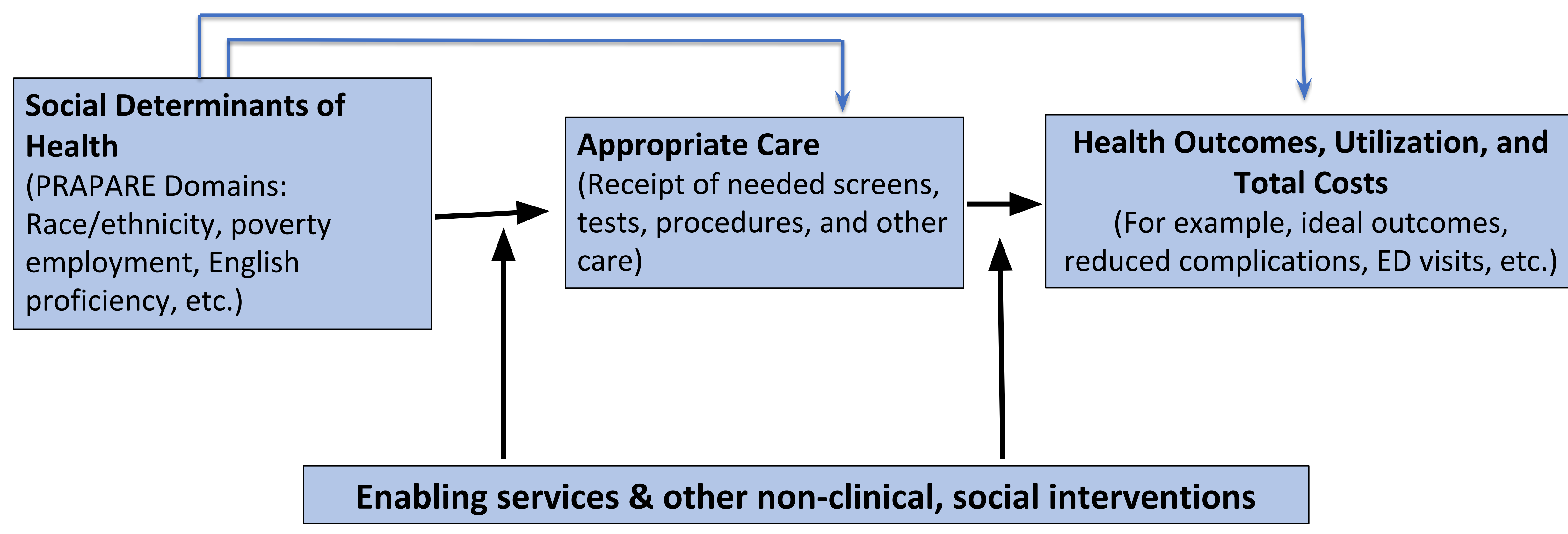


© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

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



© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

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

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

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

ADDITIONAL PATIENT DATA

Maritial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Separated

Student Status: ☐ FT ☐ PT ☐ Not in School

Employment Status: ☐ FT ☐ PT ☐ None | Spouse Employment Status: ☐ FT ☐ PT ☐ None

Primary Care Provider (Medicaid Only):

Pharmacy: | Pharmacy Phone #

Preferred Language: ☐ English ☐ German ☐ Spanish ☐ Other:

Housing Status: ☐ Doubling Up ☐ Homeless Shelter ☐ Not Homeless ☐ Other

Agricultural Status: ☐ Not Agricultural ☐ Migrant ☐ Seasonal

Race: ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Unknown ☐ Refused

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino | Veteran: ☐ Yes ☐ No ☐ Unknown

HOW MAY WE CONTACT YOU REGARDING YOUR MEDICAL OR DENTAL CARE?

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

If you are not available, may we speak to anyone else?

☐ Do not speak to anyone but me.

☐ You may leave a message on my answering machine/ voice mail.

☐ I give my permission to speak with

Name: | Phone:

Relationship to Patient:

☐ To remind me I am due for a test/ appointment.

☐ To give details about dates and/or preparations for a test or appointment.

☐ To discuss my test results, condition, and/or medical care.

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

What questions are in PRAPARE?

Core	
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

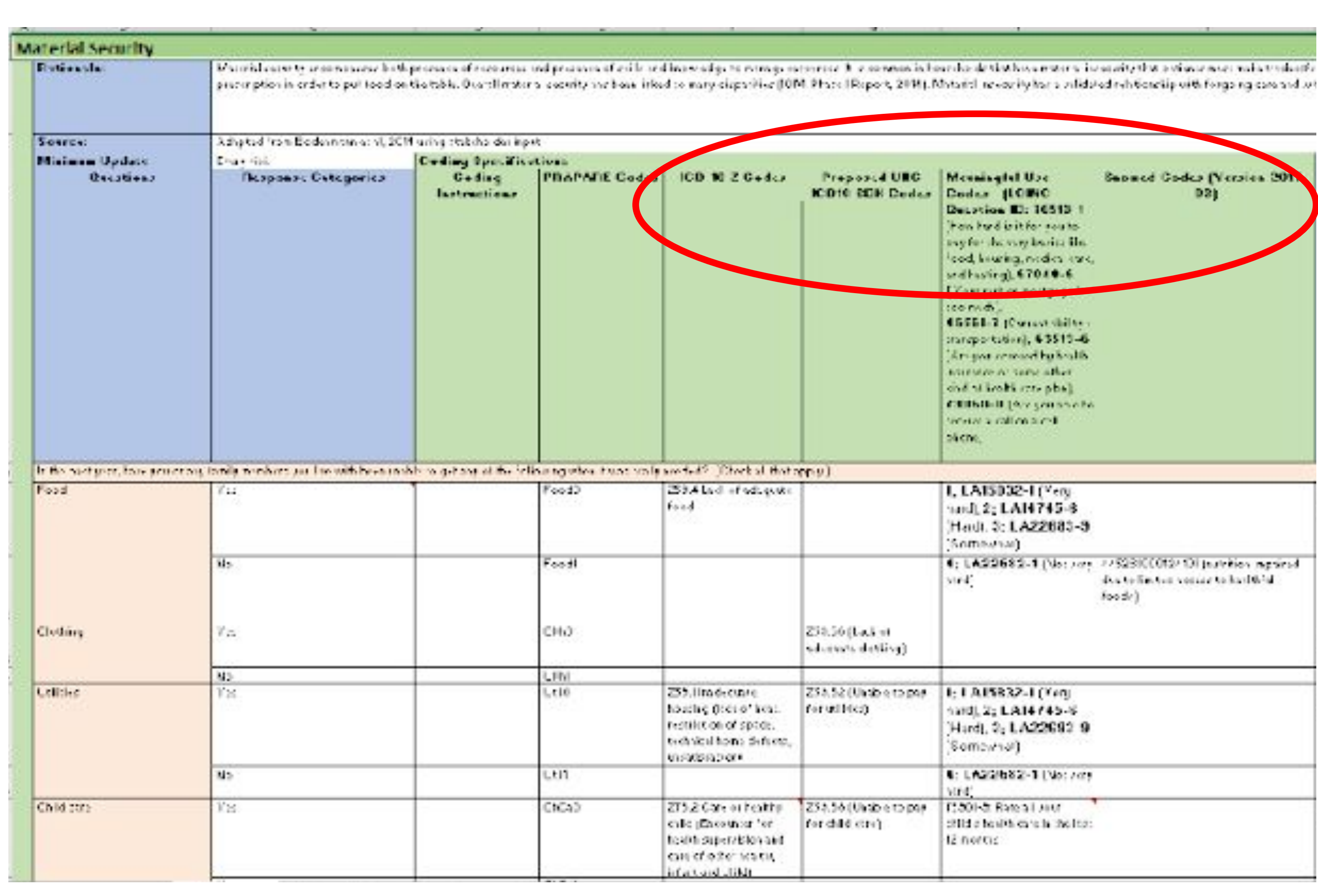
Optional Granular	
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

* 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

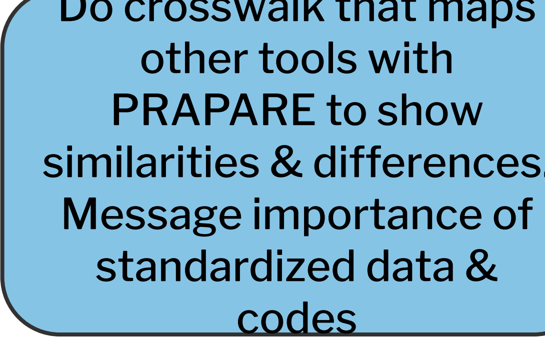
PRAPARE Coding and Data Dictionary

- 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



COMMON CHALLENGES AND RESPONSES

State or organization already committed to using other SDH tools (AHC, homegrown)

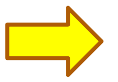


Do crosswalk that maps other tools with PRAPARE to show similarities & differences. Message importance of standardized data & codes

Inability to Address SDH

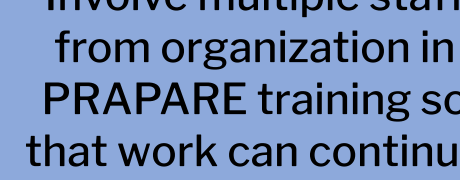
Message: "Have to start somewhere and do the best we can with what we have. Collecting information will help us figure out what services to provide."

Competing Priorities



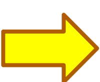
Message how PRAPARE will add value to other initiatives (PCMH, ACO Participation, Payment Reform, etc.)

Staff Turnover at both CHC and PCA and HCCN



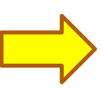
Involve multiple staff from organization in PRAPARE training so that work can continue despite turnover

How do we implement this without increasing visit time?



Find "Value-Added" time, whether in waiting room, during rooming process, or after clinic visit

Fitting PRAPARE into Workflow



Incorporate into other assessments to encourage completion (Health Risk Assessment, Depression Screening, PAM, etc.)

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

Learning objective #3

Share a health center's approach to implementing social risk screening and tracking of social interventions during COVID-19.

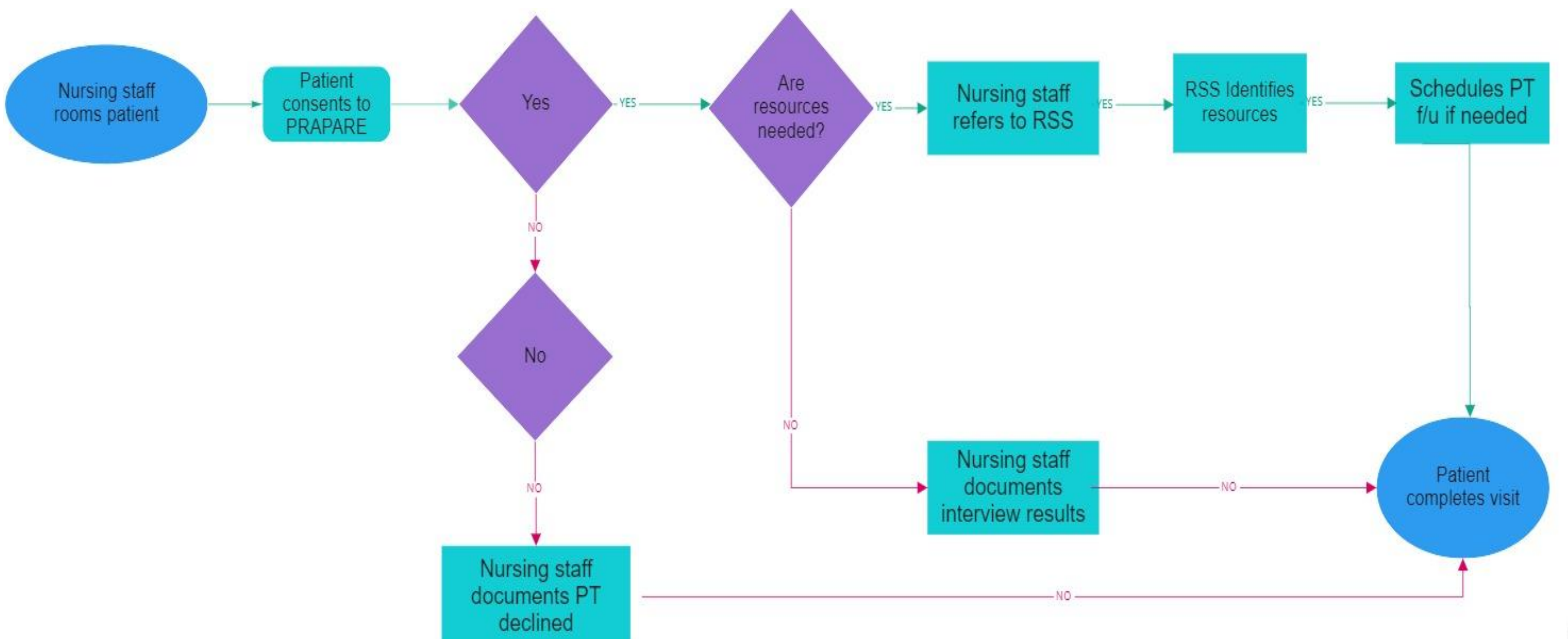
Jessica Mussetter,
Optimal Performance Manager
Bighorn Valley Health Center

ASHLAND, CHINOOK, HARDIN, HARLEM, LEWISTOWN, MILES CITY, MONTANA

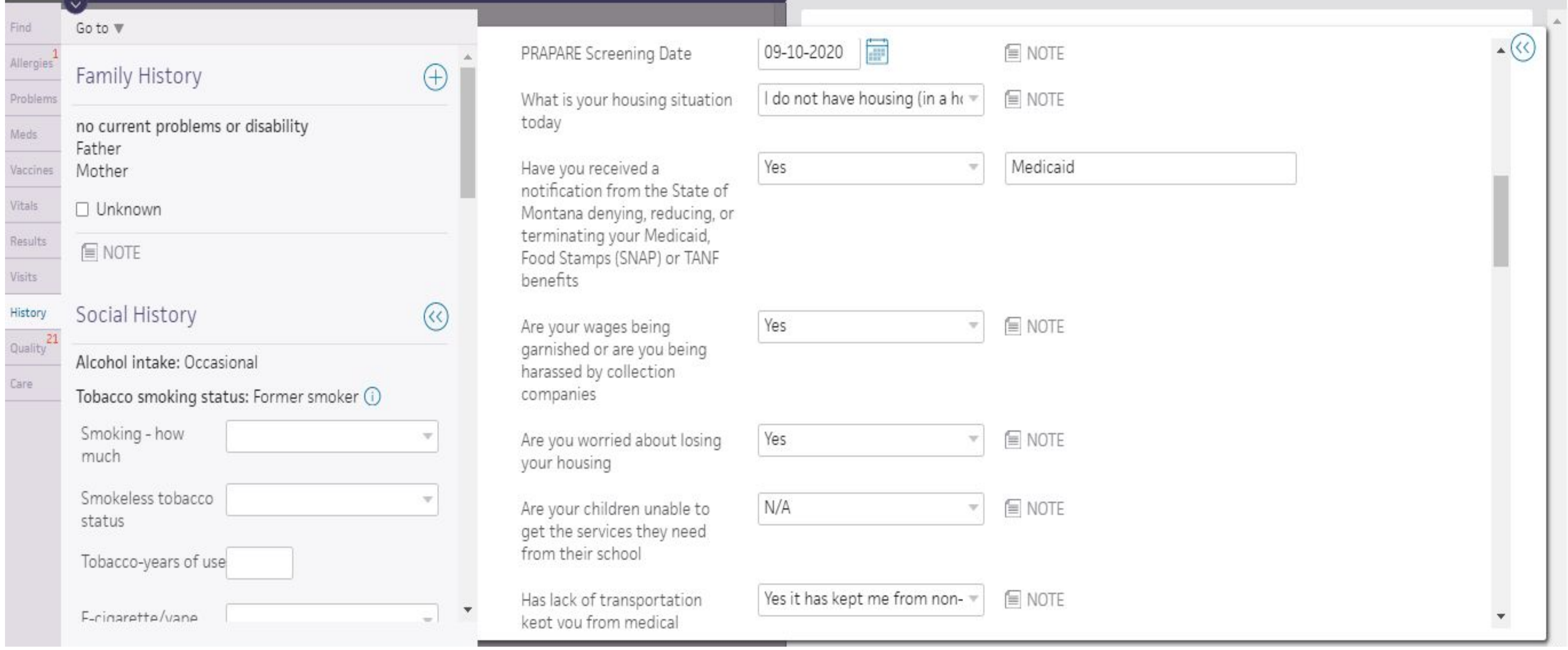
Why is PRAPARE important?

- Meet the SOD needs of patients
- Impact future development of resources

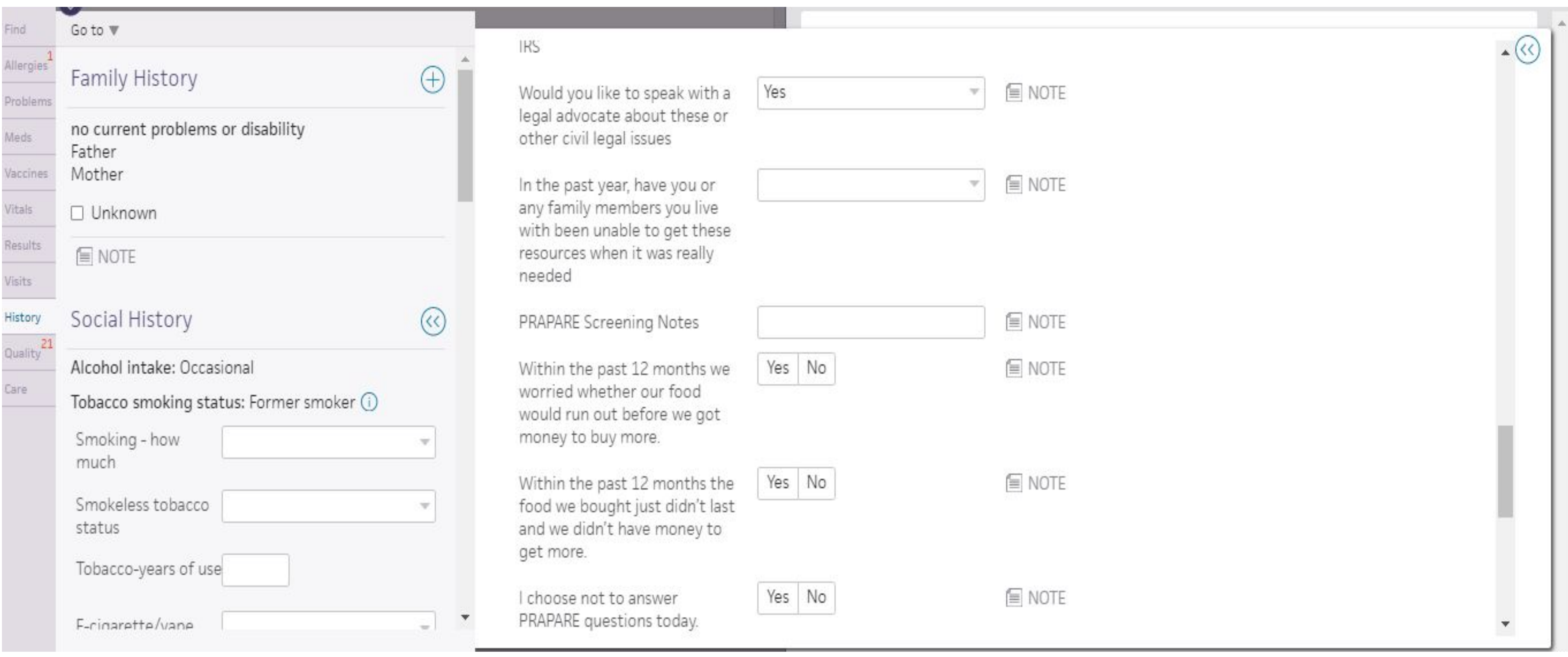
Nursing/MA Staff Workflow Chart



Athena workflow



Athena workflow



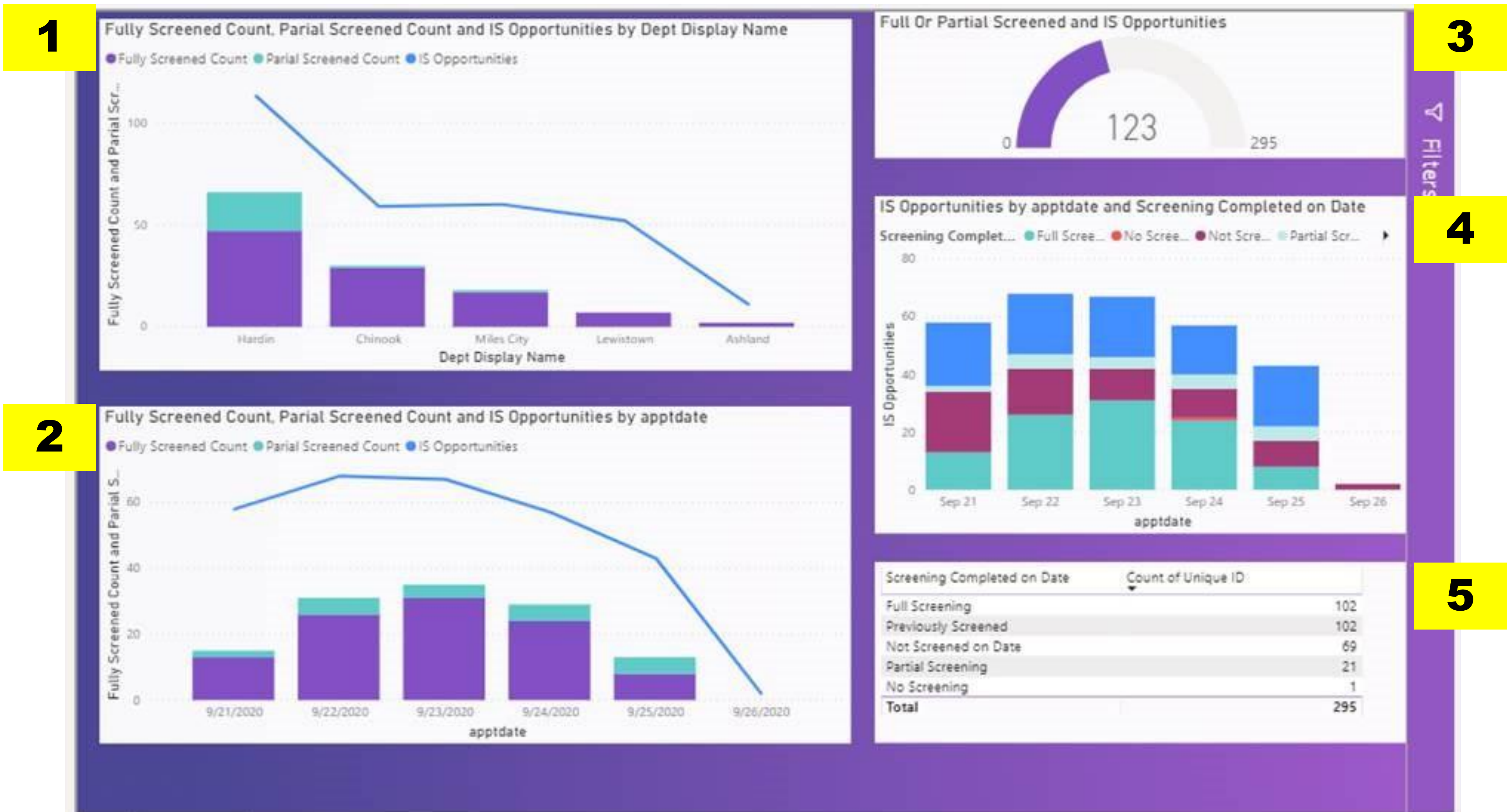
Referral to Community Health Advocate

- 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



Screening Completed on Date	Count of Unique ID
Full Screening	102
Previously Screened	102
Not Screened on Date	69
Partial Screening	21
No Screening	1
Total	295

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:

HOUSING	UTILITIES (electricity, phone, heat, etc.)	FOOD	PHYSICAL SAFTEY	MENTAL HEALTH
TRANSPORTATION				HEALTH INSURANCE
EMPLOYMENT				LEGAL ASSISTANCE
MATERIAL GOODS (clothing, furniture, diapers,etc.)	HEALTH SUPPLIES (glasses, medicine, etc.)	EDUCATION	CHILD CARE	SOCIAL SUPPORT

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?

Questions & Discussion

Next Steps

- Webinar recording will be posted
- Office hours will be launched soon
- Please complete evaluation
- Share topics for future webinars

“Assessing and Addressing Social Determinants of Health During COVID-19” – Webinar Series

This Photo by Unknown Author is licensed under CC BY-SA

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!

Share your story: http://bit.ly/PromisingPracticesEquity

PRAPARE Related Resources

PRAPARE IMPLEMENATION AND ACTION TOOLKIT

www.nachc.org/prapare

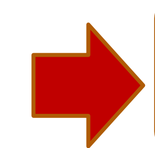
- Chapter 1: Understand the PRAPARE Project
- Chapter 2: Engage Key Stakeholders
- Chapter 3: Strategize the Implementation Process
- Chapter 4: Technical Implementation with EHR Templates
- Chapter 5: Develop Workflow Models
- Chapter 6: Develop a Data Strategy
- Chapter 7: Understand and Evaluate Your Data
- Chapter 8: Build Capacity to Respond to SDH Data
- Chapter 9: Respond to SDH Data with Interventions
- Chapter 10: Track Enabling Services

EHR Templates

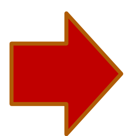
FREE EHR Templates Available:

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

- **In Development:**
  - ✔ Allscripts
  - ✔ Meditech



70% of all health centers



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

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

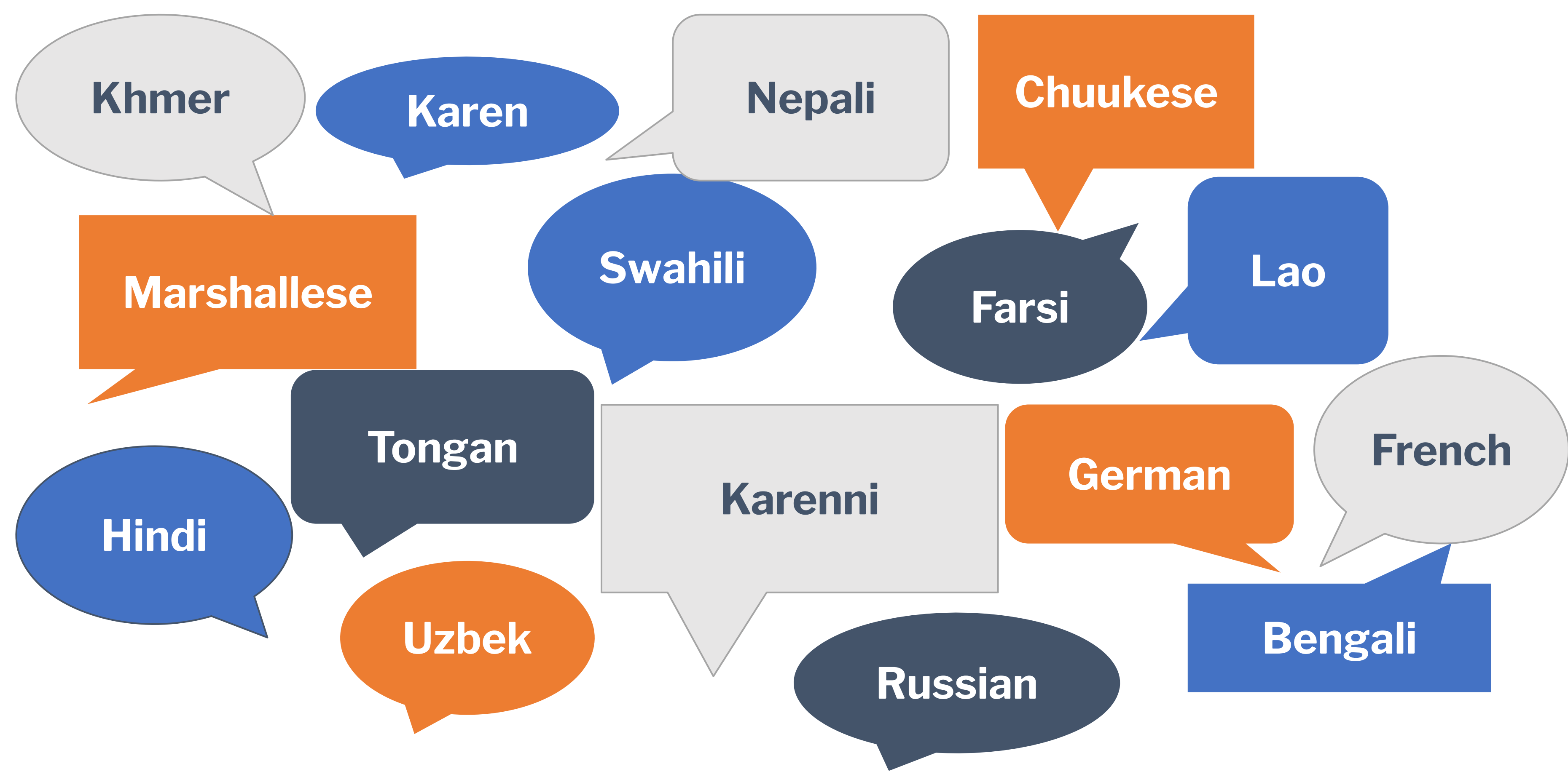
* Automatically map to ICD-10 Z codes so you can easily add relevant Z codes to problem or diagnostic list

Recorded demos of each PRAPARE EHR template available at www.nachc.org/prapare

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

PRAPARE is Now in 26 Languages!

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



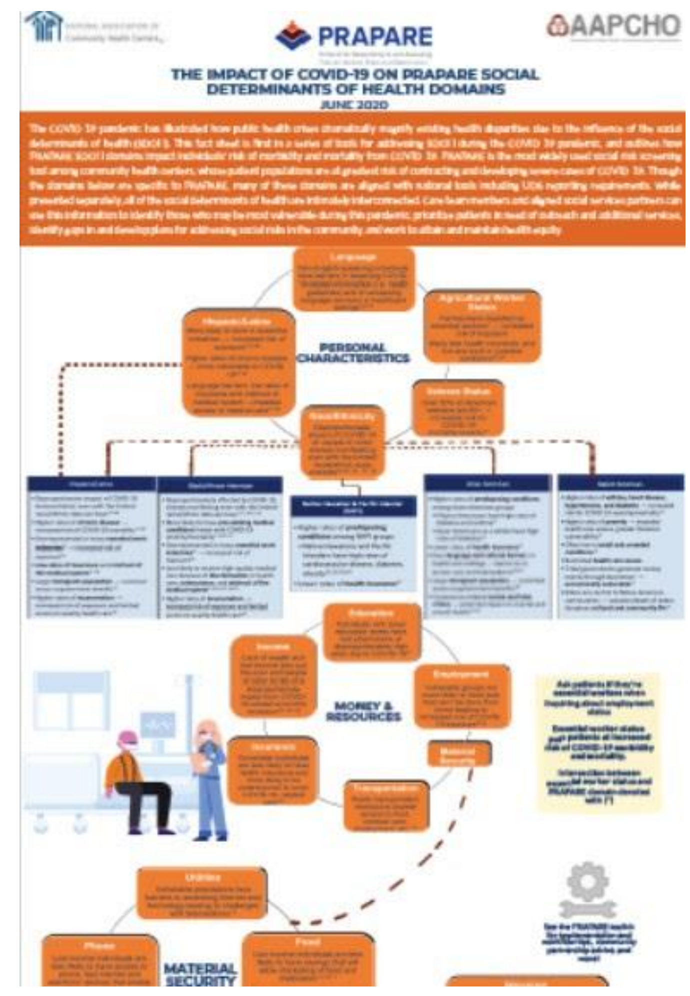
PRAPARE SDOH & COVID-19 Fact Sheet

NEW

Fact Sheet: The Impact of COVID-19 on PRAPARE Social Determinants of Health Domains

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!]



© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

NEW! Research Publication

NEW

Publication in the Journal of Health Care for the Poor and Underserved: Collecting Social Determinants of Health Data in the Clinical Setting: Findings from National PRAPARE Implementation

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

ORIGINAL PAPER

Collecting Social Determinants of Health Data in the Clinical Setting: Findings from National PRAPARE Implementation

Rosy Chang Weir, PhD
Michelle Proser, PhD, MPP
Michelle Jester, MA, PMP
Vivian Li, MS
Carlyn M. Hood-Ronick, MPA, MPH
Deborah Gurewich, PhD

Abstract: **Background.** The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) is a nationally recognized standardized protocol that goes beyond medical acuity to account for patients' social determinants of health (SDH). *Aims.* We described the magnitude of patient SDH barriers at health centers. **Methods.** Health centers across three PRAPARE implementation cohorts collected and submitted PRAPARE data using a standardized data reporting template. We analyzed the scope and intensity of SDH barriers across the cohorts. **Results.** Nationally, patients faced an average of 7.2 out of 22 social risks. The most common SDH risks among all three cohorts were limited English proficiency, less than high school education, lack of insurance, experiencing high to medium-high stress, and unemployment. **Conclusions.** Findings demonstrated a high prevalence of SDH risks among health center patients that can be critical for informing social interventions and upstream transformation to improve health equity for underserved populations.

Key words: Social determinants of health, community health center, vulnerable populations, health equity, complex patients, safety net, underserved populations, social risk factors.

There is growing consensus over the past few decades that a wide array of social and community-level risk factors—such as food insecurity, homelessness, lack of transportation, and unemployment—drive health and wellbeing as well as health care expenditures.[1] Health care providers face increasing expectations to lower health

ROSY CHANG WEIR and VIVIAN LI are affiliated with the Association of Asian Pacific Community Health Organizations. MICHELLE PROSER and MICHELLE JESTER are affiliated with the National Association of Community Health Centers. CARLYN M. HOOD-RONICK is affiliated with the Oregon Primary Care Association. DEBORAH GUREWICH is affiliated with the Center for Healthcare Organization & Implementation Research, VA Boston Healthcare System. Please address all correspondence to Rosy Chang Weir, Director of Research, Association of Asian Pacific Community Health Organizations, 101 Callan Avenue, Suite 400, San Leandro, CA 94577; phone: 510-272-9536 x107, email: rcweir@aapcho.org.

© Meharry Medical College Journal of Health Care for the Poor and Underserved 31 (2020): 1018–1035.

© 2020. National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, Oregon Primary Care Association.

COVID-19 Related Resources

COVID-19 Resources: Found at nachc.org/coronavirus/

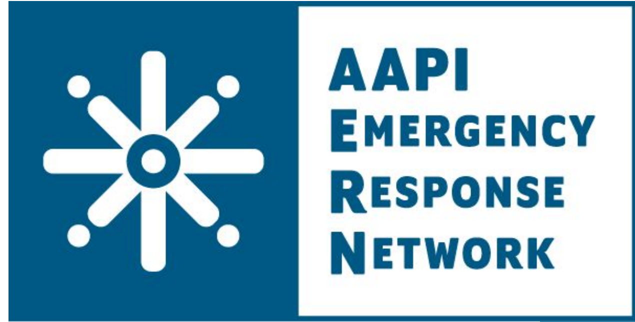
	Centers for Disease Control Coronavirus (COVID-19) resources page – includes strategies for optimizing the supply of PPE
	Health Resources and Services Administration (HRSA) Health Center Program COVID-19 Frequently Asked Questions (FAQ) – includes Federal Torts Claim Act (FTCA) updates
	Centers for Medicare and Medicaid Services (CMS) FAQs – includes information on diagnostic lab services and hospital services
NATIONAL ASSOCIATION OF Community Health Centers®	NACHC's Coronavirus webpage – information, event postings, and resources for health centers; NACHC also manages the resources below
	NACHC's Elevate learning forum – evidence-based practices, tools and protocols for the health center response to COVID-19 **Health centers sign up @** **bit.ly/2020ElevateCHC** **PCAs, HCCNs, and NCAs sign up @** **bit.ly/2020ElevatePCA-HCCN-NCA**
	Health Center Resource Clearinghouse Priority Page COVID-19 –training events and tailored materials for serving special populations 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

coronavirus.aapcho.org

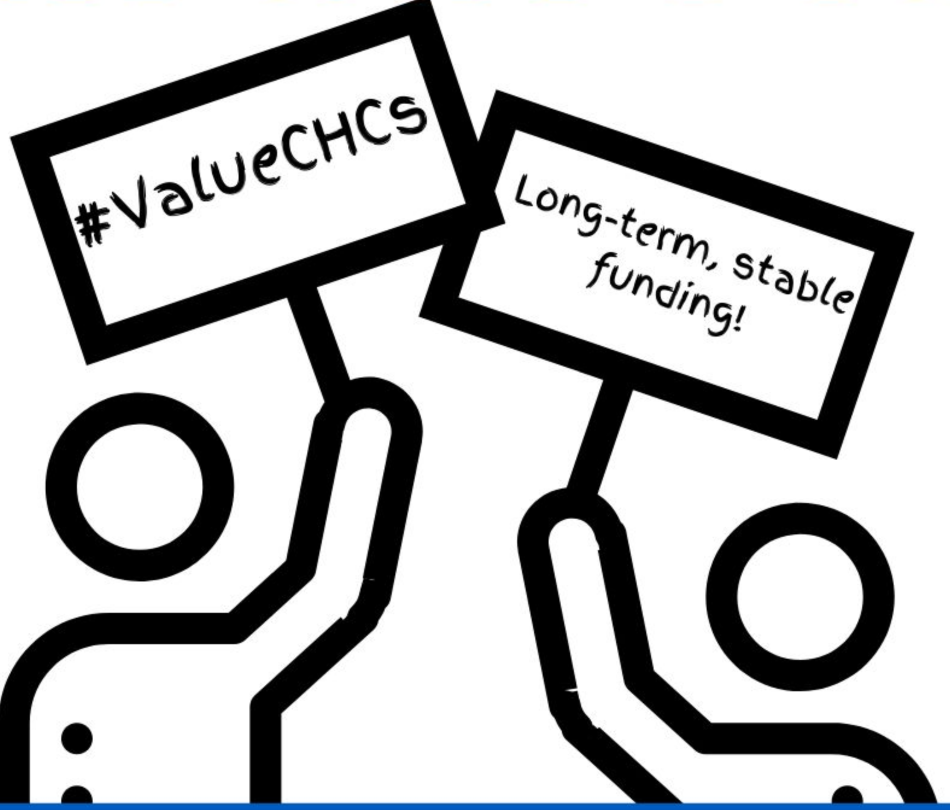
www.pi-copce.org

www.aapiern.org



STAND UP FOR COMMUNITY HEALTH CENTERS.

Be an advocate.



WWW.HCADVOCACY.ORG/JOIN

@HCADVOCACY

GRASSROOTS@NACHC.ORG

We appreciate your time and commitment!

Have any questions or feedback?

E-mail: prapare@nachc.org
Website: www.nachc.org/prapare

Twitter: @prapare_sdoh

Join our Listserv