PRAPARE Implementation and Data Strategy in Urban & Rural Pennsylvania

JULY 2019

The Pennsylvania PRAPARE Academy engaged the Primary Care Association (PACHC), a Health Center Controlled Network (Health Federation) and four diverse PA health centers – Family First Health (York, PA), Keystone Health (Chambersburg, PA), Keystone Rural Health Consortia (Emporium, PA), and Spectrum Health Services (Philadelphia, PA).

Health Center	# of Patients (2018 UDS)	Geography	EHR	Sites	# of PRAPARE screenings by May 2019
Family First Health	25,003	Urban	Athena	6	373
Keystone Health	50,692	Rural	NextGen	6	10,800
KRHC	4,195	Rural	Centricity	4	1517
Spectrum	11,867	Urban	Centricity	3	?*

**Due to staff turnover, this information was unavailable.*

The health centers were all able to implement PRAPARE to different degrees and using a variety of workflows and approaches. The PA PRAPARE Academy supported the health centers with technology assistance, workflow support, individualized coaching, and group convening, both telephonic and twice in person to share challenges and lessons learned. In addition, the group worked together to brainstorm about data strategy, building on work being done at the individual health center level. The HCCN (Health Federation) is in the process of embedding this data strategy into the Network data warehouse, so there will be capacity to report out on social determinants at a Network level (encompassing twenty health centers across the state).

Policy Influences on PRAPARE Implementation & Data Strategy:

During 2018-2019, a number of policy-level actions occurred at the state level that have already had and will continue to have an impact on PRAPARE sustainability and the overall approach to social determinants

Acknowledgements
This project was made possible with generous support from the Kresge Foundation.

screening and referral in Pennsylvania health centers. A value-based payment program in Pennsylvania's Medicaid program (dubbed Patient Centered Medical Home) engages many of the health centers statewide, and introduced a requirement for 2019 that practices screen all patients annually for social determinants using a nationally recognized tool, and that they report results using ICD-10 coding. This requirement has been unevenly implemented, but it raised the profile of SDOH screening and provides a framework for sustainability and spread of the PA Academy's work.

The focus on coding has been somewhat unfortunate. Requiring that practices "report" to their Medicaid managed care organizations via codes on a claim has forced practices to change workflow (for example, so that screening takes place within a billable visit – not always ideal). In addition, some practices that were already engaged in extensive social determinants screening have resisted coding because they find patients react negatively to seeing social determinants as "problems" on an after-visit summary or in the patient portal.

The HCCN and PCA are advocating with managed care organizations and the state (and encouraging health centers to do the same) to lessen the reliance on coding and allow for aggregate reporting on social determinants screening. This is challenging since coding is the language that managed care organizations best understand. Nonetheless, there is no doubt that the state Medicaid program's prioritization of social determinants screening and reporting contributes to sustainability and spread of this initiative.

The state Department of Human Services is also currently planning adoption of a statewide resource and referral platform to support connecting Medicaid patients to social and community services. This action could be positive in its potential to allow multiple actors to communicate and coordinate around individual patients, as well as to support effective referrals.

However, one concern is that the state will also require that health care providers and other participants utilize a single screening tool, which may or may not be PRAPARE. The PCA is represented in the decision-making structures of this process and can advocate for an arrangement that helps to sustain the PRAPARE Academy's work.

In terms of data strategy, as mentioned above, the HCCN is working with its population health management vendor (i2i) to enable network-level mapping and reporting of social determinants screening at participating health centers.

Some areas where health centers have expressed interest in seeing data and looking at social determinants in relation to other health issues include:

- Employment – two of the health centers in the Academy reported extremely high rates of un-and under-employment.
- Housing and its relationship to various chronic disease outcomes (e.g. COPD, Asthma)
- Transportation needs and the relationship to issues like no-shows, ER

Acknowledgements
This project was made possible with generous support from the Kresge Foundation.

utilization, and ability to complete needed referrals for specialty care.
- Social isolation and stress and the relationship with disease outcomes like uncontrolled hypertension.

One health center, Keystone Health, has done a great deal of analysis with their individual data utilizing i2i tools and has found some very interesting correlations between social determinants and health issues. They have also looked at social determinants and their relationship with the NACHC & AAPCHO risk score categories on chronic disease. The Medical Director at Keystone Health presented on SDOH data and risk stratification findings at both the HCCN annual quality improvement meeting in May and on a PACHC-hosted webinar in June, which was one way to support the spread and sustainability of this initiative.

The work of this health center has also inspired others and influenced the Network's data strategy. One example is that Keystone Rural Health Consortia took the report that was developed by Keystone Health and used it to begin their own data analysis. They use the same population health management system supported by the Network, therefore this type of sharing is relatively easy.

Next Steps:

PACHC and the Health Federation, in collaboration with the participating health centers, have identified a number of next steps:

- Continue to spread PRAPARE screening internally: health centers that have participated in the Academy are looking at expanding screening to a more universal population, including potentially screening dental patients, and integrating screening more fully into the general population in cases where screening has been restricted to identified "high risk" patients.

- Focus on addressing immediate needs for assistance: one health center that has been screening universally has created a system to flag and follow-up immediately with patients who have specific needs in the areas of domestic violence, housing insecurity, financial insecurity (food, utilities, telephone, etc.), transportation, and access to health care.

- Integrate individual health center level data into a Network approach to data reporting by adding social determinants data elements to the Network data warehouse and mapping health center data appropriately. Develop Network level dashboards and reports to monitor progress and report back to health centers.

- Continue to engage with state level initiatives to promote screening and reporting, as well as continue participation on the advisory committee for the proposed statewide resource and referral platform.

Acknowledgements
This project was made possible with generous support from the Kresge Foundation.

- Disseminate PRAPARE Academy process and outcomes: We are planning a panel presentation by the 4 participating PRAPARE Academy health centers at the PACHC conference in October to showcase the work done this year to their colleagues.

- Utilize data collected to advocate for additional resources to connect patients with needed services. It is an ongoing challenge for health centers to staff care management and referral tracking adequately; finance offices/CEOs are sometimes resistant to hiring non-billable staff like social workers.

- Explore some issues in screening results: the numbers of patients coming up as un- and under-employed is surprising in some settings; and it also appears that food insecurity may be under-reported in certain health center populations.

Acknowledgements
This project was made possible with generous support from the Kresge Foundation.