

Practical Strategies for Social Risk Screening during COVID-19

October 22, 2020



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!

To: All panelists and attendees ▾

Your text can be seen by panelists and other attendees



Chat



Chat



Lower Hand



Q&A



Q&A

All questions(1)

My questions(1)

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!

AT 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.



1

[Comment](#)

My Question 10:01 AM

How can I sign-up for future webinars?

AAPCHO T/TA is going to answer this question live.



1

[Comment](#)

Type your question here...

Send anonymously

[Cancel](#)

[Send](#)

Leave Meeting



Unmute



Chat

Lower Hand

Q&A

Quick Polls

Get a sense of who is in the virtual room



Agenda

Topic	Timing in EST
Opening and Housekeeping	4:00pm
Social Risk Screening Using Patient-Centered Care Approaches and Principles <ul style="list-style-type: none">• Yuriko de la Cruz, SDOH Manager, NACHC	4:05pm
Health Center and Partner Showcase for Screening during COVID-19 <ul style="list-style-type: none">• Maria Reyes, MPH, Community Health Education Manager @ La Clínica de la Raza• Rosamaria Martinez, MBA, RD, Vice President of Community Health Initiatives @ Sixteenth Street Community Health Centers• Beth Thorson, LCSW, ACSW, Director of Social Work Services @ Bread of Healing Clinic	4:10pm
Panel Interview and Q&A <ul style="list-style-type: none">• Albert Ayson, Jr., Associate Director of Training and Technical Assistance, AAPCHO	4:35pm
Closing and resources	4:55pm

Project Team at NACHC & AAPCHO



Michelle Proser
Director of Research
NACHC



Jason Patnosh
*Associate VP,
Partnership &
Resource Development*
NACHC



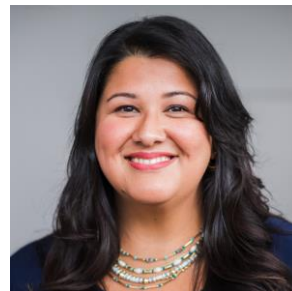
Rosy Chang Weir
Director of Research
AAPCHO



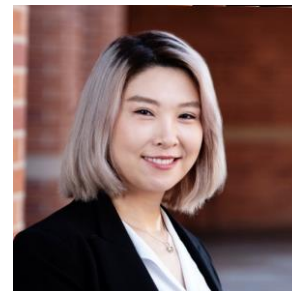
Joe Lee
*Training and Technical
Assistance Director*
AAPCHO



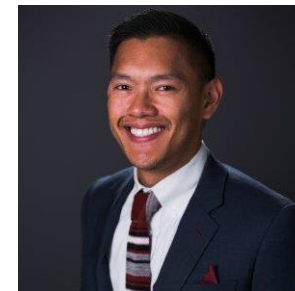
Sarah Halpin
Program Associate
NACHC



Yuriko de la Cruz
SDOH Manager
NACHC



Vivian Li
*Research Project
Manager/Analyst*
AAPCHO



Albert Ayson, Jr.
*Associate Director,
T/TA*
AAPCHO

Today's Guest Speakers and Panelists



Maria Reyes, MPH *Community Health Education Manager*
La Clínica de la Raza
(Oakland, CA)



Rosamaria Martinez, MBA, RD *Vice President of Community Health Initiatives*
Sixteenth Street Community Health Centers
(Milwaukee, WI)



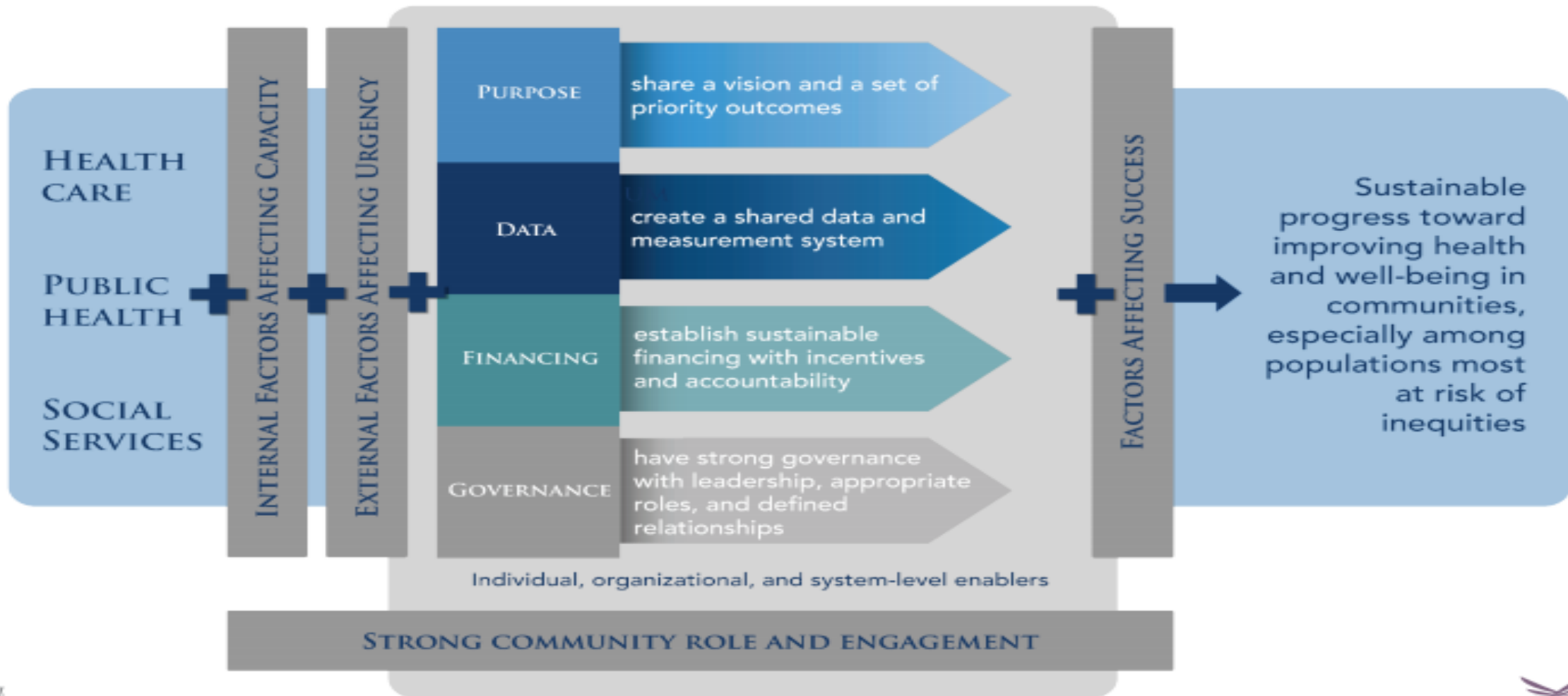
Beth Thorson, LCSW, ACSW *Director of Social Work Services*
Bread of Healing Clinic
(Milwaukee, WI)

Acknowledgements

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



CROSS-SECTOR ALIGNMENT THEORY OF CHANGE



"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. Moreover, health centers are using the SDOH data to develop new and/or stronger collaborations with community partners to provide social interventions during the COVID-19 pandemic.

"Assessing and Addressing Social Determinants of Health During COVID-19" - Webinar Series



This Photo by Unknown Author is licensed under [CC BY-SA](#)

Session #1: "Adapting SDOH Data Collection Workflows during COVID-19"

- Thursday, October 8, 2020 | 4:00 – 5:00pm ET
- [Slides \(click here\)](#)
- [Webinar Recording \(click here\)](#)
 - *Access passcode: SDOH2020!*

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



This Photo by Unknown Author is licensed under [CC BY-SA](#)

Session #2: “Practical Strategies for Social Risk Screening during COVID-19”

- TODAY, Thursday, October 22, 2020 | 4:00 – 5:00pm ET

Session #3: “Emerging Strategies to Address SDOH Through Community Referrals and Cross-Sector Partnerships”

- Thursday, October 29, 2020 | 4:00 – 5:00pm ET
 - Register now: http://bit.ly/covid-19-webinar_10292020

Social Risk Screening Using Patient-Centered Care Approaches and Principles



Importance of Patient-Centered Approaches

- Importance of patient-centered approaches, empathic inquiry, cultural humility, motivational interviewing, and more!
 - Focus is on building relationships with your patients
 - Shift mindset from “collecting data” to getting to know your population one person at a time
 - One person’s data is another person’s difficult life experiences, so important to emphasize sensitivity, compassion, strengths, autonomy, privacy, etc.
 - Don’t miss an opportunity to enhance patient and staff well-being

More information and resources on patient-centered approaches available in Chapters 2 and 5 in the PRAPARE Implementation and Action Toolkit
www.nachc.org/prapare

Strategies to Screen SDOH Needs of Patients

- Patient-entered Questionnaires
- Email with a link to the screening tool
- Tablets and kiosks
- Paper form



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

Best Practices for Messaging Strategies

- Develop a script to introduce PRAPARE to patients and staff
 - Finetune the language and outline the key talking points

Lone ★ Star Circle of Care

Hello _____,

Thank you for choosing Lone Star Circle of Care as your healthcare provider. We understand that many things in life can affect your health. We are always looking to better understand our patients' needs to improve the services we can offer.

Would you be willing to help us learn?

The survey below takes less than 2 minutes.

With the help of Aunt Bertha, a directory of free and reduced cost direct services, we will provide you with community resources based on your answers.

This survey is private.

We protect everything that you share just like we protect your health information.

Take Quick Survey to Find Resources

UPDATED: 8/15/17

PRAPARE Survey Sample Script- English

INTRODUCE SURVEY AND ASK IF INTERESTED IN PARTICIPATING

Hello, my name is _____ and I work here at Venice Family Clinic. We are conducting a survey to help us know what other services and resources can help our patients. Is this something you would be willing to do?

IF NO: Thank you for your time.

IF YES: Great! What's your child's name?

ASK/GIVE SURVEY

Thanks for participating in the survey. The survey will only take a few minutes. Some of the questions are personal and you don't have to answer them if you don't want to. All the information from the survey is confidential. Do you have any questions before we get started?

[ASK/GIVE SURVEY QUESTIONS]

[IF PATIENT GIVES AN ANSWER THAT PROVIDER/HEALTHCARE TEAM SHOULD ADDRESS]

If you answered yes to any of the questions or if we touched on something that was uncomfortable or that worries you, we have people here that you can talk to. Here's a flier. If you want to talk to someone, just let the doctor know and we'll set it up for you.

[IF THE SURVEY PARTICIPANT ANSWERS YES TO THE DV AND/OR HOUSING QUESTIONS: Notify the MA who will enter DV or Housing in the HPI. The provider will address accordingly.]

[FOR DR. TEJANI'S PATIENTS: Leave copy of the completed paper screener on Dr. Tejani's desk]

Health Center and Partner Showcase for Screening during COVID-19

- **Maria Reyes, MPH**, *Community Health Education Manager @ La Clínica de la Raza*
- **Rosamaria Martinez, MBA, RD**, *Vice President of Community Health Initiatives @ Sixteenth Street Community Health Centers*
- **Beth Thorson, LCSW, ACSW**, *Director of Social Work Services @ Bread of Healing Clinic*





Special Initiative: Social Determinants of Health

About La Clínica de La Raza, Inc. (La Clínica)

La Clínica is a non-profit Federally Qualified Health Center with over 49 years of experience providing comprehensive, culturally appropriate, clinical, and community health services in the East Bay region of California.

35 service sites across three (3) counties.
91,000 patients served
367,000 visits
1,200 employees

La Clínica's Mission

To improve the quality of life of the diverse communities we serve by providing culturally appropriate, high quality and accessible health care for all.



La Clínica's Patients

2019 Data



PATIENTS SERVED

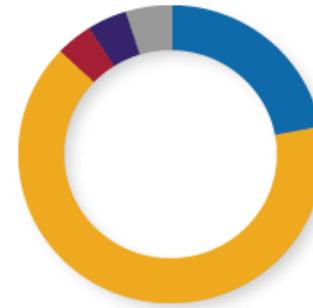
- Medical
- Dental
- Vision
- Mental Health
- Health Education/
Preventive Medicine

VISITS

- 224,236
- 99,105
- 13,134
- 20,422
- 10,177

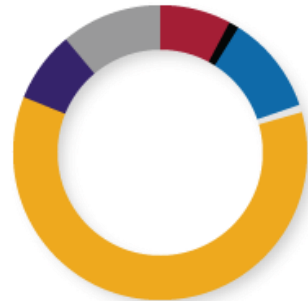
Total Number of Visits

367,074



PERCENT OF PATIENTS BY PAYOR SOURCE

- Uninsured 22%
- Medi-Cal 65%
- Medicare 4%
- Other Public 4%
- Private Insurance 5%



PERCENT OF PATIENTS BY RACE

- Asian 8%
- Pacific Islander 1%
- Black/African American 11%
- American Indian/Alaska Native 1%
- White 61%
- More than one race 8%
- Unreported 11%



PERCENT OF PATIENTS BY ETHNICITY

- Hispanic/Latino (of all races) 64%
- Not Hispanic/Latino 32%
- Unreported 4%

Community Health Education Department

The goal of La Clínica's Community Health Education (CHE) department is to promote and improve the health of our communities through prevention, access, community engagement, and empowerment.



Pilot Programs implementing PRAPARE

- In 2017 La Clinica received funding from NACHC to implement the first pilot for data collection where over 400 patients were screened SDoH.

Different workflows work for different staff - based on where they were meeting patients.

- Community Health Educators (CEC) during enrollment activities
- Mental Health Stigma Prevention- Presentations
- Contra Costa Cares Patients (over the phone)
- T3+ Patient Navigator Project.

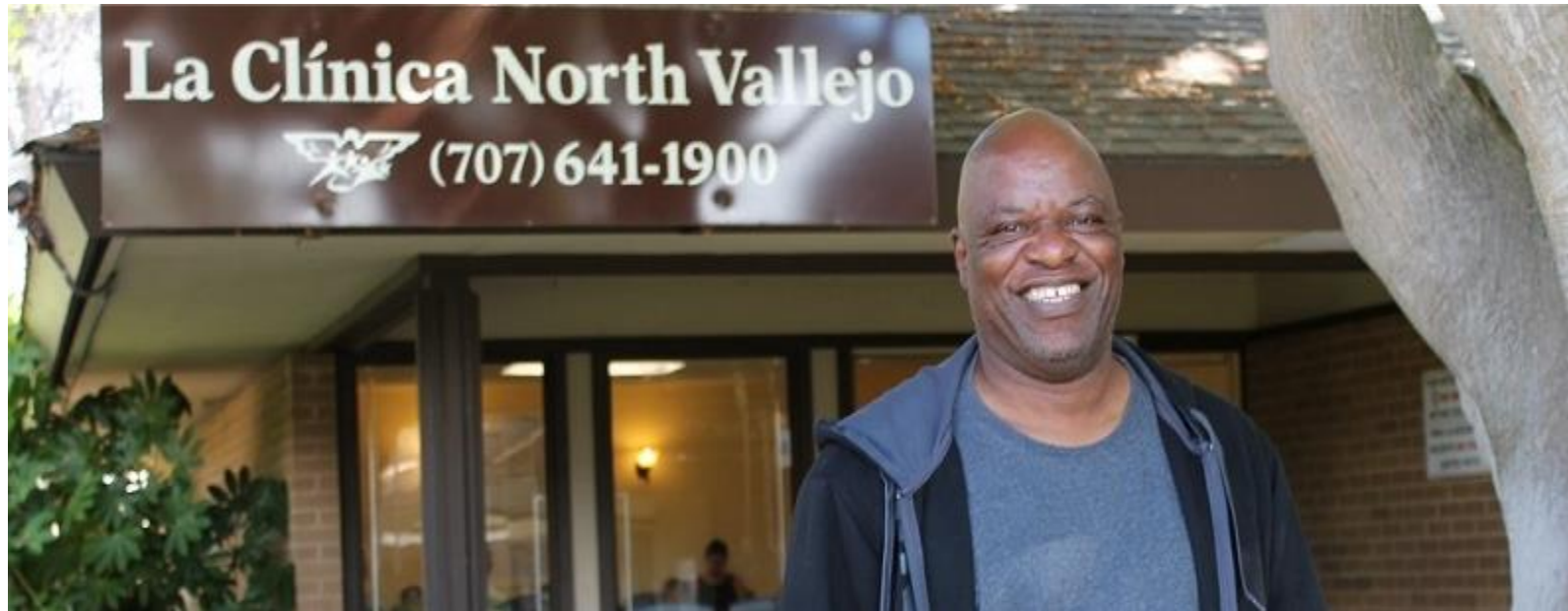
What **Makes**
Us Healthy



What We **Spend**
On Being Healthy



Integrating SDoH into Care Teams



- Our North Vallejo Transitions Clinic is modeled after and a part of the Transitions Clinic Network, based out of San Francisco.

Integrating SDoH into Care Teams

Transitions Clinic

- Vision- based on the identified need to link formerly incarcerated patients to medical care and other resources.
- A dedicated clinical health worker (CHW) provides case management to these patients and works directly with the provider to troubleshoot patients' needs.



PATH TO IMPROVED HEALTH

The Transitions Clinic addresses the medical and non-medical needs that impact a patient's overall health after incarceration.

Six months after enrollment:

33% REPORT IMPROVED HEALTH

50% REPORT IMPROVED MENTAL HEALTH

41% HAVE DECREASED BLOOD PRESSURE

Beyond Our Four Walls:

40% SUCCESSFULLY LINKED TO HOUSING

37% CONNECTED WITH FULL-TIME OR PART-TIME/ TEMPORARY EMPLOYMENT

50% ESTABLISHED FOOD SECURITY

What Knowing SDoH Data Could Provide

SDoH data will enable La Clínica staff to document the complexity of our patient population.

Having hard figures will reinforce the case to funders and policymakers about the need for services for our community and patient population

Allow CHE department to make decisions regarding program design to address patient's complex needs.

Results

La Clínica continue to gather data, to date has administered the PRAPARE tool to over 2,500 patients.

The data from these surveys continues to identify top areas of need for our patients and their families:

- a. Food
- b. Housing
- c. Transportation
- d. Mental Health (Stress, anxiety)

Staff Training

Community Health Education Department

- ▶ Project Kick-Off Meetings
- ▶ PRAPARE data collection and data entry manual.
- ▶ Staff role play- holding a conversation
- ▶ How to access 211 database

IT Department

- ▶ How to enter data into Next-Gen Template
- ▶ How to run a Next-Gen report
- ▶ How to input ICD-10 codes

Other Trainings Community Health Workers Quarterly series

- Boundaries when working with patients
- Compassion Fatigue
- Motivational Interviewing

The Future

- Explore opportunities to strengthen warm hand off to local services and resources. Possible collaboration with 211.
- Continue to gather PRAPARE data - incorporate into SOW of existing and future grants.
- Develop a system to document referral outcomes.
- Implement PRAPARE with Veteran Peer Navigator Project 2020-2021
- Explore use of enabling codes to assist with addressing and tracking SDoH needs.





La Clínica

a californihealth⁺center

La Clinica de La Raza, Inc.

▶ www.laclinica.org

(510) 535-4000

1515 Fruitvale Avenue

Oakland, CA 94601

THANK YOU!!
Contact Information

▶ Maria Reyes,
Community Health
Education Manager

mreyes@laclinica.org

(925) 431-7106



Sixteenth Street Community Health Centers

Celebrating 50 years of delivering quality, patient-centered,
family-based healthcare and supportive services



Sixteenth Street Mission



To improve the health and well-being of Milwaukee and surrounding communities by providing quality, family-based health care, health education and social services, free from linguistic, cultural and economic barriers.

Our History

- Since 1969, Sixteenth Street has been a community leader in primary health services for our city's most vulnerable residents
- Our reputation for compassion, innovation, and quality is recognized both locally and nationally
- An independent non-profit agency, Sixteenth Street now operates at six locations, including four full-service medical clinics, seven in-school clinics, and a Women, Infants & Children (WIC) nutrition program
- Now cares for more than 43,000 patients



Impact | 2019 Demographics

43,206 Patients
200,372 Encounters

85%
Identify as Latino



70%
Best served in a language
other than English



86%
Under- or Uninsured



61%
Are women



46%
Are under the age of 18



76%
Living 100% and below
Federal Poverty Level



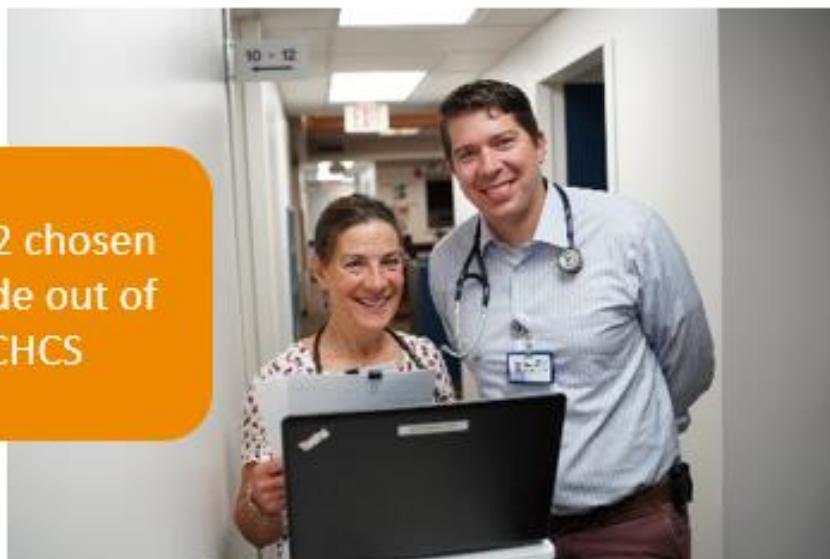
HRSA Health Center **GOLD** Quality Leader



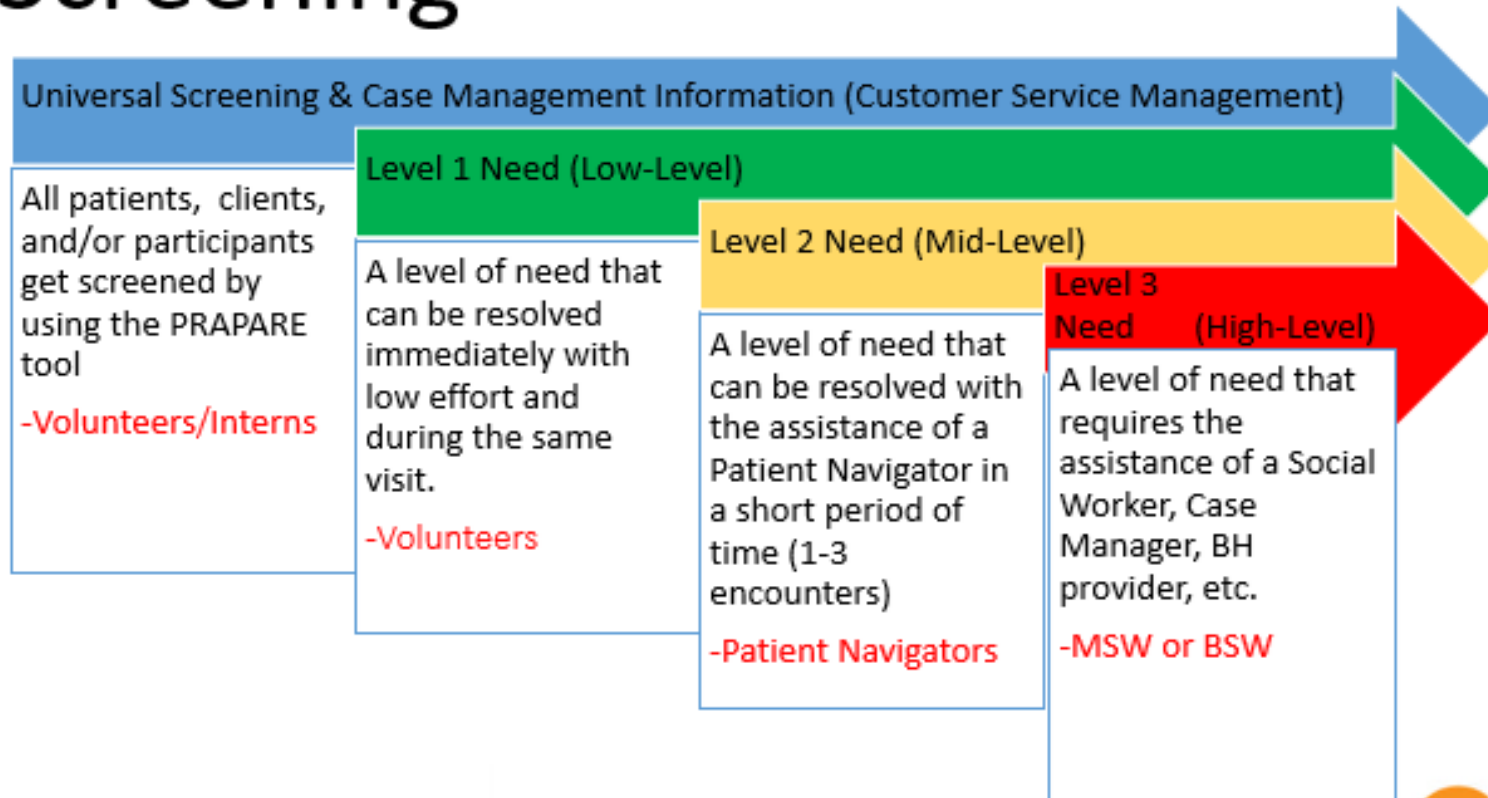
Sixteenth Street was named a HRSA 2020 Health Center Quality Leader. Sixteenth Street was among the **top 10% of all HRSA-supported health centers** that achieved the best overall clinical outcomes, demonstrating high-quality across clinical operations.


One of 140 chosen nationwide out of more than 1,400 CHCs

One of 2 chosen statewide out of 17 CHCs



SDOH Screening





Beth Thorson, LCSW, ACSW
Director of Social Work
Services
Bread of Healing Free Clinic

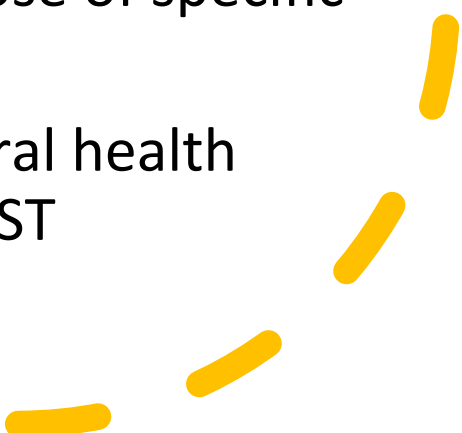


Bread
of healing
clinic

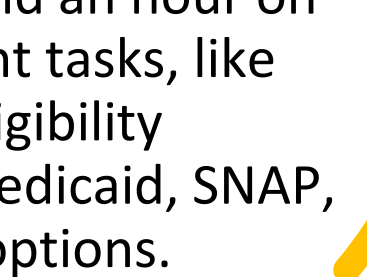
Bread of Healing Free Medical Clinic— Milwaukee, Wisconsin

- **Bread of Healing Free Clinic just celebrated its 20th Anniversary**
 - 3 sites are located in urban Milwaukee neighborhoods offering day, evening and weekend hours
- **Patient Demographics & Target Populations**
 - Uninsured adults with chronic diseases, i.e. diabetes, hypertension, asthma
 - About 2,000 individuals served annually
- **Bread of Healing is a Primary Care Medical Home**
 - Primary and Specialty Medical Care, Behavioral Health, Dental Care, Medical Care Navigation and Social Services
- **Staffing**
 - In 2019, there were about 150 volunteers that supported the clinic
 - BOH is a teaching clinic with med students, residents, pharmacy, behavioral health, social work and public health students doing rotations and projects
 - We have a small number of staff that includes the Resource Center (SDOH screening & intervention team)

Social Risk Screening Process Overview

- New patients meet with a Resource Center team member at initial visit to have a face to face screen. If we miss them, we flag their chart to be screened at the next visit.
 - Patients receive a verbal “Welcome to the Clinic” & clinic overview. They are given a clinic brochure, demographic info on the registration form is reviewed and PRAPARE screening questions are completed. Patient questions are answered.
 - Emphasis during screen is on building relationships with patients and explaining the purpose of specific questions.
 - Patient’s also receive 3 paper behavioral health screenings: PQH-9, ACE and Audit/DAST
- 


Social Risk Screening Process Overview

- Staff record responses on a paper form which is later entered into Health Leads Reach technology platform.
 - A typical screen takes about 30 minutes (5 minutes to locate form/pen and place to sit, 10 minutes for the screen and 15 minutes to enter into database). Can be longer if interpretation is needed, or if time allows and the patient is chatty. Remember: the E in PRAPARE stands for “Experiences”
 - About 60% of patients screen positive. This high number reflects all needs identified, medical and social
 - For the 60% of positive patients, staff spend an hour on average on the day of screen in assessment tasks, like requesting medical records, conducting eligibility assessments for programs, applying for Medicaid, SNAP, Energy Assistance or explaining resource options.
- 


Workforce Development Tips & Staff Training Opportunities

- Resource Center Team members provide face to face screening with patients, usually at the initial visit using PRAPARE (standard items, optional items and some BOH specific items)
- Screens are conducted in a conversational manner, offering strengths-based feedback to patients along the way
- Responses are entered into Health Leads Reach database
- About 2,900 screens have been completed since program inception July 1, 2016. Declined screen rate is below 1%

Screening Data Learnings

- **Screening**
 - Items we anticipated to have high volumes, but did not— low education level and have you been incarcerated more than 2 nights in the last 12 months
 - High volume needs identified are: insurance, specialty medical care, cancer screening, vision and dental care, food.
 - Our wide need scope includes many unique needs.
 - **Barriers/Challenges/Limitations**
 - Technology limitations in recording data over time
 - Communication of SDOH screening data to medical team
- 

Screening Data Learnings

- **Resource Center Staff include MSW, BSW, RN, CHW and students**
 - **Pandemic Screening Observations**
 - Decrease in new cases, has allowed us to catch up on “missed screens”
 - Brief “check in” visits ask: Has your work scheduled changed? If, so have you applied for unemployment? Have trouble paying rent due to a Covid-19 work change?, Might you be eligible for SNAP?, Have you applied for Energy Assistance?, What about Medicaid?
- 

Future Plans



Continue to use PRAPARE screening tool and Health Leads Reach technology to gather screening data for patients cared for at BOH



Plan best way to re-screen—which questions at which time frame to advance equitable access to resources. Otherwise the squeaky wheels get the grease.



Staff continues to get better at assessing readiness to access services which contributes to better engagement and success in accessing benefits.



Develop better ways to communicate with providers, so they can incorporate SDOH information into their overall treatment plan.

Panel Interview and Q&A



Panel Interview

Implementation

- Since the start of the pandemic, how have you been implementing social risk screening?
- What has changed and what have been your staff's overall experience with COVID-19 at front and center stage?

Community Engagement & Cross-Sector Partnerships

- Please describe how you have partnered with local/regional/state level organizations (e.g. CBO, SSO, LHD) to assess and address the social needs in your community.

Data and Technology

- How are you leveraging technology to enhance your social risk screening and data documentation efforts?
- How does your organization approach SDOH data sharing with external partners?

Questions & Discussion



Next Steps

What's next?



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

PRAPARE Related Resources



PRAPARE IMPLEMENTATION 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**

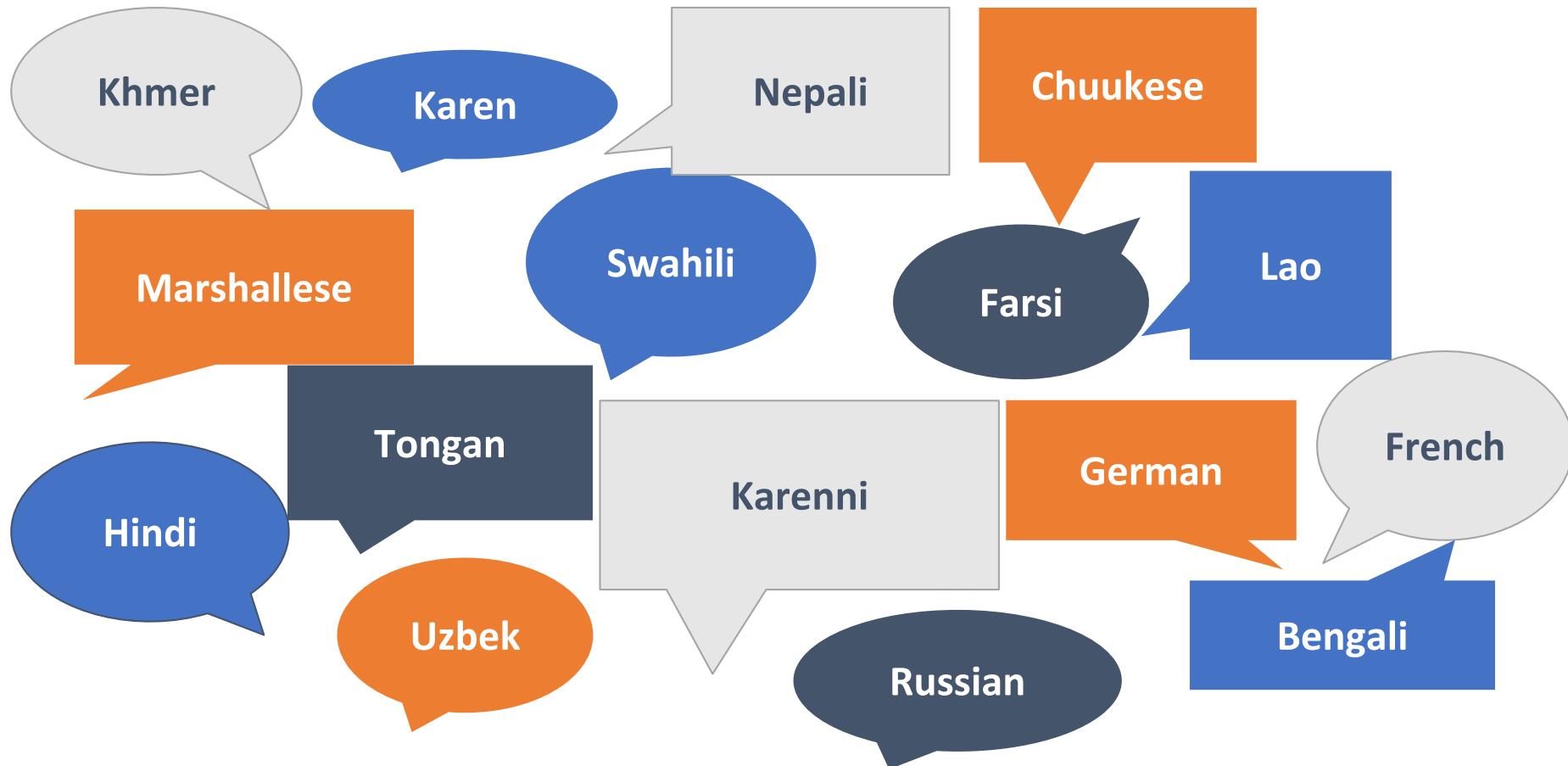
■ **Chapter 8: Build Capacity to Respond to SDH Data**

■ **Chapter 9: Respond to SDH Data with Interventions**

■ **Chapter 10: Track Enabling Services**

PRAPARE is Now in 26 Languages!

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



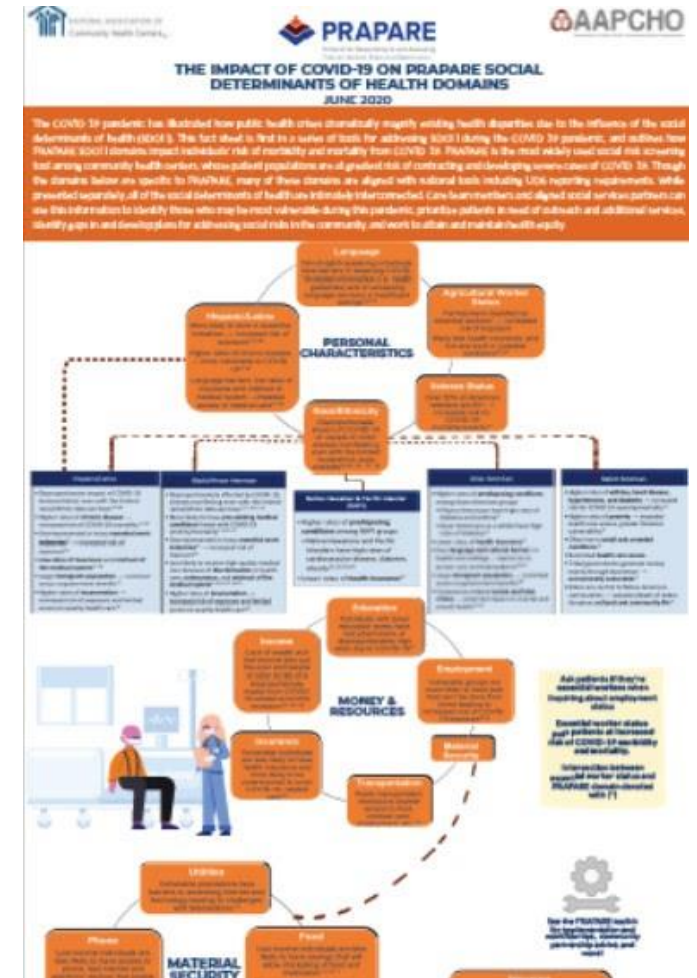
PRAPARE SDOH & COVID-19 Fact Sheet



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!](#)



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

