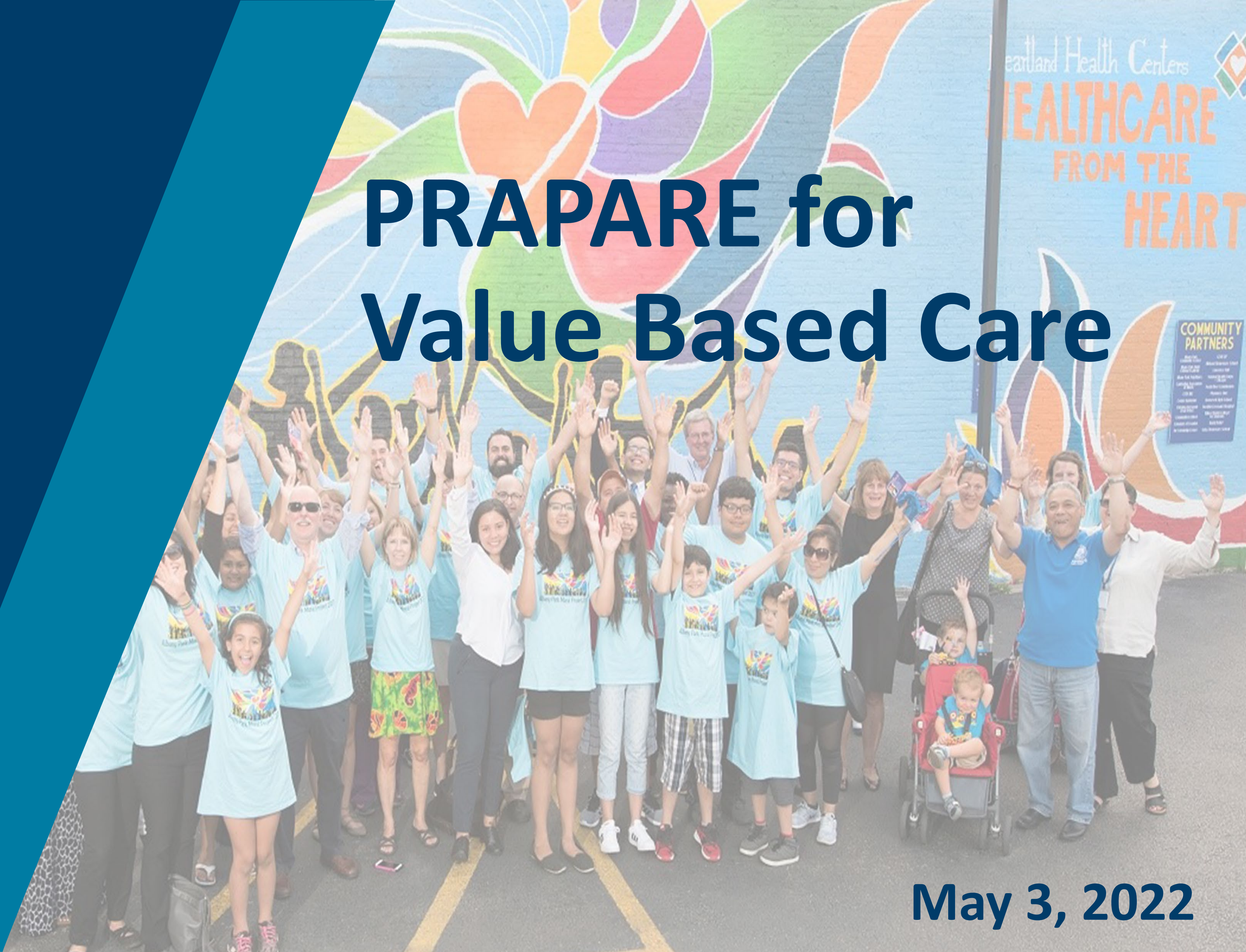
NATIONAL ASSOCIATION OF
Community Health Centers®

PRAPARE for Value Based Care



May 3, 2022

NATIONAL ASSOCIATION OF Community Health Centers®

THANK YOU TO ALL COMMUNITY HEALTH CENTERS

#ThankYouCHCs

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Session Presenters

Yuriko de la Cruz
Program Manager,
Social Drivers of Health

Nalani Tarrant
Deputy Director,
Social Drivers of Health

Ellen Hey
Chief Quality Officer

Rhonda Hauff
Chief Executive Officer

Learning Objectives

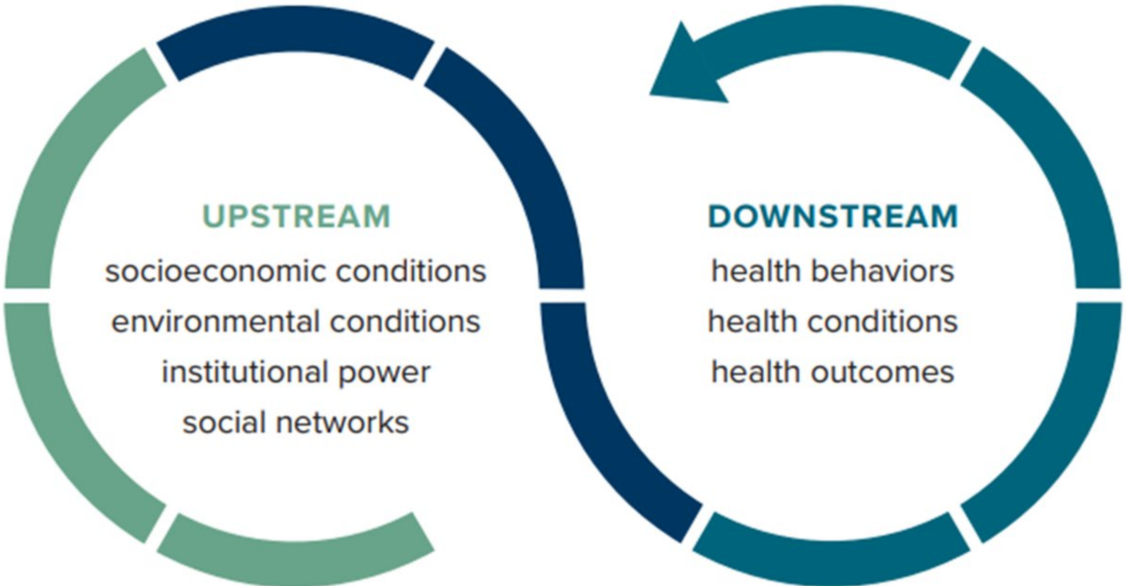
- Understand the importance of tracking SDOH needs using standardized screening tools such as PRAPARE.
- Understand how value-based models are key to addressing SDOH and unmet social needs and promoting health equity.
- Discuss the experiences of organizations using PRAPARE to improve the delivery of care for Medicaid patients through enhanced data collection.

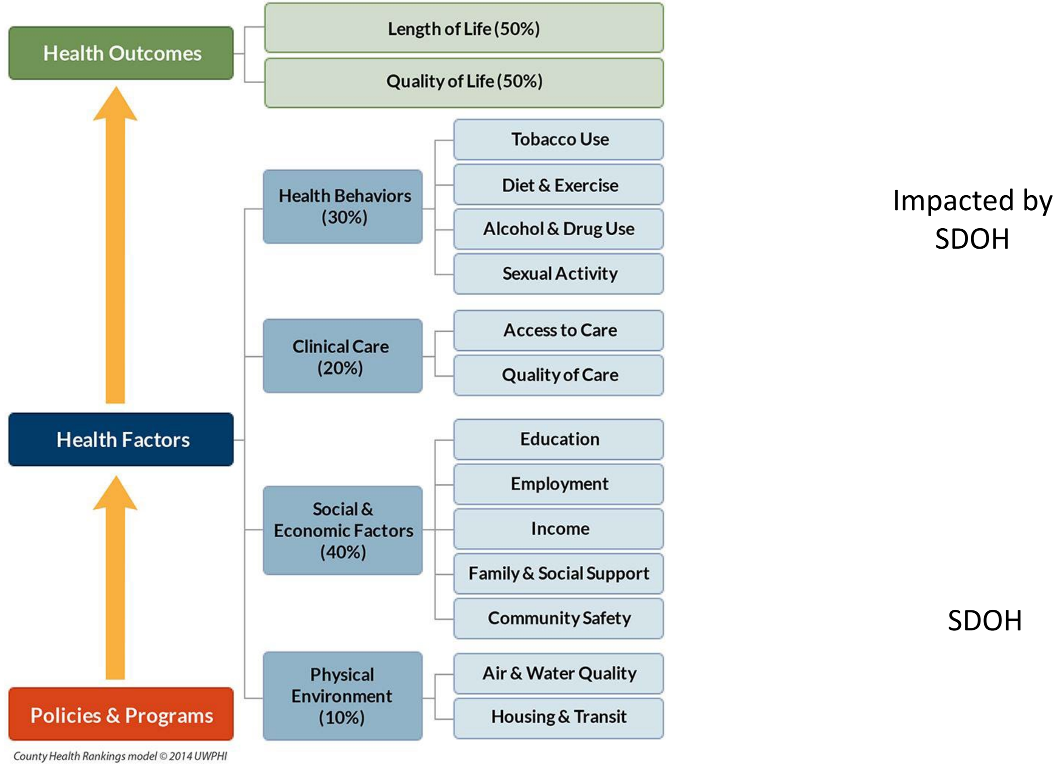
PRAPARE and SDOH Overview

Yuriko de la Cruz
Program Manager, Social Drivers of Health
National Association of Community Health Centers

Social Drivers of Health

- Social drivers of health (SDOH): the conditions in which people are born, grow, live, work, and age. These conditions are shaped by the distribution of money, power, and resources.





Impacted by SDOH

SDOH

Increased Awareness of SDOH during COVID-19

February 8, 2021

COVID-19 Mortality Tied to Social Determinants of Health

Counties with higher proportion of Black residents, poverty, lower education have higher COVID-19 death rates

INSIGHTS REPORT

Health Inequity and Racism Affects Patients and Health Care Workers Alike

NEJM Catalyst Insights Council members say health disparities have worsened with the Covid-19 pandemic.

CORONAVIRUS

CDC Report: LGBTQ Community at More Risk for Severe COVID-19 Cases

BY JACOB REYNOLDS | CHARLOTTE
PUBLISHED 3:48 PM ET MAR. 07, 2021

CHARLOTTE, N.C. — The Centers for Disease Control and local health care experts say the LGBTQ community could be more at risk for severe COVID-19 outcomes, due to underlying discrimination and a lack of access to health care.

y shows disparities in care delivery at health care rsonal racism affecting clinicians and staff, but also ng to combat the problem.

ı health care organizations' ability to provide evealing that much work needs to be done to re, according to a recent NEJM Catalyst Insights equity.

has magnified issues to the extent that disparities ger be ignored," says Lisa Cooper, MD, MPH, Professor, Equity in Health and Healthcare, at School of Medicine and Bloomberg School of and health systems across the globe have been , due to health inequities between more and less advantaged groups.

Impact of SDOH during COVID-19

- Risk of getting COVID-19
- Mortality and morbidity
- Accessing care
- Impact of economic downturn
- Discrimination and bias
- Vaccination: access and hesitancy

Addressing SDOH Barriers:

Thought Question:
Where are many systems that address SDOH offered?

Build partnerships with community-based organizations and government agencies that address SDOH

Co-locate in facilities, including government offices, that address SDOH

Share staff through partnership agreements to facilitate addressing SDOH needs of health center patients

Streamline eligibility requirements across multiple systems of care so that patients are not required to present the same documentation repeatedly**

Slide credit: Neighborhood Health (Virginia)

PRAPARE

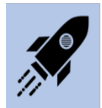
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences

A national **standardized** patient risk assessment **protocol** designed to **engage patients** in assessing and addressing social determinants of health

ACTIONABLE

STANDARDIZED and WIDELY USED

EVIDENCE-BASED and STAKEHOLDER-DRIVEN



DESIGNED TO ACCELERATE SYSTEMIC CHANGE

PATIENT-CENTERED

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

PRAPARE

Use Cases for PRAPARE During COVID-19

Level	Use Case
Individual & Community Level	**Identify and address top social needs of highly vulnerable groups at high risk for COVID-19** (e.g., individuals experiencing homelessness, food insecurity, unemployment) and target outreach to these groups **in collaboration with the social service sector** (e.g., food banks, homeless shelters, job assistance).
Population Level	**Identify patients at higher risk of simultaneous complications/hospitalization/death due to COVID-19 in PRAPARE Risk Stratification.** Patients with high risk identified using social risk stratification (e.g., comorbid conditions + compounding social barriers) could be targeted for outreach (e.g., checking in with patients to inform them of their high-risk status and providing resources and social referrals)
System & Policy Level	**Elucidate trends regarding how the virus is disproportionately impacting certain groups with social risk barriers.** PRAPARE can be used to track how COVID-19 impacts at-risk groups (e.g., individuals experiencing homelessness, food insecurity, incarceration, domestic violence). Data can **inform national policy, resource allocation, and health equity conversations.**

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

Value Based Payment Models

Nalani Tarrant
Deputy Director, Social Drivers of Health
National Association of Community Health Centers

Landscape of VBP Models Addressing SDOH

VBP models provide greater flexibility to address SDOH than fee-for-service, but different payers have stronger or weaker structural avenues to pay for SDOH.

Different Opportunities by Payer to Address SDOH

Payer	Opportunities to Address SDOH
Traditional Medicare	Modified payment approaches (e.g. Accountable Health Communities, Accountable Care Organizations)
Medicare Advantage	Supplemental benefits, with many newly allowable benefits related to SDOH
Commercial plans	Great flexibility in what can be covered, but limited by what counts as "medical expenses"
State Medicaid programs	Various structural avenues to cover social supports; level of activity highly depends on the State (As of 2021, 18 states plus DC have taken at least foundational steps)

State Medicaid Programs are Active in Using VBP Models to Address SDOH

State Medicaid programs have the most structural avenues to cover social supports, have been active in using VBP to address SDoH.

Commonly Used Medicaid Mechanisms to Address SDOH

Mechanism	State Examples
Section 1115 Waivers	• North Carolina's Healthy Opportunity Pilots • New York's DSRIP program
Medicaid Managed Care Organization Contracts	• New York, North Carolina's VBP targets for MCOs • Massachusetts' adjusted reimbursement model for MCOs, based on neighborhood stress scores
Medicaid Accountable Care Organizations (and ACO-like entities)	• Massachusetts ACOs and MassUP program • Rhode Island Accountable entities • Oregon's Coordinated Care Organizations

Model Design Considerations

- SDOH can be addressed under many payment models (including ACOs, bundles, global budgets, and others), but models with prospective payment tend to allow for more flexibility to cover social services.

- **Savings produced through improved SDOH may not follow a payer's standard timeline for savings**
  - SDOH interventions can have high overhead investments, and improvements in SDOH may take years to translate into improvements in health and utilization

Challenges and Strategies for Success to Address SDOH Under VBP

Domain	Challenges	Strategies for Success
Data Collection and Sharing	• Screening and referral tools not standardized across programs/clinicians • Legal and regulatory obstacles to data exchange	• Use existing standardized screening tools • Standardize SDOH data collection; maintain robust data exchange infrastructure
Social Risk Factor Adjustment	• Social risk adjustment remains controversial • Data and methods challenges operationalizing social risk adjustment	• Stratify measures by sociodemographic characteristics to identify areas of disparities
Building Partnerships	• Health and social service sectors have different power dynamics, cultures, histories, processes, and language	• Build partnerships early, establish regular communication channels • Build infrastructure and human capital together to ensure sustainable collaboration
Organizational Competencies	• Many health care organizations need support to build VBP organizational competencies, especially VBP focused on SDOH.	• Provide upfront capital and technical assistance to help build needed competencies

FQHCs and Value-Based Payment Models

Advancing Mission through VBP Models

Flexibility of VBP funding allow for innovative and patient-centered care delivery, with opportunities for community linkages.

Collaborating with States on Aligned Metrics & Goals

Medicaid is the primary payer for most FQHCs, and there are opportunities for strategic collaboration on VBP goals and outcomes.

Opportunities and Challenges for Implementing FQHC-VBP Models

Opportunities

- Momentum for health transformation and promoting health equity
  - Medicaid expansion
- Aligning quality metrics and goals among payers
  - Medicaid as main player
- Providing up-front capital to help FQHCs build infrastructure and VBP competencies

Challenges

- No "one size fits all" solution
- Patient Attribution
- Behavioral health and social risk adjustments
- Confusion around whether FQHCs can legally take on downside risk
  - All payments must remain above PPS rates

Ellen Hey
Chief Quality Officer

PRAPARE for Value-Based Care

Federally Qualified Health Center

2021 FLCH Data

- 28,092 unique patients served
- 7836 agriculture workers
- 62% of patients want to be seen in a language other than English

Initial Use

- Pilot focus to introduce PRAPARE form
- Available as a "Smart Form" in EHR
- Focus on Patient Navigator – Provider Panel

Pros/Challenges

PROS

- Helped us “ask the questions”
- Provided in structured fields
- Feeds into Social History in the progress note

CHALLENGES

- Information is buried in a progress note
- Does not “auto-connect” to an ICD-10 code
- How do we get the information in a space where the full team has access

ICD-10 Cross Walk

- Created an IPA focus group
- Developed a cross-walk of basic ICD-10 codes related to Social Determinants of Health
- Expanded training and confidence building on ICD-10 codes
- Added to the patient's active problem list
- Expanding the goal - "Everyone adds to the list"

Agricultural Teams

- Community Health Workers are essential in getting the information
- Complete the questions - even if partial - during outreach
- Document SDOH questions during health screenings
- Add the ICD-10 codes to the patient’s problem list

Connection to Value-Based Payment

- Awareness of cost of providing care
- Knowledge of barriers to care specific to your population
- Identification of needed or responsive Community Based Organizations in your network
- Opportunity to provide care with resources that make a difference or utilize staff to highest license
- Gives us data and information needed at the bargaining table

Thank you!

Ellen Hey

Chief Of Quality

Email: ellenh@flchealth.org

YAKIMA Neighborhood Health

Rhonda Hauff
Chief Executive Officer

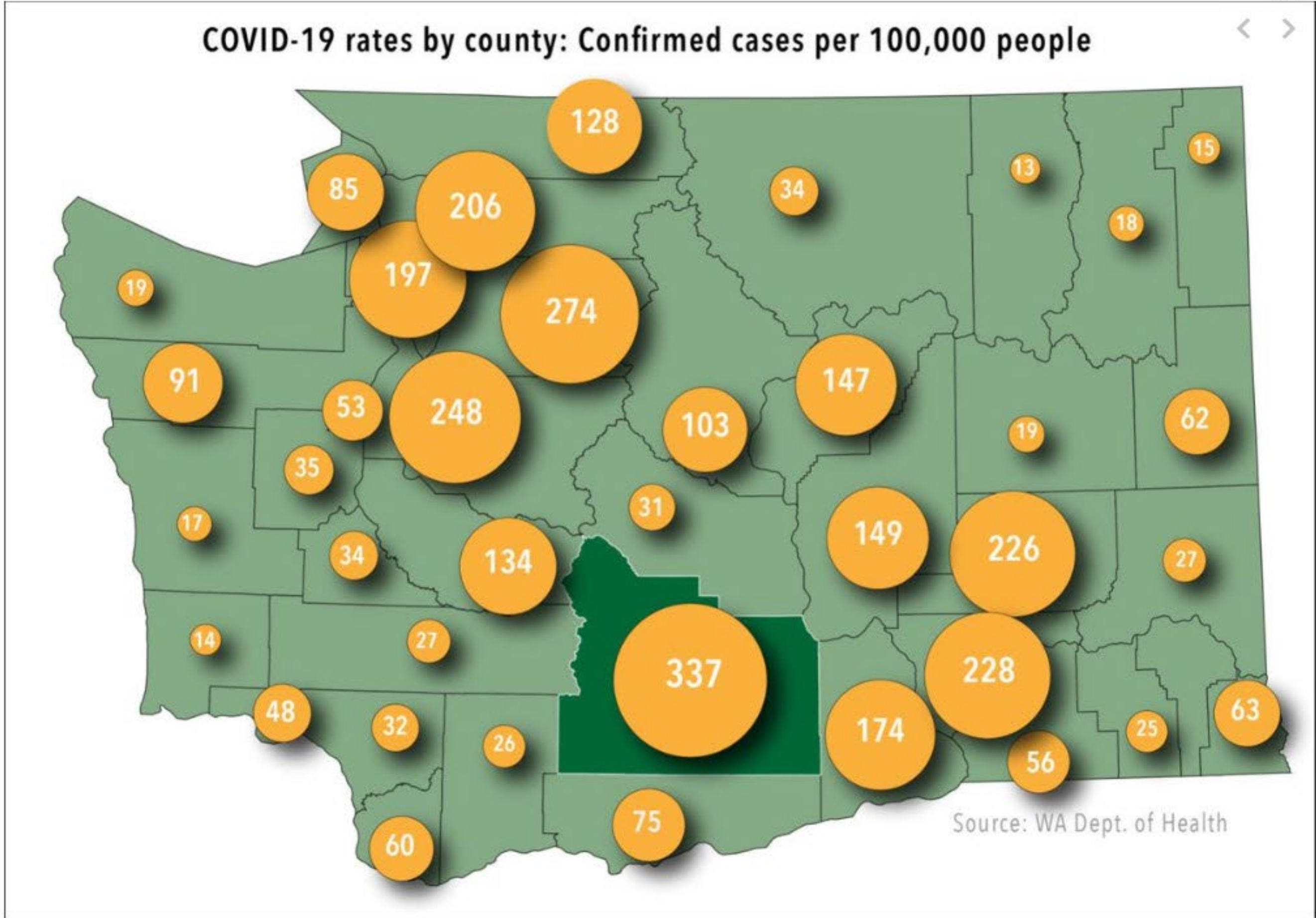
Operational Considerations: Using PRAPARE for Value-based Care

Our mission is to provide accessible, affordable, quality health care, provide learning opportunities for students of health professions, end homelessness and improve quality of life in our communities.

Yakima County has highest rate of COVID-19 cases in Washington, double the state rate

JANELLE RETKA Yakima Herald-Republic Apr 23, 2020 Updated 1 hr ago

1 of 2



The Great Yakima Valley

2021 Profile
Health Care and Housing

ALL YNHS Patients and Clients	
All Patients	35,872
All Visits (medical, dental, mental health, outreach, case management, care coordination)	163,236
Youth Served at “The Space” (LGBTQ Youth Resource Center) Visits at The Space	77 619
Women, Infants & Children Nutrition Program	4,400 Clients / Month
Affordable Care Act Applications	16,282

People Experiencing Homelessness	
People Experiencing Homelessness	3,903
All Visits to PEH (medical, dental, mental health, outreach, case management, care coordination)	29,136
Permanent Supportive Housing	126 households 200 people
Medical Recuperative Respite (Average 12 days each) ============================== Covid Isolation / Quarantine (Average 9 days each)	96 People 1,114 nights ================= 199 People 1,799 nights
Basic Needs (rent, food, utility assistance, education, legal, childcare, employment, etc.)	1,964 People 921 Households
Unaccompanied Homeless Youth	85 Youth Served Age 13-24

Community Health Workers Support Value Based Care by Reducing Barriers

- NWRPCA / NHCHC
  - **Vaccine Ambassadors**

- Greater Columbia ACH / Virtual Care Innovation Network / CHPW
  - Increasing Digital Literacy
    - Access to Smart Phones

Community Health Workers Support Value Based Care by Reducing Barriers

BPHC Optimizing Virtual Care

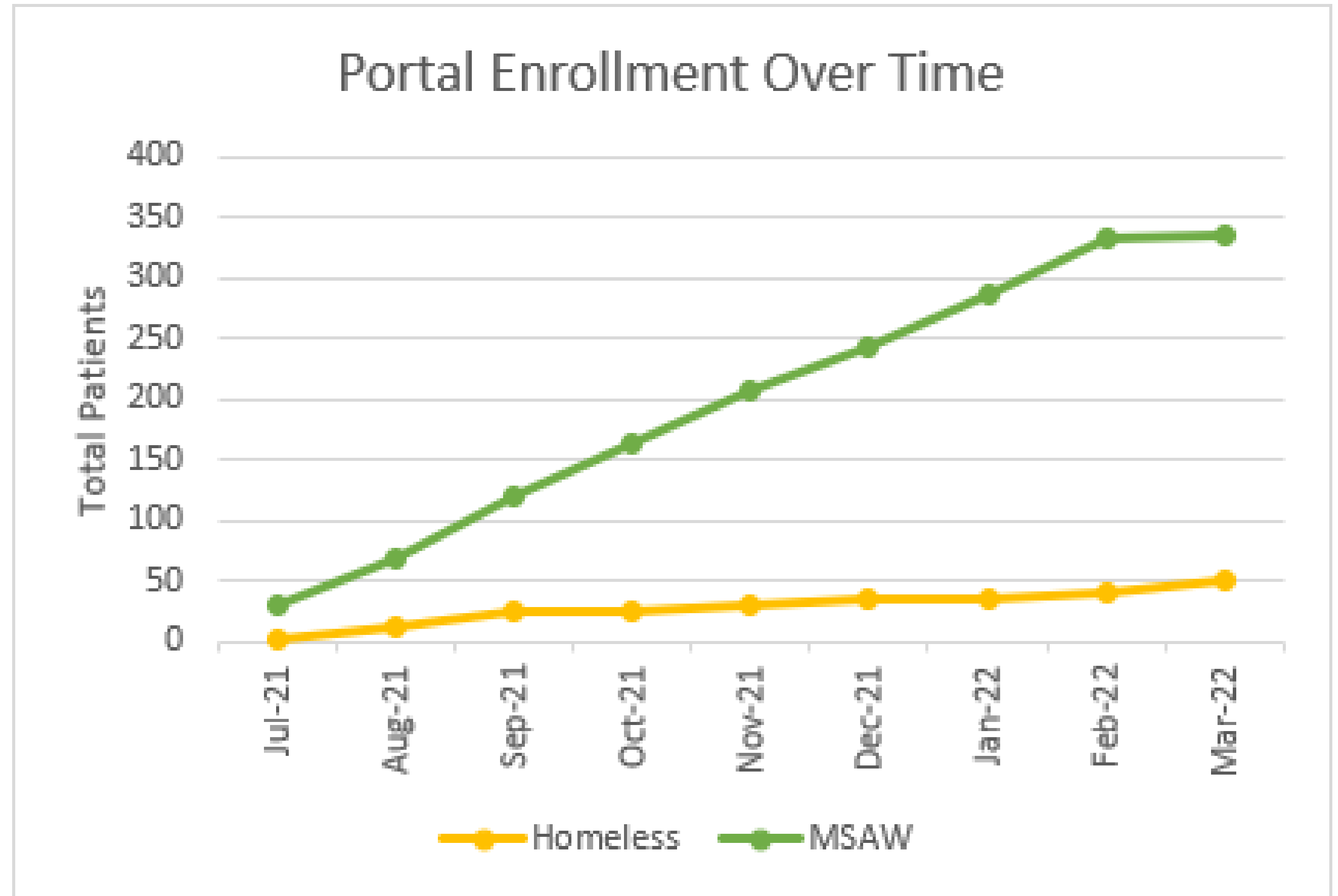
- Dedicating CHWs to patients about the value and use of patient portals / video visits
  - Convenience (refills, records, communication)
  - One on one support getting and using Smart Phones

WA State Dept of Commerce

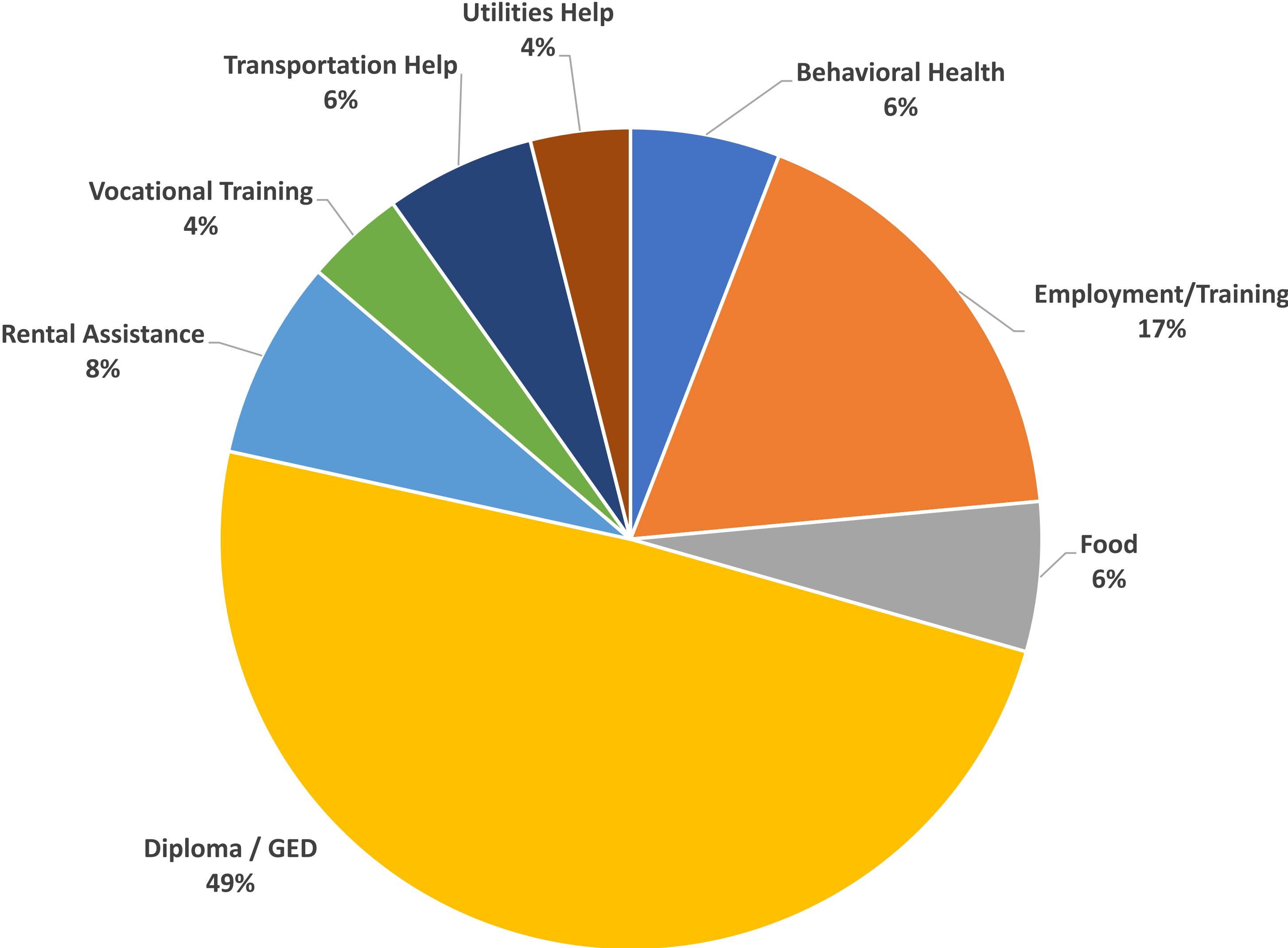
- Increasing Access to State & Federal Programs
  - SNAP
  - Medicaid
  - SSI /SSDI
  - WIC
  - Child Care Assistance
  - Broadband Benefit

CHW Success Helping Special Populations!

- refills
- messages
- records
- appointments

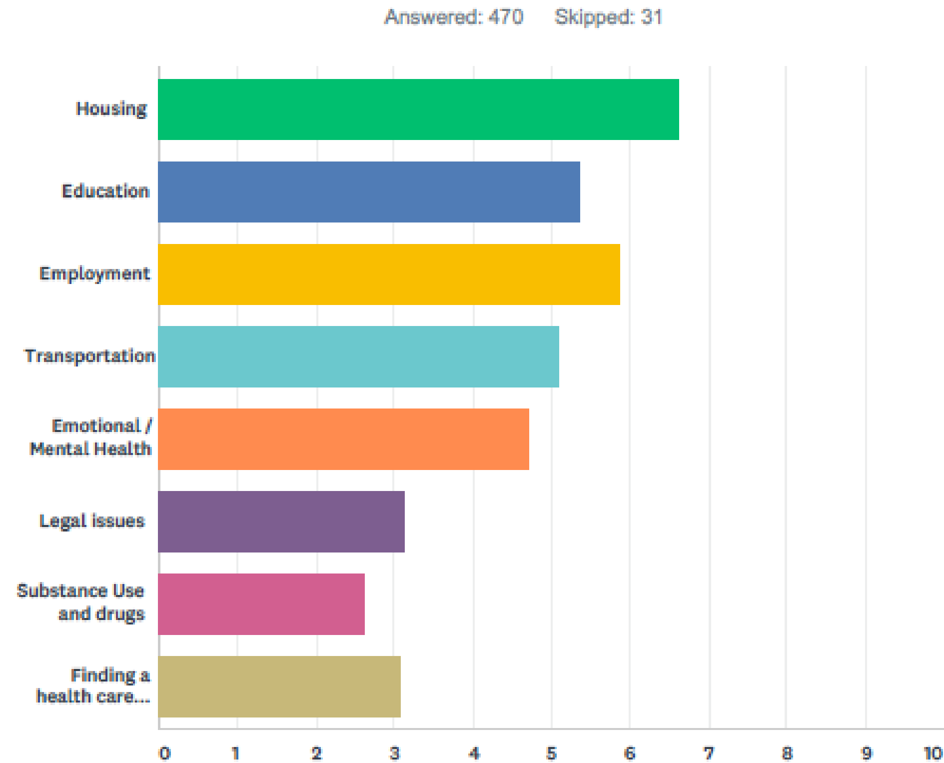


Referrals from PRAPARE – All Clinic Patients



Consumer Engagement – Prioritization Results

- Housing
- Employment
- Education
- Transportation
- Emotional / Mental Health



How Social Determinants Affect Health Care

(Wrap Around Services Provides Value Based Care)

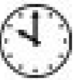
- Improving rate of successful connection to primary care
- Increasing rate of compliance with care plans
- Improvement in chronic disease measures (e.g. A1c scores, BP measure)
- Reduction in communicable disease (e.g. Influenza, TB, STDs, Hep C)
- Reduction in behavioral health crisis episodes
- Medications are better managed
- More likely to obtain and maintain employment or education
- Greater success for recovering SUD recovering patients in supportive housing

- ✓ Avg 44 visits per year per participant
- ✓ Better diabetes control
- ✓ Better hypertension control
- ✓ Increase in flu vaccines
- ✓ Fewer behavioral health crises
- ✓ Greater success in medication adherence

Questions and Discussions

Mini Round Table Discussion

- In groups of 3, reflect on the question and discuss amongst yourselves
- After each question, we will have an opportunity for sharing with the larger group
- About 5 minutes per question



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Question 1

What do you know about your state's efforts on value-based care?

Question 2

What are potential challenges or barriers for value-based care? (Health center, state?)

Question 3

From the strategies previously presented, which ones would you consider to advance value-based care? (Health center, state?)

Wrap-up and Closing Remarks

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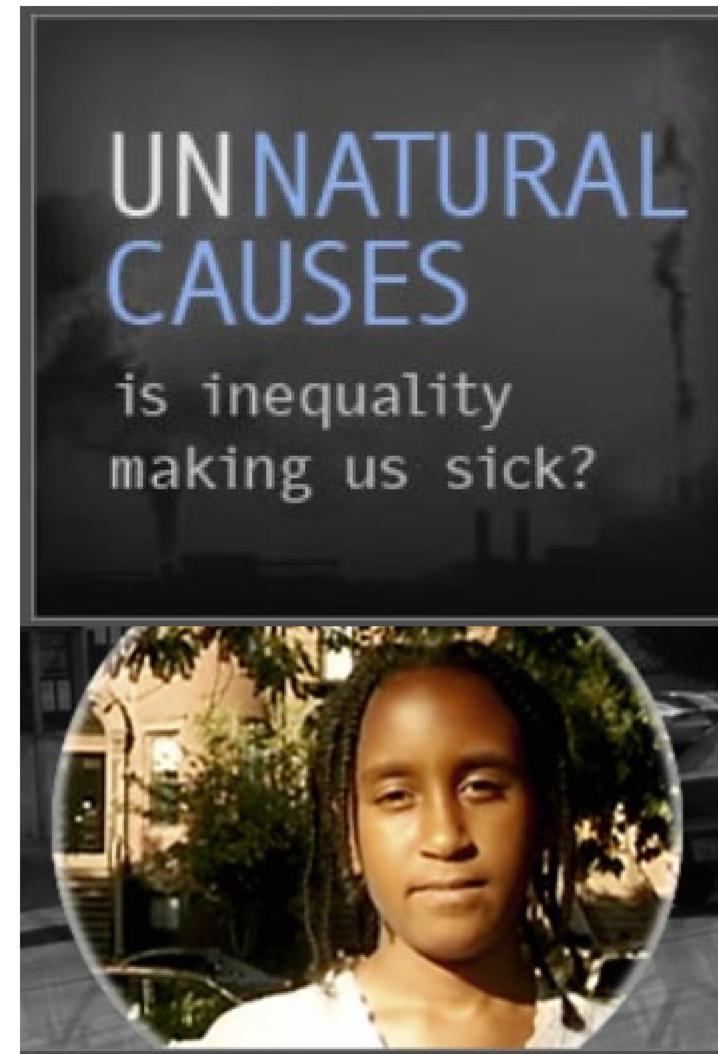
Health Equity Community of Practice

- Utilize PBS documentary series, “Unnatural Causes”
- Over 7 months, host live webinar session per month
- Utilize online discussion forums to continue the conversation
- Affinity groups may be created to allow for a deeper dive in a specific topic
- Create community agreements to allow for brave, courageous conversations
- Session 1: May 18th, 3pm ET
- Visit www.prapare.org for more information



Responding to SDOH Needs During COVID

Given the ongoing social needs of the communities you serve, **we hope to understand your efforts to assess and address social drivers of health (SDOH).**

Our goal is to continue to learn more about the circumstances in which communities are currently operating and how we can advance our support of organizations in responding to social needs during COVID-19.

Questions include:

- Assessing + addressing SDOH needs within special and vulnerable populations
- The use of funding from the American Rescue Plan Act to address SDOH needs
- Initial thoughts on your organization's ability to address SDOH needs once the public health emergency declaration expires

Complete the Needs Assessment: https://www.surveymonkey.com/r/SDOHCOVID3

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