Innovative Uses of PRAPARE to Improve Population Health of Racial/Ethnic Minority Groups and Special Populations

Community Health Institute and Expo 2021
August 23, 2021

Housekeeping

- Session will be recorded
- PowerPoint slide deck and resources are available for download
- Use the conference platform for engaging with us and each other

Acknowledgements

This session is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $7,287,500 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Session Presenters

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

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Learning Objectives

1. Understand how PRAPARE can enable health centers to advance health equity and demonstrate value.
2. Hear examples of how health centers are screening and addressing patient-level SDOH needs.
3. Consider strategies for using SDOH data for population health management, with a focus on racial/ethnic minority groups and special populations.

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- Navigate to https://chi.cnf.io and tap the session titled "CMA1 - Innovative Uses of PRAPARE to Improve Population Health of Racial/Ethnic Groups and Special Populations"

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Live Content Slide

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Poll: Does your health center currently collect SDOH needs data?

Live Content Slide

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Poll: Does your organization use SDOH data to inform population health management efforts?

Anchoring Health Equity Efforts in SDOH Data

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

A national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health.

What does PRAPARE Measure?

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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.*

Find the tool at www.nachc.org/prapare

Why use PRAPARE to collect SDOH?

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ACTIONABLE

STANDARDIZED and WIDELY USED

EVIDENCE-BASED and STAKEHOLDER-DRIVEN

DESIGNED TO ACCELERATE SYSTEMIC CHANGE

PATIENT-CENTERED

Our Guiding Why: Advancing Health Equity

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- Recognition that structural racism and discriminatory policies drive SDOH and impede health equity.
- Communities are seeking strategies that unearths and changes the root causes of poor health outcomes.
- Effective cross-sector collaborations can be a force for driving sustainable and upstream change.

Our Guiding Why (continued)

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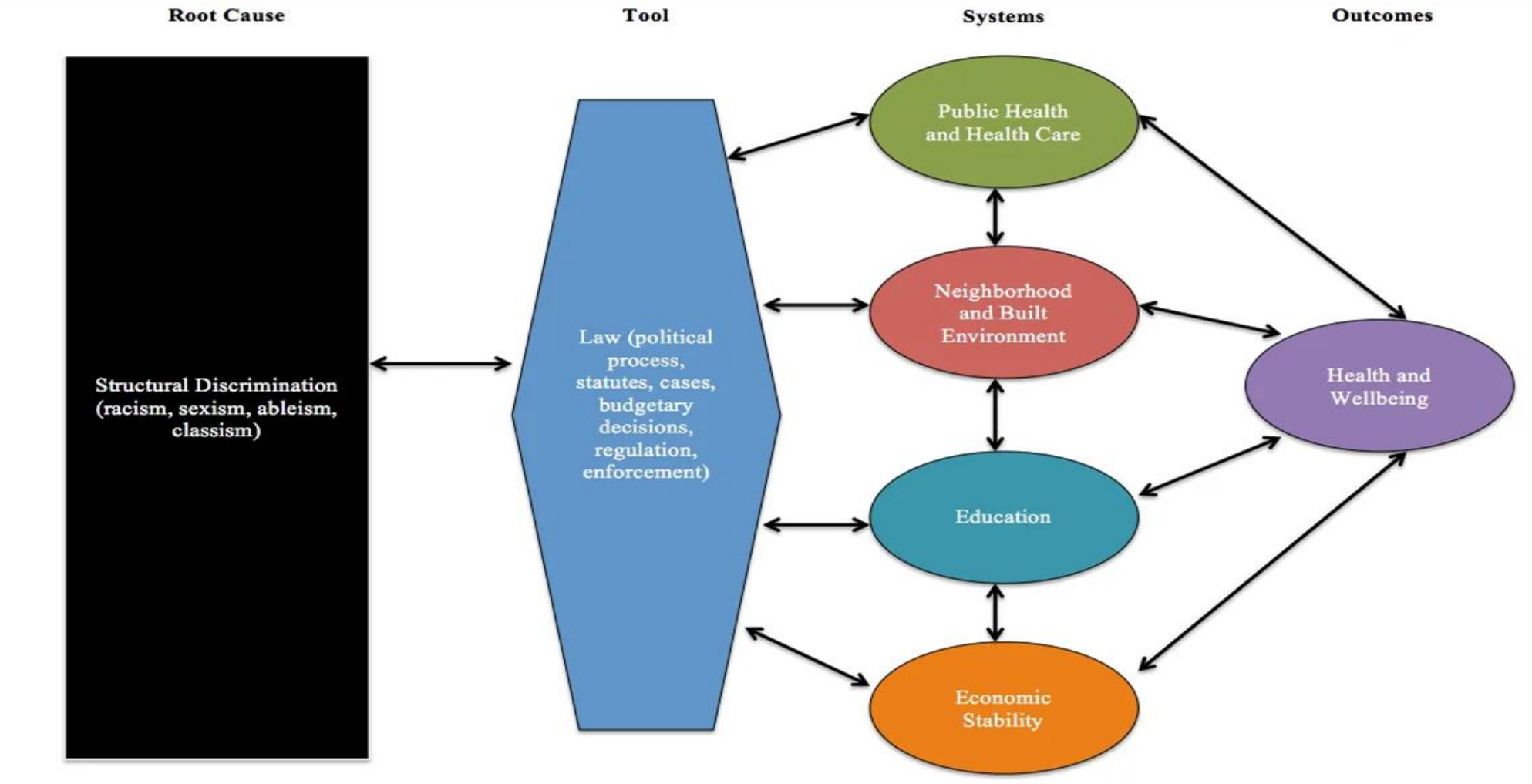

Revised SDOH Framework created by Ruqaiijah Yearby (2020)

CDC Declares Racism is Serious Public Health Threat

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Racism is a Serious Threat to the Public's Health

Racism is a system —consisting of structures, policies, practices, and norms—that assigns value and determines opportunity based on the way people look or the color of their skin. This results in conditions that unfairly advantage some and disadvantage others throughout society.

Racism—both interpersonal and structural —negatively affects the mental and physical health of millions of people, preventing them from attaining their highest level of health, and consequently, affecting the health of our nation.

A growing body of research shows that centuries of racism in this country has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These conditions—often referred to as social determinants of health—are key drivers of health inequities within communities of color, placing those within these populations at greater risk for poor health outcomes.

> Confronting the impact of racism will not be easy...I know that we can do this if we work together. I certainly hope you will lean in and join me.
> — Rochelle P. Walensky, MD, MPH
> Director, CDC, and Administrator, ATSDR

Read full CDC Statement

Increased Awareness of SDOH during COVID-19

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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

MONDAY, Feb. 8, 2021 (HealthDay News) -- Racial differences in COVID-19 death rates are explained by adverse social determinants of health, including education and poverty, according to a study published Jan. 5 in the *Journal of Racial and Ethnic Health Disparities.*

Article #1 Link

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.

Article #2 Link

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.

Summary

An Insights Council survey shows disparities in care delivery at health care organizations and interpersonal racism affecting clinicians and staff, but also many programs and training to combat the problem.

Advisor Analysis

Covid-19 is taking a toll on health care organizations' ability to provide equitable access to care, revealing that much work needs to be done to overcome disparities in care, according to a recent NEJM Catalyst Insights Council survey on health equity.

"The Covid-19 pandemic has magnified issues to the extent that disparities in care delivery can no longer be ignored," says Lisa Cooper, MD, MPH, Bloomberg Distinguished Professor, Equity in Health and Healthcare, at Johns Hopkins University School of Medicine and Bloomberg School of Public Health. "Countries and health systems across the globe have been immobilized, in large part, due to health inequities between more and less advantaged groups."

Article #3 Link

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How Inequity Gets Built Into America's Vaccination System

People eligible for the coronavirus vaccine tell us they are running up against barriers that are designed into the very systems meant to serve those most at risk of dying of the disease. We plan to continue tracking these roadblocks.

by Maryam Jameel and Caroline Chen

March 1, 5 a.m. EST

Article #4 Link

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

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

Role of Health Centers

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- Identifying and documenting the **socioeconomic and structural drivers** of poor outcomes, health disparities, and higher costs is recognized as a necessary step for providers caring for complex patients and accountable for **population health** goals.
- Current events underscore the critical importance of addressing these **social determinants of health (SDOH),** with populations served by Health Center Program grantees and look-alikes being disproportionately impacted by **COVID-19** and health centers committed to addressing **structural racism** and **health equity**.
- By collecting standardized data on the social determinants of health (SDOH), Health Center Program grantees and look-alikes can use that information to provide more **appropriate, comprehensive, and integrated patient-centered care**—either in-house through **interdisciplinary teams** or through **community partnerships**.

Realizing Resilience Part 2

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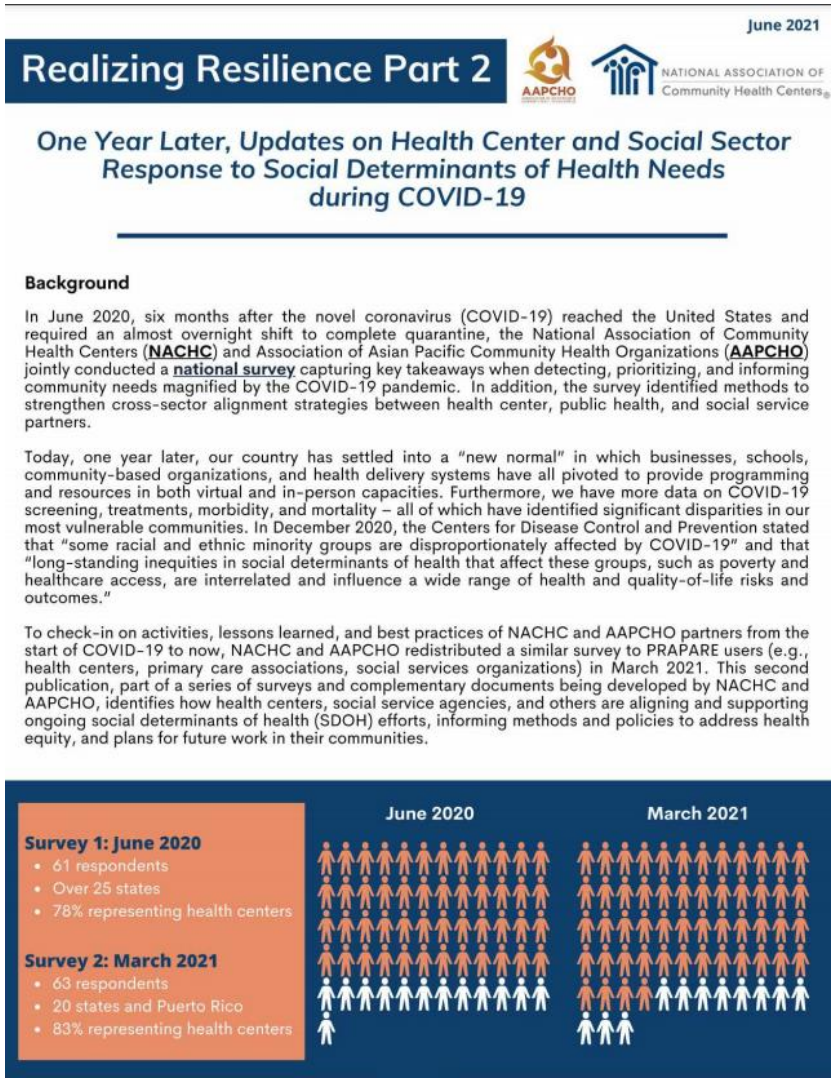
"One Year Later, Updates on Health Center and Social Sector Response to Social Determinants of Health Needs during COVID-19"

A follow-up to *Realizing Resilience: A First Look at Health Center and Social Sector Response to Social Determinants of Health Needs during COVID-19*, this brief captures how health centers, social service agencies, and others are aligning and supporting ongoing SDOH efforts, informing methods and policies to address health equity, and planning for the future in the wake of the COVID-19 pandemic.



June 2021

Realizing Resilience Part 2

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One Year Later, Updates on Health Center and Social Sector Response to Social Determinants of Health Needs during COVID-19

Background

In June 2020, six months after the novel coronavirus (COVID-19) reached the United States and required an almost overnight shift to complete quarantine, the National Association of Community Health Centers (NACHC) and Association of Asian Pacific Community Health Organizations (AAPCHO) jointly conducted a national survey capturing key takeaways when detecting, prioritizing, and informing community needs magnified by the COVID-19 pandemic. In addition, the survey identified methods to strengthen cross-sector alignment strategies between health center, public health, and social service partners.

Today, one year later, our country has settled into a "new normal" in which businesses, schools, community-based organizations, and health delivery systems have all pivoted to provide programming and resources in both virtual and in-person capacities. Furthermore, we have more data on COVID-19 screening, treatments, morbidity, and mortality – all of which have identified significant disparities in our most vulnerable communities. In December 2020, the Centers for Disease Control and Prevention stated that "some racial and ethnic minority groups are disproportionately affected by COVID-19" and that "long-standing inequities in social determinants of health that affect these groups, such as poverty and healthcare access, are interrelated and influence a wide range of health and quality-of-life risks and outcomes."

To check-in on activities, lessons learned, and best practices of NACHC and AAPCHO partners from the start of COVID-19 to now, NACHC and AAPCHO redistributed a similar survey to PRAPARE users (e.g., health centers, primary care associations, social services organizations) in March 2021. This second publication, part of a series of surveys and complementary documents being developed by NACHC and AAPCHO, identifies how health centers, social service agencies, and others are aligning and supporting ongoing social determinants of health (SDOH) efforts, informing methods and policies to address health equity, and plans for future work in their communities.

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Assessing What Has Changed: Key Findings from the Field

Survey 1: June 2020

- 61 respondents
- Over 25 states
- 78% representing health centers

Survey 2: March 2021

- 63 respondents
- 20 states and Puerto Rico
- 83% representing health centers

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Assessing What Has Changed: Using PRAPARE to Address Racial and Structural Inequalities

- "An entire team of bilingual (Spanish/ English) case managers has been established to meet the needs of the Latinx community."

- "We are working with the local college [to analyze PRAPARE data] allowing us to make connections between SDOH and race/ethnicity."

- "..based on the patients' replies, [a designated staff person] works with individual patients to address racial and social structural inequality issues in their lives."

Image Source: This slide has been designed using resources from Flaticon.com

Power of Language and Words

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Person-Centered Language Resource Guide

Given that health professionals are being "called in" to reflect on our language, thoughts, and behavior to identify blind spots, the PRAPARE team at NACHC and AAPCHO developed the resource guide for each of us, regardless of where we are on our individual and collective journey.

The guide is a conversation starter and will be a living document; we will revise it with feedback and as the field evolves. We look forward to partnering together on this journey towards health equity.

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Person-Centered Language Resource Guide

Purpose

Advancing health equity requires a shift in how professionals talk about health disparities and how we describe individuals and communities most impacted by negative health outcomes. Language reflects our thoughts and attitudes and has a profound impact on efforts to advance health equity. This resource guide was developed by the PRAPARE team at NACHC and AAPHCO and born with the acknowledgement that the field has learned hard lessons about the negative impact of language that has been used. The resource guide is a starting point to invite readers to understand key concepts and explore language that is affirming to communities that are marginalized by thoughts, language, and policies. The resource guide will evolve over time and feedback is welcomed to inform the evolution of the document.

Fostering equitable workspaces, partnerships, research, programming, and policy are part of achieving an inclusive environment; using person-centered language when disseminating information and findings on diverse communities is also critical. Person-centered language focuses on the individual and their experience, emphasizing that things happen **to** a person, not that they have defined or created the situation themselves (e.g., slaves v. enslaved persons, diabetics v. persons living with diabetes). This guide aims to ensure that all forms of organizational communication (e.g., reports, emails, presentations, etc.) acknowledge cultural humility, the impact of systemic racism, and the marginalization of communities, while demonstrating the complexities of the care, needs, preferences, and circumstances of all.

Cultural Humility is defined by the National Institutes of Health as "a lifelong process of self-reflection and critique whereby the individual not only learns about another's culture, but one starts with an examination of [their] own beliefs and cultural identities."[1] ***When communicating about vulnerable populations, it is important not to assign feelings based on assumptions of one's own experiences or beliefs.*** Microaggressions are a common form of privileged language wherein accidental or purposeful biased statements are made towards or about a vulnerable population (e.g., telling someone who is a person of color that they are "very articulate" or a person living with a physical disability that they "move well for their situation").

Systematic Racism presents itself through 1) *institutional racism*: discrimination formed by following the dictated prejudice and biases of another and/or society, and 2) *structural racism*: bigotry founded in systems-based inequalities that isolate, penalize, or harm a person or persons based on their cultural identify and/or beliefs. ***According to the National Juvenile Justice Network, we must continuously recognize and reflect upon white power structures and privilege and how communications can actively counteract those principles.***[2]

Marginalized populations are "groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions" (National Collaborating Centre for Determinants).[3] This includes notions such

[1] Yeager KA, Bauer-Wu S. Cultural humility: essential foundation for clinical researchers. *Appl Nurs Res.* 2013;26(4):251-256. doi:10.1016/j.apnr.2013.06.008
[2] National Juvenile Justice Network. *Four Questions to Ask Yourself about Your Campaign.* https://www.njjn.org/our-work/training-and-resources
[3] National Collaborating Centre for Determinants of Health. https://nccdh.ca/glossary/entry/marginalized-populations

Health Center Spotlight:
An interview with Sonia Deal, Affinia Healthcare

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Advancing Health Equity for Racial/Ethnic Minority Groups and Special Populations

Joe H. Lee, MHSA
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SDOH Screening Strategies T/TA Needs Assessment: Methodology

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- **Purpose:** To assess how AAPCHO and NACHC can better support T/TA providers as they assist health centers in implementing patient-level SDOH screening and data standards, documenting findings in clinical records, and development strategies to address SDOH risk factors at the patient and population levels
- **Time Frame:** February 28, 2021 - April 5, 2021
- **Target Population:** NTTAPs, PCAs, and HCCNs
  - ❑ Migratory & Seasonal Agricultural Workers, Residents of Public Housing, Individuals or Families Experiencing Homelessness, School-Aged Children, Older Adults, LGBTQIA+ People, Intimate Partner Violence
- **Survey Administration:** Online Questionnaire - SurveyMonkey

SDOH Screening Strategies T/TA Needs Assessment: Questions

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- ***What challenges has your organization encountered, if any, in supporting health centers in implementing patient-level SDOH screening in terms of…***
  - *Assessing*
  - *Operational*
  - *Responding*
- ***What strategies are you currently using to support implementation of patient-level SDOH screening for your health centers?***

SDOH Screening Strategies T/TA Needs Assessment: Results

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T/TA Provider	# of Responses	Notes
PCA	41	24 are also HCCNs
HCCN	37	25 are also PCAs
NTTAP	14	Special & Vulnerable Populations Serving NTTAPs

SDOH Screening Strategies T/TA Needs Assessment: Results

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- **T/TA needs for SDOH screening implementation**
  - Workflow, staff buy-in, impact stories, best practices and lessons learned
- **Upstream opportunities**
  - Demonstrating value, advocacy, risk stratification
- **T/TA Strategies**
  - Peer sharing/learning - group by different readiness levels

New Publication!

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"Collecting Standardized Data on Social Determinants of Health to Address Structural Racism, Drive Health Equity, and Respond to COVID-19"

HRSA-funded T/TA providers -- including National Training and Technical Assistance Partners (NTTAPs), state and regional Primary Care Associations (PCAs), Health Center Controlled Networks (HCCNs) -- can utilize this publication to strengthen existing T/TA strategies to increase or improve health centers' SDOH screening, documentation, and intervention efforts.

Publication Goal

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Goal: To assess NTTAP, PCA, and HCCN T/TA strategies for supporting CHCs in systematically implementing patient-level SDOH screening and data standards, documenting findings in clinical records, and developing strategies to address SDOH risk factors at the patient and population levels. NACHC, AAPCHO, and the T/TA stakeholders will determine SDOH screening challenges, particularly during COVID-19, and the existing screening strategies for the populations served by health centers.

Publication Goal

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- Table of Contents
  - Overview of NTTAPs, PCAs, HCCNs
  - SDOH Screening Needs Assessment Findings
  - SDOH Screening Workflows
  - SDOH Screening Strategies During/After the COVID-19 Pandemic
  - SDOH Screening T/TA Recommendations
  - Acknowledgments

“Power Pack” Example

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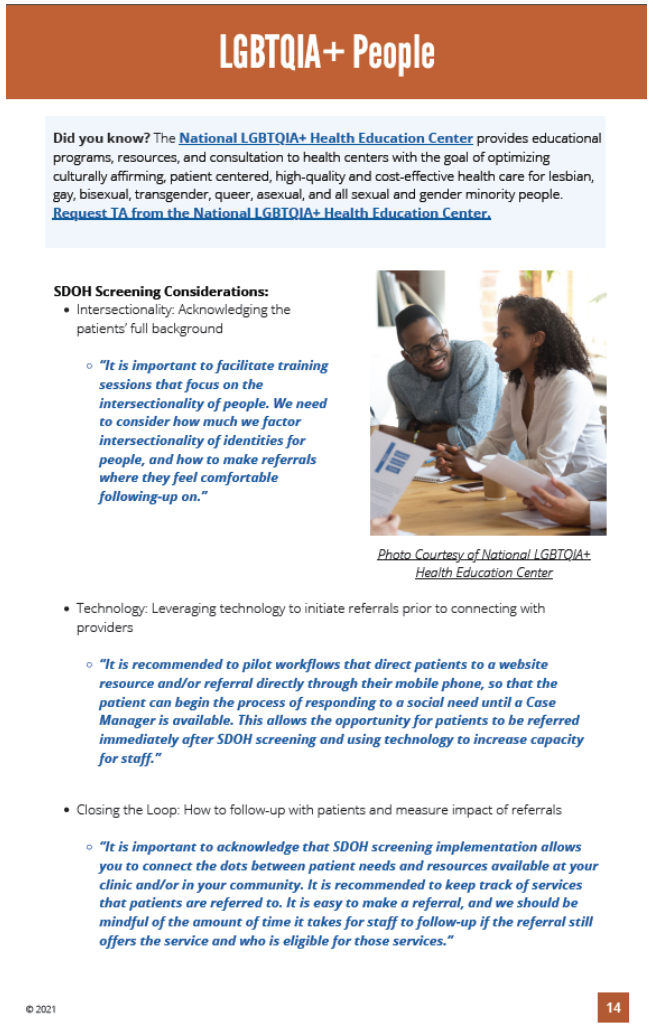
- Highlights NTTAP(s) that are subject matter experts
- SDOH Screening Considerations
  - Workflow & Workforce
  - Cultural Humility
  - Cultural Safety
  - Technology
  - Closing the Loop
  - Policy Effects



LGBTQIA+ People

Did you know? The National LGBTQIA+ Health Education Center provides educational programs, resources, and consultation to health centers with the goal of optimizing culturally affirming, patient centered, high-quality and cost-effective health care for lesbian, gay, bisexual, transgender, queer, asexual, and all sexual and gender minority people. Request TA from the National LGBTQIA+ Health Education Center.

SDOH Screening Considerations:

- Intersectionality: Acknowledging the patients’ full background
  - ***“It is important to facilitate training sessions that focus on the intersectionality of people. We need to consider how much we factor intersectionality of identities for people, and how to make referrals where they feel comfortable following-up on.”***

- Technology: Leveraging technology to initiate referrals prior to connecting with providers
  - ***“It is recommended to pilot workflows that direct patients to a website resource and/or referral directly through their mobile phone, so that the patient can begin the process of responding to a social need until a Case Manager is available. This allows the opportunity for patients to be referred immediately after SDOH screening and using technology to increase capacity for staff.”***
- Closing the Loop: How to follow-up with patients and measure impact of referrals
  - ***“It is important to acknowledge that SDOH screening implementation allows you to connect the dots between patient needs and resources available at your clinic and/or in your community. It is recommended to keep track of services that patients are referred to. It is easy to make a referral, and we should be mindful of the amount of time it takes for staff to follow-up if the referral still offers the service and who is eligible for those services.”***

Key Contributors

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Acknowledgements: this report is made possible through the contributions of our HRSA-funded stakeholders below -

National Training & Technical Assistance Partners (NTTAPs)

- Association of Asian Pacific Community Health Organizations (AAPCHO)
- Corporation for Supportive Housing (CSH)
- Farmworker Justice (FJ)
- National Center for Equitable Care for Elders (NCECE)
- National Health Network on Intimate Partner Violence and Human Trafficking (FUTURES Without Violence)
- National LGBTQIA+ Health Education Center (a program at The Fenway Institute, Fenway Health)
- National Nurse-Led Care Consortium (NNCC)
- School-Based Health Alliance (SBHA)

Primary Care Associations (PCAs) and Health Center Controlled Network (HCCNs)

- Arizona Alliance for Community Health Centers (AACHC)
- Collaborative Ventures Network (CVN)-Healthy Community Collaborative Network (HCCN)
- Community Health Center Association of Connecticut (CHCACT)
- Missouri Primary Care Association (MPCA)

Community Health Centers (CHCs)

- Brockton Neighborhood Health Center, Inc. (Massachusetts)
- Central City Concern (Oregon)
- Colorado Coalition for the Homeless (Colorado)
- El Rio Health (Arizona)
- Fenway Health (Massachusetts)
- Generations Family Health Center (Connecticut)
- Great Lakes Bay Health Centers (Michigan)
- Greater Danbury Community Health Center (Connecticut)
- La Clínica del Pueblo (Washington, DC)
- Little River Medical Center (South Carolina)
- Lowell Community Health Center (Massachusetts)
- Mariposa Community Health Center (Arizona)
- Mercy Care (Georgia)
- Muskingum Valley Health Centers, Inc. (Ohio)
- MyCare Health Center (Michigan)
- Neighborhood Health (Virginia)
- Public Health Management Corporation (Pennsylvania)
- SEMO Health Network (Missouri)
- Swope Health Services (Missouri)
- Tapestry Health (Massachusetts)
- Watts Healthcare Corporation (California)
- Yakima Neighborhood Health Services (Washington)

Questions & Discussion

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Poll: Population of focus: select all that apply

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: Please share the population health management strategies you use to care for racial/ethnic groups and special populations.

Live Content Slide

When playing as a slideshow, this slide will display live content

Social Q&A for CMA1 - Innovative Uses of PRAPARE to Improve Population Health of Racial/Ethnic Groups and Special Populations

We appreciate your time and commitment!

If you have questions, please contact:

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Related Resources

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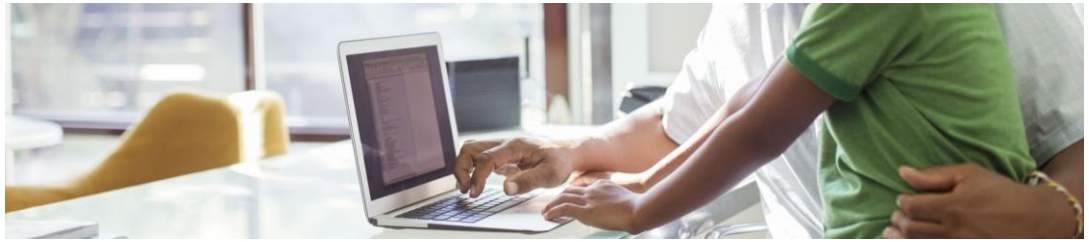
"Assessing and Addressing Social Determinants of Health During COVID-19" – Webinar Series



Session #1:

Adapting SDOH Data Collection Workflows during COVID-19

Slides | Recording

Session #2:

Practical Strategies for Social Risk Screening during COVID-19

Slides |Recording |Q&A with Panelists

Session #3:

Emerging Strategies to Address SDOH Through Community Referrals and Cross-Sector Partnerships

Slides | Recording

Session #4:

Aligning Social Needs Data and Social Interventions Coding for Health Equity

Slides | Recording

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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!