Health IT for Health Equity: Implementing Social Interventions Coding by Leveraging PRAPARE Data

November 16, 2021

Acknowledgements

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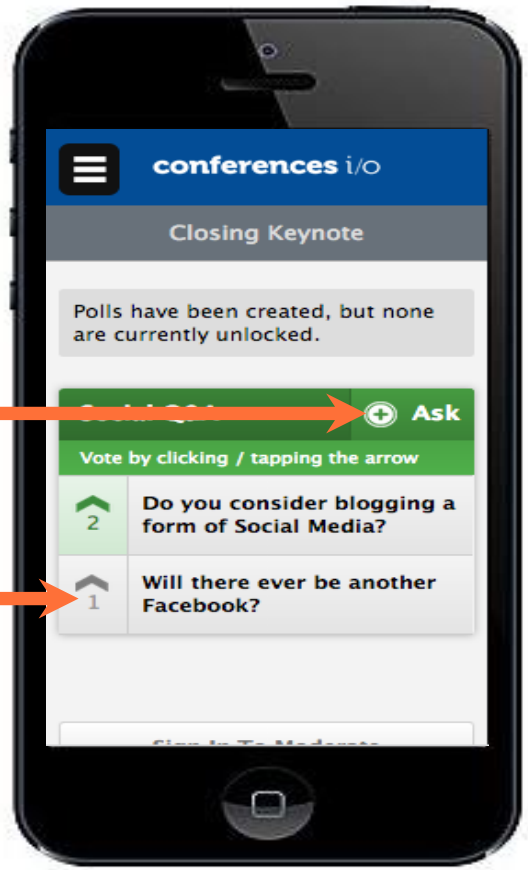
Housekeeping

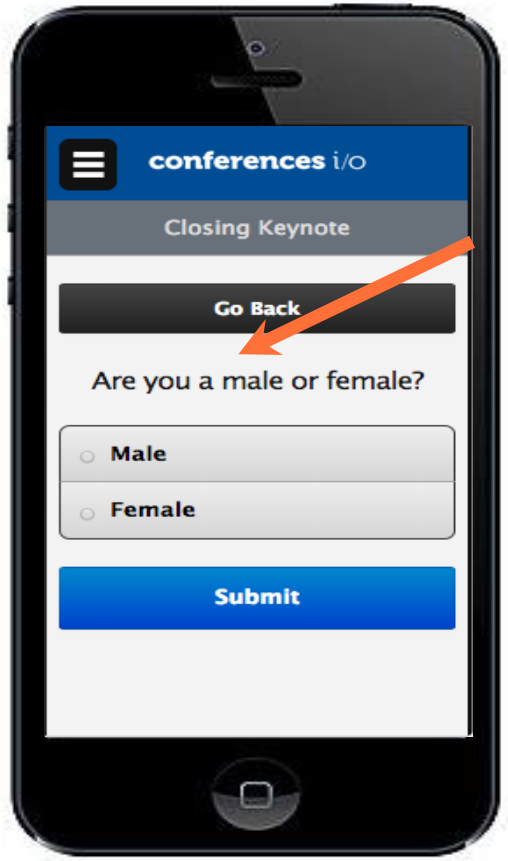
- Session will be recorded
- PowerPoint slide deck and resources are available for download
- Use the conference platform and NACHC mobile for engaging with us and each other

In-Person Participants

Give us Feedback

Up-Vote a Comment





Click on question and then Respond to Polls when they appear

Vote / Give Feedback/ Respond to Polls

Virtual Participants

Chat
(use to talk with peers)

Polling/Q&A
(participate in polls, ask questions to faculty)

Agenda

Topic	Timing in EST
Opening and Housekeeping • Nalani Tarrant, NACHC	1:00pm
PRAPARE Social Interventions Protocol & Data Documentation for Impact • Albert Ayson, Jr., AAPCHO	1:05pm
Implementing the Social Interventions Protocol • Meaghan Arzberger, Nasson Health Care/York County Community Action Corporation	1:15pm
Addressing SDOH Using PRAPARE in Missouri: A Programmatic Perspective • Angela Herman-Nestor & Shannon Bafaro, Missouri Primary Care Association	1:25pm
Panel Discussion	1:35pm
Q&A	1:50pm
Adjourn	2:00pm

PRAPARE Team at NACHC & AAPCHO

Ben Money
Senior VP, Public Health Priorities
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Associate Director, T/TA
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PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Today's Special Guest Speakers

Meaghan Arzberger
Service Integration and Data Driven Project Manager

Angela Herman-Nestor
Director of Health Care Transformation and Quality Initiatives

Shannon Bafaro
Director of Value Based Care

NASSON Health Care | York County COMMUNITY ACTION Corporation

MPCA Missouri Primary Care Association

Learning Objectives

1. Understand the importance of tracking interventions provided in response to social determinants of health needs.

2. Describe the data collection protocol to track social interventions provided in response to the identification of PRAPARE social determinants of health needs.

3. Hear experiences of organizations in using the standardized social interventions data collection protocol

Anchoring SDOH Data in Health Equity

Nalani Tarrant
Deputy Director, Research Projects

NATIONAL ASSOCIATION OF
Community Health Centers®

What is PRAPARE?

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

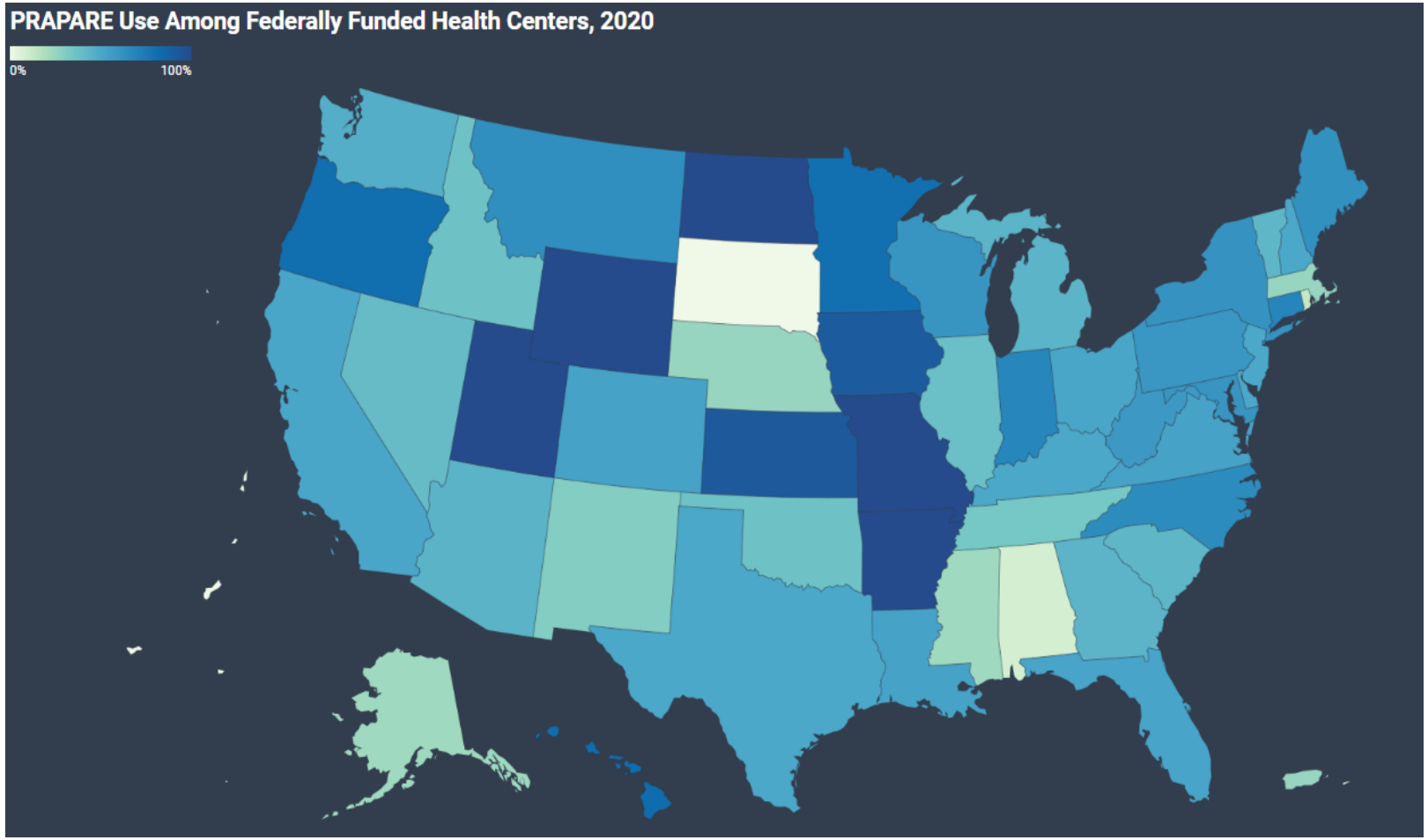
Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences

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

National PRAPARE Use 2020

http://bit.ly/PRAPAREMap2020

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



Note: Percentages reflect PRAPARE use among federally funded health centers that report screening for social risk. Excludes Health Center Program Look-Alikes and may underestimate the true volume of federally funded health centers using PRAPARE. For example, data may not capture all health centers accessing PRAPARE through some Electronic Health Records or other Health Information Technology platforms and does not capture health centers using parts of PRAPARE.

Source: 2020 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.

Roadmap to Health Equity

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

Community Context

Social risks are driven by social and institutional inequities, including racism

Fragmented care delivery system is not equipped to address or manage these risks

Understand Patients & Communities

Understand & document social risks & interventions

Communicate needs across care teams, community partners, and payers

Transform Care

New or improved interventions/ community linkages/closed loops

Efficient and integrated care decisions and management

Empower patients to address care

Impact

Improve care outcomes, costs

Establish social care evidence base

Build community capacity to address SDOH

Accelerate policy and payment change

Achieve Health Equity

At the patient, community, state, and national levels

Effective local/national models for dismantling racism

Reparative strategies for achieving equity

Modernized common data system for equity accountability
Understand and address hidden disparities and needs to dismantle barriers

PRAPARE Social Interventions Protocol and Data Documentation for Impact

Albert Ayson, Jr.
Associate Director of Training and Technical Assistance

AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

Social Interventions address SDOH

Social Interventions =

*Non-clinical services, **including***

***"enabling services,"** that address non-medical, health-related social determinant of health needs*

-Adapted from National Academies of Sciences, Engineering, and Medicine report, 2019

Standardized Social Interventions Data Use Cases Patient to Policy Level

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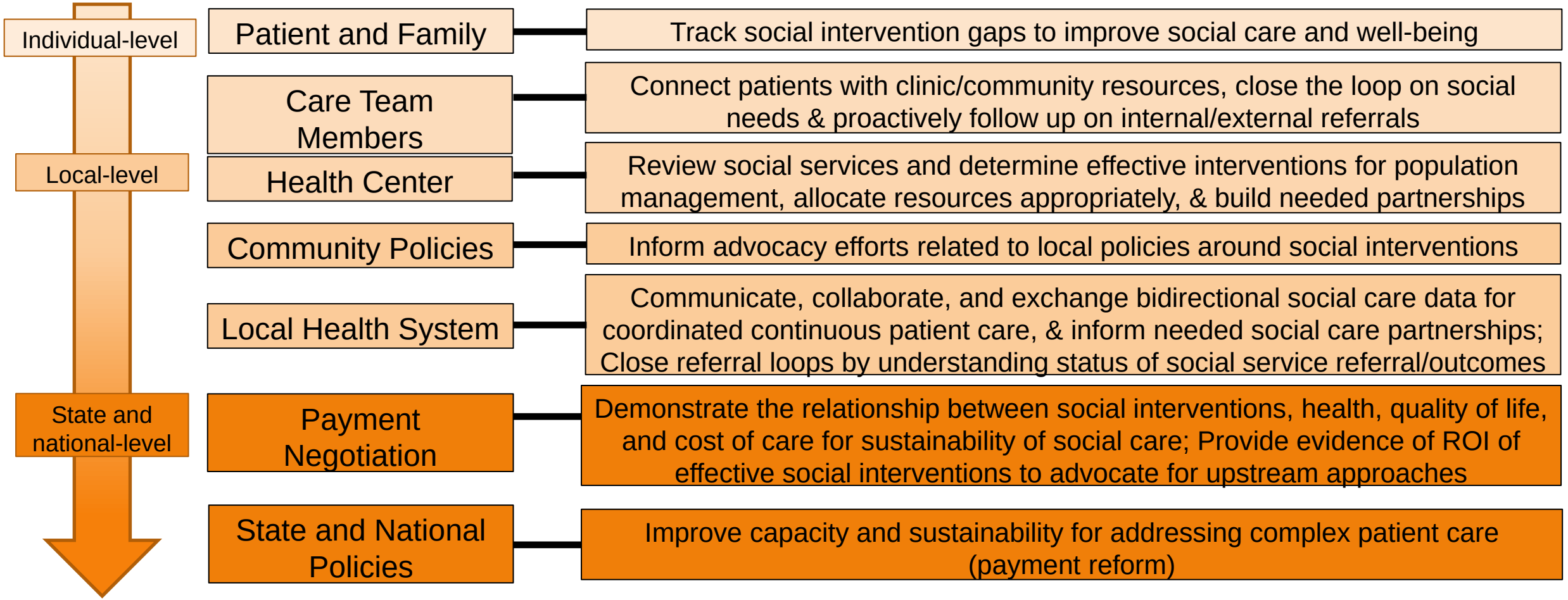

VISION: Integrated, efficient cross-sector social & care delivery system to understand needs and address hidden disparities

USE CASE: Care Narrative *without* PRAPARE & Social Interventions Documentation

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Maria's Story: Example of a care narrative without PRAPARE and Social Interventions

MEDICAL HISTORY

Uncontrolled diabetes, missed appointments, and poor medication adherence

COMPLAINT

Maria fell asleep at the stove and almost caused a fire

DIAGNOSIS

Sleep apnea, hypertension, and dangerously high blood sugar

INTERVENTION

Hospitalized for blood sugar, prescription for hypertension, and placed on a CPAP machine for sleep apnea

FOLLOW-UP

Two weeks later, Maria is back with the same clinical presentation of symptoms

SDOH INVESTIGATION

Care team discovers she has not been taking her medicine or using the CPAP machine because she can't afford them

USE CASE: Care Narrative *with* PRAPARE & Social Interventions Documentation

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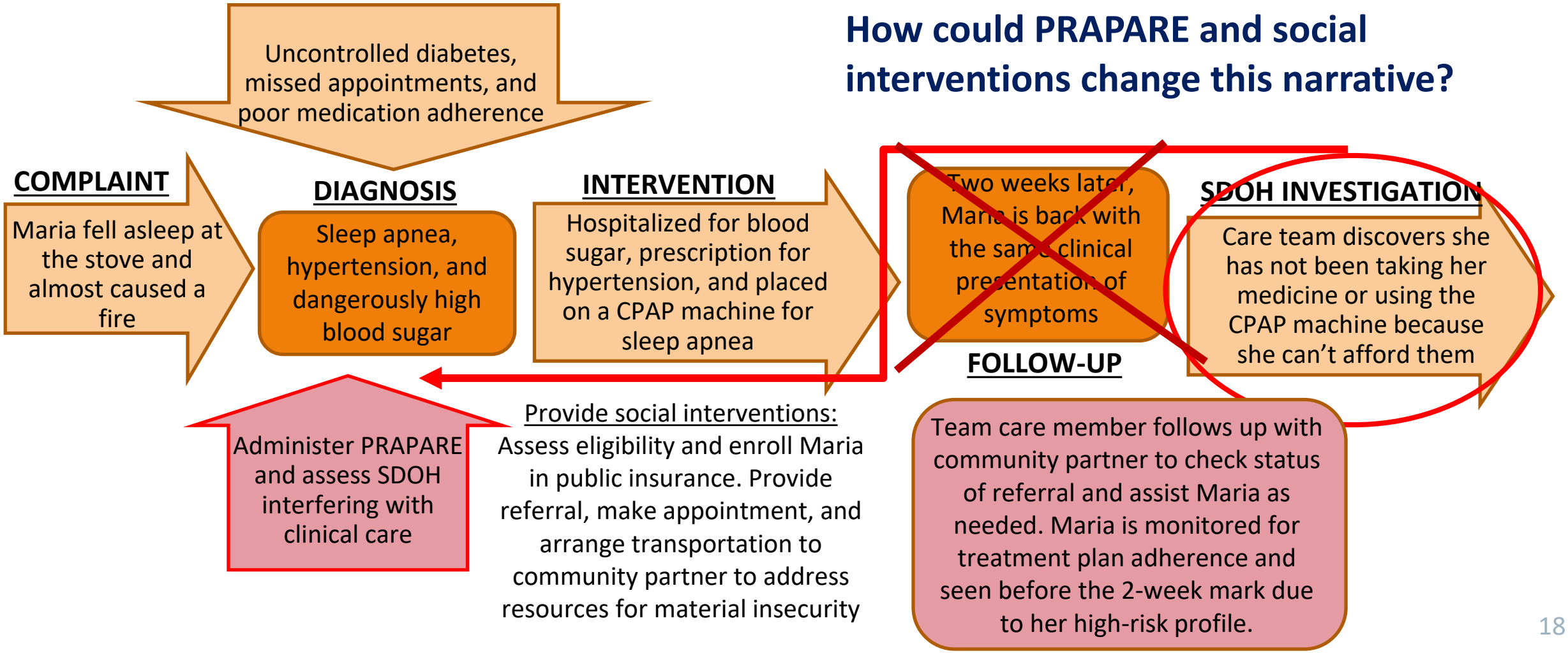

Strategy

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Step 1: Social Intervention Response Categories

Code	Social Intervention Response
SI-RE	Racial/Ethnic Support Services
SI-FW	Farmworker Support Services
SI-VN	Veteran Support Services
SI-IN	Interpretation Services
SI-HS	Housing Support Services
SI-FC	Financial Counseling/Eligibility Assistance
SI-ED	Education Support Services
SI-EM	Employment Support Services
SI-FD	Food Support Services
SI-UT	Utilities Support Services
SI-CC	Child Care Support Services
SI-MH	Medicine or Health Care Support Services

Code	Social Intervention Response
SI-CL	Clothing Support Services
SI-PH	Phone Support Services
SI-OM	Other Material Security Support Services
SI-MT	Medical Transportation Services
SI-NMT	Non-Medical Transportation Services
SI-SI	Social Integration Support Services
SI-ST	Mental Health Support Services
SI-IN	Incarceration Support Services
SI-RF	Refugee Support Services
SI-ST	Safety Support Services
SI-DV	Domestic Violence Support Services

Step 2: Social Intervention Response: Activity Codes

Code	Social Intervention Activity	Definition
AM001	PRAPARE Assessment	General social risk assessment using the PRAPARE instrument. This activity code is used to recognize organizations for the time used to conduct the general PRAPARE assessment.
AM002	Assessment	Social assessment used as a follow-up to a positive PRAPARE response or social need that includes the use of an acceptable instrument measuring socioeconomic status, wellness, or other non-medical health status.
CM001	Social Care Management	An encounter with a patient or their household or family member in which a comprehensive patient-centered social care plan is developed or monitored to address a positive PRAPARE response or social need. The care plan focuses on supporting patients in meeting social service needs of the patients and may include a followup plan to close the social service loop.
RF001	Referral	Facilitation of a visit with a patient to a social service provider. Includes re-referrals if necessary.
RF002	Follow-up on Social Service Closed Loop, Referral Status	Follow up with a patient who was previously referred to an external organization or other department. Please indicate care team followup status of social intervention using the following categories: 0 = Patient social need was not met and requires followup to address social need (select primary reason) a. Patient has not yet followed up with referral dept/organization b. Patient unable to be served at referral dept/organization c. Patient lost to follow up d. Patient social intervention in progress (e.g. awaiting application eligibility, patient newly enrolled in program) e. Other, please specify:_____ 1 = Patient social need was met through social intervention 2 = Patient no longer needs service a. Patient used different organization b. Patient chose not to use referral resource c. Patient situation changed and no longer needs service d. Patient requested not to be called again e. Other, please specify:_____ 3 = Other, please specify:_____

Step 2: Social Intervention Response: Activity Codes (cont'd)

Code	Social Intervention Activity	Definition
EA001	Eligibility Assistance	Counseling of a patient and assessing the patient's eligibility of a program to address a social need.
ED001	Education	The provision of learning experiences in an encounter designed to help individuals improve their social health, including: describing appropriate use of social services, teaching self-management approaches, explaining how to prevent injuries for patients, and other promoting behaviors to address social needs.
SC001	Supportive Counseling	The provision of support to patients to mitigate distress or concerns regarding issues affecting their social wellbeing. This would include listening to patient concerns and providing encouragement when appropriate.
IN001	Interpretation	Provision of interpreter services by a third party (other than the service provider) intended to reduce barriers to a limited English-proficient (LEP) patient or a patient with documented limitations in writing or speaking skills sufficient to affect the outcome of an encounter.
OR001	Outreach	Providing information about social services to engage patients to address social need(s) including checking in with a patient to close the social service loop in order to ensure appropriate and timely social service.
TR001	Transportation	Providing transportation assistance to a patient requiring transport to receive appropriate social services.
OT001	Other Social Intervention Activity: Please Specify (OPTIONAL)	If the social intervention does not fall into the above categories, please enter free text name and description of other social intervention. This is REQUIRED if the social intervention service type field "Other" is marked.

Social Interventions: Supplementary Documentation

Organization	Organization Type	Service Date	Provider ID	Provider Type
Patient ID	Patient Date of Birth	Patient Current Gender Identity and Sexual Orientation	Language Used to Provide Social Intervention	Length of Social Intervention
	Encounter Type (includes phone & video telehealth)	Appointment Type	Scope of Service	

Social Interventions Documentation Workflow Example

If referral provided, document Social Service Closed Loop Referral Status

Document PRAPARE positive response(s)

Under each positive response, document the PRAPARE Social Intervention Response(s)

Under the Social Intervention category, document the PRAPARE Social Intervention Activity Code(s)

Document the Social Intervention Supplementary data (e.g. visit length, provider type)

PRAPARE data is transmitted to referral dept/organization

Care Team member follows up to track and close the social service referral loop

Re-assess PRAPARE based on PRAPARE guidelines (see Toolkit)

Close the social service referral loop

Why are Social Interventions Data Important?

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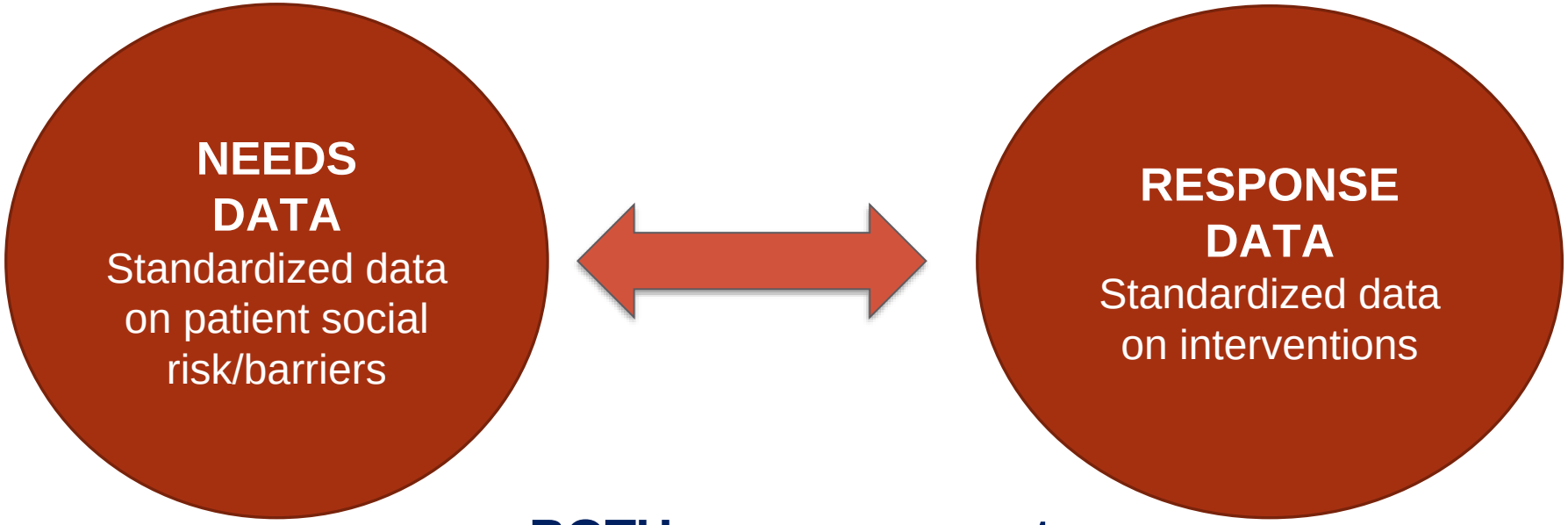

BOTH are necessary to:

- ✓ Increase community capacity to recognize hidden disparities and proactively address SDOH with effective social interventions
- ✓ Demonstrate community value of social interventions for equity
- ✓ Provide necessary evidence to achieve adequate financing for interventions to address equity
- ✓ Better coordinate patient care to comprehensively address the root causes of health inequities
- ✓ Achieve integrated, value-driven delivery system and reduce total cost of care

Examples of Reporting Metrics

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- # of SDOH screens and corresponding social interventions by month, by category & provider type
- # of SDOH interventions addressed compared to number of PRAPARE needs
- Top patient SDOH needs that lack community resources/interventions
- Mean length of time spent on social interventions, by category & provider type
- Summary of patient referral status (e.g. completed, lost to follow up, etc.) by social intervention, by organization

Impact & Outcomes of Social Interventions Data Documentation

- ✔ Reduction in missed appointments
- ✔ Reduction in ER visits and hospitalizations
- ✔ Improvement in appropriate, preventive care
- ✔ Improvement in quality indicators such as A1C and overall health outcomes

Implementing the Social Intervention Protocol

Meaghan Arzberger,

Service Integration and Data Driven Project Manager,

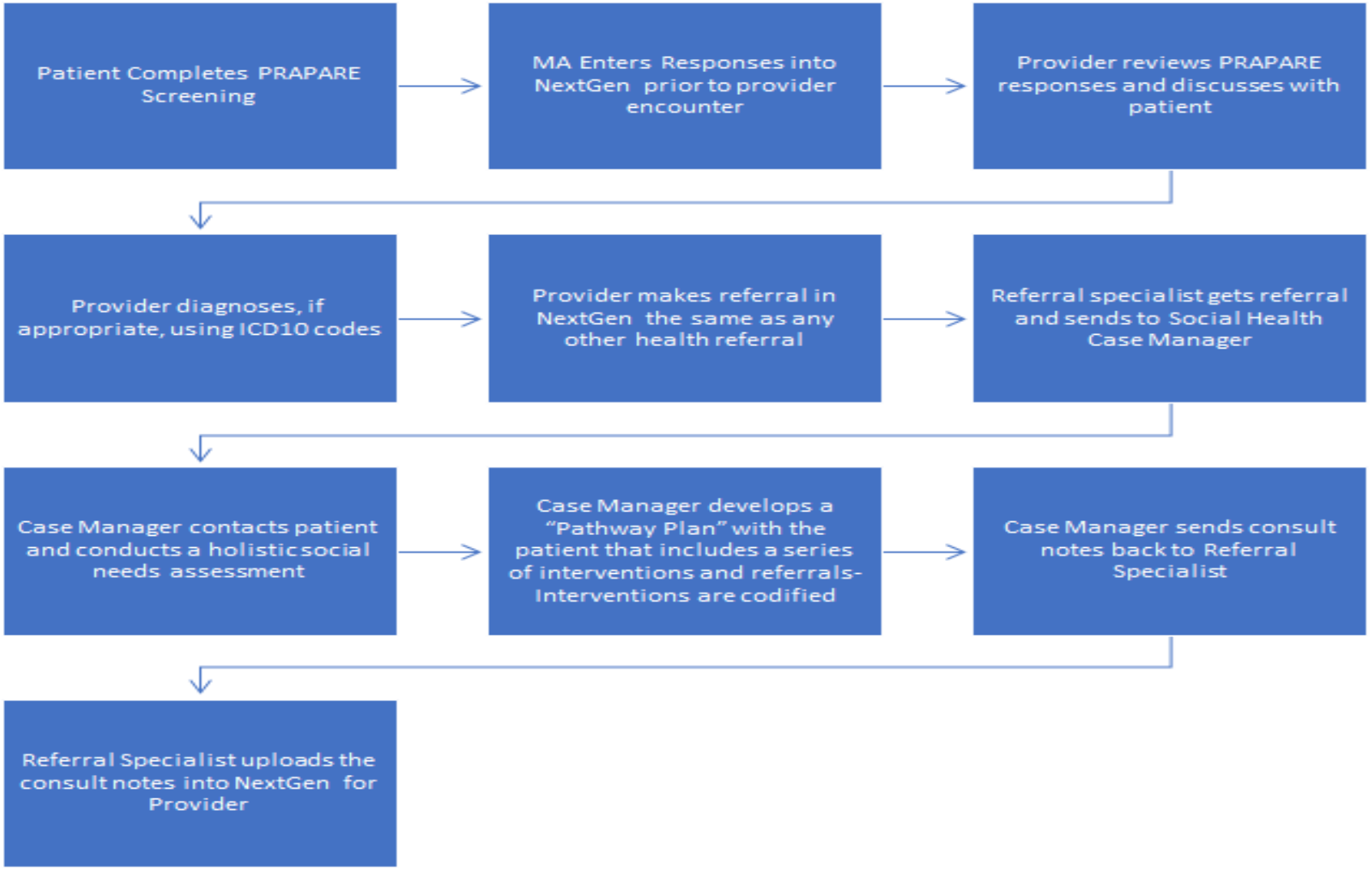
NASSON Health Care | York County COMMUNITY ACTION Corporation

York County Community Action and Nasson Health Care

- ✔ FQHC embedded in a Community Action Agency
  - Founded in 1964
  - The mission of York County Community Action Corporation is to alleviate the effects of poverty, attack its underlying causes, and to promote the dignity and self-sufficiency of the people of York County, Maine.
    - Programs include Children's Services, WIC, Transportation, Energy Services, Economic Opportunity (Financial and Housing Support), Nasson Health Care

- ✔ 5,800 patients served across Primary, Dental, and Behavioral Health

Social Interventions Workflow



Measuring the Social Intervention Workflow

- We track:
  - Number and % of patients screened using PRAPARE
  - Number of patients diagnosed with social need and what needs have been identified
  - Number of social diagnosis by provider
  - Number and type of social need referrals
  - Number and type of social interventions provided
  - Number of visits and time spent with social service case manager

- What we want to track:
  - Improved health
  - Cost savings

Monitoring and Lessons Learned

- SDOH Leadership Team monitors and supports implementation
- Lessons Learned:
  - MAs need to get PRAPARE responses in for the provider
  - A dedicated social service position to receive referrals
  - Case Management rather than only triage
  - Some providers have bought into the process more so than others
  - Communication between social side and health side along with building trust

Addressing SDOH Using PRAPARE in Missouri: A Programmatic Perspective

Angela Herman-Nestor,
Director of Health Care Transformations & Quality Initiatives

Shannon Bafaro,
Director of Value Based Care

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Growing Necessity for SDOH Understanding

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- Association between SDOH elements and preventative and chronic disease management/outcomes for patients
- Dollars attributed to quality metrics that are influenced by SDOH elements
- Dollars attributed to collecting SDOH elements
- Alignment with recognition programs, such as NCQA PCMH

State & Federal Alignment with SDOH Reporting

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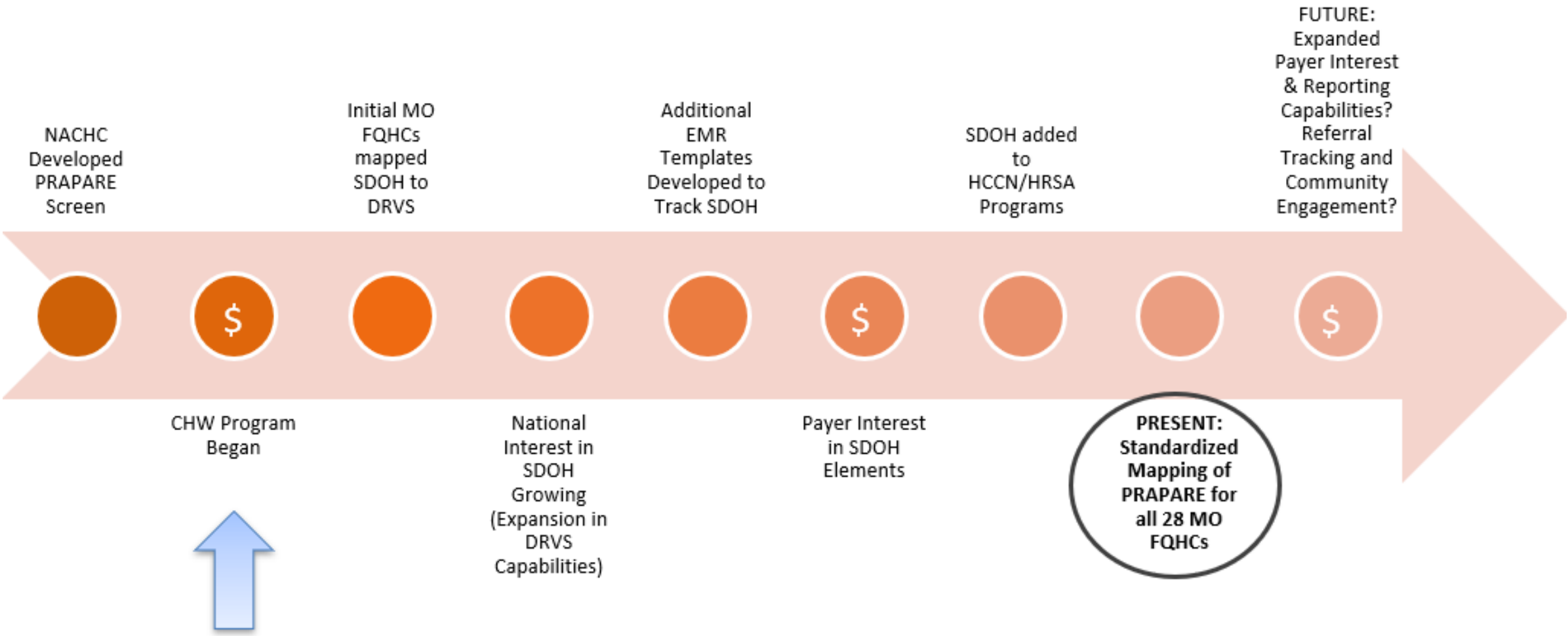
Programs	SDOH Alignment
UDS (Federal Reporting)	13 SDOH elements; all patients
CHW Program (27 FQHCs, 1 Look Alike)	Total PRAPARE (21 elements); Medicaid
St. Louis Alliance (city/state program) ***(*4 STL FQHCs only)***	Total PRAPARE (21 elements); all patients except Medicaid; focus on patients with chronic diseases to support successful participation in Centers for Disease Control Lifestyle Change Programs
CHW Foster Care Initiative	Total PRAPARE (21 elements); patients in foster care and assist foster families with SDOH needs
Health Center Control Network (Federal Reporting)	Incorporate SDOH into Care Plans
Value Based Plans	Continuously growing interest; Requests vary by contract
Patient Engagement (State Program)	Total PRAPARE (21 elements); MCO Assigned Members

Missouri SDOH Tracking Over Time



SDOH Screening and Addressing Identified SDOH

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- Missouri is utilizing PRAPARE as the sole SDOH screening
- Structured documentation of PRAPARE in EMR/PMS to allow mapping to population health management system.
- SDOH Information from PRAPARE is available in Azara DRVS the population health management system used in Missouri in registries, dashboards, pre-visit planning tool/alerts, and ability to apply SDOH to various quality metrics.

SDOH Screening and Addressing Identified SDOH

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- SDOH screening is not enough, need a workforce to assist patients with navigating resources to meet SDOH needs identified by screening.
- Missouri is building a robust Community Health Worker workforce
- Movement towards SDOH referrals being tracked and treated the same as referrals to clinical specialties.
- MO PCA is facilitating conversations with common IT solutions for community referrals UniteUs and Aunt Bertha soon to be Find Health

PRAPARE Adoption Plan: Roadmap to Structured Reporting

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Don’t expect individual processes with similar systems to have “cookie cutter” results.

2020 – 2021 PRAPARE Missouri Standardized Mapping

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- Multidisciplinary Mapping Team essential to success: CHW, CHW Supervisor, Quality Lead, IT Support
- Use of Standardized SDOH Screening Tool: Only PRAPARE Assessment used with mapping of Completion date, Questions and Responses Mapped to SDOH Elements with Locked Fields *(*Exception with UDS Elements)*
- SDOH Screening Workflow and Referral: Organization-wide Screening Workflow Discussed/Established and status of SDOH referral workflow
- Payer and Coding Discussion: Payer Mapping Reviewed/Updated and status of SDOH coding

Mapping Process

MPCA review of individual data elements and state decisions on documentation expectations including exceptions.

Health Center review of workflow for screening collection and documentation. Make modifications as necessary.

Azara (pop health vendor) review of back end mapping to identify outdated connections and instill new guidelines to mapping.

NOTABLE OUTCOMES:

- If no way to document true response, leave blank
- Lock down all responses – no free text!
- Complete date should ONLY come from a structured field or "save" click – Never an encounter.

Barriers and Areas of Advocacy

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- Limitations in documentation of PRAPARE elements for EVERY EMR vendor.
- CHW work often exists outside of a patient visit, however systems are often not designed for documentation and use by non-clinical staff.
- Collection and reporting of SDOH ICD-10 codes is of growing importance, but not easily accessible/available.
- SDOH referral tracking and closing loops remains a struggle however making progress

Questions & Discussion

Discussion Questions

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1. From your point of view, what role or impact does data collection on social needs and social interventions have on health disparities amongst structurally marginalized populations?
2. What support or resources would be needed to support health centers collect data on social needs and social interventions?
3. What keeps you up at night when it comes to addressing the social drivers of health?
4. What gives you hope in your role or line of work?

Key Points:

Leveraging Health IT for Health Equity

Nalani Tarrant
Deputy Director, Research Projects

Practical Applications of SDOH Interventions Data for Equity

1. Enable population-level analysis to track and ensure equitable allocation of SDOH interventions across race/ethnicity
2. Set goals/targets for SDOH intervention programs for the most vulnerable racial/ethnic populations for equity accountability
3. Understand staffing & resource needs for SDOH interventions to achieve equity
4. Evaluate impact and outcomes for addressing SDOH interventions for vulnerable populations
5. Assess impact of cross-sector partnerships to improve cross-sector alignment

Health Equity Impact

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- Common language across sectors
  - Awareness of services provided to clients across sectors
  - More coordination and less duplication
  - Measurement of progress toward dismantling racism & health equity
  - Enhanced capacity to promote alignment across health centers and community social service organizations
- Less fragmented social care system across sectors → Collaboration across sectors to proactively assess and address client social risks
- Understanding of needs, effort, & resources to work upstream to address health equity
- **Effective local/national evidence-based models for dismantling racism/disparities**

Contact Information – Guest Speakers

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We appreciate your time and commitment!

If you have questions, please contact:

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