Documenting PRAPARE social interventions to improve health equity and demonstrate value

Acknowledgements

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

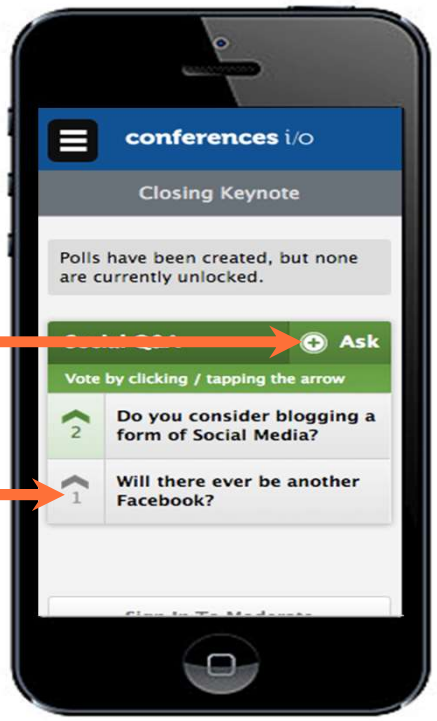
Housekeeping

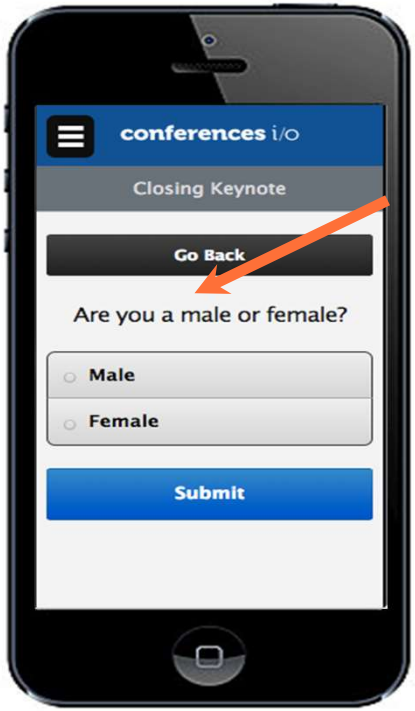
- Session will be recorded
- PowerPoint slide deck and resources are available for download
- Use the conference platform and NACHC mobile for engaging with us and each other

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)

Session Presenters

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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

PRAPARE Overview

Nalani Tarrant
Deputy Director, Research Projects
National Association of Community Health Centers

Live Content Slide

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

Poll: Are you using PRAPARE?

What is 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

What does PRAPARE Measure?

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*	

* UDS measures are automatically populated into PRAPARE EHR templates.

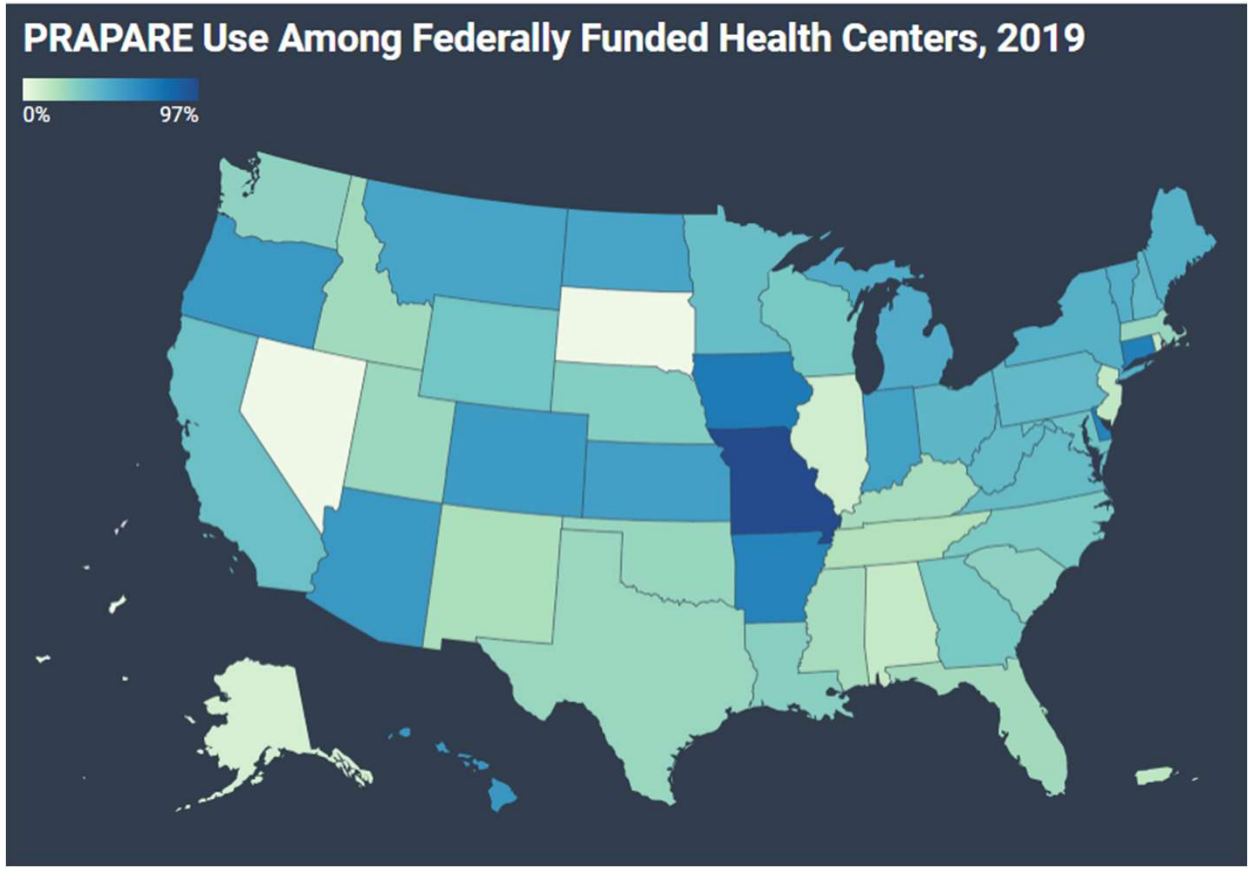
Optional	
1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

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?**

Find the tool at www.nachc.org/prapare

National PRAPARE Use 2019

http://bit.ly/PRAPAREMap2019

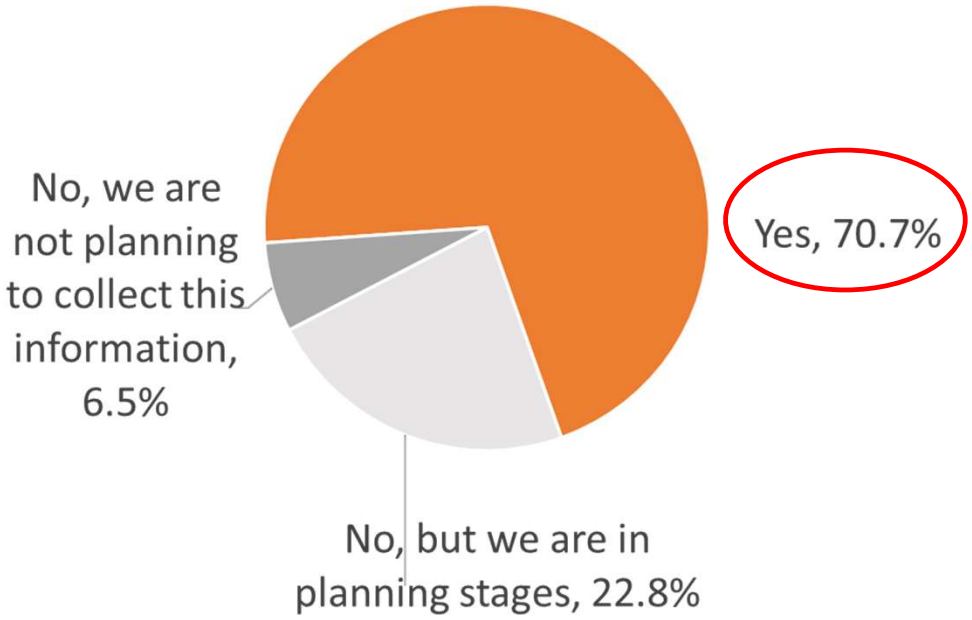


Note: Excludes Health Center Program Look-Alikes and may underestimate the true volume of federally funded health centers using PRAPARE. For example, data may not capture all health centers accessing PRAPARE through some Electronic Health Records or other Health Information Technology platforms and does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

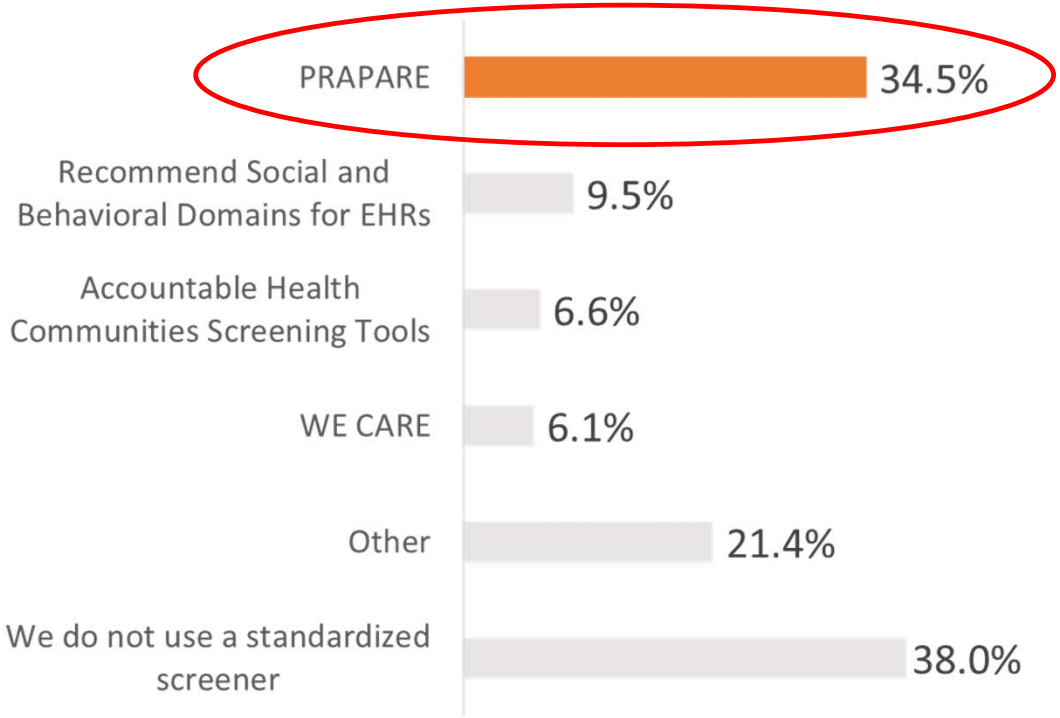
Source: 2019 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.

National SDOH Screening 2019-UDS

Does your health center collect data on individual patients social risk factors, outside of the data reportable in the UDS?



Which standardized screener(s) for social risk factors, if any, do you use?



Why use PRAPARE to collect SDOH?

ACTIONABLE

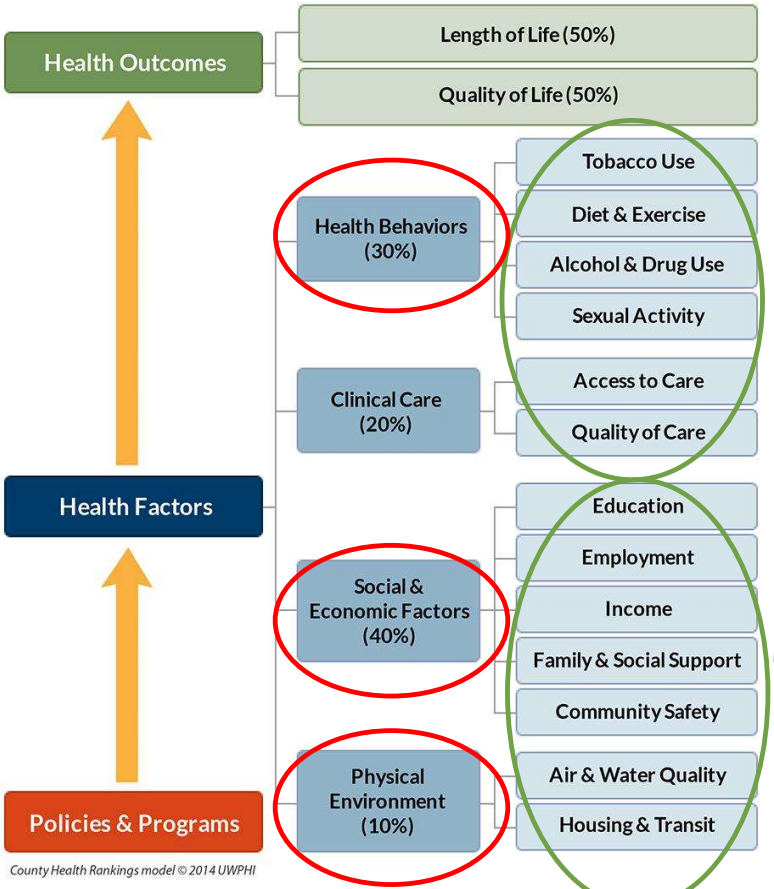
STANDARDIZED and WIDELY USED

EVIDENCE-BASED and STAKEHOLDER-DRIVEN

DESIGNED TO ACCELERATE SYSTEMIC CHANGE

PATIENT-CENTERED

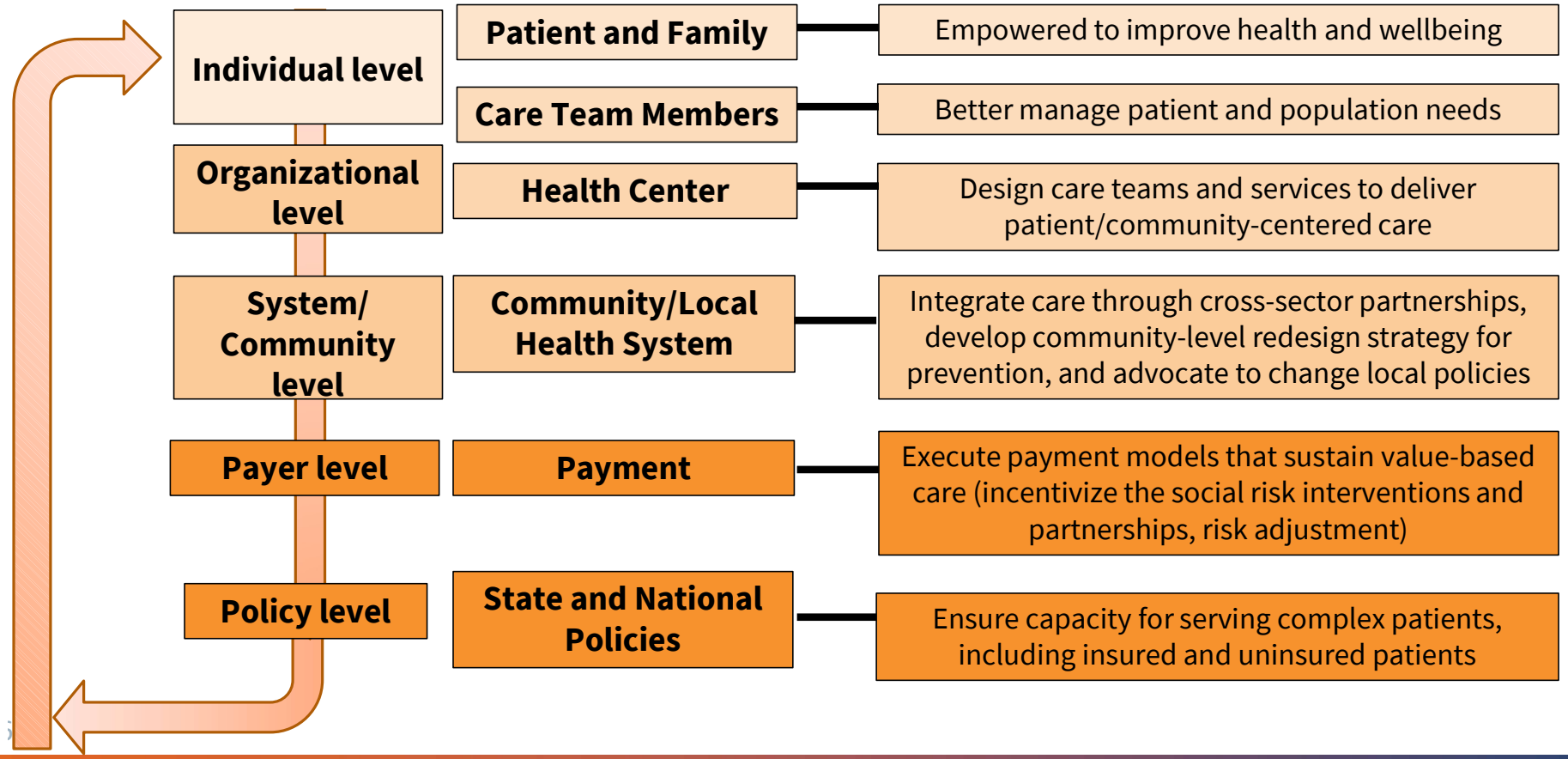
Why are Social Determinants of Health Important?



Impacted by the social determinants of health

Social determinants of health

Why Collect Standardized Data on SDOH?



Overview of Social Interventions Protocol

Rosy Change Weir
Director, Research
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

Live Content Slide

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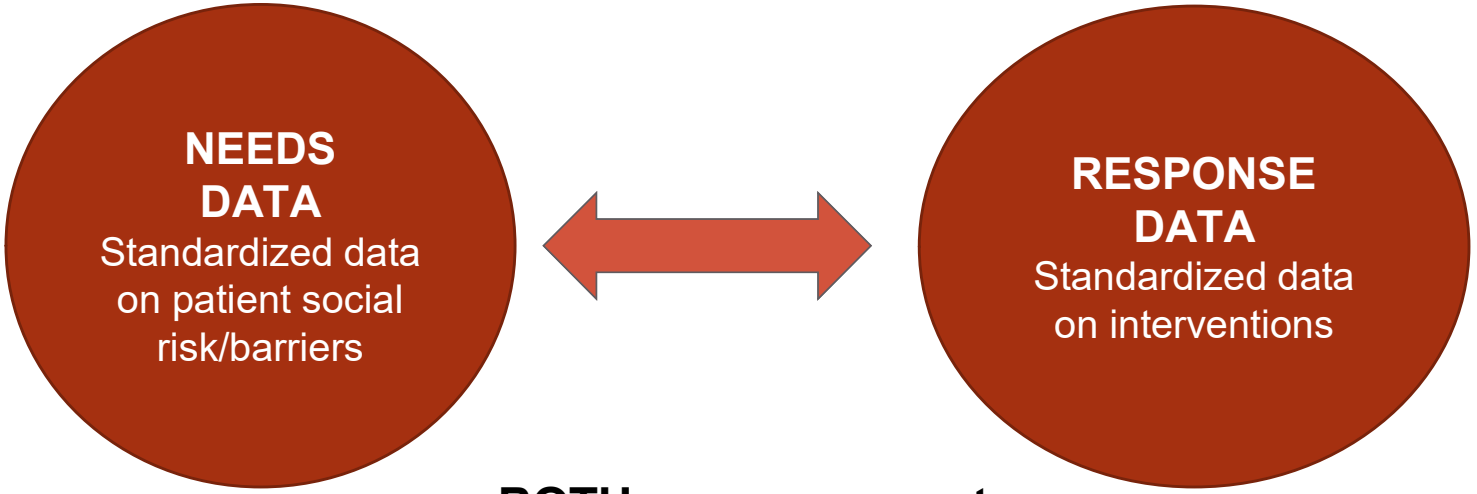
Poll: Are you documenting Social Interventions that your organization provides to address your patients' needs?

Why are Social Interventions Data Important?



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

How have social interventions data collection helped?

Waianae Coast Comprehensive Health Services (Hawaii) – used data to support reduction in ER utilization. Received better funding from local health plan by submitting social intervention data.

LifeLong Medical Care (California) – tracked data for community/non-patients to sustain or expand health education programs (e.g. walking groups, zumba, cooking classes)

Valley Wide Health Systems (Colorado) – worked with Colorado Medicaid office for per member per month (PMPM) for care coordination staff

Charles B. Wang CHC (New York) – reallocation of resources to hire more care coordinators or case managers. Also, lead to more Medicaid eligibility assistants for enrollment and eligibility

Acknowledgement to Waianae Coast Comprehensive Health Services, LifeLong Medical Care, Valley Wide Health Systems, and Charles B. Wang CHC for their contributions. Image Source: Wikipedia.

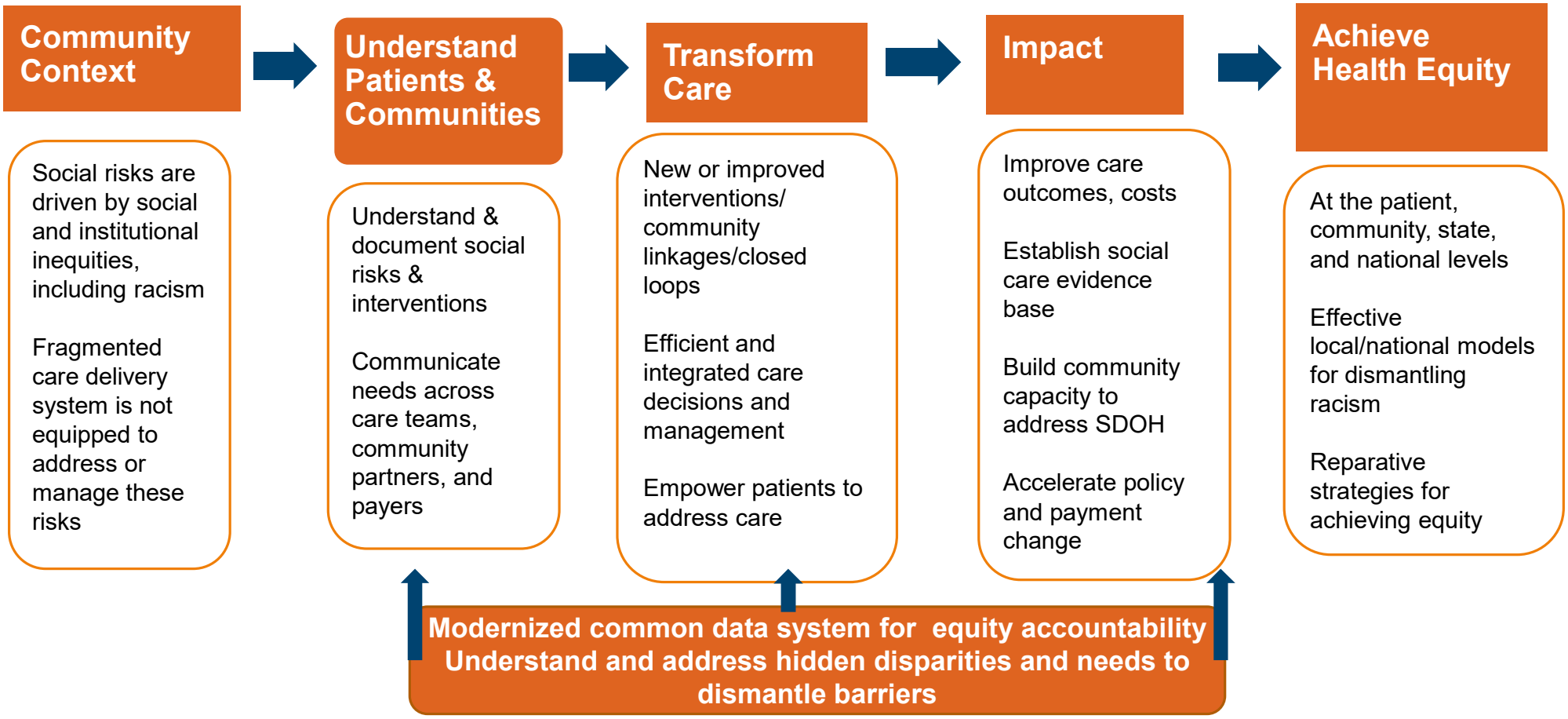
Practical Applications of SDOH Interventions Data for Equity

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

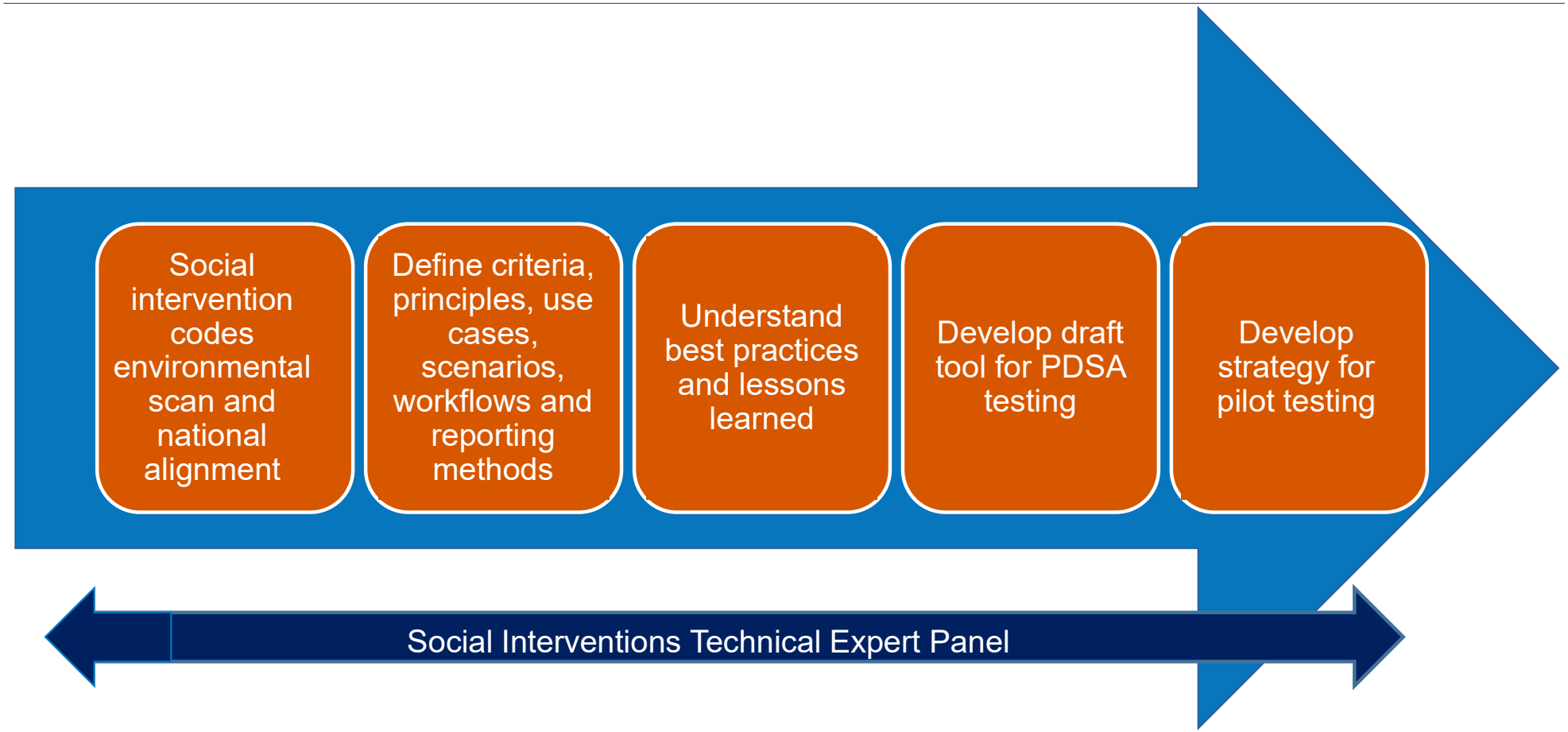
- Common language across sectors
  - Awareness of services provided to clients across sectors
  - More coordination and less duplication
  - Measurement of progress toward dismantling racism & health equity
  - Enhanced capacity to promote alignment across health centers and community social service 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**

Roadmap to Health Equity



PRAPARE
Social Interventions Protocol

Strategy


Social intervention codes environmental scan and national alignment
Define criteria, principles, use cases, scenarios, workflows and reporting methods
Understand best practices and lessons learned
Develop draft tool for PDSA testing
Develop strategy for pilot testing
Social Interventions Technical Expert Panel

Social Interventions Protocol – *Draft*

Table of Contents

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)

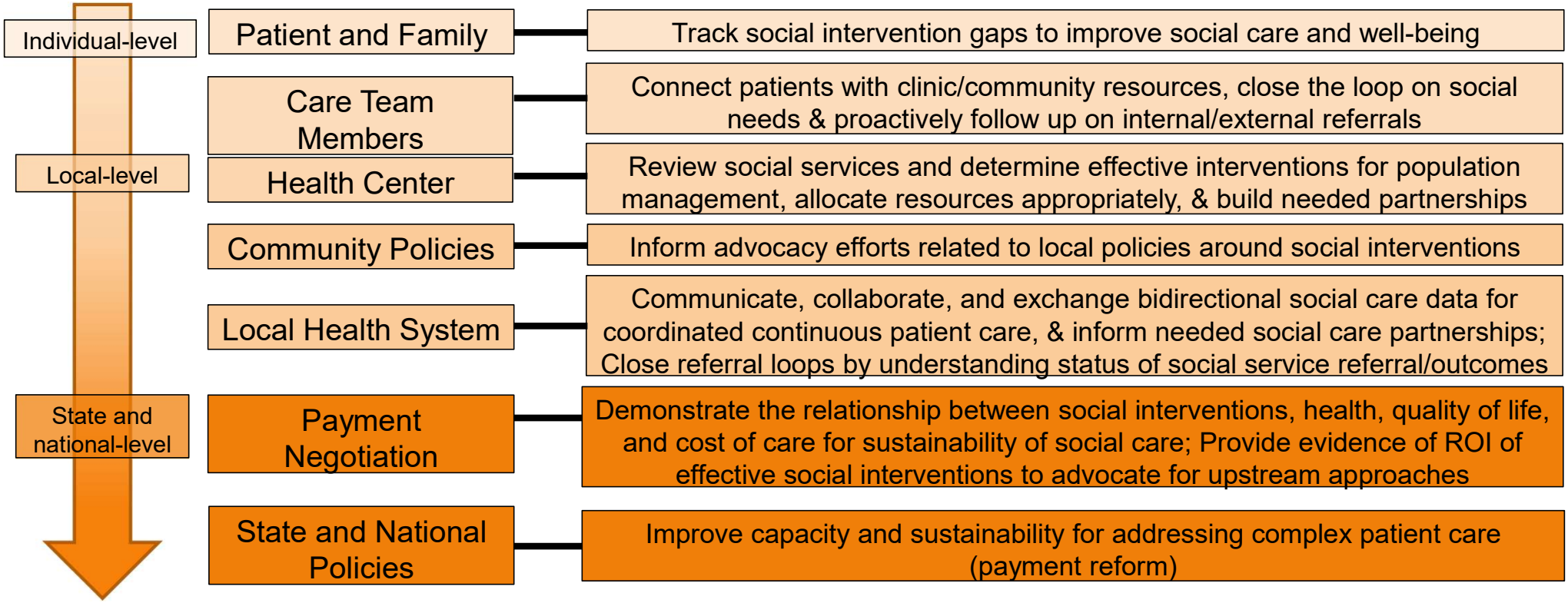
Code	Social Intervention Activity	Definition
EA001	Eligibility Assistance	Counseling of a patient and assessing the patient's eligibility of a program to address a social need.
ED001	Education	The provision of learning experiences in an encounter designed to help individuals improve their social health, 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.

Step 3: Social Interventions: Contextual Documentation

Required Fields Additional Fields

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

Standardized Social Interventions Data Use Cases Patient to Policy Level



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

PRAPARE Social Interventions PDSA Experiences

Martin Sabol
Director of Health Services
Nasson Health Care

Meaghan Arzberger
Service Integration Manager
YCCAC

PRAPARE Social Interventions PDSA - Plan

- **What did we do?**
  - PRAPARE Screening
  - Diagnosis
  - Referral- Referral Specialist to “Outreach Worker”
  - Social intervention provided
  - Consult notes and social service reports with results

- **What did we predict would happen and why?**
  - We believed that social service providers may struggle to connect with patients due to disconnected phones and lack of interest in services.

PRAPARE Social Interventions PDSA - Do

- **What happened when we tested the protocol?**
  - Generally, we have the proper systems in place, however, we immediately learned that we needed to improve communication between social and medical.

- **Who was involved?**
  - Providers, Outreach Worker, Referral Specialist, Supervisors, Integrated Services Manager
- **How long did it take to implement?**
  - We already had a workflow developed and systems of support in place prior to the PDSA. The PDSA took about a month, however, we built out a design for the referral workflow about 6 months ago.
- **What resources did we need?**
  - NextGen, Referral Specialist, Social Service tracking database (empowOR), Outreach Worker

Live Content Slide

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Poll: Do you know who your community partners are and how to connect with them?

Live Content Slide

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

Poll: Have you identified closed loop referral sources to connect patients with?

PRAPARE Social Interventions PDSA - Study

- **What observations did we make?**
  - The success rate varied significantly.

- **What were the unintended consequences, surprises, successes, failures?**
  - Just seeing our data in front of us was a success. Did our findings match our predictions?
  - Somewhat, however, there were more successful results than anticipated.

PRAPARE Social Interventions PDSA - Study

Seeing our Data:

Patient	SERVICE DATE (MM/DD/YYYY)	PRAPARE POSITIVE RESPONSE	Medical Diagnosis	SDOH Diagnosis	Diagnostic Code	SOCIAL INTERVENTION RESPONSE	SOCIAL INTERVENTION ACTIVITY CODE	Outreach Worker	Notes from empowOR
XX	5/3/2021	Food Insecurity	Y	Food and Transportation	Z59.8	*SI-FD (Food Support Services), SI-CL (Clothing Support Services), SI-MT (Medical Transportation Services)*	RF002-1 (Patient social need was met through social intervention)	Danielle Raitt	OW is already working with XX of applying for SNAP. Scheduled a new appt to apply. Family is in need of clothes. OW made referral to Kennebunk Clothing Closet and will deliver to client when in XX will need help with getting to her medical appointments come winter. Her husband is driving her now but will not In the winter. Son is 23 with MR and incapable of driving. XX is afraid to walk with the condition of her feet. They do not have Mainecare. OW will reach out to transportation department to see if they are still offering one time a month rides. OW will
XX	5/11/2021	No Transportation/Unstable Housing	Y	Housing	Z87.898	SI-FC (Financial Counseling/Eligibility Assistance)	EA001 (Eligibility Assistance)	Danielle Raitt	5/12/21 XX needs rides to medical appt. Had MC and then moved to NH for 6 months and not sure if he still has it. XX has a case worker that is already working with him on his transportation needs. XX is familiar with Logisticare and has used them in the past
XX	5/4/2021	Unstable Housing	Y	Housing		SI-HS (Housing Support Services)	RF002-1 (Patient social need was met through	Marie Hogue	Many case notes regarding foreclosure prevention work

PRAPARE Social Interventions PDSA - Act

- **How should we change our approach next time we use the protocol?**

  - We had some people referred for a particular social need but were helped with a different social need after assessment with the Outreach Worker. We need to figure out a better way to account for this.

  - We are going to provide more training to all involved and meet with providers to better understand why we have so few referrals.

Next Steps: Piloting Social Interventions Protocol

- Develop and pilot with cross-sector teams of health center networks, health centers, CBOs, payers, CIE, and other interoperability partners to refine tools and resources
- EHR templates and configuration guides that are aligned with existing SDOH templates
- Best practice implementation workflows
- Reporting templates
- Data Strategy from Patient to Policy Level
- Future work:
  - Spread and scale
  - Payment strategy in collaboration with payers

Questions & Discussion

Discussion Questions

1. What are you doing to risk adjust your patients based on their complexity?
2. How are you addressing/responding to needs for anti-racism (e.g. race/language)?
3. What is missing from the Social Interventions Protocol?
4. What other considerations/ strategies should we consider in the national standardized Social Interventions Protocol?

We appreciate your time and commitment!

If you have questions, please contact:

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