



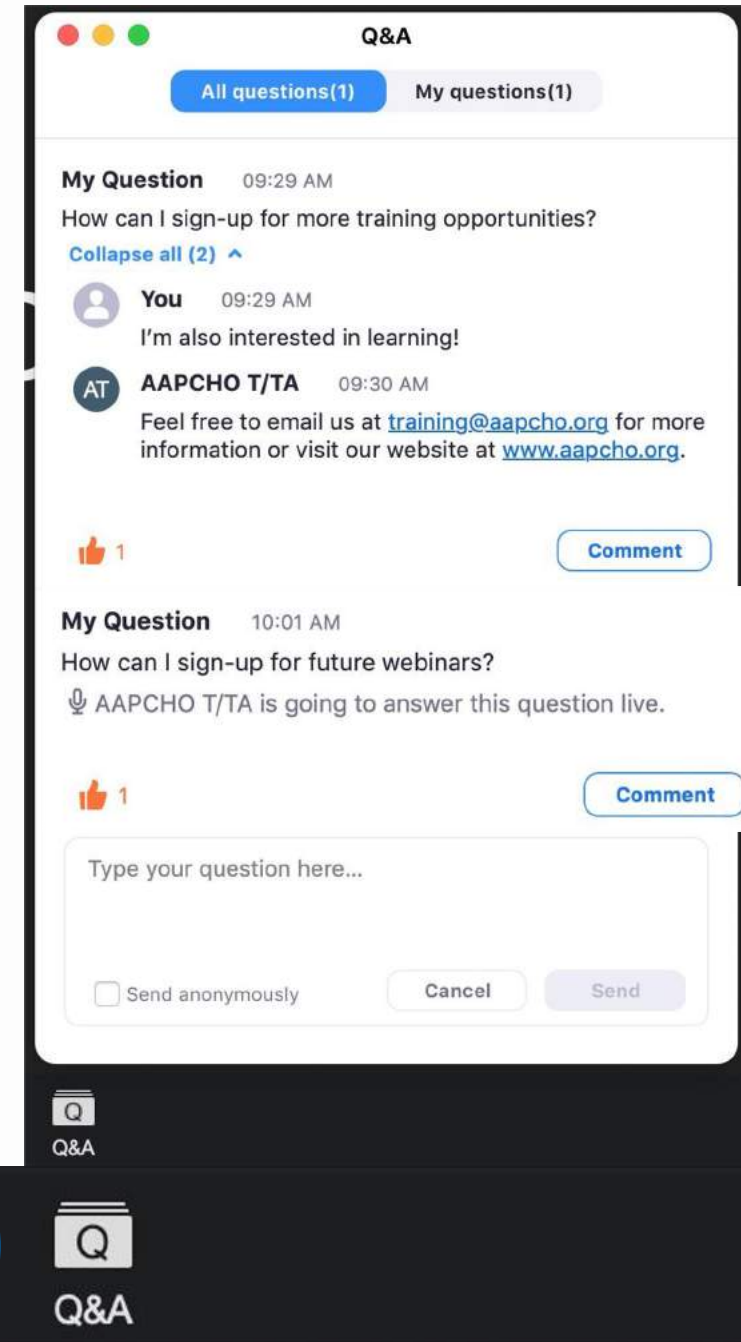
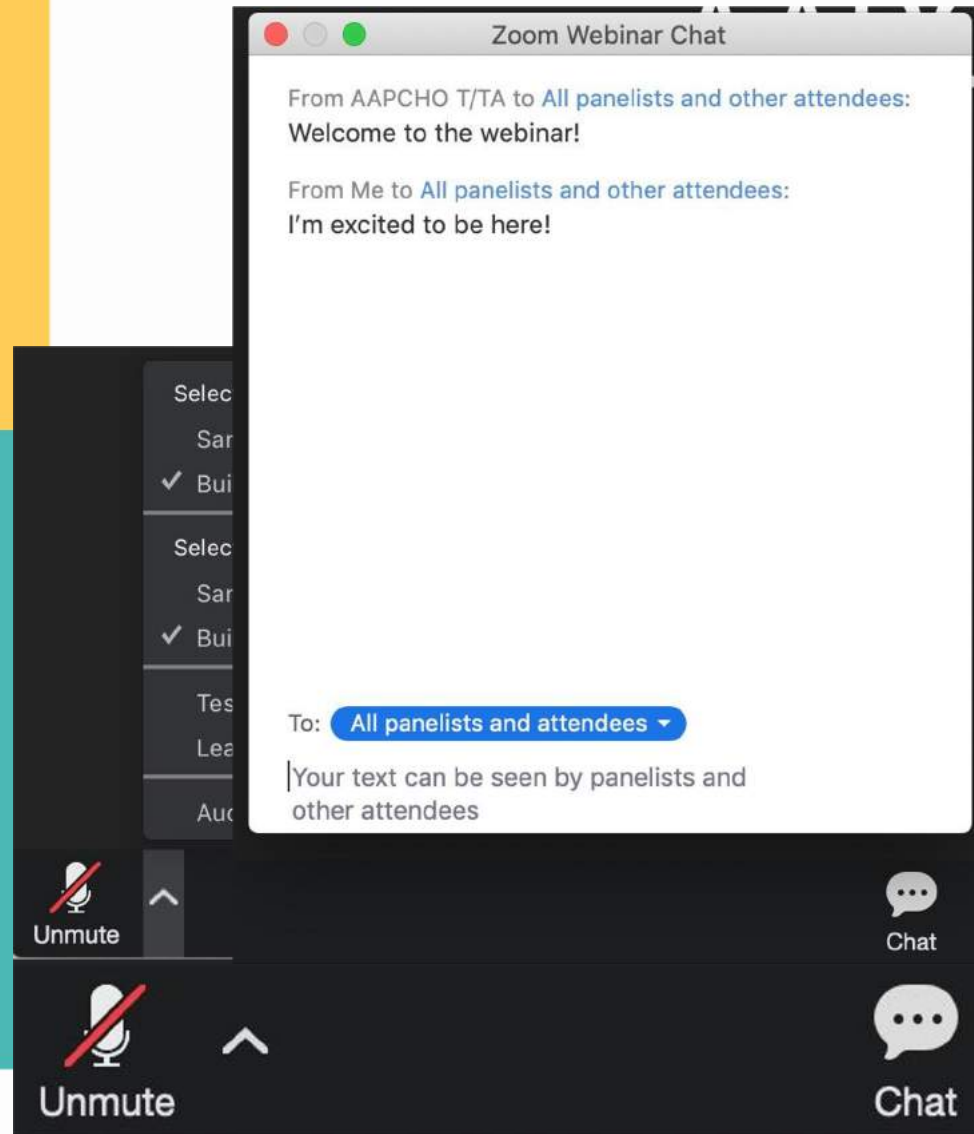
Understanding and Applying SDOH Screening Data to Address Barriers to Health

*Wednesday, July 21
9:00AM HT/ 12:00PM PT / 2:00PM CT / 3:00PM ET*

**Welcome! We will begin
the webinar in a few minutes.**



Using Zoom Webinar



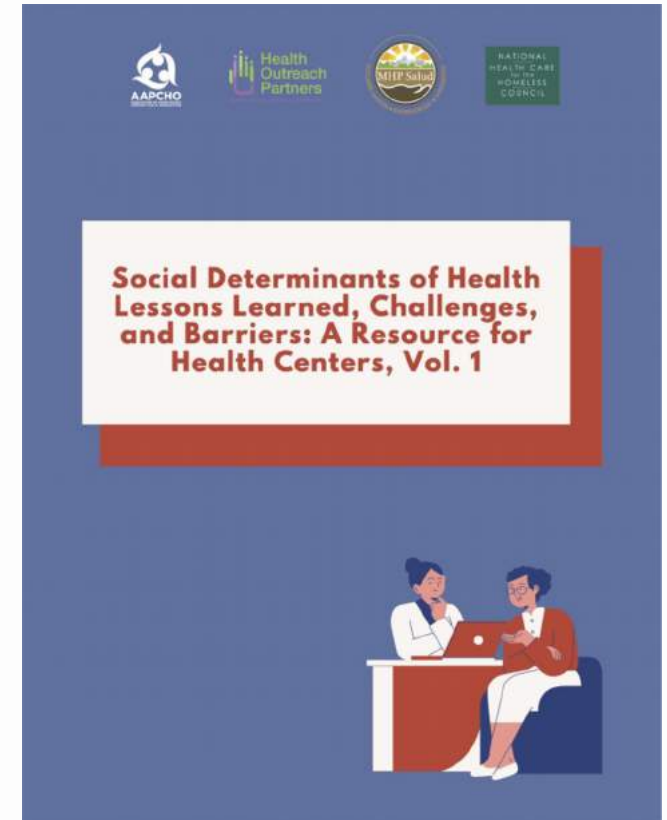
ICYMI: Last Year's Introductory Webinar + Report

Purpose:

To explore strategies to screen special and vulnerable populations for SDOH and build effective practices to begin addressing SDOH through Enabling Services. Given the COVID-19 pandemic, this training highlighted the critical importance for Enabling Services providers to collect social risk data among health center patients.

Year 1 Report:

<https://bit.ly/SDOH-Lessons-Learned-Vol1>



NTTAP Faculty & Presenters



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Learning Objectives

1. To highlight the enabling services (ES) workforce as key drivers in assessing and addressing the social determinants of health (SDOH).
2. To demonstrate the overall value and impact of ES.
3. To conceptualize the use of data to support value-based care.
4. To provide an overview of relevant data collection tools used for assessing and addressing the needs of special and vulnerable populations at health centers.



Agenda

1. Overview of ES workforce and SDOH (AAPCHO - 15 minutes)
2. Demonstrating the overall value and impact of ES (MHP - 15 minutes)
3. Conceptualizing the use of data to support value-based care (HOP - 15 minutes)
4. Overview of data collection tools for assessing and addressing the needs of special and vulnerable populations (NHCHC - 15 minutes)
5. Highlight upcoming Learning Collaborative (5 Min)
6. Questions/Discussion (20 Min)



Learning Objective #1

To highlight the enabling services (ES) workforce as key drivers in assessing and addressing the social determinants of health (SDOH).



ES Workforce and SDOH

Sakura Miyazaki

Program Manager, Training and Technical Assistance, AAPCHO



What are enabling services or ES?



- *Non-clinical services that promote, support, and assist in the delivery of health care and facilitate access to quality patient care.*

Enabling Services = Social Interventions



Other Social Needs Screening Tools

siren

[About Us](#) [SIREN Resources](#) [News & Events](#) [COVID-19 Resources](#) [Evidence & Resource Library](#)

	AAFP-Tool	Access Health: Spartanburg	AHC-Tool	Arlington	BMC-Thrive	HealthBegins	Health Leads	MLP IHELLP	Medicare Total Health Assessment	NAM domains	NC Medicaid	PRAPARE
# Social Needs Questions	15	10	19	11	11	24	10	10	9	12	11	17
# Non-Social Needs Questions	0	28	8	0	0	4	0	0	30	12	0	4
Patient or Clinic Population	NS	NS	Medicare & Medicaid	NS	NS	NS	NS	NS	Medicare	NS	Medicaid	CHCs
Reading Level*	7th grade	5th grade	8th grade	10th grade	7th grade	11th grade	6th grade	8th grade	College	6th grade	5th grade	8th grade
Reported Completion Time	NR	NR	NR	NR	NR	NR	NR	NR	10 - 20 min.	NR	NR	NR
Languages											Spanish, Arabic, Chinese, French, German, Swahili, Vietnamese	25 languages

Source: <https://sirennetwork.ucsf.edu/SocialNeedsScreeningToolComparisonTable>

Health Center & ES Workforce

Discipline	2017	2018	2019	Δ 2017 - 2019
Physicians	12,894	13,394	14,083	^ 9%
Nurse Practitioners	8,852	9,658	10,513	^ 19%
Physician Assistants	3,077	3,227	3,348	^ 9%
Certified Nurse Midwives	692	728	730	^ 5%
Nurses	17,663	18,445	19,273	^ 9%
Other Medical Service Providers	34,120	32,464	34,758	^ 2%
Dentists	4,882	5,100	5,324	^ 9%
Other Dental Service Providers (Hygienists, Therapists, Aids, Techs)	12,920	13,616	14,374	^ 11%
Psychiatrists	754	814	897	^ 19%
Psychologists	869	925	962	^ 11%
Other Mental Health Providers and Staff	9,025	10,031	11,683	^ 29%
Substance Use Disorder Providers	1,416	1,748	2,137	^ 51%
Other Professional Services	1,511	1,697	1,881	^ 24%
Vision Service Providers	770	896	1,012	^ 31%
Enabling Service Providers	21,732	22,598	24,071	^ 11%
Total Facility and Non-Clinical Support Service Providers	79,691	83,323	88,946	^ 12%
TOTAL	223,840	236,151	252,868	^ 13%

Source: HRSA Uniform Data System, 2017-2019



ES Workforce (UDS)

Case Managers

Community Health Workers

Enrollment Eligibility Assisters

Interpretation Staff

Outreach Staff

Patient/Community Education Specialists

Transportation Staff



ES Workforce

UDS Data: National - Staffing & Utilization (*Enabling Services Staff*)

Staff	2015	2016	2017	2018	2019	Δ '15-'19
Case Managers	6,761.63	7,621.93	8,495.99	9,140.72	10,103.86	+49%
Patient/Community Education Specialists	2,594.16	2,587.65	2,585	2,645.50	2,681.75	+3%
Outreach Workers	2,763.21	2,645.83	2,688.06	2,578.45	2,656.12	-4%
Transportation Staff	616.12	665.3	750.68	796.07	896.15	+41%
Eligibility Assistance Workers	4,639.81	4,535.2	4,455.06	4,421.25	4,460.65	-4%
Interpretation Staff	1,011.38	1,061.7	1,129.46	1,194.08	1,244.41	+23%
Community Health Workers	N/A	879.28	1,130.3	1,293.36	1,483.09	+68%
Other Enabling Services	473.18	500.31	497.41	528.52	571.73	+21%
Total Enabling Services	18,859	20,497.2	21,732.02	22,597.95	24,070.76	+28%



Enabling Services Data Collection

WHICH TYPE OF SERVICES WERE PROVIDED AND FOR HOW LONG?

SERVICE DATE (MM+DD+YR) _____ PATIENT DOB (MM+DD+YR) _____

PROVIDER ID _____ PATIENT GENDER _____

PATIENT ID _____ PATIENT ZIP CODE _____

ENCOUNTER TYPE (CHECK ONLY ONE) ☐ FACE TO FACE ☐ TELECOMMUNICATION ☐ OFF-SITE ☐ OTHER

APPOINTMENT TYPE (CHECK ONLY ONE) ☐ SCHEDULED ☐ WALK-IN

GROUP OR INDIVIDUAL (CHECK ONLY ONE) ☐ GROUP ☐ INDIVIDUAL

SERVICE PROVIDED IN LANGUAGE OTHER THAN ENGLISH (SPECIFY LANGUAGE) _____

ENABLING SERVICE	CODE	MINUTES												OTHER
Social Services Assessment	SS001	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management	CM001	10	20	30	40	50	60	70	80	90	100	110	120	
Referral - Health	RF001	10	20	30	40	50	60	70	80	90	100	110	120	
Referral - Social Services	RF002	10	20	30	40	50	60	70	80	90	100	110	120	
Eligibility Assistance/ Financial Counseling	FC001	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education - Individual (one-on-one)	HE001	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education - Small Group (2-12)	HE002	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education - Large Group (13 or more)	HE003	10	20	30	40	50	60	70	80	90	100	110	120	
Supportive Counseling	SC001	10	20	30	40	50	60	70	80	90	100	110	120	
Interpretation	IN001	10	20	30	40	50	60	70	80	90	100	110	120	
Outreach	OR001	10	20	30	40	50	60	70	80	90	100	110	120	
Inreach	IR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation - Health	TR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation - Social Services	TR002	10	20	30	40	50	60	70	80	90	100	110	120	
Other	OT001	10	20	30	40	50	60	70	80	90	100	110	120	

What AAPCHO advocates for

- **15** Enabling Services Categories
- **Volume** and **length of time** for all Enabling Services
- **Setting** of the services
- **Language** assistance



AAPCHO ES Categories and Codes

Old ES Categories	Up-to-Date ES Categories (2017)	Code
Case Management Assessment (CM001)	Social Services Assessment	SS001
Case Management Treatment and Facilitation (CM002)	Case Management	CM001
CM Referral (CM003)	Referral- Health	RF001
	Referral- Social Services	RF002
Financial Counseling/ Eligibility Assistance	Financial Counseling/Eligibility Assistance	FC001
Health Education/Supportive Counseling *Individual *Group	Health Education- Individual (one-on-one)	HE001
	Health Education- Small Group (2-12)	HE002
	Health Education- Large Group (13 or more)	HE003
	Supportive Counseling	SC001
Interpretation	Interpretation	IN001
Outreach	Outreach	OR001
	Inreach	IR001
Transportation	Transportation- Health	TR001
	Transportation- Social Services	TR002
Other	Other	OT001



Major SDOH Screening Tools Used by Health Centers

- **2019 Uniform Data System (UDS):**

- 70% of health centers reported collecting data on individual patients' social risk factors
- 23% in planning stages to collect individual patients' social risk factors

- **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) toolkit:** <http://www.nachc.org/research-and-data/prapare/>

- 2019 UDS: 34.4% of health centers reported using PRAPARE

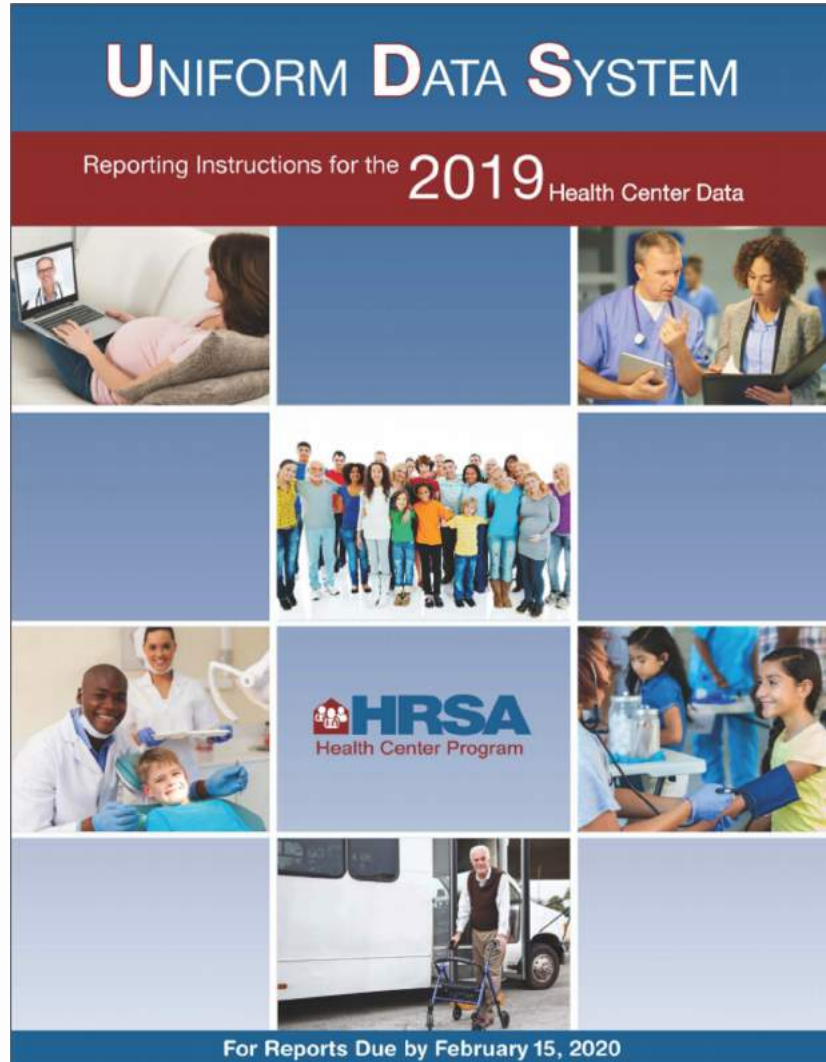
- **Centers for Medicare & Medicaid's (CMS) Accountable Health Communities (AHC) Screening tool:** <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

- 2019 UDS: 6.5% of health centers reported using AHC screening tool

Source: HRSA Uniform Data System, 2019



UDS Question

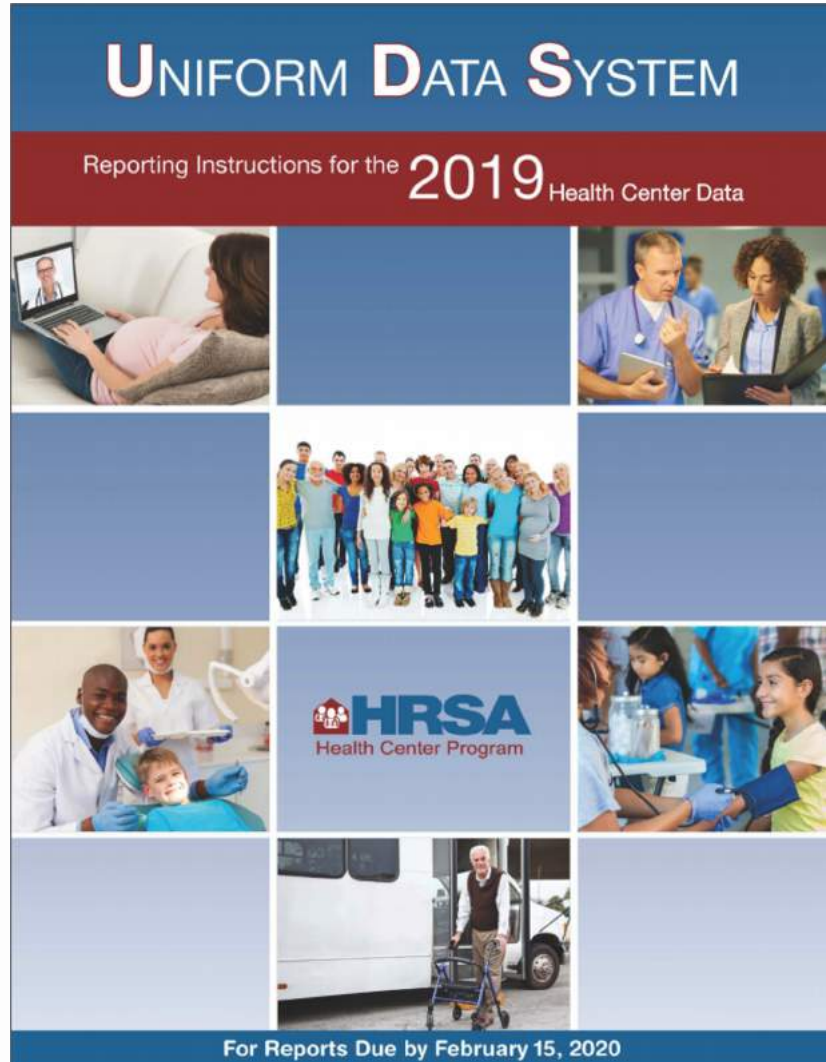


- Appendix D: Health Center Health Information Technology (HIT) Capabilities
- Questions 11 and 12
 - “Does your health center collect data on individual patients’ social risk factors...?”
 - “Which standardized screener(s) for social risk factors... do you use?”

http://www.bphcdata.net/docs/uds_rep_instr.pdf



New questions for 2020



12a. Please provide the total number of patients that screened positive for the following:

- a. Food insecurity ____
- b. Housing insecurity ____
- c. Financial strain ____
- d. Lack of transportation/access to public transportation ____

12b. If you do not use a standardized assessment to collect this information, please indicate why. (Select all that apply.)

- a. Have not considered/unfamiliar with assessments
- b. Lack of funding for addressing these unmet social needs of patients
- c. Lack of training for staff to discuss these issues with patients
- d. Inability to include with patient intake and clinical workflow
- e. Not needed
- f. Other (please describe _____)

http://www.bphcdata.net/docs/uds_rep_instr.pdf



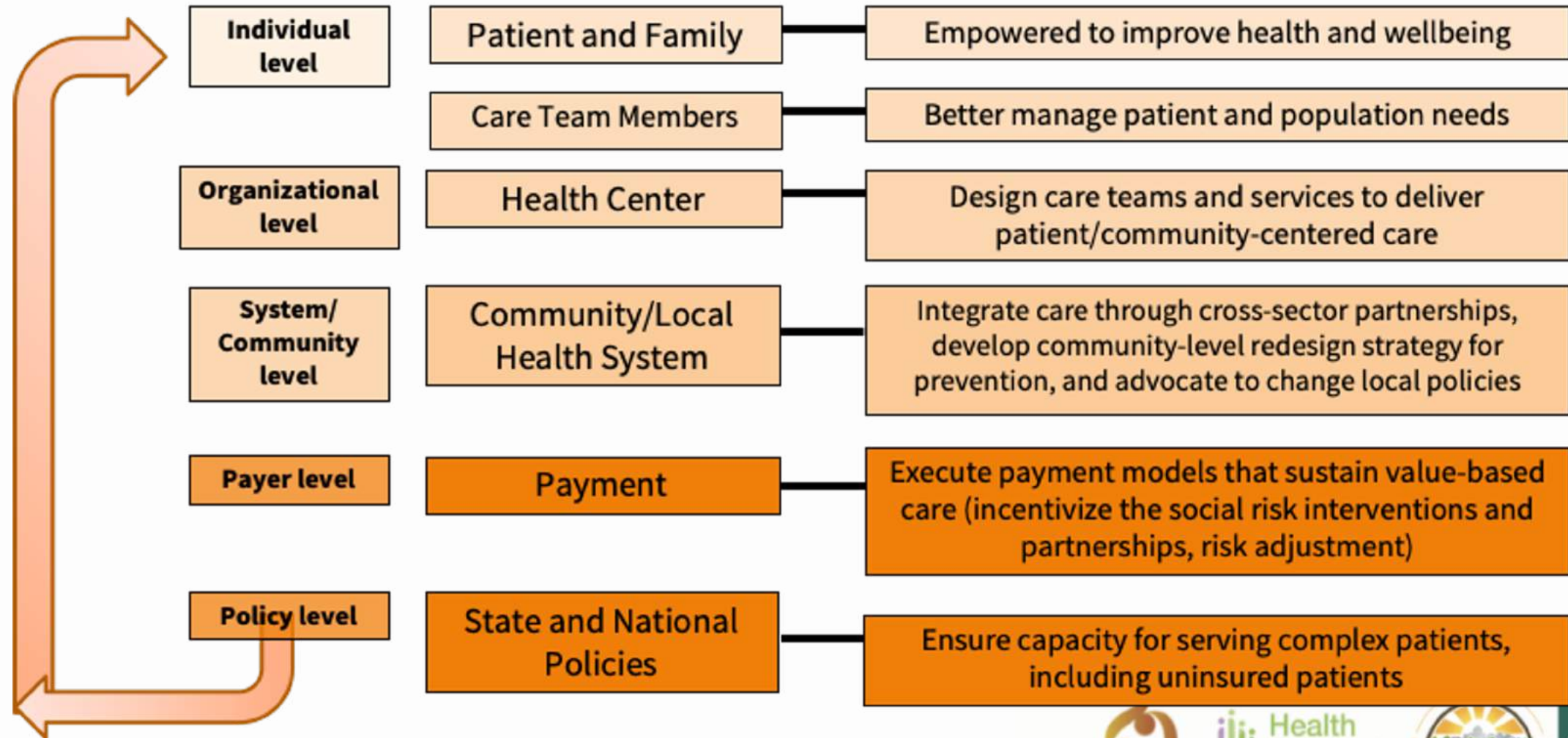
💡 Poll Question 💡

- **Which standardized screener(s) for social risk factors, if any, do you use? (Select all that apply)**
 - a. Accountable Health Communities Screening Tools
 - b. Upstream Risks Screening Tool and Guide
 - c. iHELP
 - d. Recommend Social and Behavioral Domains for EHRs
 - e. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
 - f. Well Child Care, Evaluation, Community Resources, Advocacy Referral, Education (WE CARE)
 - g. WellRx
 - h. Other (**please describe in chat box**)
 - i. We do not use a standardized screener

Source: HRSA Uniform Data System, 2019



Why collect standardized SDOH data?



Population of Focus May Affect Your Workflow

- What will the population of focus be? How does that affect the workflow model?
 - All patients: multiple types of staffing possibilities
 - Patients with multiple co-morbidities: chronic care disease management team
 - Patients with behavioral health conditions: behavioral health integration specialists
- What other activities could PRAPARE leverage or add value to? Does this affect or inform the workflow model?
 - Other health assessments (e.g., HRA, SBIRT, PAM, ACE, PH-Q, etc.)
 - Other initiatives or priorities? (e.g., addressing opioid epidemic)
- How does PRAPARE align with existing staff and workflows? Are there staff with similar responsibilities where PRAPARE could add value?
 - Don't necessarily need new staff
 - Cross-train staff



What workflow to use for SDOH screening?



Sample Workflow Models

Who	Where	When	How	Rationale
Non-clinical staff (patient navigator, community health workers)	In waiting room or in staff office	Before or after provider visit	Administered PRAPARE with patients who would be waiting 30+ mins for provider	Provided enough time to discuss SDH needs. Wanted same person to ask question and address need. Often administer PRAPARE with other data collection effort (Patient Activation Measure) to assess patient's ability and motivation to respond to their situation.
Nursing staff and/or MAs	In exam room	Before provider enters exam room	Administered it after vitals and reason for visit. Provider reviews PRAPARE data and refers to case manager	Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info
Care Coordinators	In office of care coordinator	When Completing chart reviews and administering Health Risk Assessments	Administered PRAPARE in conjunction with Health Risk Assessments	Allows care coordinators to address similar issues in real time that may arise from both PRAPARE and HRA
Any staff (from Front Desk Staff to Providers)	No wrong door approach	No wrong door approach		Allows everyone to be part of larger process of "painting a fuller picture of the patient" and taking part in helping the patient
Patient Self- Assessment	At home, in waiting room, etc.	Before visit with provider	Self-administered using email, mobile, tablets, kiosks, etc.	Low burden on staff to collect data. Privacy for patient to complete assessment. Utilize time when patient would otherwise be waiting. Staff time can be used to discuss results with patients to address needs.

Example: Using ES Staff for Screening Post-Visit

- Reasons to Use This Model:

- Non-clinical staff often employed from the community so can more easily relate to patients, understand their needs, and build trusting relationships
- Non-clinical staff also often more aware of available community resources
- Ensures staff person administering PRAPARE also addresses needs

- Advantages:

- Doesn't delay visit with provider
- Provides immediate warm hand-off to services and resources

- Tradeoffs:

- Provider doesn't have data available at point of clinic visit to inform care
- Could lengthen overall visit time

Recorded webinar walking through advantages and tradeoffs of each workflow model available at www.nachc.org/prapare

www.nachc.org/prapare



SDOH Screening in Action: Siouxland CHC's Interventions To Address Food Insecurity for Diabetic Patients (Iowa)

Health center helps Siouxlanders meet basic needs to improve medical outcomes

Sioux City Journal

DOLLY A. BUTZ dbutz@siouxcityjournal.com Jun 23, 2017 (1)



Acknowledgement: Dave Faldmo, PA-C, MPAS @ Siouxland Community Health Cent

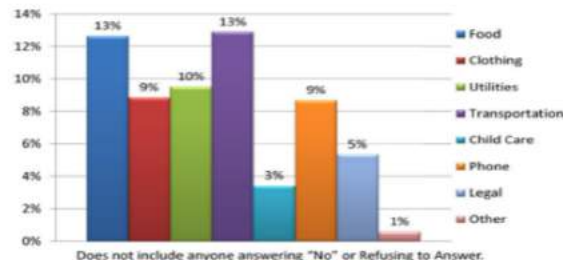
When patients arrive at SCHC or Siouxland Community Health of Nebraska, SCHC's satellite clinic in South Sioux City, they receive a paper PRAPARE, Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences, questionnaire to help identify any needs they might have. In the last 12 months, 6,317 patients have been screened.

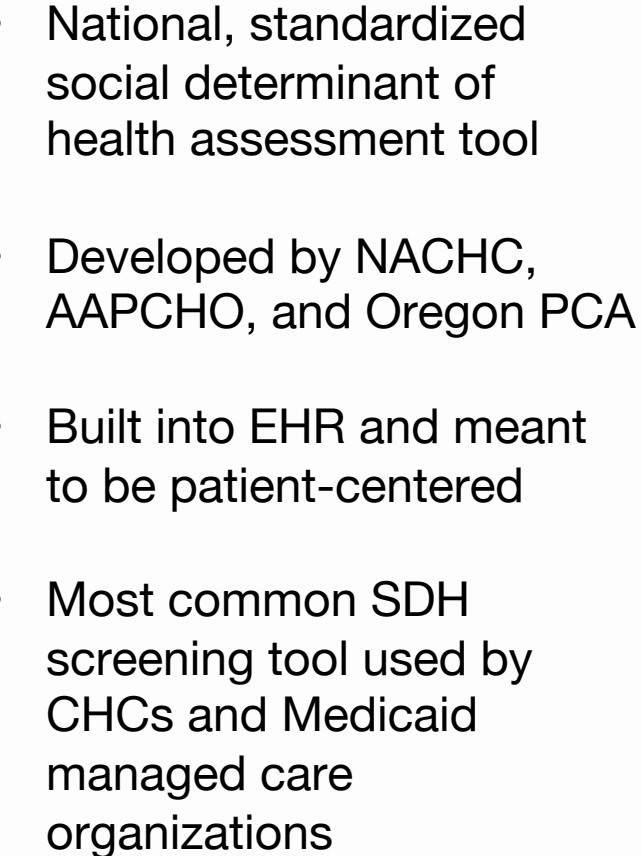
Thirteen percent of those patients said they or the family members they live with had been unable to get food and transportation when they really needed it in the past year, while 10 percent said they couldn't pay for utilities.

PRAPARE project graphics

2 of 5

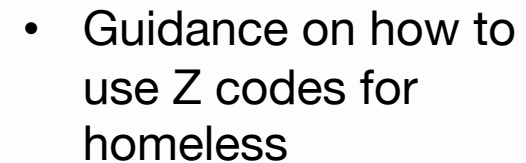
In the past year, have you or any of your family members you live with been unable to get any of the following when it was really needed?





- Standardized codification system to document enabling services provided
- ESDC Toolkit developed by AAPCHO
- ESAP Training provided by AAPCHO x HOP x NHCHC

- Screening guide for legal needs
- Developed by MLP



- Written by NHCHC



Learning Objective #2

To demonstrate the overall value and impact of enabling services.



Demonstrating the Impact and Value of Enabling Services

Hansel O. Ibarra, MPA

Program Director, MHP Salud



Impact of Enabling Services

Health Outcomes



Service
Delivery



Quality of
Care



And a fourth one.....



Return on Investment



A return-on-investment (ROI) calculation is the **total value of the benefit/profit** resulting from a **program/intervention** divided by the **total program cost**.

$$\text{ROI} = \frac{\text{Total Value of Benefits}}{\text{Program Costs}}$$

ROI < \$1 = Negative ROI.

ROI = \$1 = Breakeven. *Note, this can still be good!

ROI > \$1 = Positive ROI.

ROI Benefits

Estimates direct financial impact- Forecast

Versatile and simple

Relatively easy to understand

Offers a basic gauge of an investment's profitability

Types of ROI

Community
Level



Institutional
Level



Individual
Level



Community Level



How much benefit (or return) is the entire community receiving as a result of investment by the community?

Example: Preventing hospitalizations because patients/community members are following their care plans due to ES outreach, case management and follow-up.



Institutional Level

What return did the host clinic or network receive based on their inputs?

Example: Increase of patient attendance to doctor's appointments due to ES staff reminders and follow-up.

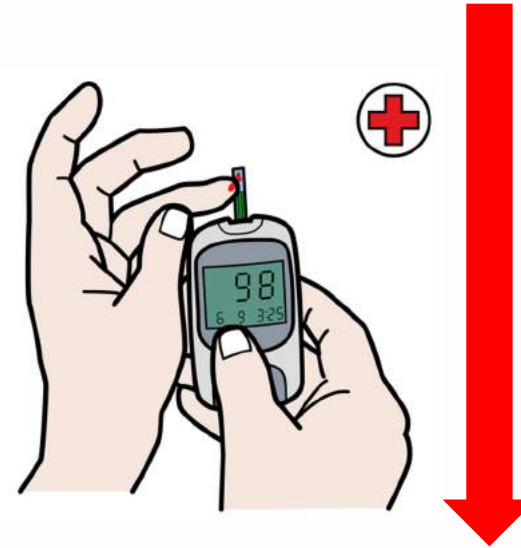


Individual Level



What savings did the individual receive based on inputs to their program?

Example: Decreased out of pocket costs for diabetes care due to ES staff education, follow-up, and case management.



Example:

Reduce Costs of Care per Patient

Denver Health: Return on Investment (ROI) of \$2.28 in savings for each dollar spent due to decrease in urgent care and uncompensated costs. Annual savings were \$95,941.

Arkansas Community Connector Program: Tracked Medicaid spending of 900 patients and saw a 3 years savings of over 2.6 million, or \$2.92 savings for each dollar spent.

Spectrum Health (Grand Rapids, MI): \$2.53 savings for every \$1 of cost for patients diagnosed with diabetes or heart failure.

Sources:

Whitley, E., Everhart, R & Wright, R. (2006). Measuring return on investment of outreach by community health workers. *Journal of Health Care for the Poor and Underserved*, 17, 6-15. <http://communityvoices.org/assets/wp-content/uploads/2014/02/ROI-of-Community-Health-Workers.pdf>

Felix, H., Mays, G., Stewart, M., Cottoms, M. & Olson, M. (2011). Medicaid savings resulted when community health workers matched those with needs to home and community care. *Health Affairs*, 30(7), 1366-1374.

Michigan Community Health Worker Alliance. (2015). Community health workers & Michigan: Outcomes. http://www.michwa.org/wp-content/uploads/MichiganCHWOutcomesTable_MiCHWA_2015.pdf



💡 Poll Question 💡

- Have you or has your organization used Return on Investment (ROI) to demonstrate the value of Enabling Services Staff?

Yes

No

Not sure



ROI EDUCATIONAL TOOL



A Guide For Conducting A Return On Investment Analysis of Your Community Health Worker Program

- Building your ROI team
- Finding your numbers
- Getting to know your financial information
- Calculations of ROI
- Health Center Examples

<https://mhpsalud.org/portfolio/roi-toolkit/>



Starting a Community Health Worker Program?

Topics

- Organizational Conceptual Fitness
- CHW Program Readiness Checklist
- A Guide to Hiring Qualified Supervisors for CHW Programs
- Finding Qualified Candidates: How to Hire Community Health Workers
- CHW Pre-Hiring Checklist

<https://mhpsalud.org/starting-a-chw-program/>



Sharing ES Value



“Periodically sharing the success of ES staff with CHC leadership and the entire care team gives value and credibility to ES staff and supports the sustainability of these positions.”

“Having supportive leadership members and/or medical providers is essential to strengthen the ES profession. Further, receiving support from these professionals fosters respect and increases the trustworthiness and credibility of ES staff.”

Learning Objective #3

To conceptualize the use of data to support value-based care.



Leveraging Outreach & Enabling Services to Provide Quality Care

Value-Based Care

Beleny Reese, MPH

Project Manager, Health Outreach Partners

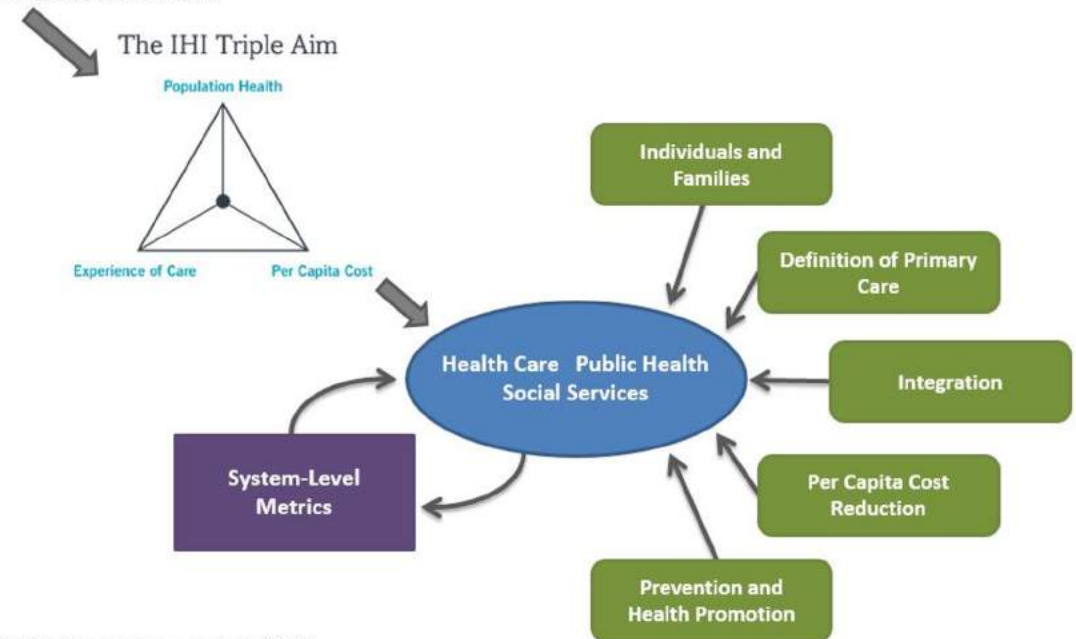


The Triple Aim

1. Improve the patient experience of care
1. Improve the health of populations
1. Reduce the per capita cost of healthcare

Design of a Triple Aim Enterprise

Define "Quality" from the perspective of an individual member of a defined population



Institute for Healthcare Improvement, 2012

Alternative Payment Methodology

Fee for Service

Payor reimburses the provider for each billable service rendered

- Often tied to face-to-face visits
- Prioritizes volume (quantity) of visits over quality

Alternative service delivery/payment models

PCMH, A/MCO; Capitation, Pay for Performance (P4P), Shared Savings, Bundled

- Provide flexibility to provide additional services and be reimbursed
- *Incentivizes* quality over quantity



💡 Poll Question 💡

What types of value-based care, models and/or payment are you providing or engaging with at your health center? (please check all that apply)

- a. We collect SDOH data on our patients
- b. We engage in population health activities
- c. Patient-Centered Medical Home (PCMH)
- d. Accountable Care Organization (ACO)
- e. Medicaid Managed Care Organization(s)
- f. Medicare Managed Care Organization(s)
- g. Shared savings programs
- h. Other?



What is Value-Based Care?

- Value-based programs reward health care providers with incentive payments for the **quality** of care they give, using **data** and **metrics** to *measure quality improvements and performance*.
- They aim to **improve individual and population health outcomes** while **reducing costs** in the long term

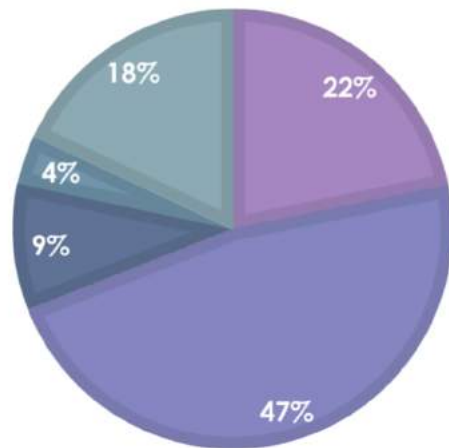


The Importance of VBC to FQHCs

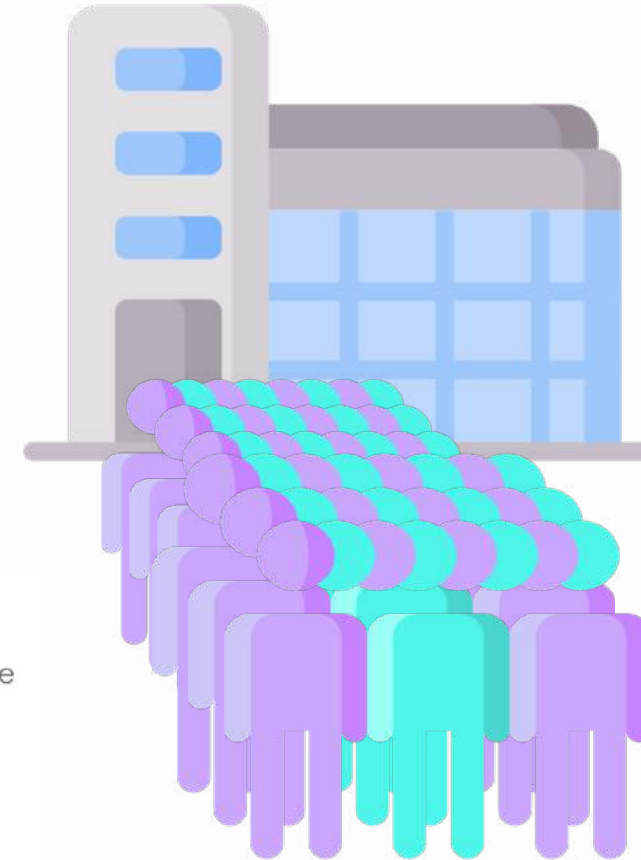
1. High utilization rates
2. Diverse patient population
3. Federal and state policy

HEALTH CENTER PAYOR MIX: 2018

■ Uninsured ■ Medicaid/CHIP ■ Medicare ■ Dually Insured (Medicaid and Medicare) ■ Private



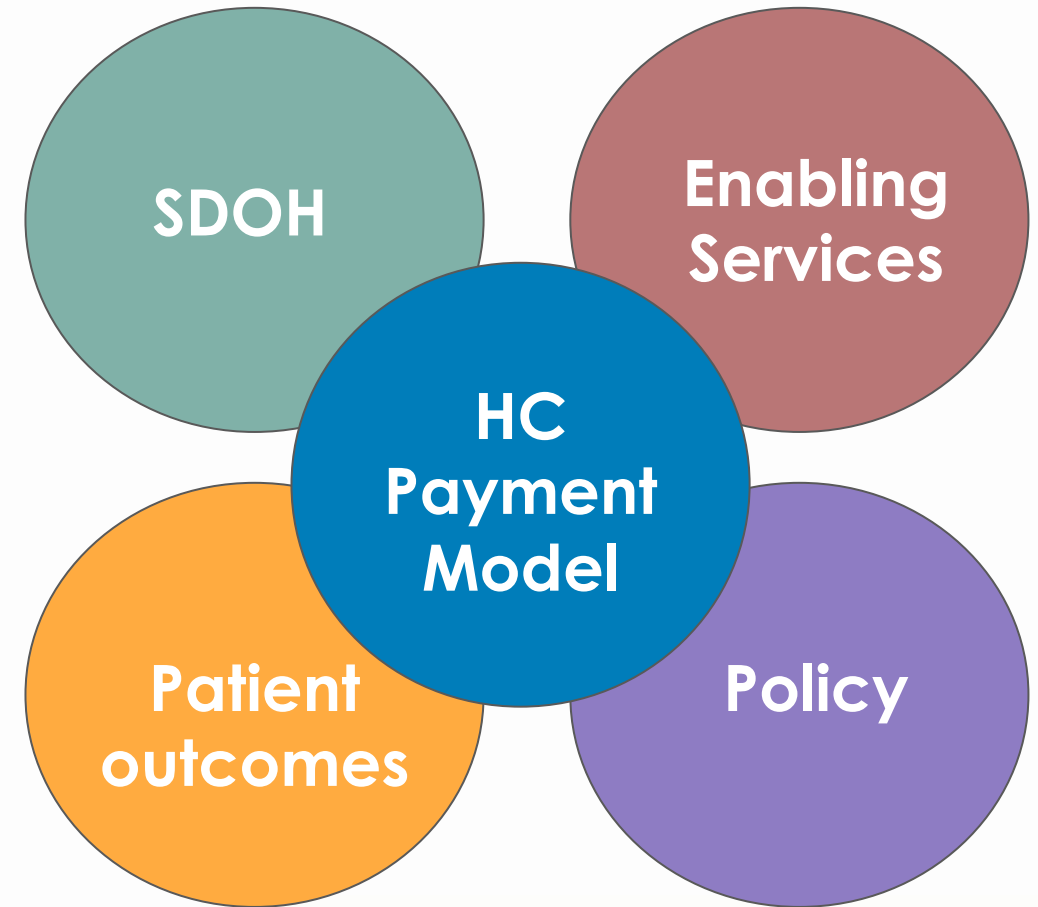
[HOP VBC Primer](#)



Aligning Payment and Care Models

Does the health center payment model:

- ❑ Take into account SDOH?
- ❑ Enable the health center to be reimbursed for the various services provided to address SDOH?
- ❑ Reward patient outcomes and value of care?
- ❑ Leverage the state's Medicaid policy for optimum reimbursement?



VBC, SDOH & Data Collection

- ICD-10 Z Codes to document SDOH, Enabling Services

ICD-10 Z Code ¹⁵	SDOH Documentation
Z59.0,	Homelessness
Z59.1	Inadequate housing
Z59.5	Extreme poverty
Z75.1	Person awaiting admission to adequate facility elsewhere
Z75.3	Unavailability and inaccessibility of health-care facilities
Z76.2	Encounter for health supervision and care of other healthy child
Z99.12	Encounter for respirator dependence during power failure

VBC, SDOH & Data Collection

System Manager
EASTSIDE MEDICAL (1)

Compile UDS Reports

Date to Begin: 01-01-2018
Date to End: 12-31-2018

Doctor:
Location:
Patient Class:
Billing Group:

Grant Type: ☒ All ☐ Migrant/Seasonal ☐ Homeless ☐ Public Housing ☐ School-Based

Table	User	Status	Parameters
☐ 3A - Patients by Age and Sex Assigned at Birth	DORA (DMR)	Ready	Dates: 01-01-2017 thru 12-31-2017
☐ 3B - Demographic Characteristics	DORA (DMR)	Ready	Dates: 01-01-2017 thru 12-31-2017
☐ 4 - Selected Patient Characteristics	HOPEFUL SMITH (HOPE)	Ready	Dates: 01-01-2017 thru 11-24-2017
☐ 5 - Staffing and Utilization	MELANIE BROOKS (MEL)	Ready	Dates: 01-01-2018 thru 12-31-2018
☐ 6A - Selected Diagnoses and Services Rendered	MELANIE BROOKS (MEL)	Ready	Dates: 01-01-2019 thru 03-06-2019
☐ 6B - Quality of Care Measures	CompuGroup Medical US (MARS)	Ready	Dates: 01-01-2017 thru 11-28-2017
☐ 7 - Health Outcomes and Disparities	HOPEFUL SMITH (HOPE)	Ready	Dates: 01-01-2017 thru 11-26-2017
☐ 9D - Patient Related Revenue	DORA (DMR)	Ready	Dates: 01-01-2106 thru 12-01-2016
☐ A - Audit Report	DORA (DMR)	Ready	Dates: 01-01-2016 thru 12-01-2016
☐ Zip - Patients by Zip Code Report	HOPEFUL SMITH (HOPE)	Ready	Dates: 01-01-2017 thru 11-24-2017

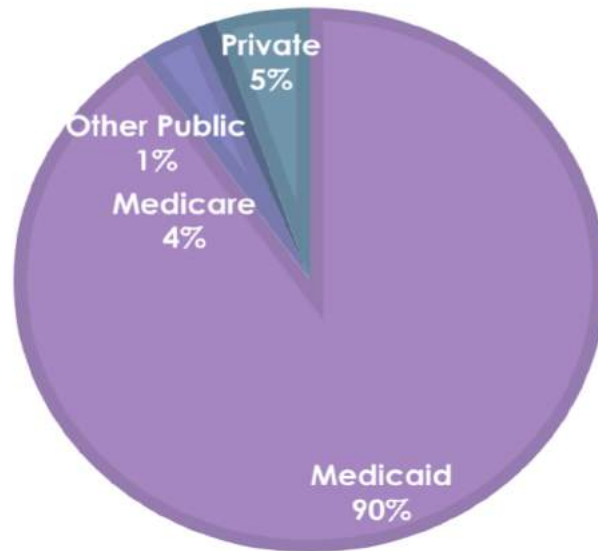
- UDS to identify trends in payment, opportunities
- Health center SDOH and ES data collection



VBC, SDOH & Data Collection

PERCENTAGE OF MCO MEMBER MONTHS BY MCO TYPE IN 2018 FOR ALL HEALTH CENTERS

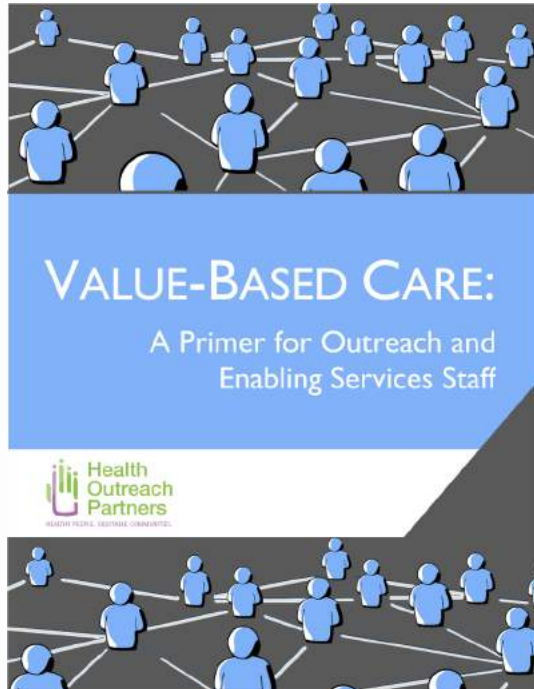
■ Medicaid ■ Medicare ■ Other Public ■ Private



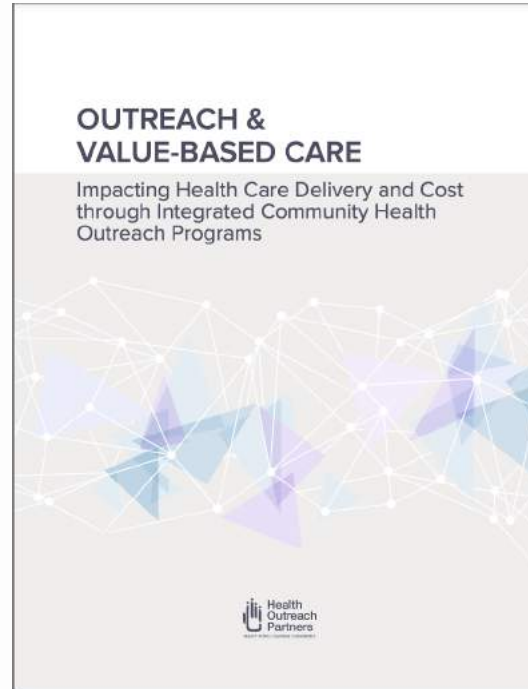
[HOP VBC Primer](#)

- ACO/CCO/MCO data sharing to help understand trends in total cost of care

Value-Based Care Resources



Explore the impact of various payment and delivery models on FQHCs



Examples of integration of outreach services into various APMs

OBV Toolkit

Make the business case for investing in and sustaining strong outreach programs



Learning Objective #4

To provide an overview of relevant data collection tools used for assessing and addressing the needs of special and vulnerable populations at health centers.



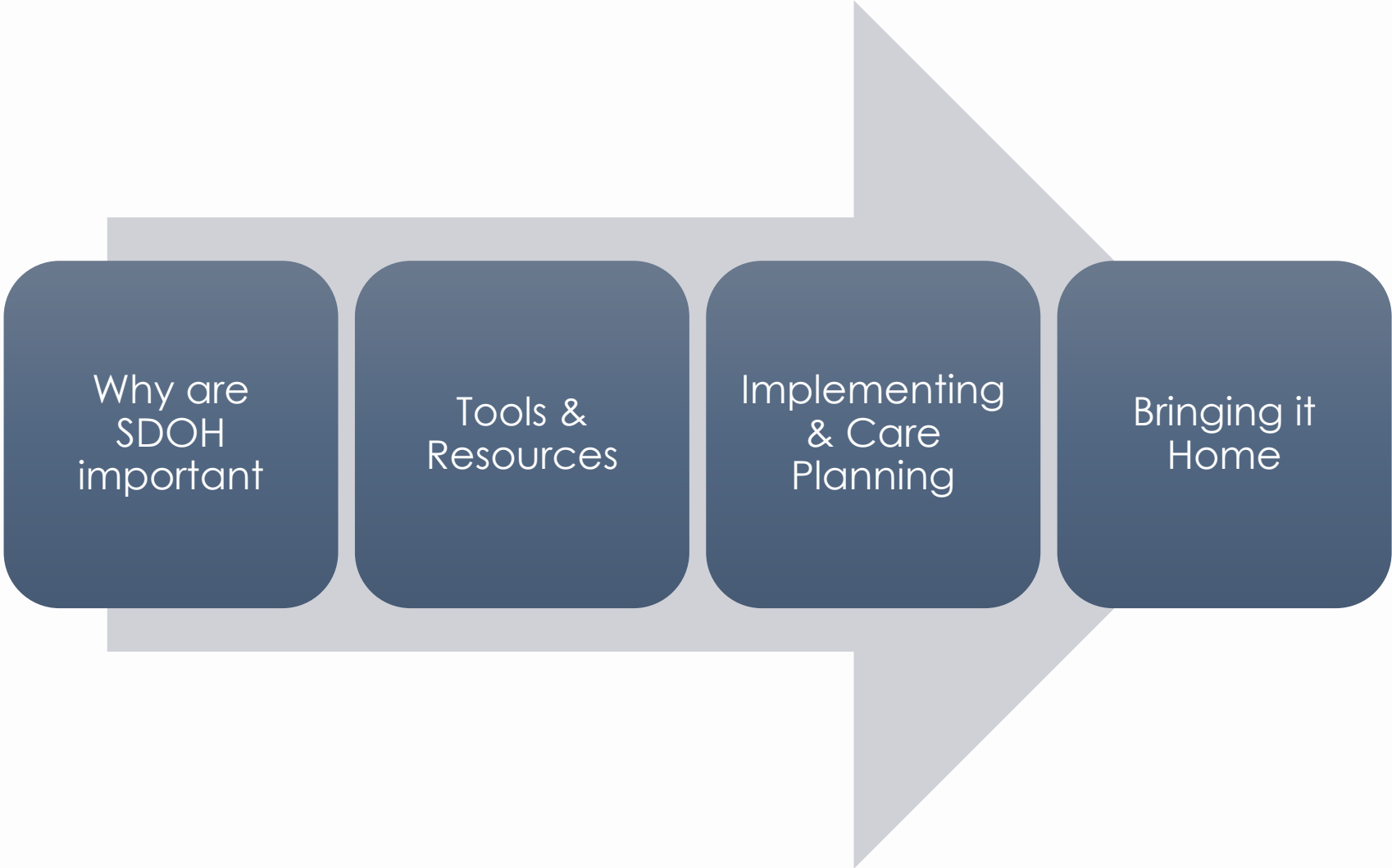
Frameworks & Implementation for Special Populations

Tools and Resources

Brett Poe

Research Associate, NHCHC





Why are
SDOH
important

Tools &
Resources

Implementing
& Care
Planning

Bringing it
Home



Social Determinants of Health Equity for People who are Homeless



Why do SDOH Matter to Health Centers?

Level of Security

Food

Housing

Employment

Why treat people and send them back to the conditions that made them sick in the first place?

Health Outcomes

hypertension,
hyperlipidemia, poor
physical & mental health

Asthma, lead poisoning,
other respiratory
conditions

Overall poor health,
heart disease, stroke

Presentation: Advancing the interoperability of social and behavioral determinants of health. Daniel Vreeman Indiana University



	EveryOne Project	Protocol for Responding to & Assessing Patient Assets, Risks, and experiences (PRAPARE)	National Committee on Vital and Health Statistics (NCVHS)	Accountable Health Communities (AHC) Health Related Social Needs (HRSN) (CMS)
Economic Stability	x	x	x	x
Education	x	x	x	x
Food	x	x	x	x
Neighborhood, Physical Environment, Community and Social Context		x	x	x
Health Care System		x	x	
Personal Health			x	x
Housing	x	x	x	x
Transportation	x	x	x	x
Utilities	x			x
Child Care	x			
Employment	x	x	x	x
Personal Safety	x	x (optional)	x	x
Language		x	x	
Public Safety		x (optional)	x	
Behavioral Health		x (stress)		x
Refugee status		x (optional)		
Incarceration History		x (optional)		



Tools & Resources

Using the Right Staff

Community
Health Workers

Nurse vs. MA vs.
Doctor?

Power Balance



Ask and Code

Asking about SDOH

Asking different questions
“Where did you sleep last night?” vs. “Are you homeless?”

Staff Training

Implement Formal Procedures

Use “Z” Codes

Sample Questionnaires

Source: <https://nhchc.org/wp-content/uploads/2019/08/ask-code-policy-brief-final.pdf>



How to Ask and Code

Common questions:

- How to ask the question? What counts as “homeless”?
- How to make time amid many screenings and questions?
- Where to insert the answer in the EHR?
- What to say to the patient/client in response?
- What if the patient doesn’t want to say due to stigma?
- Will coding for housing status benefit—or complicate—billing?

Strategies:

- Add housing status fields to the EHR (not open text!)
- Assess utility of homeless data
- Implement formal procedures for asking & coding
- Train staff



How to Ask and Code

ICD-10-CM Z Series:

Factors influencing health status & contact with health services

Z55-Z65 Series: *Persons with potential health hazards related to socioeconomic & psychosocial circumstances*

Z59 Series: *Problems related to housing & economic circumstances*

Z59.0 = Homeless



Tools & Resources

Trauma-Informed Care

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment

Motivational Interviewing

- Express empathy
- Develop discrepancy
- Roll with resistance
- Support autonomy & self-efficacy

Source: <https://nhchc.org/wp-content/uploads/2019/08/DecHealingHandsWeb.pdf>



Tools & Resources

[Using SDOH Screening in Preventive Care](#)

[Trauma and MI and Substance Use](#)

[Trauma-Informed Treatment Models](#)



Tools & Resources

- Trauma-Informed Organizational Toolkit

- Understanding Trauma
- Managing Organizational Change
- Creating Capacity and Structure
- Organizational assessment



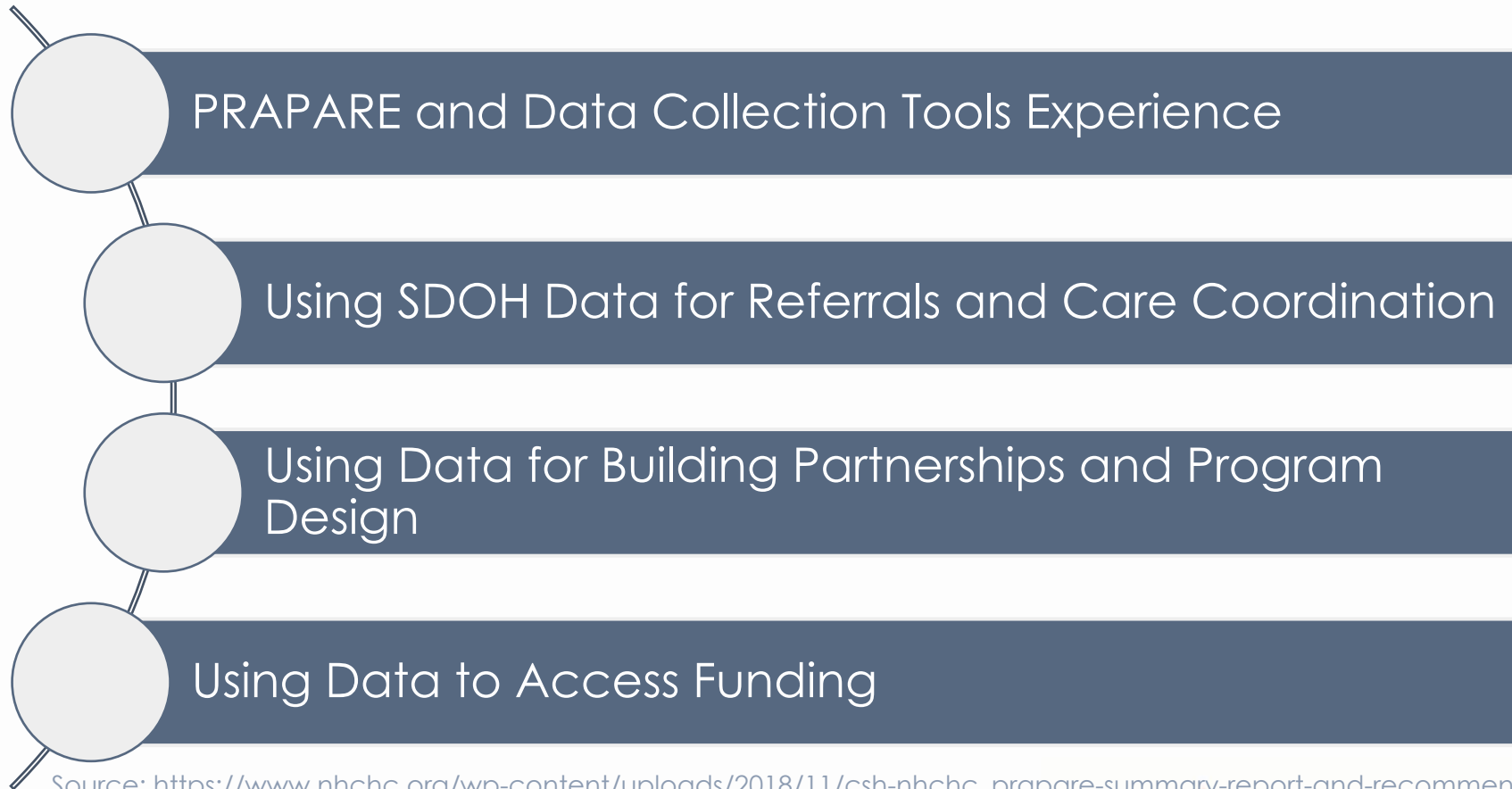
💡 Poll Question 💡

What do you do if you can't address someone's needs? (Select all that apply)

- a. Refer to existing partners
- b. Provide community information of available resources in the area
- c. Get contact information to follow-up with potential future resources
- d. Document requested needs that aren't currently addressed
- e. Don't ask the question/s if capacity or partners aren't in place
- f. Other *(Please type your response into chat box)*



Implementing & Care Planning



Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf



PRAPARE & Data Collection Tools Experience

“Health providers are trained to find cures. We get frustrated when we know about SDOH and can’t make a referral that solves the problem.”

Challenge	Success
Staff not comfortable or lack training asking about housing status and other ‘sensitive questions.’	Collecting SDOH data requires training on details of the data collection tool, and ensuring staff have a general comfort with asking personal, non-medical questions.
Data collection can be challenging or burdensome.	Interviewers find it helpful for tools to be conversational and distinct from the medical history or other health forms.
Various data collection tools are being used.	More health centers are implementing SDOH data collection, and PRAPARE specifically. PCAs/HCCNs are working with national organizations to deliver training and developing tools to encourage and support SDOH data collection and data validation.
How data is being stored varies by health center.	Ideally the data is being collected in the EHR to be used by providers and other staff members. However, it was reported that aligning the systems takes significant effort.

Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf



Using Data for Referrals & Care Coordination

“Some parents are not wanting to disclose information on social determinants for fear of children being removed from the family by the authorities”

Challenge	Success
Knowing where to make referrals, and how to follow-up.	Generally, a health center’s care coordinator, navigator or other ‘enabling services staff’ creates a resource guide to be adapted by health center staff for the community.
Understanding how SDOH can impact care plans.	Data may inform a person-centered approach to include health, and quality of life.

Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf



Building Partnerships & Program Design

“Many of our health centers are just getting to this point. We’re encouraging health centers to build partnerships and identify programs that are needed and leverage existing resources.”

Challenge	Success
Many health centers do not have the capacity to provide needed services and there are limited resources in the community.	Health centers have been able to identify potential partnerships based on high prevalence of a certain population with housing instability.

Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf



Using Data to Access Funding

“Staff response to concerns (financial and organizational capacity) about delving into non-medical areas is that ‘We are doing it already. We might as well gather the data and develop the tools to address the issues.’”

Challenge	Success
Many health centers do not yet have robust SDOH data or a team dedicated to using the data for funding and impacting policy.	Health centers and partners have used preliminary data to explore small funding opportunities.

Source: https://www.nhchc.org/wp-content/uploads/2018/11/csh-nhchc_prapare-summary-report-and-recommendations1.pdf



Visualizing Data

- How can we utilize the data we have?
- What is our purpose?



Background



Introduction

As data regarding how health centers are impacted by COVID-19 is collected and by HRSA, the National HCH Council has been extracting and processing this data. How health centers serving patients experiencing housing instability, homelessness, poverty are particularly impacted by, and responding to, the pandemic.

- Weekly reporting by Health Centers
- Capacity
- Testing & Positivity
- Vaccination Initiation & Completion
- Race & Ethnicity

<https://nhchc.org/covid-dashboard/>



CDC Dashboard

Dashboard Summary

updated 02/10/21



393

Total Testing Events Submitted



13,537

Total Clients Tested



7.35%

Client COVID-19 Positivity Rate



3,306

Total Staff Tested



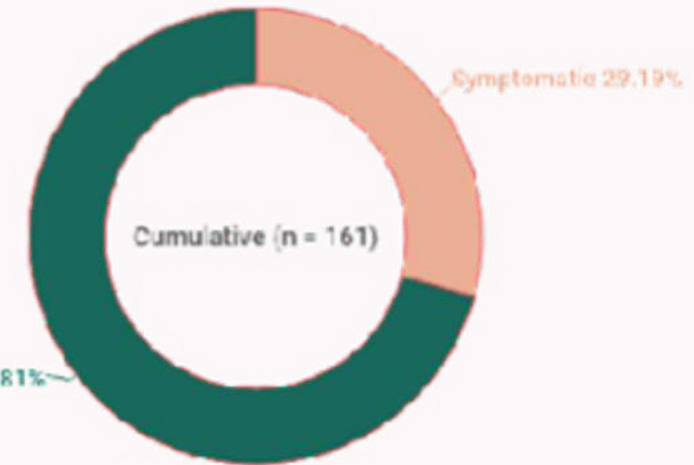
3.42%

Staff COVID-19 Positivity Rate

Presence of Symptoms in COVID-19 Positive Clients*

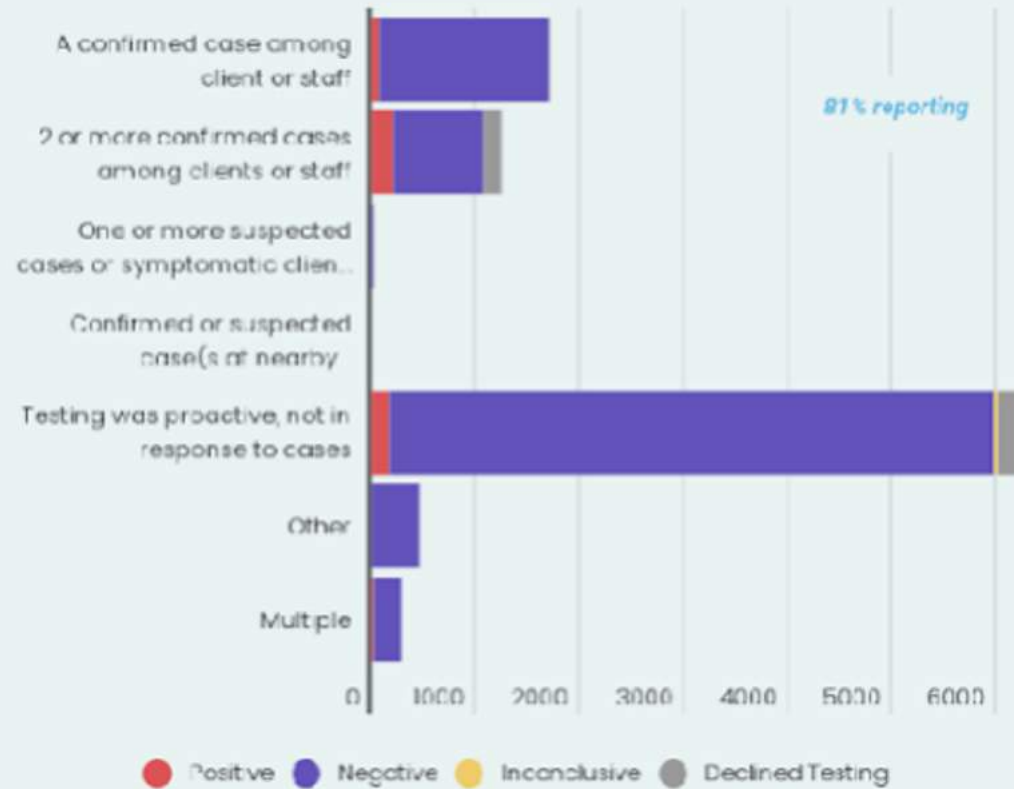


Cumulative (n = 161)

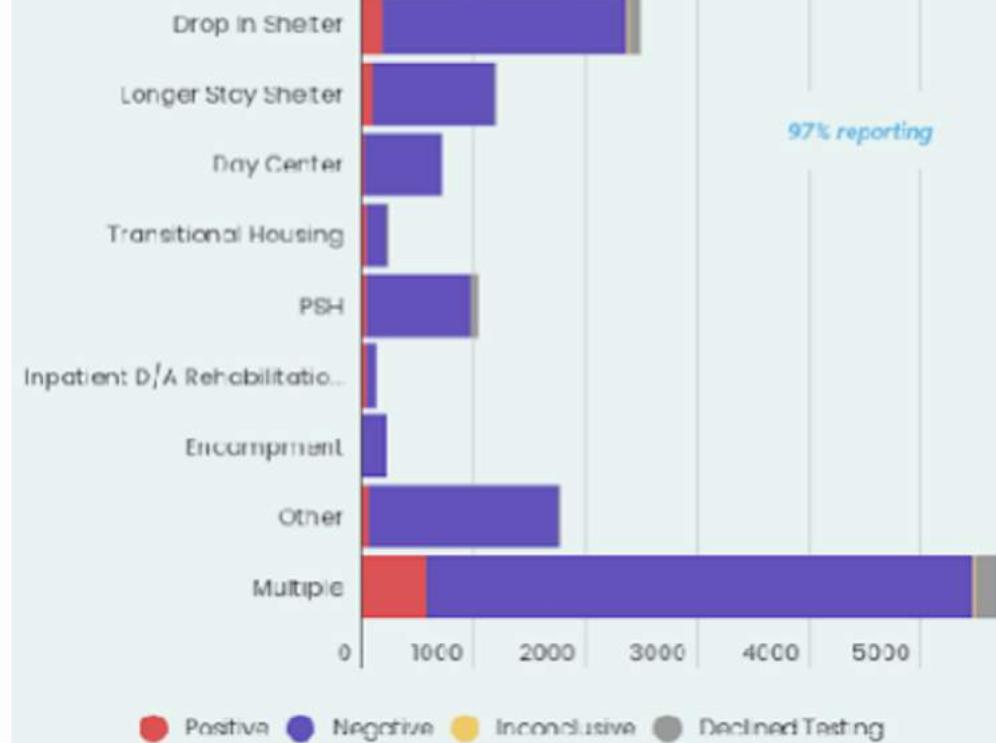


CDC Dashboard

Testing Events Results, By Reason For Testing Event

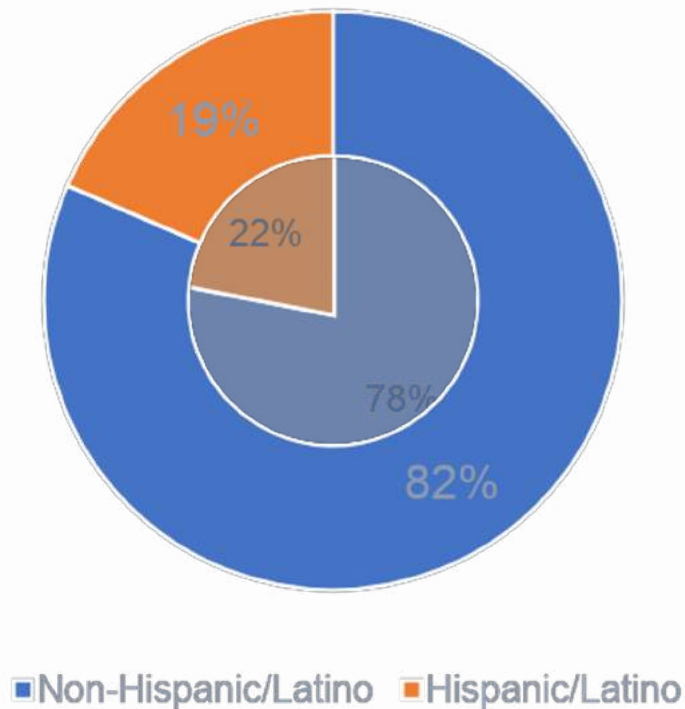


Testing Event Results, By Shelter Type

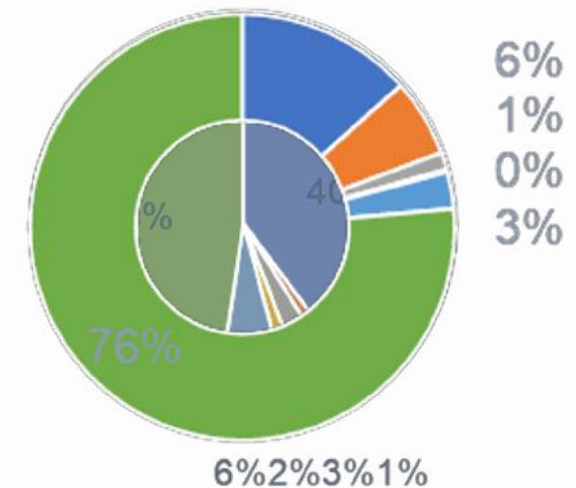


COVID-19 Testing & Homelessness

Ethnicity, US vs. PEH

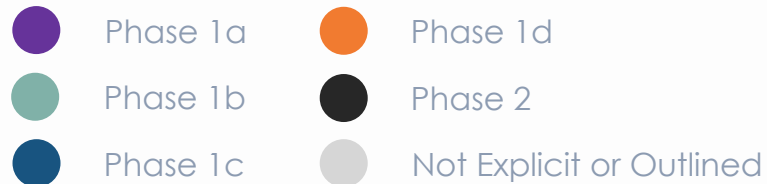


Race, US vs. PEH



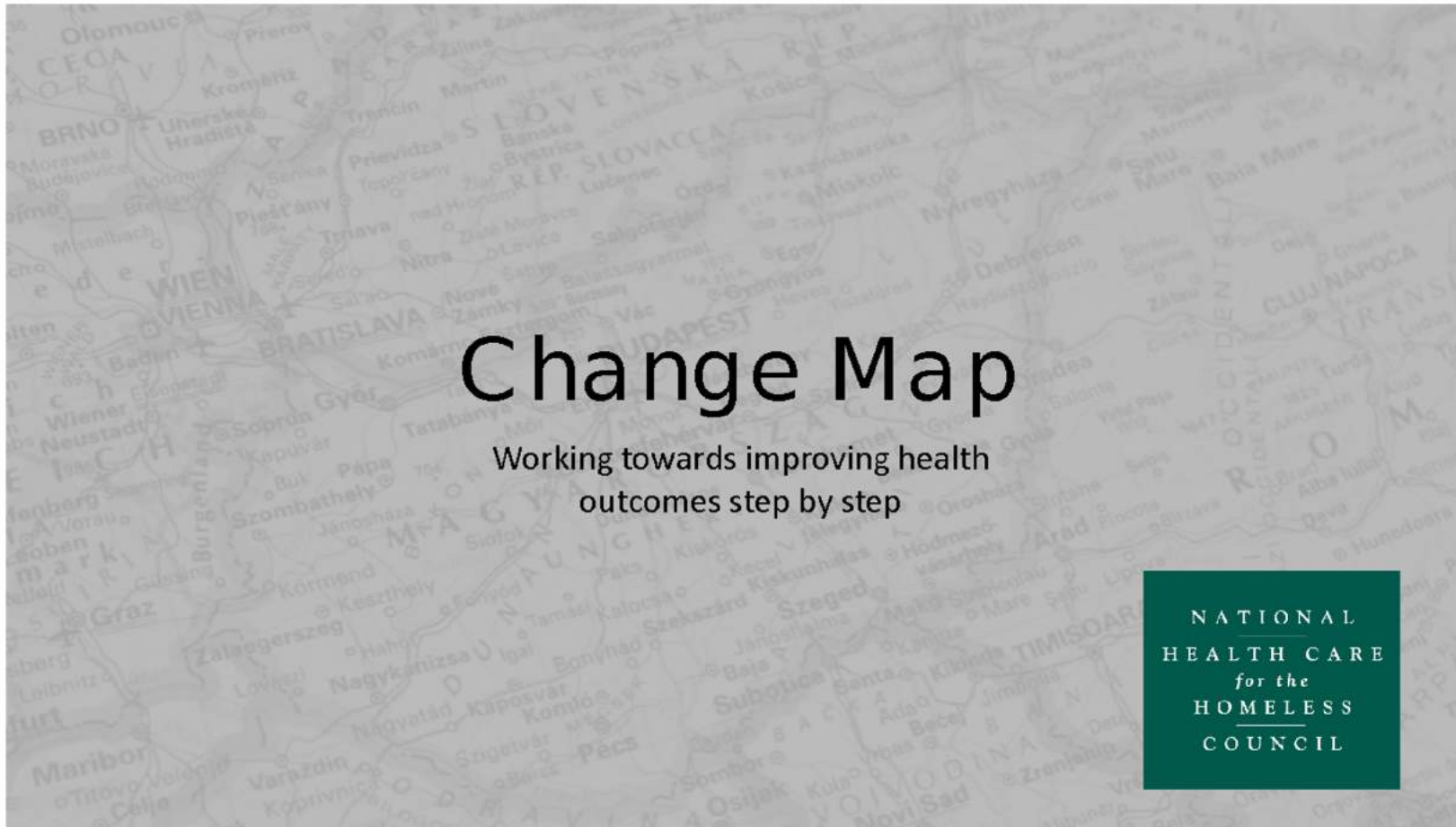
- Black/African American
- Asian
- American Indian/Alaska Native
- Native Hawaiian/Other Pacific Islander
- White
- Two or More Races

Source: 2019 AHAR Part 1, <https://www.huduser.gov/portal/sites/default/files/pdf/2019-AHAR-Part-1.pdf>
US Census Bureau, <https://www.census.gov/quickfacts/fact/table/US/RHI225219>



Source: State COVID-19 Vaccine Priority Populations, KFF, <https://www.kff.org/other/state-indicator/state-covid-19-vaccine-priority-populations/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

Bringing it Home: Implementing Change in Practice



Developed by Lauryn Berner, MSW, MPH
National Health Care for the Homeless Council



Questions to Consider

Background

- ❑ What is the big picture problem?
- ❑ What is your overall goal?
- ❑ To whom do you want to provide the initial implementation?
 - Consider using data to identify any disparities
- ❑ What is contributing to the issue within your intended population?
 - Consider talking with providers (both clinical and non-clinical) *and* consumers to understand the need.
 - Consider asking about social determinants of health and cultural factors.

Action

- ❑ What interventions could help address the need considering the contributing factors?
- ❑ Do you have to make any adjustments to ensure that the intervention is culturally appropriate for your intended population?
 - Consider asking for consumer input on this step.

Support

- ❑ What resources are needed to implement the intervention? (materials, staff time, financial need, etc.)
 - Consider using the HCH Costing Tool.
- ❑ What partnerships that would be helpful?
- ❑ Do you have buy-in from staff and leadership?

Details

- ❑ What are the steps and/or phases of implementing this project?
 - Create a list and drill down the details as possible.
- ❑ What is the expected timeline for implementing these activities?
 - Consider developing a Gantt Chart here to help frame and track activities.

Monitor

- ❑ How will you track your progress?
- ❑ What data do you have or need?
- ❑ How will you know you have reached your goal?
- ❑ What are the long-term goals for this intervention?
 - Consider sustainability and scalability

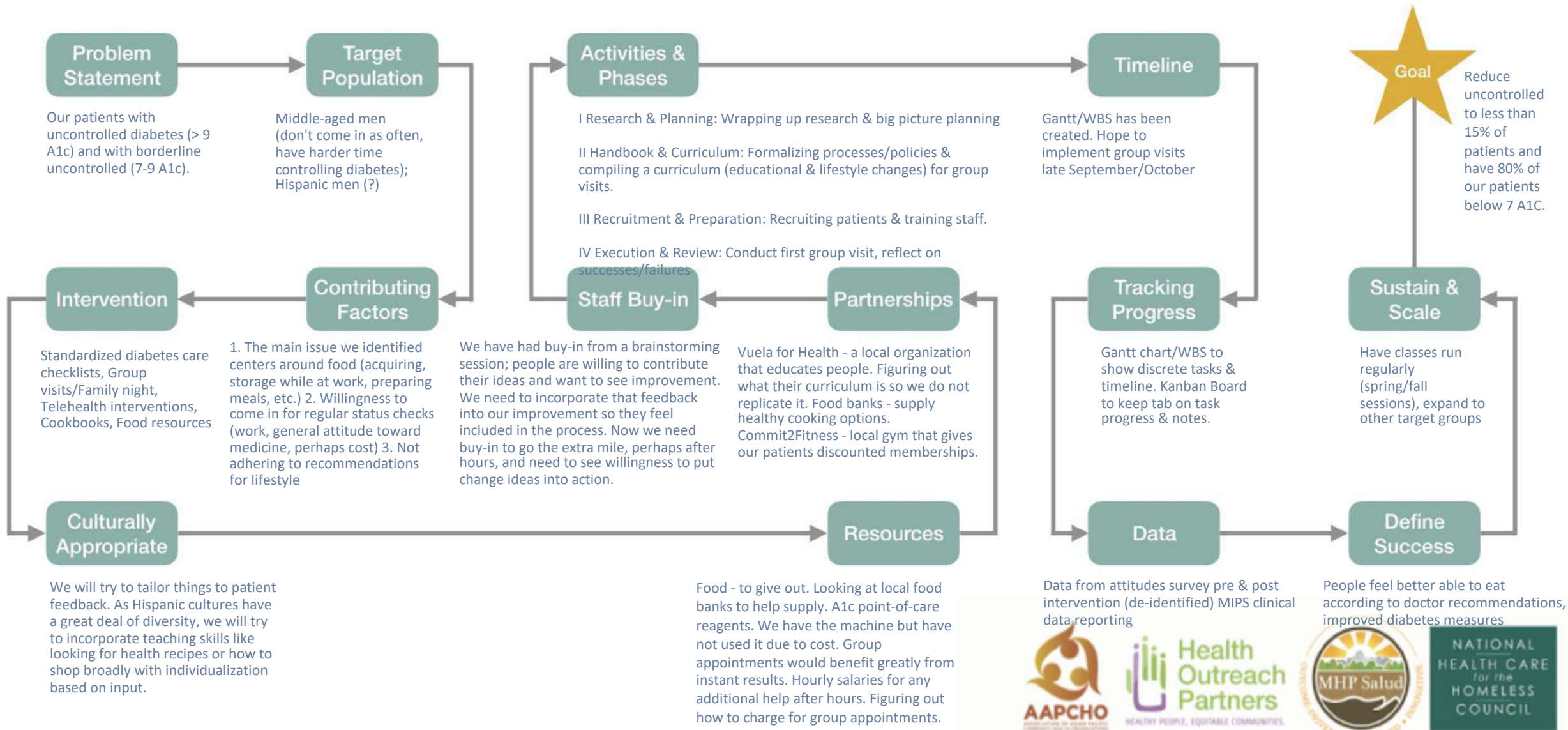




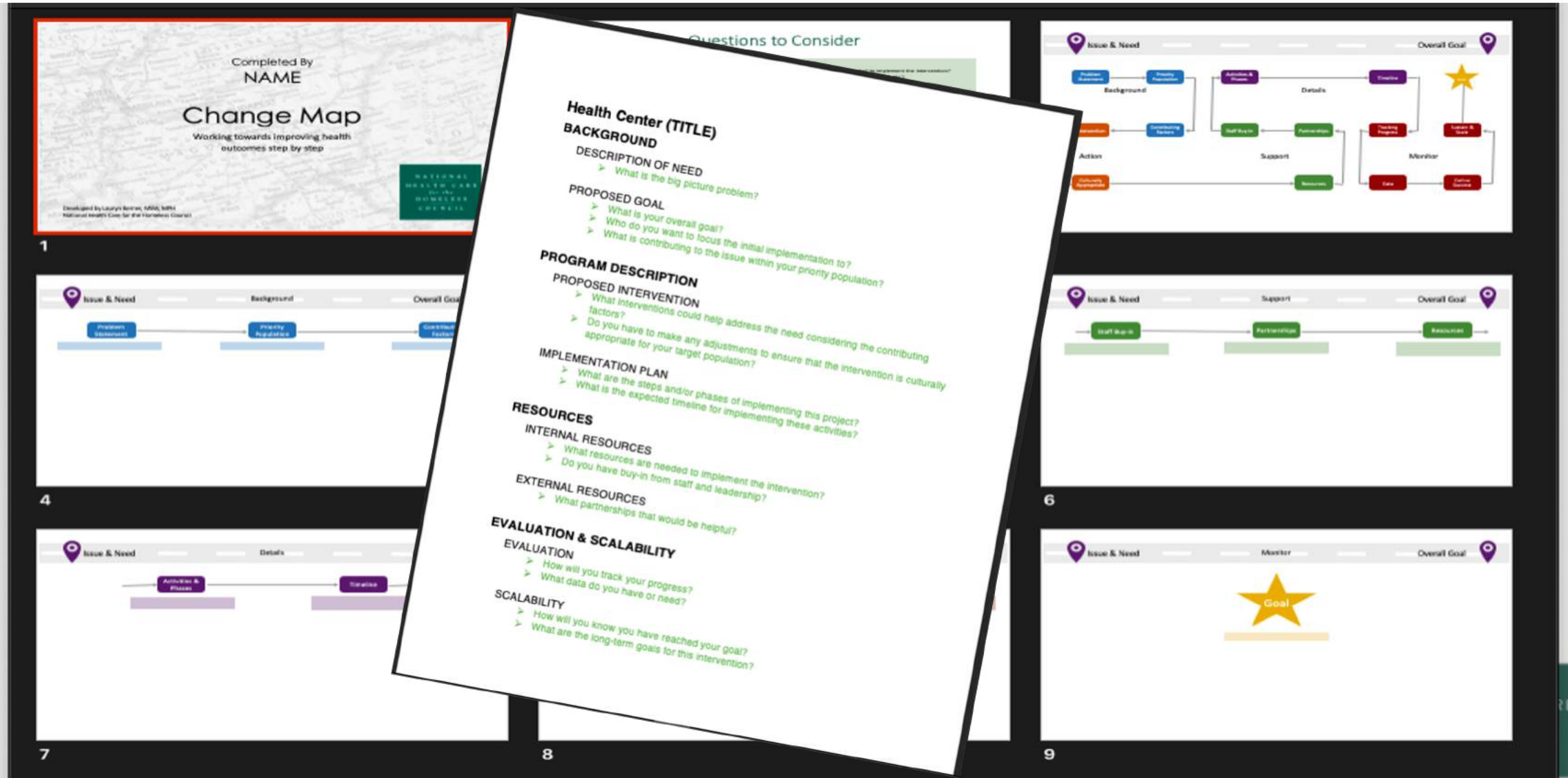
Issue & Need

Health Site Example

Overall Goal



Utilizing the Change Map





Social Determinants of Health Lessons Learned, Challenges, and Barriers: A Resource for Health Centers, Vol. 1



2020 Learning Collaborative

Screening Methods and Using Outreach and Enabling Services to Address SDOH

- Importance of SDOH Screening
- Role of Enabling Services Workforce
- Impact of Learning Collaborative
- Highlights of Participants' Change Maps

<https://bit.ly/SDOH-Lessons-Learned-Vol1>



Screening Methods and Using Outreach and Enabling Services to Address Social Determinants of Health

Learning Collaborative - Session 1
Wednesday, August 4
2:00 - 3:30pm ET

Welcome! We will begin in a few minutes.



Wednesdays, August 4, 18 and September 1, 15
2:00-3:30PM (EST)

Apply Here:

<https://forms.gle/fBAK5GBkqCRH3RdP6>





Disclaimer

This webinar is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards as follow: Association of Asian Pacific Community Health Organizations (AAPCHO) National Training & Technical Assistance Cooperative Agreement totaling \$625,000.00 with 0 percent financed with non-governmental sources, Health Outreach Partners (HOP) National Training & Technical Assistance National Cooperative Agreement totaling \$932,014.00 with 0 percent financed with non-governmental sources, MHP Salud National Training & Technical Assistance Cooperative Agreement totaling \$753,959.00 with 0 percent financed with non-governmental sources, and National Health Care for the Homeless Council Training and Technical Assistance National Cooperative Agreement totaling \$1,967,147.00 with 0 percent financed with non-governmental sources. This information or content and conclusions are those of the presenters and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government. For more information, please visit [HRSA.gov](https://www.hrsa.gov).



Post-Webinar Evaluation

Please take 2-3 minutes to provide your feedback on today's webinar

<https://www.surveymonkey.com/r/sdohwebinar07212021>



Thank you & keep in touch!



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About Us

National Training and Technical Assistance Partners (NTTAPs)





Vetting Protocol



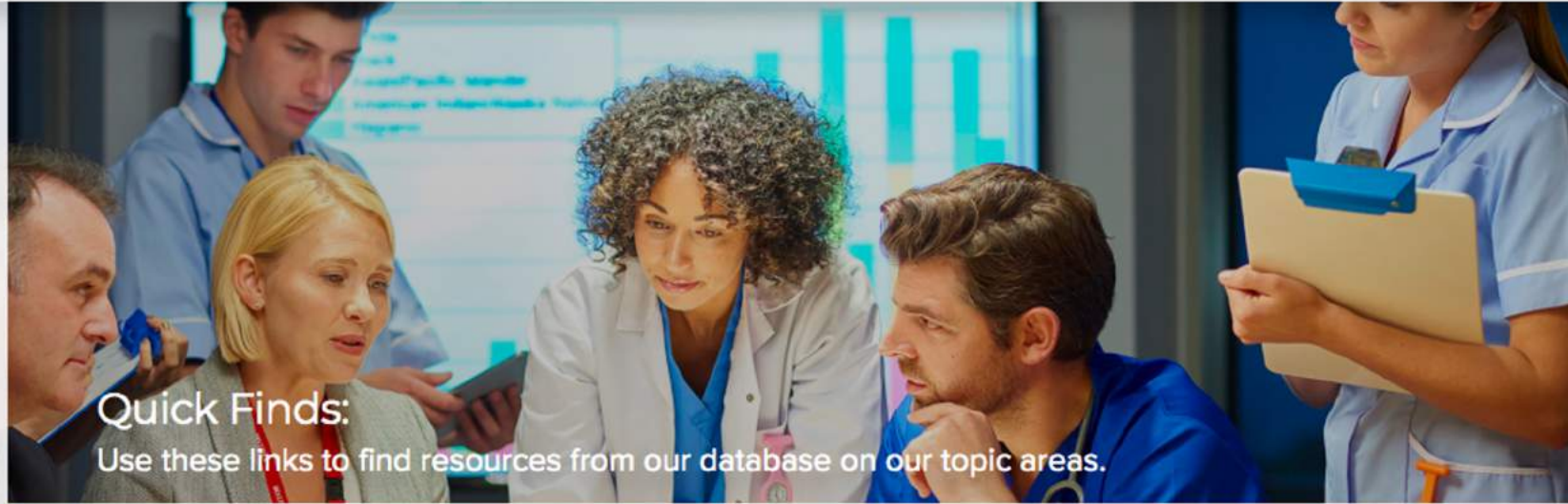
Learn About the NCAs



Find Resources



Have a Question? Ask
Us



Quick Finds:

Use these links to find resources from our database on our topic areas.



Diabetes



Capital Development



Clinical Issues



Emerging Issues



HIT/Data



Leadership



Outreach



Governance



Practice Transformation



Special & Vulnerable Populations



Social Determinants of Health



Workforce



Quality Improvement



Finance



Emergency Management

Website: www.healthcenterinfo.org



Association of Asian Pacific Community Health Organizations (AAPCHO) is a national organization representing health centers and community- based organizations (CBOs) serving Asian Americans, Native Hawaiians and Pacific Islanders (AA&NHPI). Our mission is dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of AA&NHPIs within the United States, its territories, and freely associated states, primarily through our member health centers.

Key Topics

 Disaggregated race/ethnicity data collection

 Social determinants of health data collection

 Culturally and linguistically appropriate services

 Enabling services data collection

Website: www.aapcho.org



HOP is a national non-profit organization that works to build strong, effective, and sustainable grassroots health models by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable, and underserved populations. Clients include health centers, Primary Care Associations, Health Center Controlled Networks, Clinic Consortia, local health departments, advocacy organizations, and other organizations that seek to improve health services, access to care, and health equity.

Key Topics

 Program planning and evaluation

 Transportation

 Needs assessment

 Outreach and enrollment

 Collaboration

Website: outreach-partners.org



mhpsalud.org

MHP Salud implements Community Health Worker programs to empower underserved Latino communities and promotes the CHW model nationally as a culturally appropriate strategy to improve health. MHP Salud has been implementing Community Health Worker programs in underserved communities for more than 35 years and providing training on the Community Health Worker model for more than 20. Our work extends from single organizations, assisting every step of the way in planning and executing effective CHW programs in their communities, all the way up to state and national initiatives, focused on standardizing the CHW model and advancing the profession as a whole.

Key Topics

- ✓ Implementation of CHW programs in hard-to-reach populations
- 📈 Evaluation and outcomes for CHW programs, especially related to CHW-collected data
- 🎓 Certification of and professional development for CHWs
- 🔄 Return on Investment for CHW programs
- 👤 Defining the differences between Community Health Workers, Outreach Workers, and other Enabling Services Staff

Website: mhpsalud.org

The National Health Care for the Homeless Council is a 501(c)(3) non-profit membership organization that leads a network of more than 10,000 doctors, nurses, social workers, patients, and advocates who share the mission to eliminate homelessness. The Council was founded on the principles that homelessness is unacceptable; every person has the right to adequate food, housing, clothing, and health care; all people have the right to participate in the decisions affecting their lives. Since 1986, we have been the leading organization to call for comprehensive health care and secure housing for all. We produce leading research in the field and provide the highest level of training and resources related to care for persons experiencing homelessness.

Key Topics

-  Consumer engagement
-  Medical respite
-  Trauma-informed care

-  Integrated care (Integrating health and housing, behavioral health and primary care, substance use disorders screening/treatment)
-  Health equity (Adapted clinical guidelines, enabling services, outreach, street medicine and shelter care)

Website: www.nhchc.org