Identifying the Enabling Services Workforce for SDOH Screening and Documentation

September 30, 2020
8:00 am HT / 11:00 am PT / 2:00 pm ET

Welcome! We will begin in a few minutes.

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Agenda

1. Welcome & Introductions (5 Min)
2. Enabling Services Workforce Providers for SDOH Screening and Documentation during COVID-19 (AAPCHO - 15 Min)
3. Demonstrating the Impact and Value of Enabling Services (MHP Salud - 15 Min)
4. Indicators of Structural Inequity: The Importance of Documenting SDOH (HOP - 15 Min)
5. Frameworks & Implementation for Special Populations (NHCHC - 15 Min)
6. Highlight Learning Collaborative (5 Min)
7. Questions/Discussion (20 Min)

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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 will highlight the critical importance for Enabling Services providers to collect social risk data among health center patients.

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Learning Objectives

By the end of the webinar, participants will be able:

1. To identify Enabling Services workforce providers for SDOH screening and documentation during COVID-19
2. To demonstrate the overall value and impact of Enabling Services, and how Enabling Services can highlight key structural inequities
3. To provide an overview of relevant tools used for assessing the needs of special and vulnerable populations (e.g., patients experiencing homelessness)

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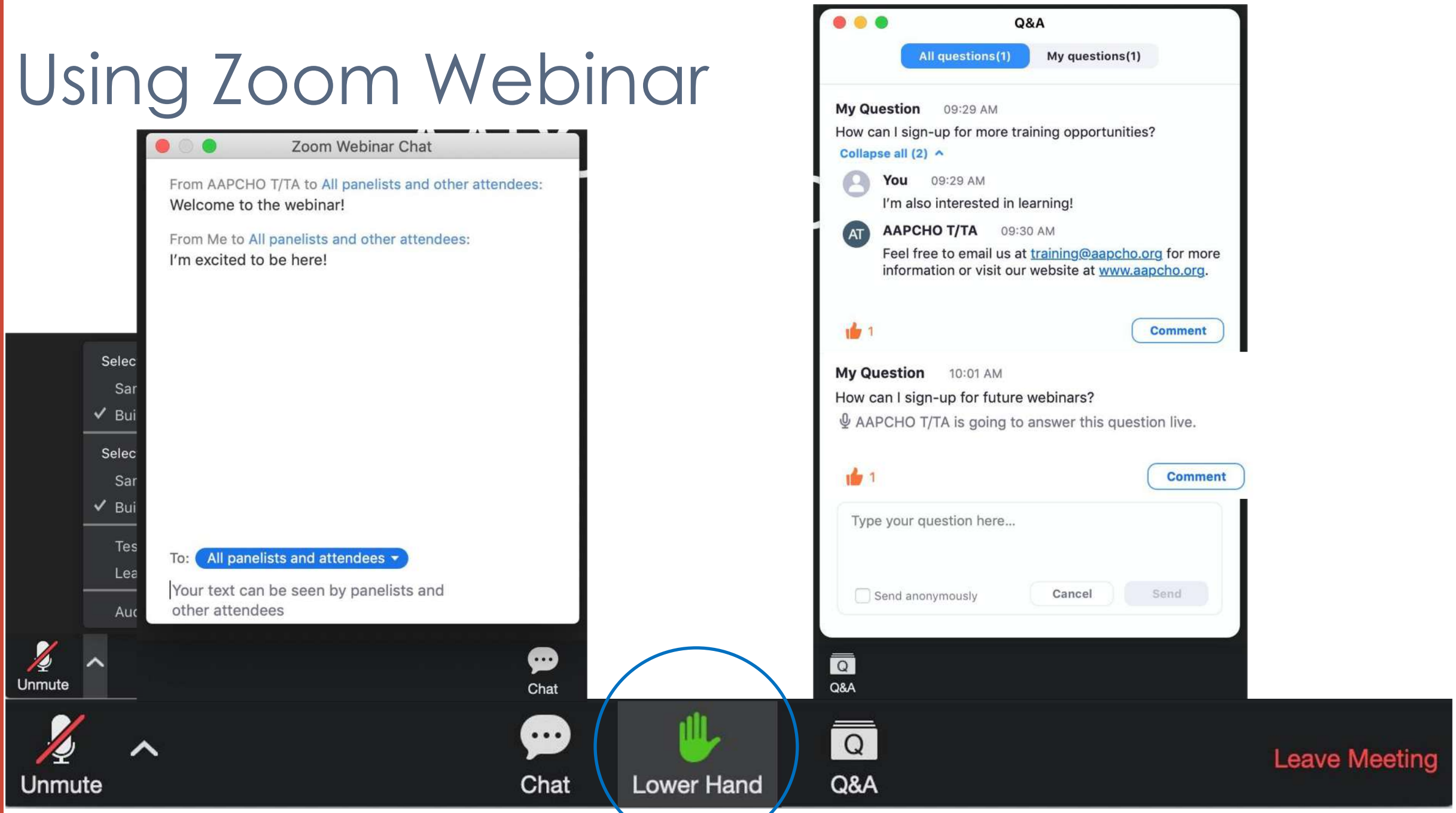
Using Zoom Webinar



NTTAP Faculty & Presenters

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Learning Objective #1

To identify Enabling Services workforce providers for SDOH screening and documentation during COVID-19

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Enabling Services Workforce Providers for SDOH Screening and Documentation during COVID-19

Albert Ayson, Jr., MPH

Associate Director, Training & Technical Assistance

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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.

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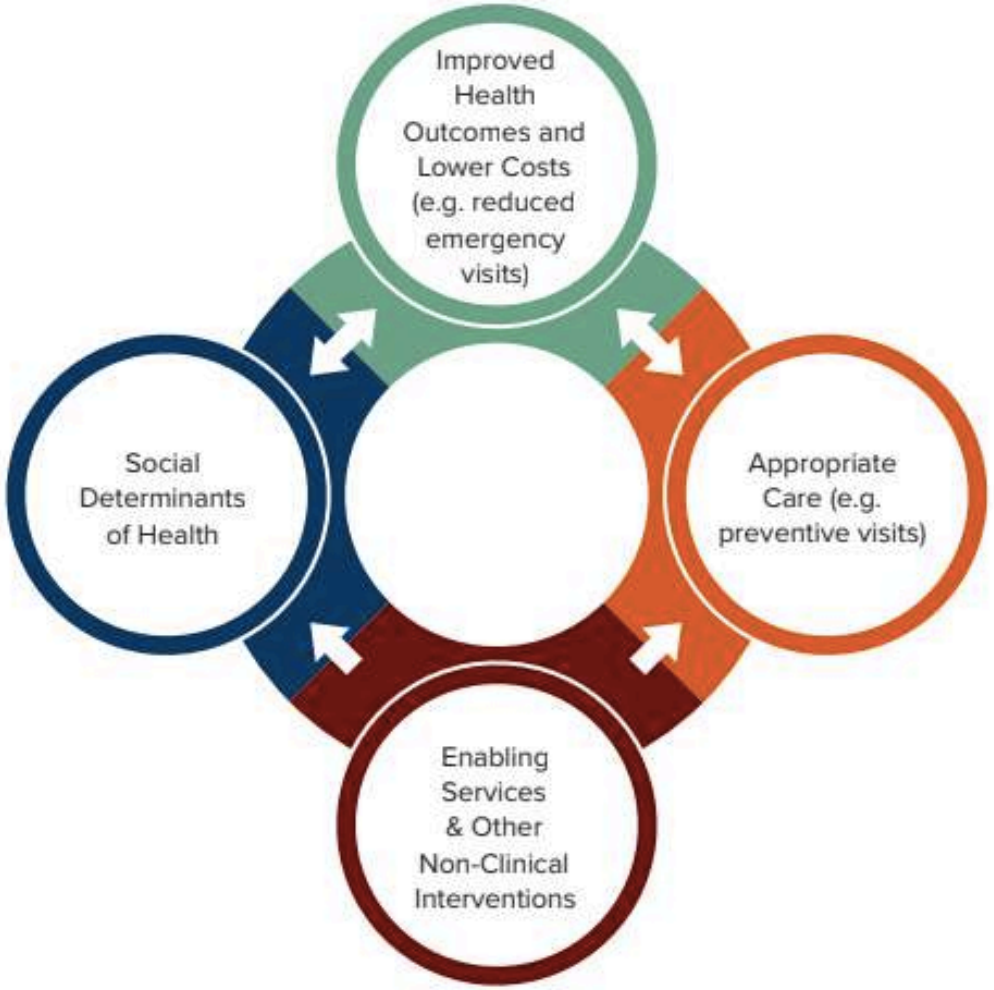
Enabling Services = Social Interventions



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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

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Enabling Services Providers (UDS)

- Case Managers
- Patient/Community Education Specialists
- Outreach Workers
- Transportation Staff
- Eligibility Assistance Workers
- Interpretation Staff
- Community Health Workers
- Other Enabling Services

Source: HRSA Uniform Data System

Enabling services workforce

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

Staff	2015	2016	2017	2018	2019	Δ 2015-2019
Case Managers	6,761.63	7,621.93	8495.99	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	869.15	↑ 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%

Source: HRSA Uniform Data System, 2015-2019

** Percent change from 2016-2019*

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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

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AAPCHO ES Categories and Codes

Old ES Categories	Revised Categories	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

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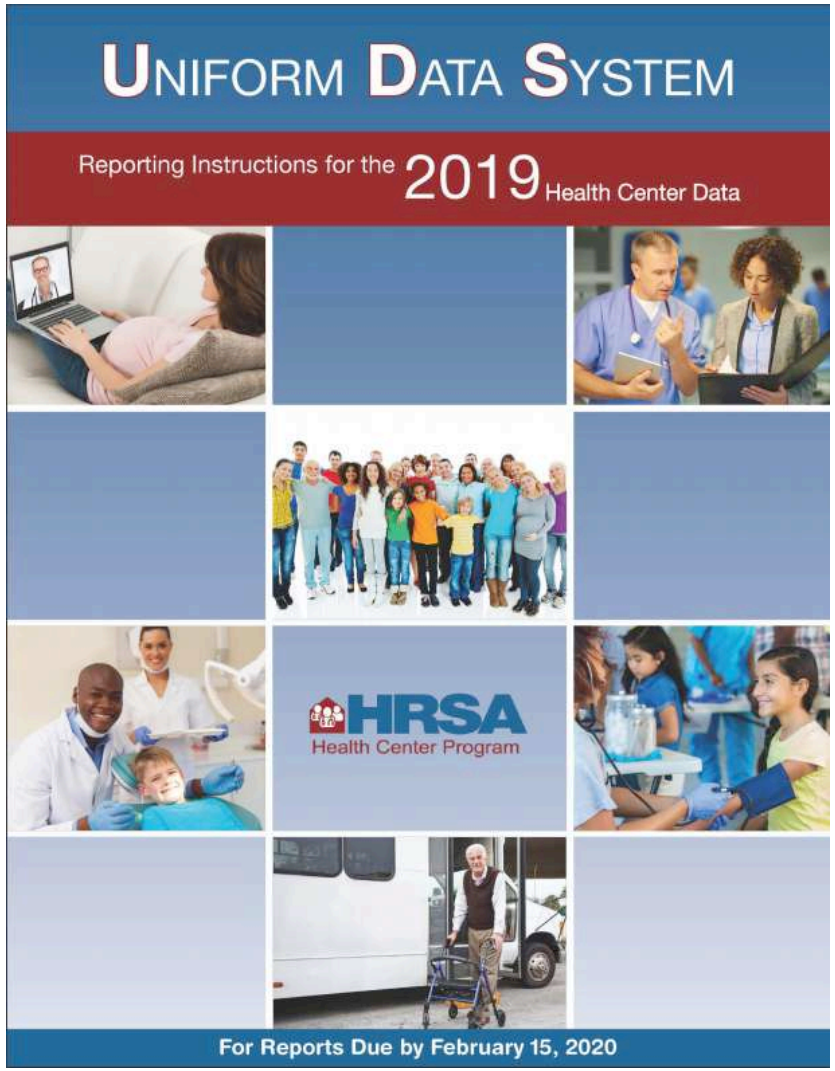
Other Social Needs Screening Tools

	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://sirenetwork.ucsf.edu/SocialNeedsScreeningToolComparisonTable

NEW UDS Question for 2019



- 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

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💡 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

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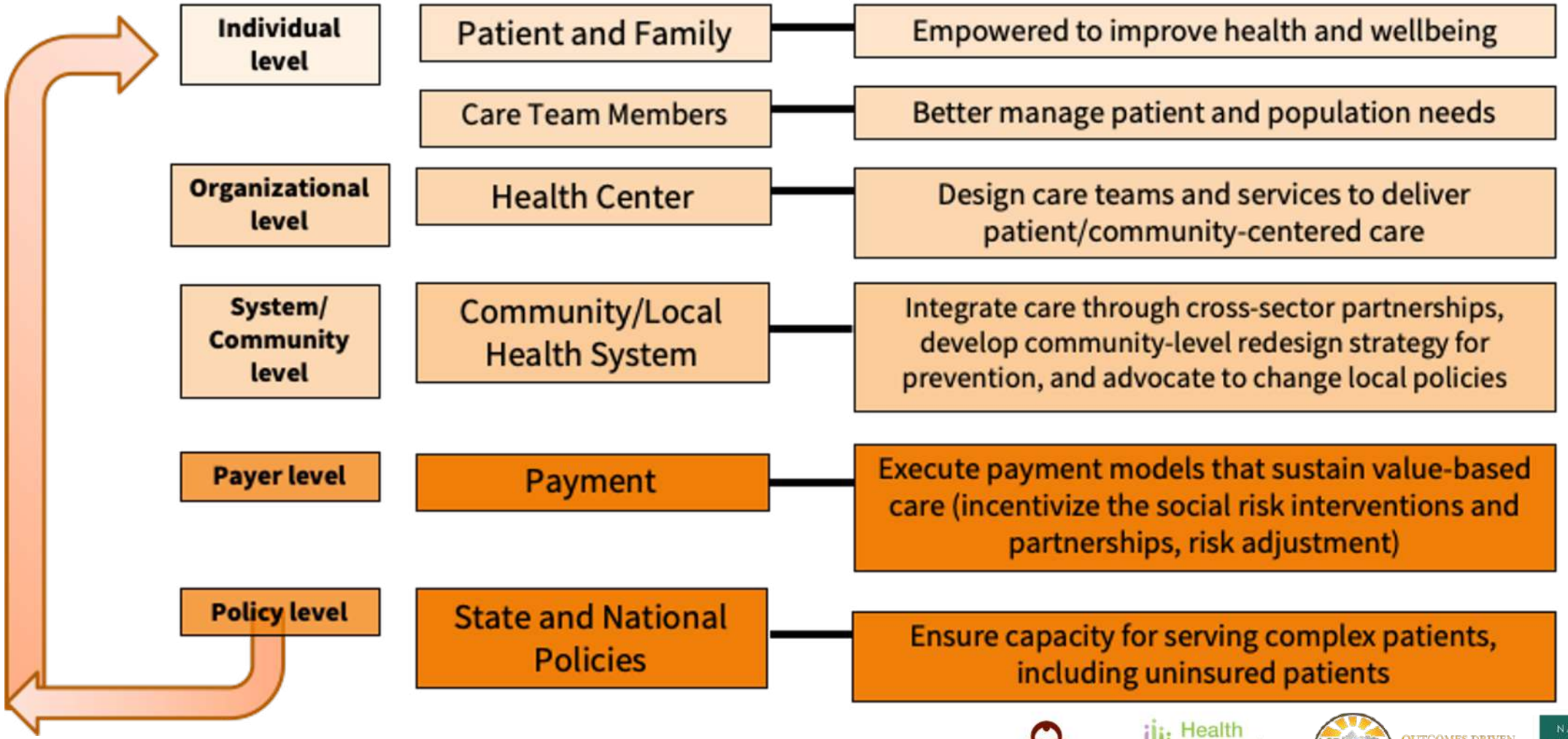
Why collect standardized SDOH data?



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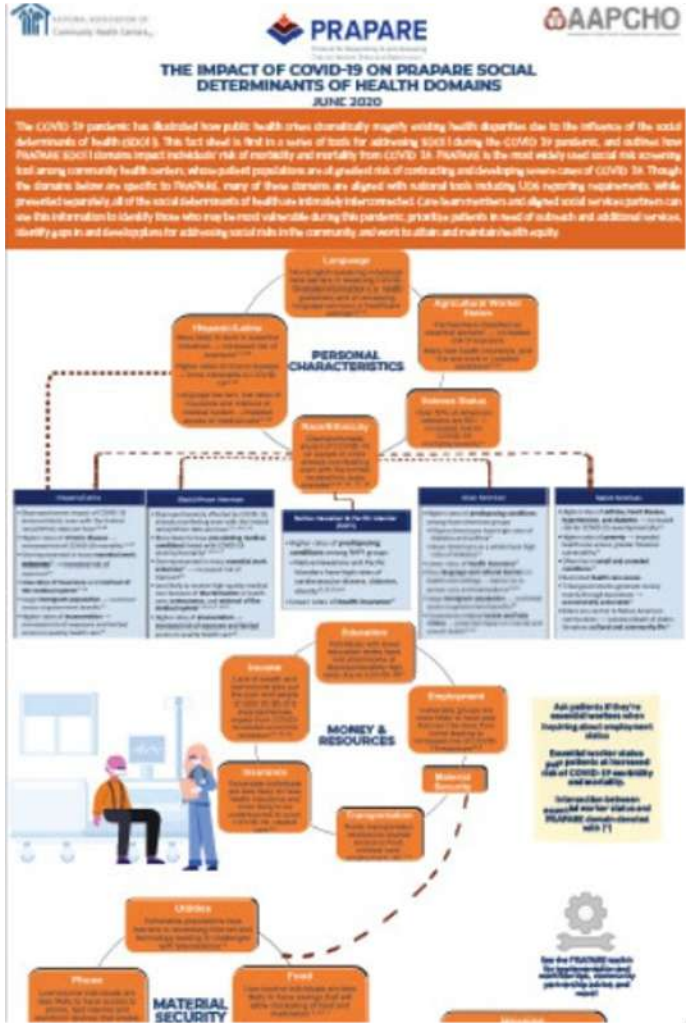
The Intersection of SDOH and COVID-19

NEW

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!



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Impact of COVID-19 on Enabling Services

- Health Center Infrastructure & Workforce
- Enabling Services Delivery
- Workforce & Policy Training
- Demonstrating Value

Source: Health Center Association of Nebraska (HCAN) – PCA Virtual Enabling Services Input (April 2020). All PCAs surveyed. 29 responses collected. Contact: Keshia Bradford MPA. Analysis by AAPCHO.

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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

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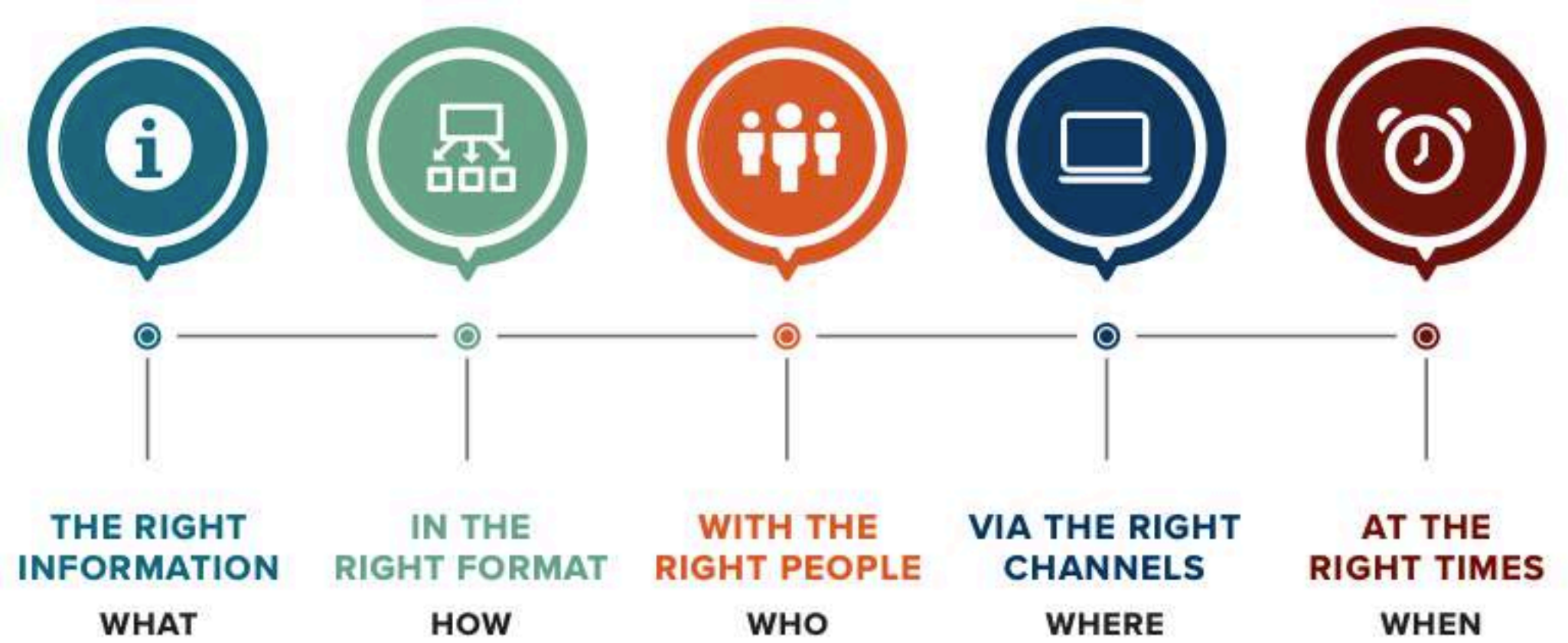
What workflow to use for SDOH screening?



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Sample Workflow Models

Who	Where	When	How	Rationale
Non-clinical staff (patient navigator, community health workers)	In waiting room or in staff office	Before of 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 patent'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.

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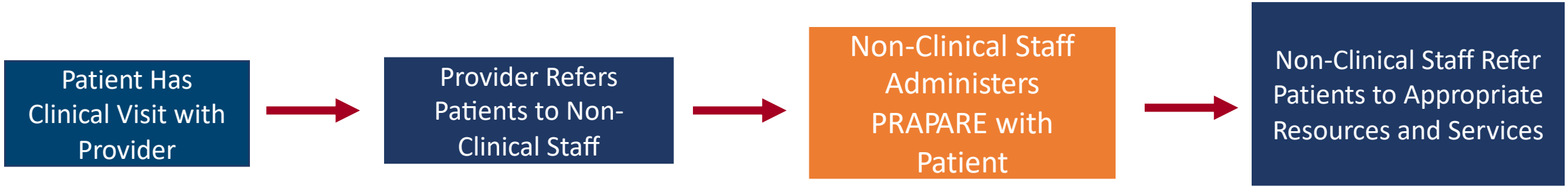
Example: Using ES Staff for Screening Post-Visit

- 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



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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

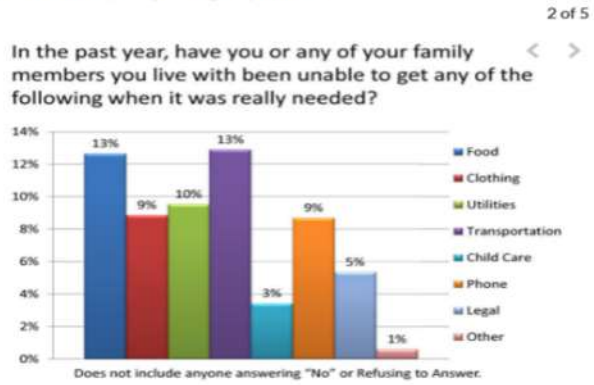
DOLLY A. BUTZ dbutz@siouxcityjournal.com Jun 23, 2017 (1)

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



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

PRAPARE

Siouxland Community Health an iowahealth center

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Resources to help your organization collect standardized data on SDOH and Enabling Services

PRAPARE

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

- National, standardized social determinant of health assessment tool
- Developed by NACHC, AAPCHO, and Oregon PCA
- Built into EHR and meant to be patient-centered
- Most common SDH screening tool used by CHCs and Medicaid managed care organizations

Enabling Services Accountability Project

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

I H E L P

- Screening guide for legal needs
- Developed by MLP

- Guidance on how to use Z codes for homeless
- Written by NHCHC

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Learning Objective #2

To demonstrate the overall value and impact of Enabling Services, and how Enabling Services can highlight key structural inequities

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Demonstrating the Impact and Value of Enabling Services

Esly Reyes, MPH

Program Director, MHP Salud

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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.

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

ROI is basically..

The money you/your organization could be saving!!!

How much money and resources do you put in and how much (and what) do you get out

ROI Benefits

Estimates direct financial impact

Versatile and simple

Supports sustainability

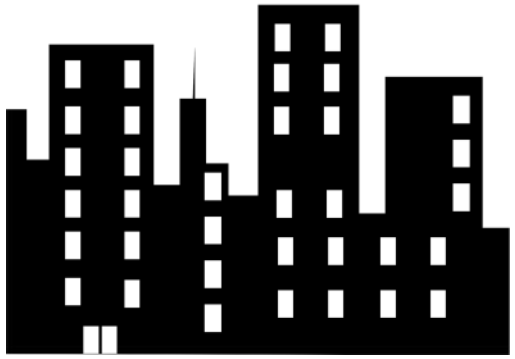
The basic estimate of profitability

Understandable **Impact**

Types of ROI

Community Level

Institutional Level



Individual Level

Community Level

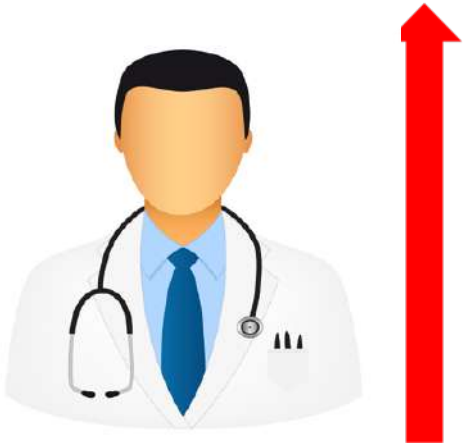
How much benefit (or return) is the entire community receiving as a result of investment by the community?

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

Institutional Level

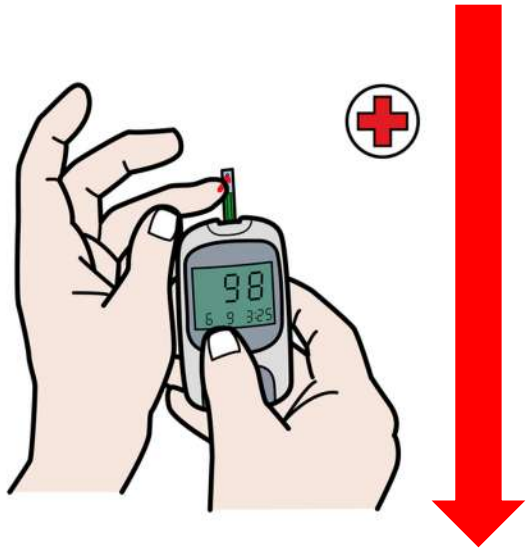
What return did the host clinic or network receive based on their inputs?

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



Individual Level

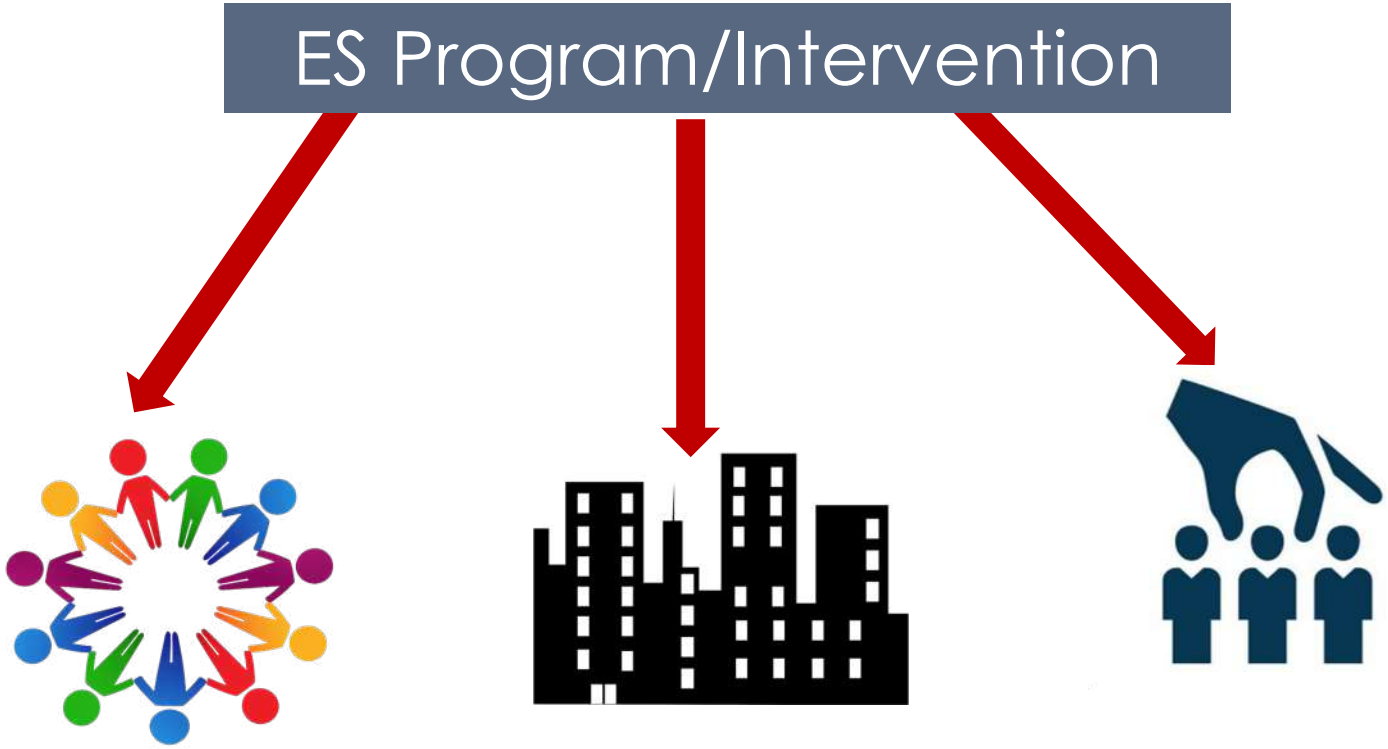
What savings did the individual receive based on inputs to their program?



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

Impact

Enabling Services programs/interventions can get **THREE different types of ROIs** to better show who benefits how much from the same program.



ROI Example

A patient who receives services from a **Community Health Worker** and learns how to better care for their health which then results in lower medical costs for them for the rest of their life is a **FOREGONE COST or UNREALIZED COST** – money not spent that would have been needed otherwise.

These concepts need to go in an **ROI** equation to make it more representative of outcome.

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

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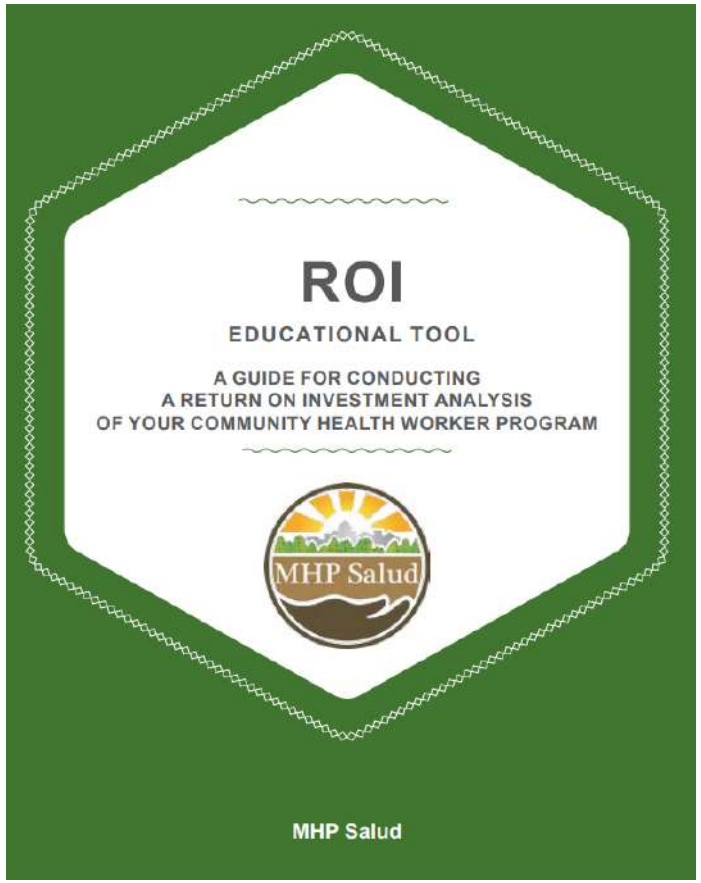
ROI
EDUCATIONAL TOOL

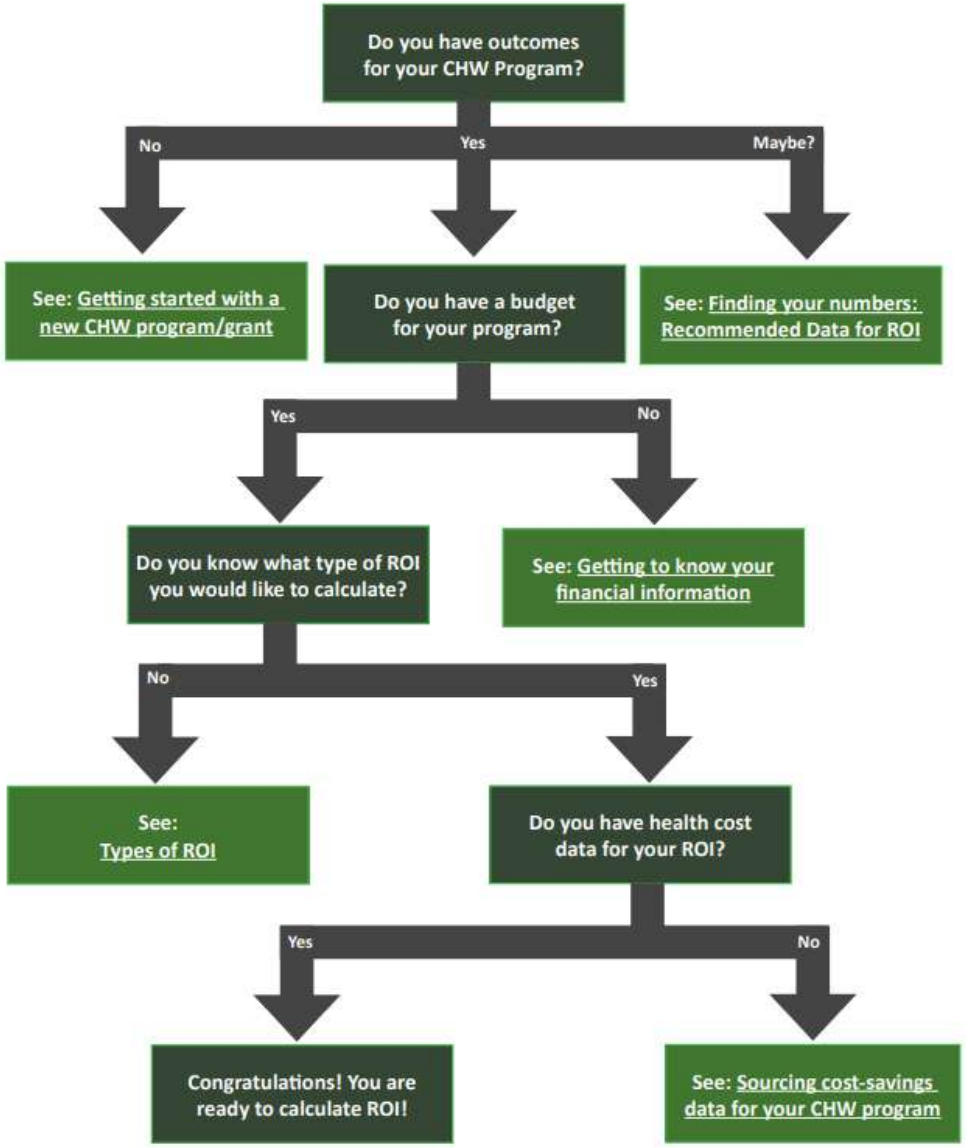


A Guide For Conducting A Return On Investment Analysis of Your Community Health Worker Program

- 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/

The following flow chart will guide you through some typical questions about where you are in the ROI process.



As you move through the educational tool, you will see these icons within each section. These will be indicators for you to pause, review, and practice what you have learned in that particular section.

Key information you should take from this section

Examples for this section

Now you try it!

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ES Value during COVID-19 Times

Access Barriers	ES Unique Response
Fear of accessing services (due to Public Charge or immigration status)	ES Staff can clarify Public Charge and immigration myths by using reliable resources and making referral to community programs
Self-medication and self-diagnosis (due to lack of health insurance)	ES Staff can help clients to apply health insurance or know where to access low-cost services (i.e. FQHCs)
Lack of health information available in their language and literacy level	Es Staff can translate information for clients and explain the meaning of important health documents
Lack of effective communication with health providers (due to language barriers)	ES Staff can act as intermediary between patient-health provider communication

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ES Value during COVID-19 Times

COVID-19 Challenges	ES Unique Response
Misinformation on COVID-19	ES Staff can educate on COVID-19 risk and share credible resources in clients' language
Fewer social service resources available	ES Staff can connect to available social services
Fewer medical resources available	ES Staff can connect community members to available medical resources (i.e. mobile services)
Lack of transportation (due to limitation and restriction applied as COVID-19 response)	ES Staff can educate on virtual services and resource available
Unavoidable exposure to COVID-19	ES Staff can educate on how to minimize risk and provide resources (i.e. face masks)

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."

NACHC, Key Consideration for Developing Core Competencies for Health Center Enabling Services Staff: A Guide for Health Centers, https://cdn1.digitellinc.com/uploads/nachc/articles/65566205d55a26d233d40485362bdb25.pdf

💡 Poll Question 💡

- What strategies have you/your organization found helpful in demonstrating the value of Enabling Services Staff?

(Please type your response into chat box)




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Indicators of Structural Inequity: The Importance of Documenting SDOH

Beleny Reese, MPH

Project Manager, Health Outreach Partners

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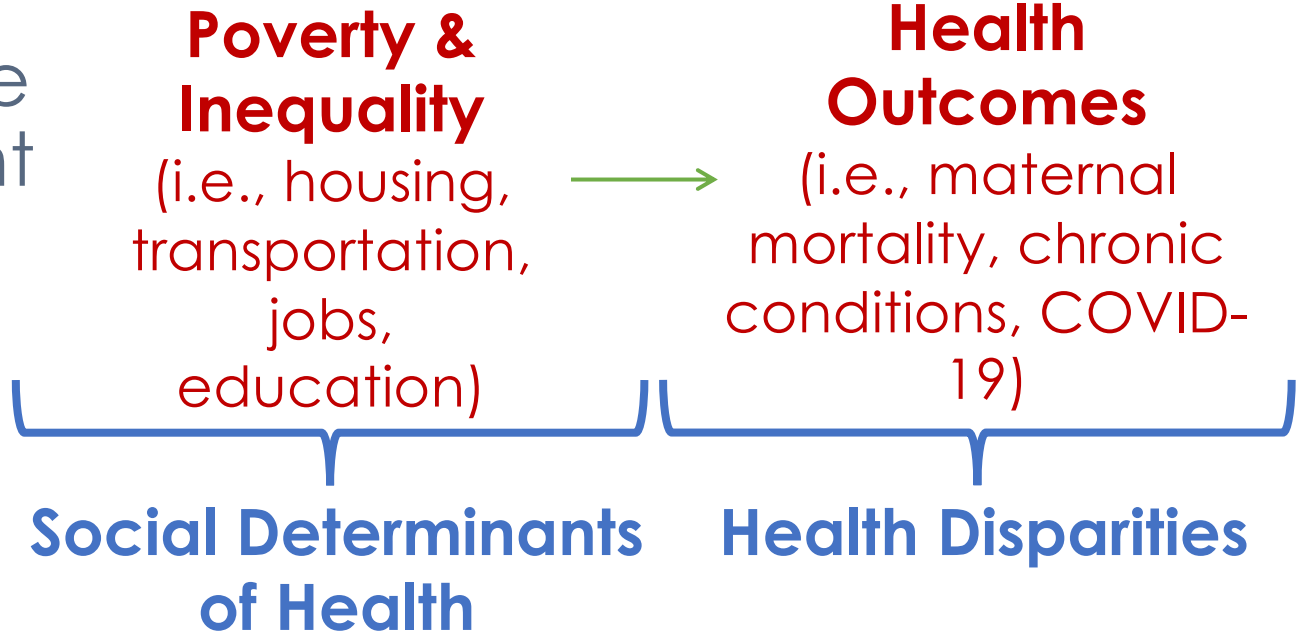
How SDOH help us understand health (in)equity

- Shifting the burden from the patient to their environment and circumstance
- What is the origin?



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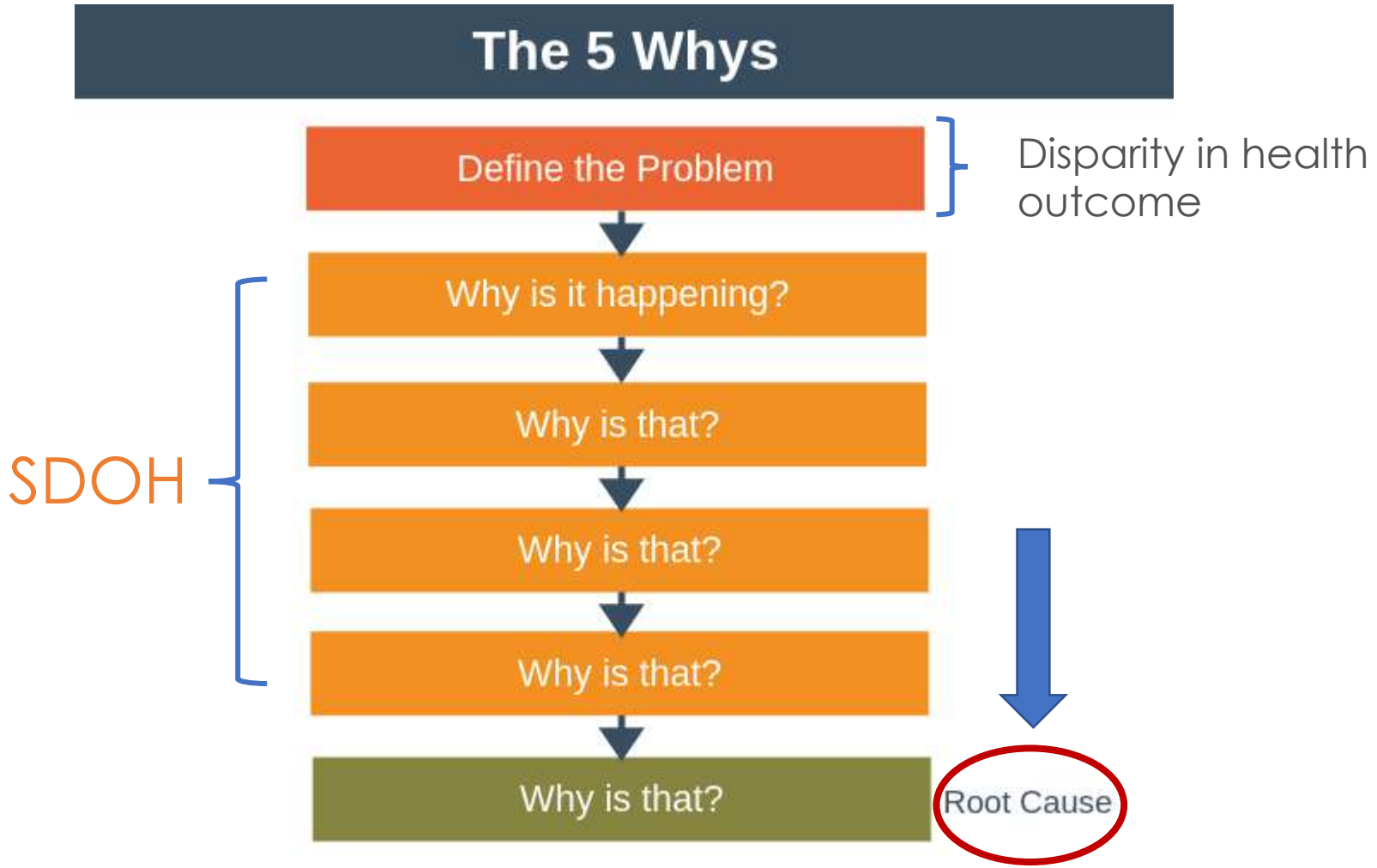
Structures

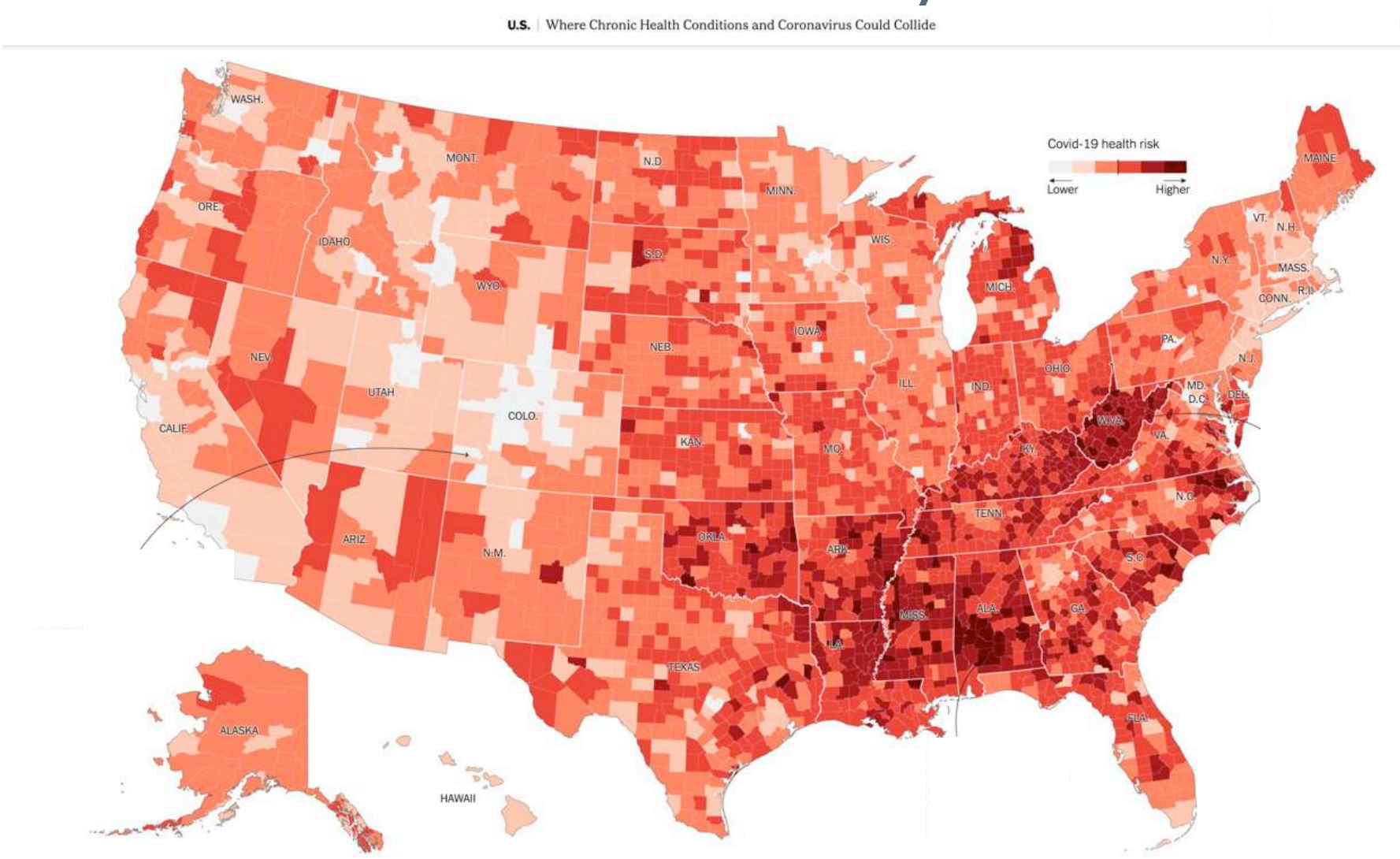
What are *structures*?

The **policies**, **economic systems**, and **other institutions** (judicial system, schools, etc.) that have produced and maintain **modern social inequities** as well as **health disparities**, often along the lines of social categories such as **race**, **class**, **gender**, **sexuality**, and **ability**.

Structural Inequity: The *underlying* cause



COVID-19 & Comorbidity



Source: New York Times

Why?

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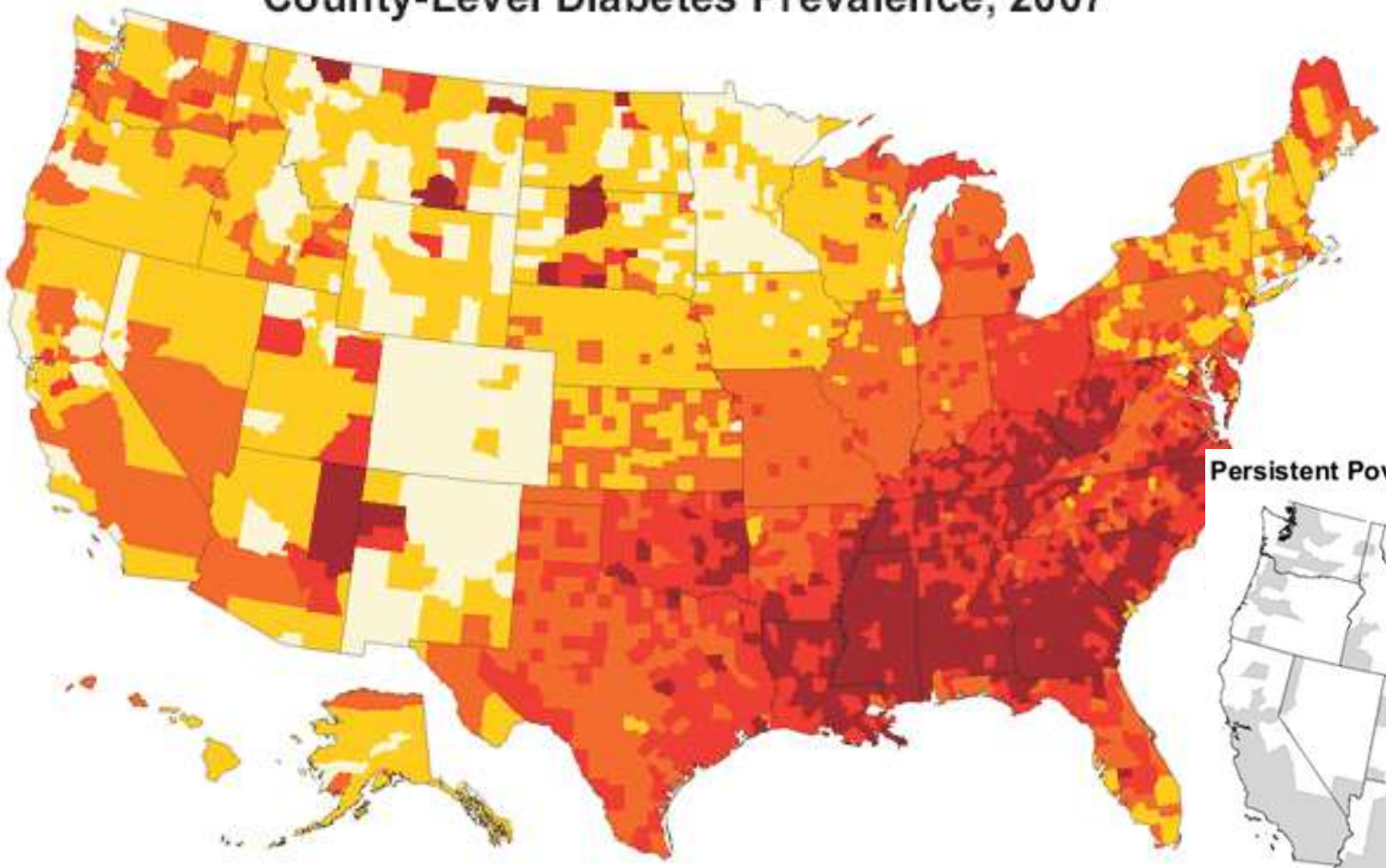
County-Level Diabetes Prevalence, 2007

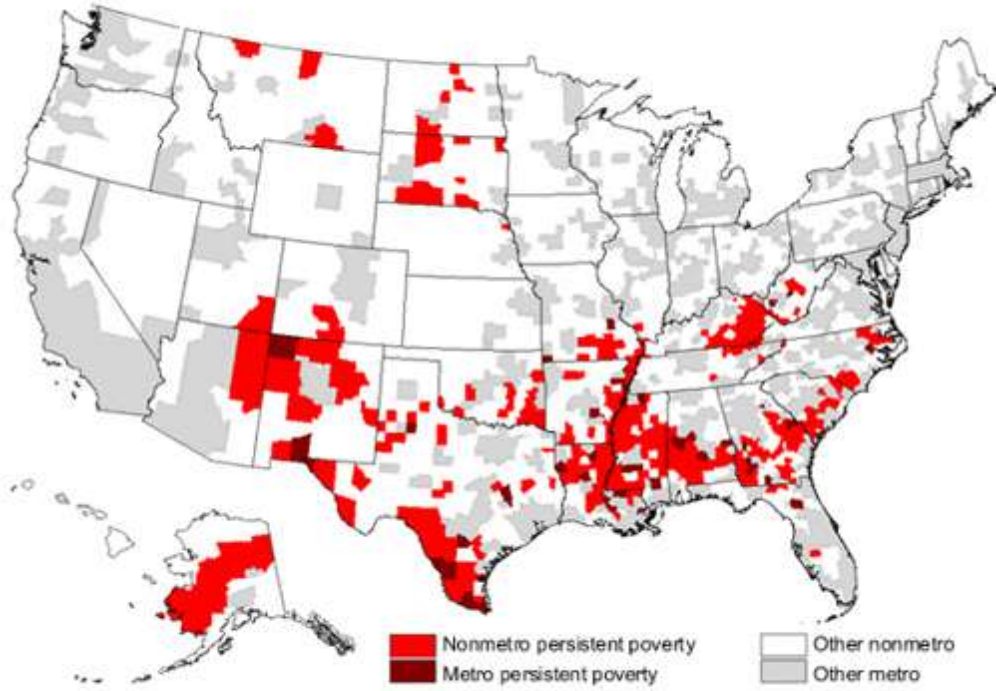


Sources: Centers for Disease Control and Prevention, "Estimated County Level Prevalence of Diabetes and Obesity—United States, 2
Morbidity and Mortality Weekly Report 58 No. 45 (Nov. 20, 2009):1259-1263.

Why?

Why?

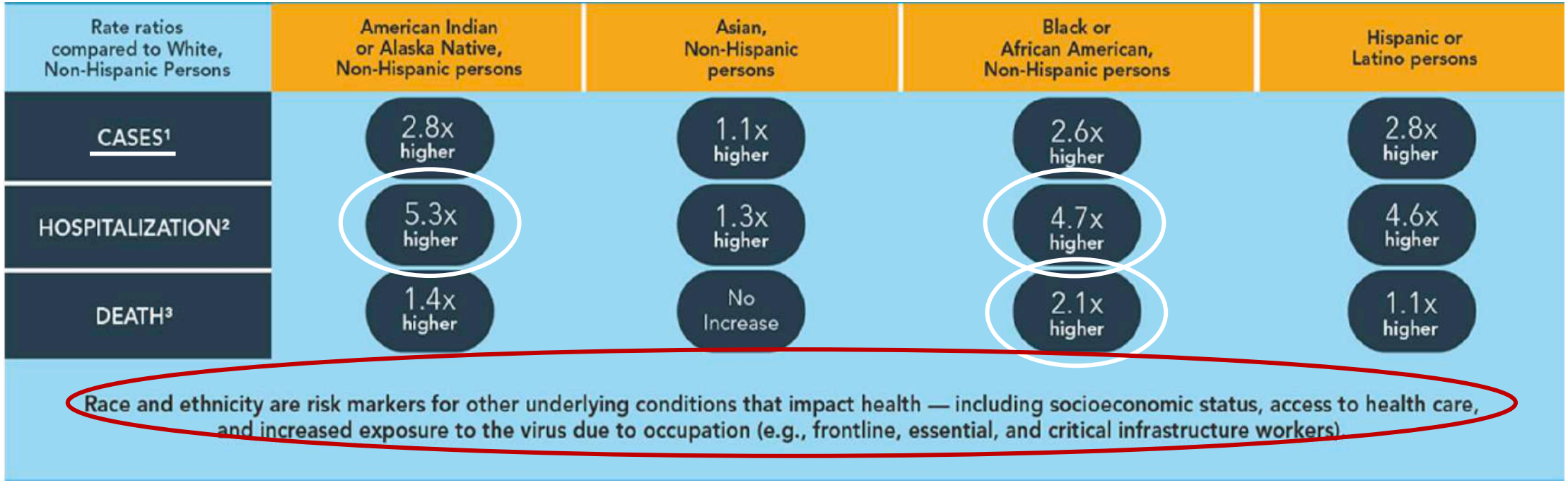
Persistent Poverty Counties, 1970-2000



Persistent poverty counties--20 percent or more residents were poor as measured by each of the last four censuses, 1970, 1980, 1990, and 2000.

Source: Economic Research Service, USDA.

COVID-19 & Racial/Ethnic Disparities



Source: CDC

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The underlying cause(s)

- Employer-based health insurance coverage
- High burden of chronic disease
- Redlining & gentrification
  - Lack of generational wealth
  - Communities lacking immediate access to grocery stores, healthcare facilities, other basic services
- Racism
- The "structural determinants of the social determinants of health"

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💡 Poll Question 💡

Can you identify **one** structure that affects the health of the patient population you serve?

(Please type your response into chat box)

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Social determinants as indicators of structural inequities

- Harmful structural factors are not easy to "see"
- Easier to measure the downstream effects
- Identifying SDOH can be a powerful clue to bigger influencing factors
- Data = POWER

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Identifying Structures

- Can be on individual patient level, community level
- Research/Data monitoring
- No single formula or indicator
- SDOH are the link

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What does this mean for health centers?

Being able to recognize structures and their influence on health outcomes is helpful in many ways:

- Understand barriers to health at population level
  - Outcome-based payment
- Project need for resources
  - Enrollment
- Adapt services, programming to specific needs
  - Case management, MLP
- **Boost community health advocacy efforts**

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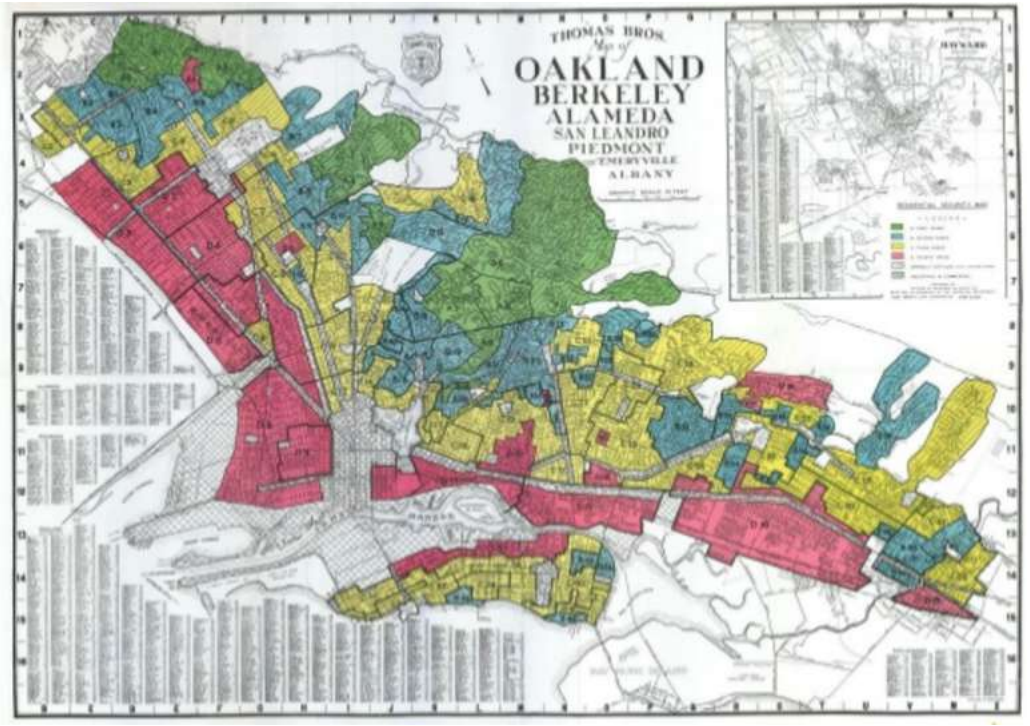
Structural Competency

- Training for health professionals
- Focus on influence of "upstream" factors on health and healthcare delivery
- Case studies applicable to the health center setting
- Customizable
- For all team levels



Visit https://outreach-partners.org/ to learn more

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Learning Objective #3

To provide an overview of relevant tools used for assessing the needs of special and vulnerable populations (e.g., patients experiencing homelessness)

Frameworks & Implementation for Special Populations

Tools and Resources

Brett Poe

Research Associate, NHCHC

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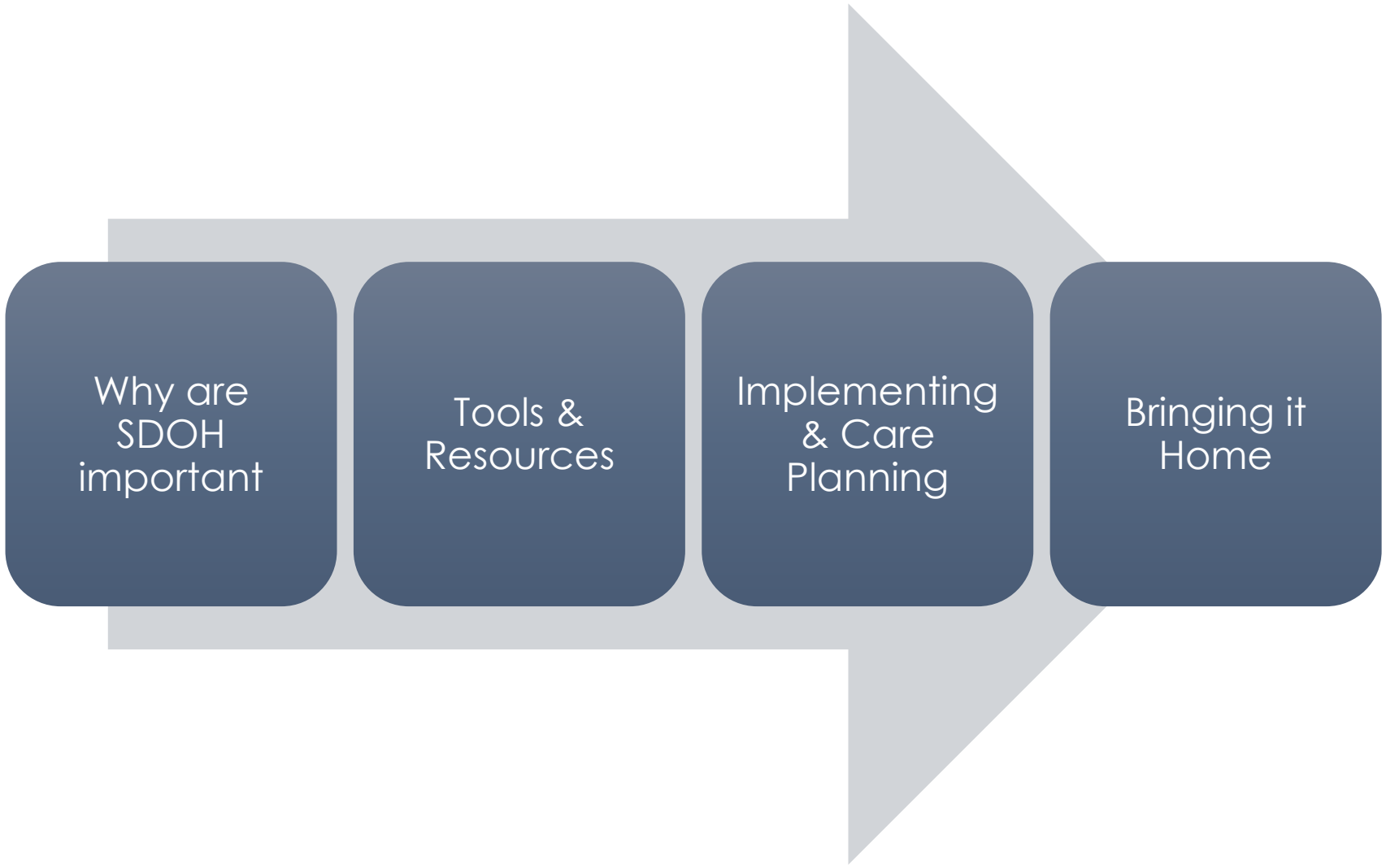

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Social Determinants of Health Equity for People who are Homeless

Source: Adopted from HealthyPeople 2020, Social Determinants of Health
*Image developed on Piktochart.com

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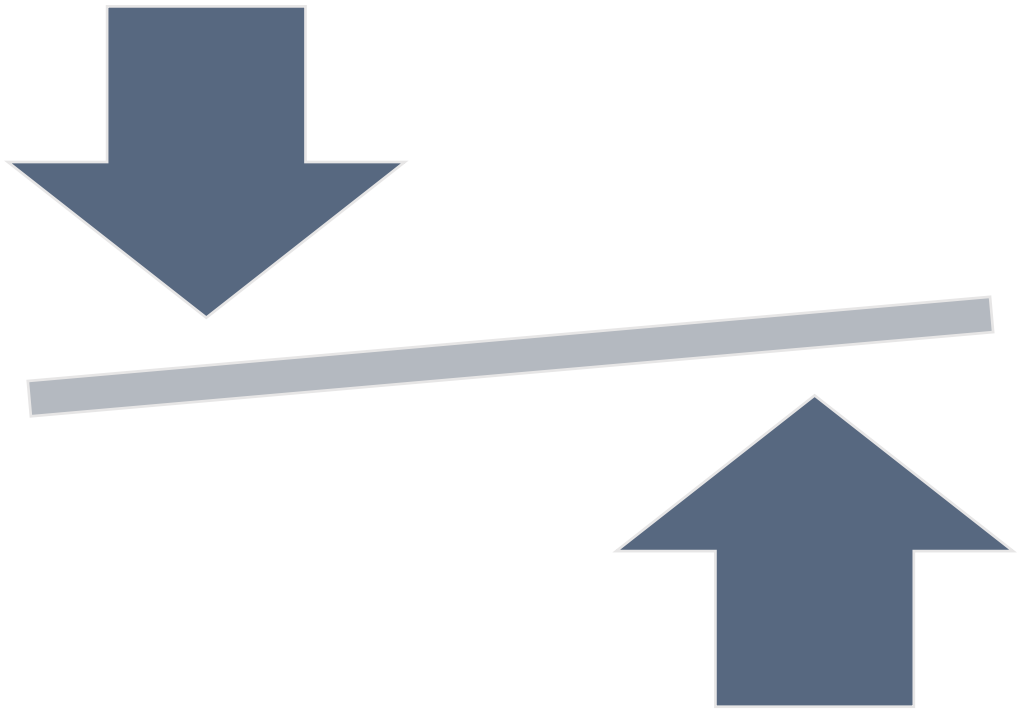
Why do SDOH Matter to Health Centers?

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

Level of Security	Health Outcomes
Food	hypertension, hyperlipidemia, poor physical & mental health
Housing	Asthma, lead poisoning, other respiratory conditions
Employment	Overall poor health, heart disease, stroke



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

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	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)		

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Tools & Resources

Using the Right Staff

- Community Health Workers
- Nurse vs. MA vs. Doctor?
- Power Balance

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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

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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

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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

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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

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Tools & Resources

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

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💡 Poll Question 💡

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

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

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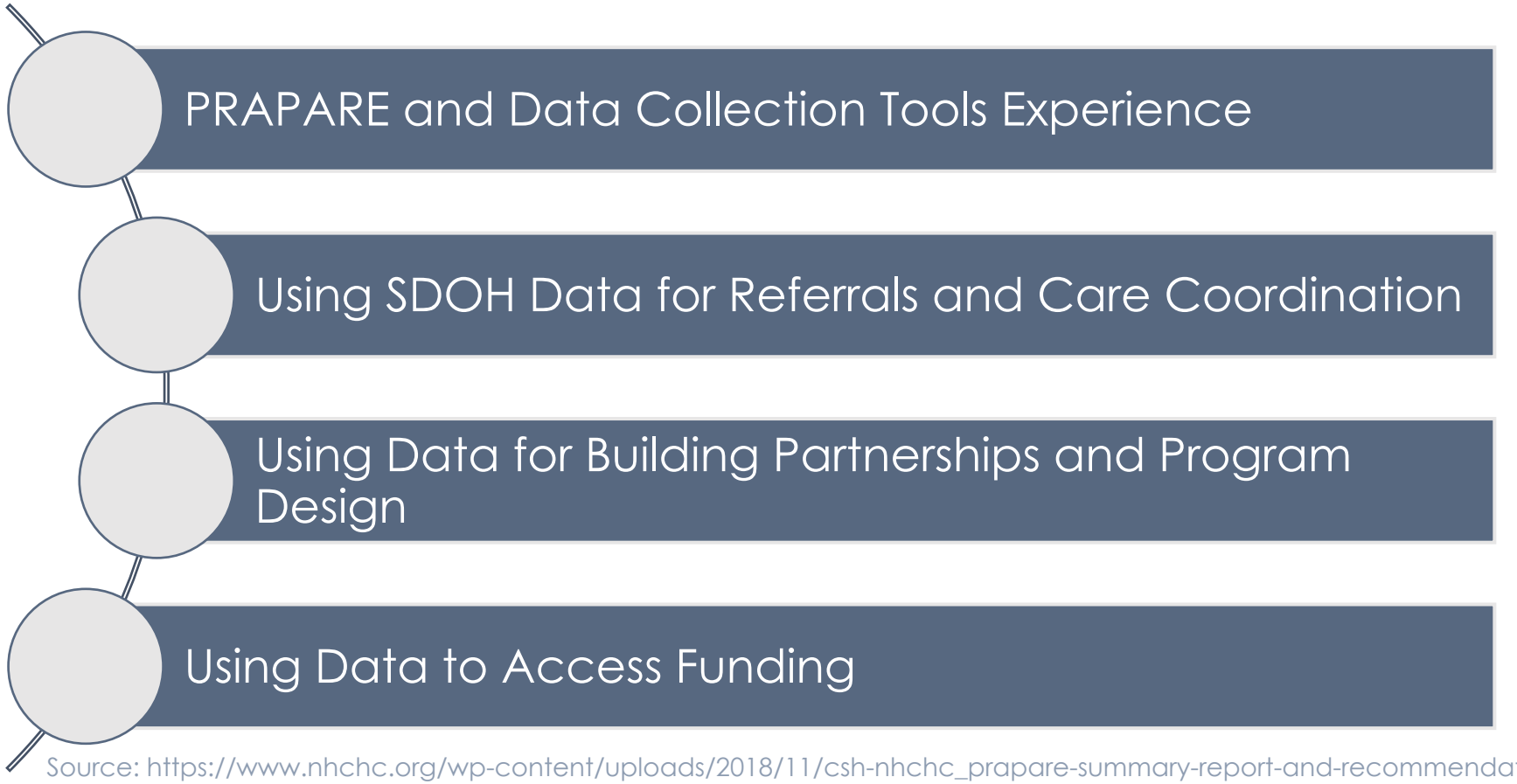
Implementing & Care Planning



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

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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

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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

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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

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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

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

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Wednesdays, October 7,21 and November 4,18
2:00-3:30PM (EST)

Apply Here:
https://bit.ly/SDOH_LearningCollaborative_10072020

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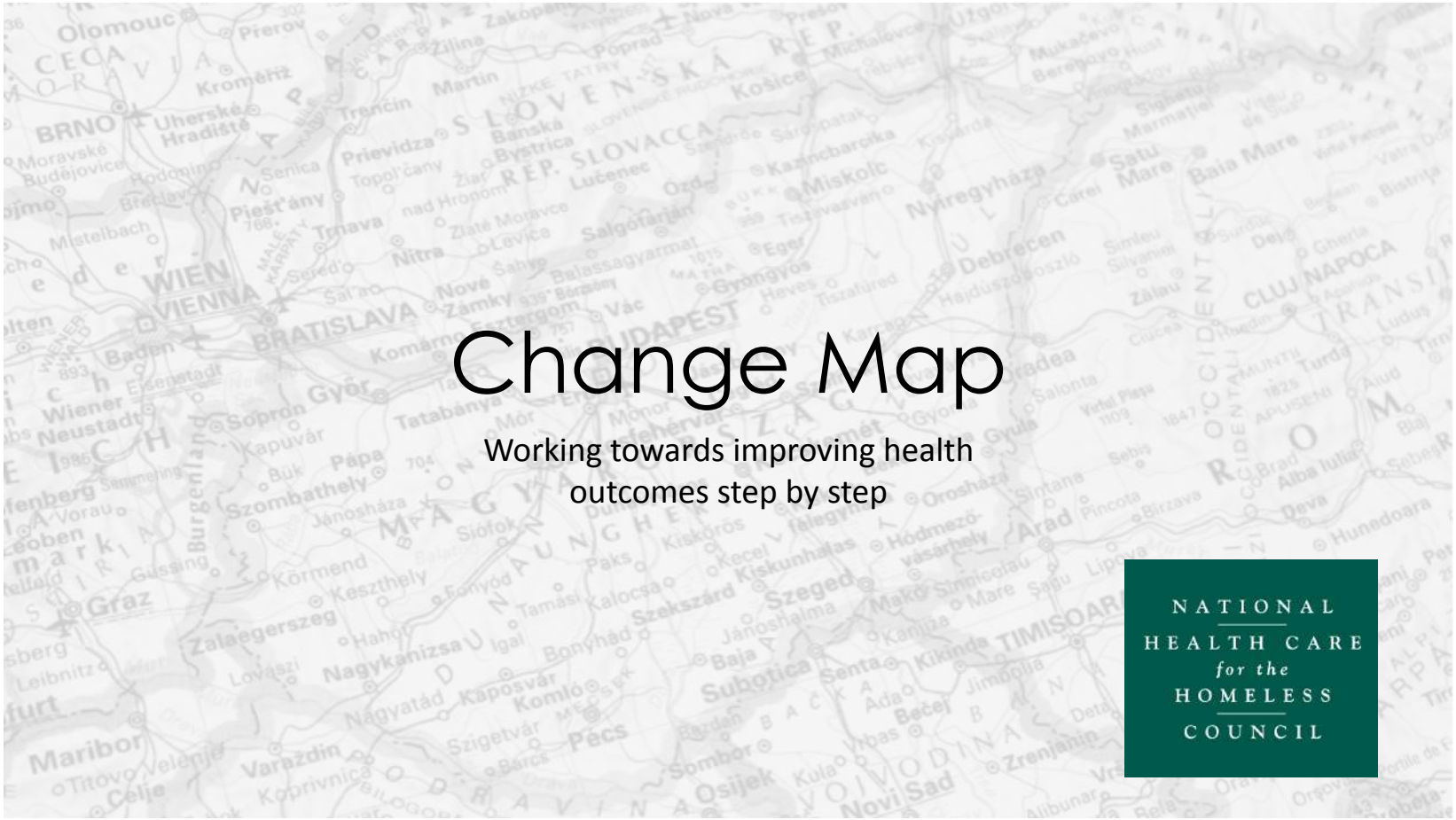
Bringing it Home: Implementing Change in Practice



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

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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

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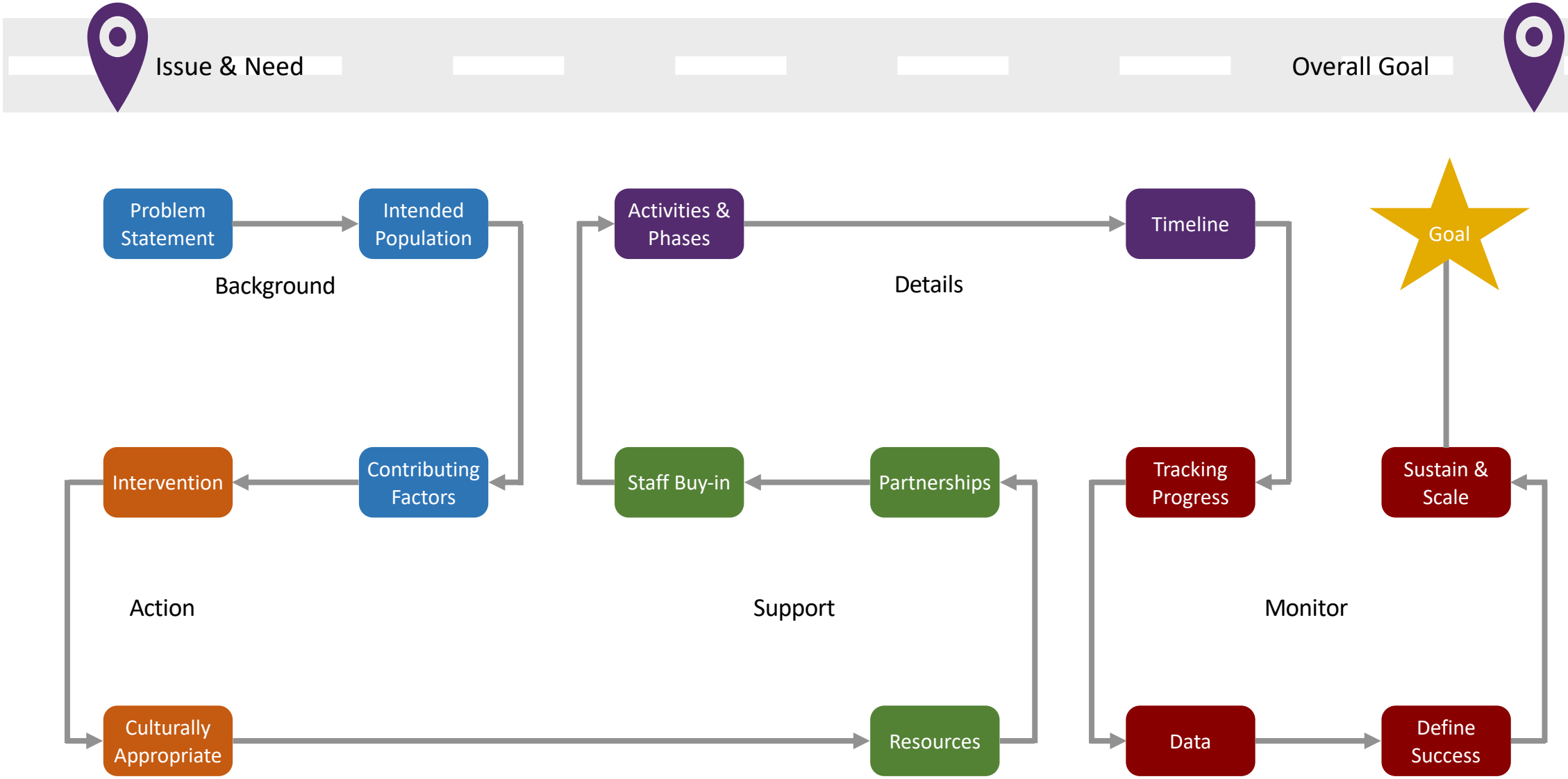
Issue & Need
Overall Goal
Problem Statement
Intended Population
Background
Activities & Phases
Timeline
Details
Goal
Intervention
Contributing Factors
Staff Buy-in
Partnerships
Tracking Progress
Sustain & Scale
Action
Support
Monitor
Culturally Appropriate
Resources
Data
Define Success

Health Site Example

Issue & Need

Problem Statement

Our patients with uncontrolled diabetes (> 9 A1c) and with borderline uncontrolled (7-9 A1c).

Target Population

Middle-aged men (don't come in as often, have harder time controlling diabetes); Hispanic men (?)

Contributing Factors

1. The main issue we identified centers around food (acquiring, storage while at work, preparing meals, etc.) 2. Willingness to come in for regular status checks (work, general attitude toward medicine, perhaps cost) 3. Not adhering to recommendations for lifestyle

Intervention

Standardized diabetes care checklists, Group visits/Family night, Telehealth interventions, Cookbooks, Food resources

Culturally Appropriate

We will try to tailor things to patient feedback. As Hispanic cultures have a great deal of diversity, we will try to incorporate teaching skills like looking for health recipes or how to shop broadly with individualization based on input.

Overall Goal

Goal

Reduce uncontrolled to less than 15% of patients and have 80% of our patients below 7 A1C.

Sustain & Scale

Have classes run regularly (spring/fall sessions), expand to other target groups

Define Success

People feel better able to eat according to doctor recommendations, improved diabetes measures

Data

Data from attitudes survey pre & post intervention (de-identified) MIPS clinical data reporting

Tracking Progress

Gantt chart/WBS to show discrete tasks & timeline. Kanban Board to keep tab on task progress & notes.

Timeline

Gantt/WBS has been created. Hope to implement group visits late September/October

Activities & Phases

I Research & Planning: Wrapping up research & big picture planning

II Handbook & Curriculum: Formalizing processes/policies & compiling a curriculum (educational & lifestyle changes) for group visits.

III Recruitment & Preparation: Recruiting patients & training staff.

IV Execution & Review: Conduct first group visit, reflect on successes/failures

Staff Buy-in

We have had buy-in from a brainstorming session; people are willing to contribute their ideas and want to see improvement. We need to incorporate that feedback into our improvement so they feel included in the process. Now we need buy-in to go the extra mile, perhaps after hours, and need to see willingness to put change ideas into action.

Partnerships

Vuela for Health - a local organization that educates people. Figuring out what their curriculum is so we do not replicate it. Food banks - supply healthy cooking options. Commit2Fitness - local gym that gives our patients discounted memberships.

Resources

Food - to give out. Looking at local food banks to help supply. A1c point-of-care reagents. We have the machine but have not used it due to cost. Group appointments would benefit greatly from instant results. Hourly salaries for any additional help after hours. Figuring out how to charge for group appointments.

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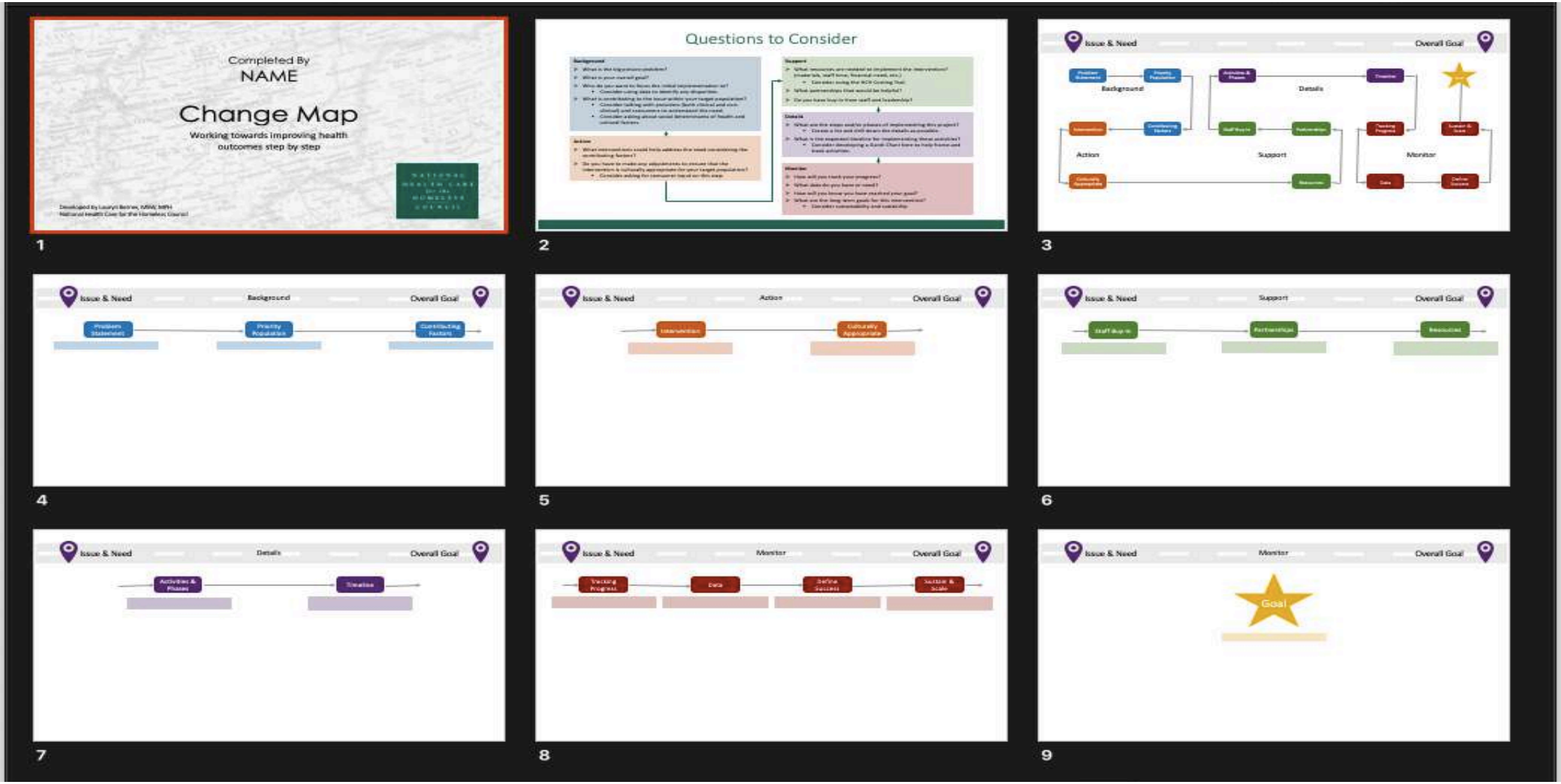
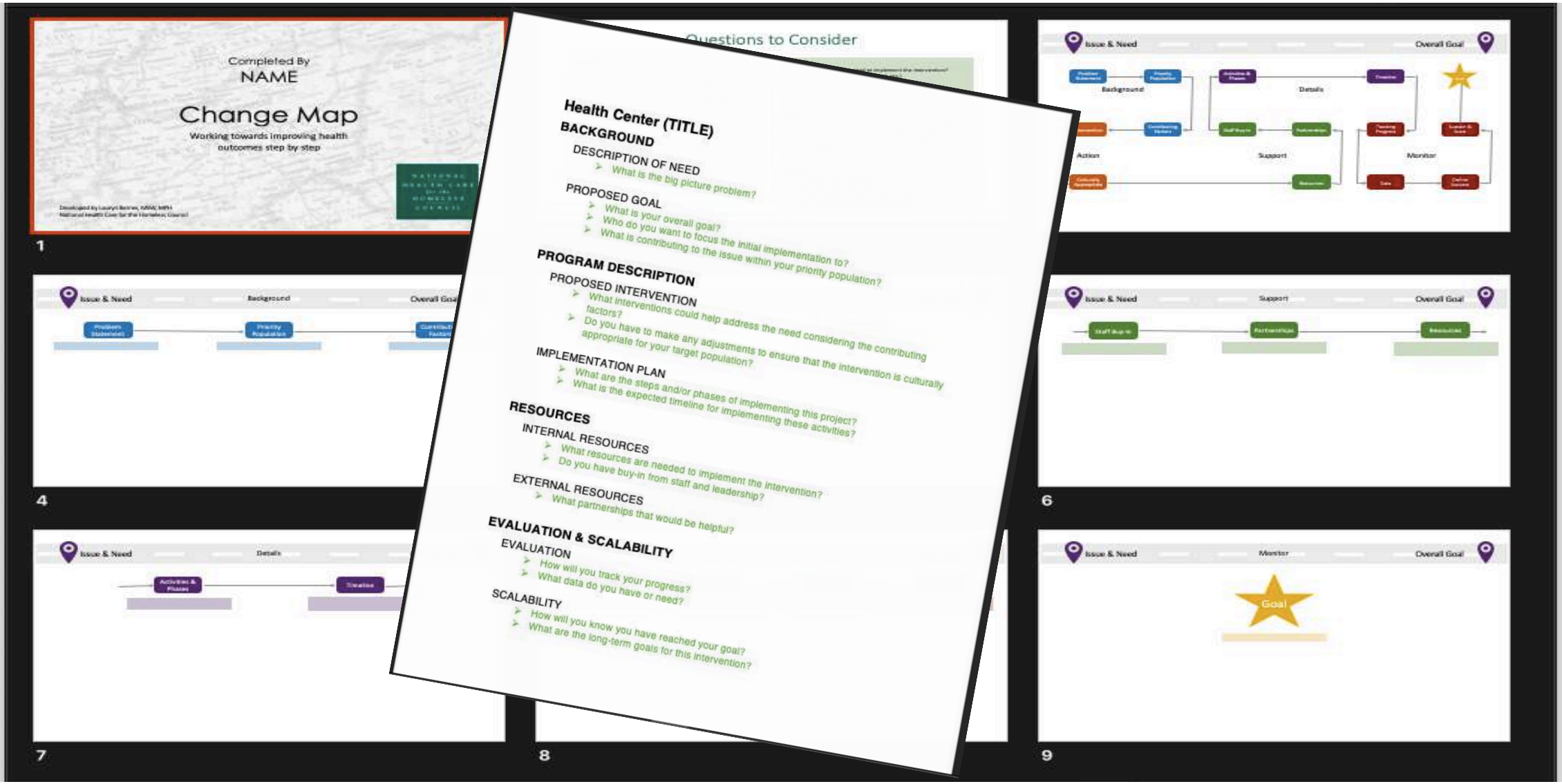
Change Map Resources



Change Map Resources



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Thank you & keep in touch!

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Appendix

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Health Center Tips & Lessons Learned for SDOH Screening

- Bread of Healing Clinic's Development of a **Business Case for Social Determinants Work** (Wisconsin)
- Compass Community Health's Implementation of **PRAPARE with Pediatric and Adolescent Patients and Their Families** (Ohio)
- Compass Community Health's Implementation of **PRAPARE with SBIRT for Patients with Behavioral Health Needs** (Ohio)
- El Rio Health's **Use of Kiosks and Tablets to Administer PRAPARE** (Arizona)
- La Clinica's Use of **PRAPARE with Formerly Incarcerated Populations** (California)
- RiverStone Health's Incorporation of **PRAPARE Data for Risk Stratification and Scoring** (Montana)
- Valley-Wide Health Systems' **Linkage of PRAPARE with Enabling Services** and Care Coordination Tracking Tools (Colorado)

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Bread of Healing Clinic's Development of a Business Case for Social Determinants Work

Bread of Healing Clinic (BOH) is a primary care medical home for the uninsured and underinsured in Milwaukee, Wisconsin. A free clinic that has operated for 20 years, Bread of Healing is well established in the community and serves over 2,000 patients each year. Bread of Healing decided to implement PRAPARE because it was a validated, comprehensive screening tool that allowed them to identify which social needs were prevalent in their community. Staff also appreciated that PRAPARE was a patient-centered tool meant to build relationships with patients as that fit with BOH's clinic culture.

Implementing PRAPARE in a Free Clinic

Bread of Healing began universal PRAPARE screening on all patients in 2016. Like most free clinics, Bread of Healing has a varied and transitional team of staff and volunteers. Given the anticipated varying levels of clinical and non-clinical needs of their patients, BOH decided to bring a Bachelor's Level Social Worker, Master's Level Social Worker, Community Health Worker, and a medical provider onto the PRAPARE team to be able to address both routine needs and highly complex patients.

At hire, staff were introduced to PRAPARE and familiarized with Bread of Healing's protocol of universal, face to face screening. PRAPARE is utilized as a conversation-starter going over a wide array of domains to identify needs that when resolved can improve overall health and wellness. Staff and student volunteers practiced asking questions with one another to smooth out question delivery. They then observed other team members screening patients before beginning to screen on their own.

Bread of Healing uses a platform to input and aggregate PRAPARE data and guide daily navigation work since they do not have an Electronic Health Record. BOH incorporates PRAPARE findings and lessons learned into staffing huddles and case reviews to update providers with varying schedules and to engage the entire care team to effectively care for the patients. A single advocate guides patients on how to use clinic and community resources to address needs identified by PRAPARE, which helps eliminate silos within a clinic featuring a financial advocate, insurance enroller, a referral coordinator, nurse case manager, and social worker. Complex patients, especially those with behavioral health needs or complex interactions with outside medical providers, are escalated to the Program Manager as necessary.

PRAPARE allowed Bread of Healing to prioritize the key socioeconomic needs of their population to help target limited resources and capacity. They are also working with a local data analytics group to map their patient population as well as their PRAPARE, ACE (Adverse Childhood Experience Survey), and PHQ-9 scores and clinical outcomes data to help BOH better understand the spatial distribution of socioeconomic and structural trends and the interplay between socioeconomic issues and clinical outcomes.

Implementation Findings and Results

Since implementing PRAPARE for universal screening in 2016, Bread of Healing has discovered the following:

- <1% OF BOH'S PATIENTS DECLINED TO BE SCREENED AND DID NOT CONSIDER THE CONVERSATION AROUND SOCIOECONOMIC CIRCUMSTANCES TO BE OFFENSIVE OR ONEROUS.
- 4% OF BOH'S PATIENTS (THOUGH INSURED) WERE UNFAMILIAR WITH HOW TO ACCESS MEDICAL AND SOCIAL SERVICES AND HENCE NEEDED NAVIGATION ASSISTANCE.
- 60% OF BOH'S PATIENTS WERE MOTIVATED TO WORK ON A NEED.
- 20% OF BOH'S PATIENTS WERE ELIGIBLE FOR INSURANCE. THIS WAS PREVIOUSLY UNKNOWN TO BOH BUT AFTER DISCOVERING THIS, STAFF AT BOH WERE ABLE TO ASSIST PATIENTS COMPLETE THE NECESSARY STEPS TO ENROLL IN INSURANCE AND ATTEND AN INITIAL APPOINTMENT WITH A PRIMARY CARE PROVIDER IN A BILLING CLINIC. WHILE THIS LEARNING IS CRITICAL FOR A FREE CLINIC, IT IS ALSO HELPFUL FOR COMMUNITY HEALTH CENTERS AND OTHER ORGANIZATIONS TO SYSTEMATICALLY IDENTIFY AND ASSIST PATIENTS SO THAT THEY RECEIVE NEEDED CARE AND SO THAT THE HEALTH CARE ORGANIZATIONS CAN INCREASE REVENUE.

Bread of Healing Clinic's Development of a Business Case for Social Determinants Work (Wisconsin)

- Justify amount of time spent with patient
- Tell your story by using qualitative data
- Patient motivation is key to success
- It is important to educate and train staff regularly
- Building and maintaining partnerships are essential

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COMPASS COMMUNITY HEALTH

PRAPARE

Compass Community Health's Implementation of PRAPARE with Pediatric and Adolescent Patients and Their Families

Compass Community Health (CCH) is a dual-site health center located in Portsmouth, Ohio that serves the Scioto County and surrounding counties located in the Southern Ohio region. CCH began implementing PRAPARE in July 2017 as organizational priorities shifted to addressing the socioeconomic needs of their behavioral health patients. They had tremendous success incorporating both SBIRT and PRAPARE in their clinic, which led to improvements in clinical quality outcomes, retention rates, and financial outcomes. For example, CCH's no show rates decreased by 13% over time.

The implementation of PRAPARE allowed CCH to develop a fully engaged care and leadership team who understood the complexities of their patients' clinical and non-clinical needs. In the words of one of CCH's leaders, "The PRAPARE tool was that missing link that CCH needed. It allowed our providers to have a better understanding of not only the person in front of them but the environment in which they lived."

With the successful implementation of PRAPARE with CCH's behavioral health patients, the team wanted to affect more change and tailor specific resources and services for their pediatric and adolescent patients battling addiction. Through NextGen, CCH is able to create specific reports and utilize evidence-based screening tools that can be used in conjunction with PRAPARE, such as the Adverse Childhood Experience survey (ACE). The team at CCH decided to "become part of the solution and use this opportunity as a way to use PRAPARE to create the very tool we lacked" to address the concerns of their pediatric and adolescent patients.

CCH's Process for Modifying PRAPARE to Use with Pediatric and Adolescent Patients

Compass Community Health utilized the same team that implemented PRAPARE with their behavioral health patients, with the exception of adding a Psychiatric Nurse Practitioner. The Psych NP works directly with the SBIRT nurse to coordinate care and identify needs of the pediatric patients and their families identified by PRAPARE and other assessments.

The SBIRT nurse, Fonda Lewis, has continued to lead the successful implementation of PRAPARE at CCH. Patient satisfaction surveys often mention Fonda or one of the behavioral health providers administering PRAPARE with positive comments about how much they helped them and/or their child.

Reviewed original PRAPARE questions and removed those that would not be applicable to patients under the age of 18 based on the discretion of Compass staff

Reworded the PRAPARE questions that would be applicable to a patient in the targeted pediatric and/or adolescent age group

Nurse with experience implementing PRAPARE trained staff on how to ask PRAPARE questions with pediatric and adolescent patients and how to respond to questions from parents, guardians, or foster parents

Developed a process on handling the "what if" scenarios and specific resources that would be needed for these situations. For example, if a child disclosed information that required additional reporting

Deveoped new workflows and documentation process for administering PRAPARE with pediatric and adolescent patients because the original PRAPARE template in EHR is geared more towards adults. Determined where the mapped and modified PRAPARE questions with PRAPARE questions in the EHR so can easily store and track data on pediatric/adolescent patients

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Compass Community Health's Implementation of PRAPARE with Pediatric and Adolescent Patients and Their Families (Ohio)

- "It's a conversation, not an interrogation"
- Provide staff with trainings
- Meet patients where they are and work at their pace
- It's not always about a dollar amount

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PRAPARE

Compass Community Health's Implementation of PRAPARE with SBIRT for Patients with Behavioral Health Needs

Compass Community Health (CCH) is located in Portsmouth, Ohio, where 89% of the population served is severely addicted to alcohol and/or illegal drugs. Also, 62% of CCH's patients are in the midst of some sort of life trauma ranging from homelessness, domestic abuse, long-term unemployment, and are living far below the poverty level. Substances include heroin, methamphetamines, opiates, cocaine, marijuana, benzodiazepines, and alcohol, with usage being significantly higher than other communities with similar demographic compositions.

To provide the patients with appropriate services to meet their needs, the staff at Compass Community Health began SBIRT (Screening, Brief Intervention and Referral for Treatment) in 2016. The goal was to reduce morbidity and mortality of alcohol, other drug use, and depression through early intervention and integration of medical and behavioral health approaches. CCH staff saw the direct positive outcomes and results of the SBIRT screening and wanted to further impact the lives of the patients they served by focusing on the socioeconomic circumstances that contribute to the trauma and substance abuse. CCH decided to implement PRAPARE to better understand their patients' needs and provide them with appropriate resources and services. PRAPARE was introduced to the staff in July 2017 with no resistance as staff saw it as another opportunity for impact with this specific population, especially when implemented alongside SBIRT screening. With the implementation of both SBIRT and PRAPARE, substance abuse treatment has become the primary and distinguishing focus of CCH's core community outreach strategy.

Incorporation of PRAPARE into SBIRT Workflow and Stratifying by Level of Risk

Training and workflow implementation were identical for both SBIRT and PRAPARE. Because of the similarities, staff felt comfortable and confident in administering both tools to patients. The CCH clinical staff directly involved in SBIRT and PRAPARE implementation included the Clinical Director, Psych Nurse Practitioner, SBIRT Nurse, Care Coordinator, Licensed Social Worker, and the Outreach and Enrollment Specialist.

CCH has a designated RN who completes both SBIRT and PRAPARE screenings. SBIRT and PRAPARE are completed during a patient's first clinic visit and updated annually thereafter unless a specific need is identified. The nurse will collect the information during the waiting time before the patient sees the provider. The Outreach and Enrollment Specialist refers and connects patients to resources and services. When patients are referred to other community services, the staff follow-up with the patient and/or their referral source to attempt to connect them again.

Compass Community Health Staff

Clinical Director	• Leads PRAPARE implementation
Providers and Nurses	• Understand the PRAPARE tool, its purpose, what information the PRAPARE screening will provide, and how it impacts the clinical outcomes of the patients
SBIRT Nurse	• Performs PRAPARE data collection using motivational interviewing techniques and serves as the point of contact for the providers and Care Coordinator on socioeconmic related items
Care Coorindator and LISW	• Assist with patient follow-ups and connecting patients to community resources
Outreach and Enrollment Specialist	• Assist with the development of the Community Resource File

Compass Community Health's Implementation of PRAPARE with SBIRT for Patients with Behavioral Health Needs (Ohio)

"It's not always about dollar amount but all about increasing the care we deliver. Your bottom line will ultimately be the impact and that's how we continue to serve the patients who need us."

- Erin Trapp, Clinical Director

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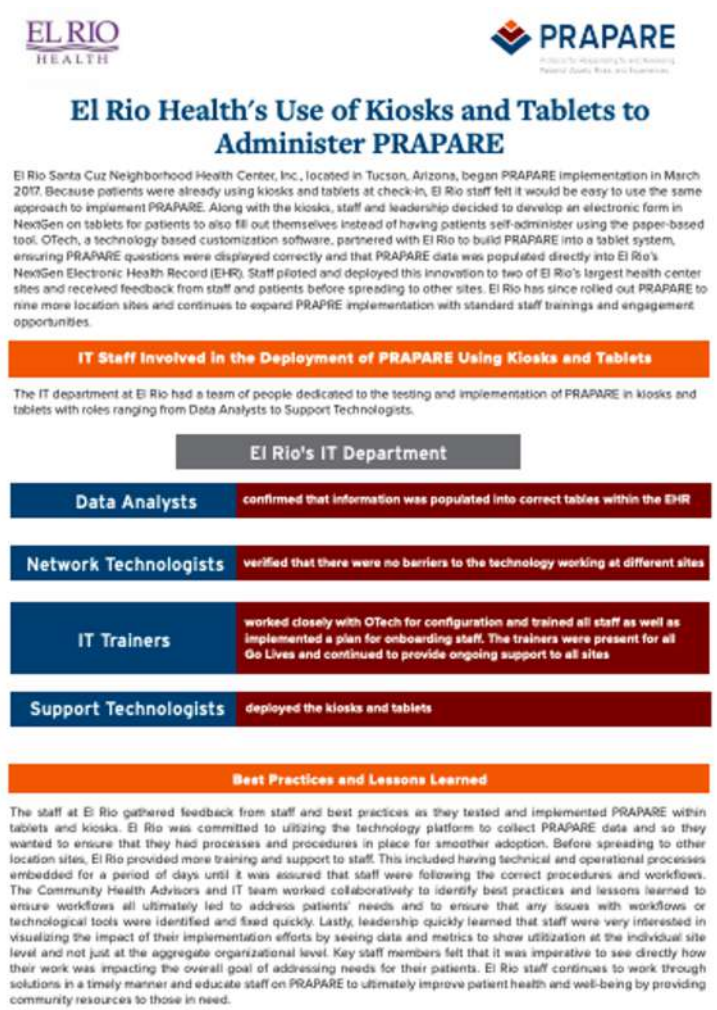

EL RIO HEALTH

PRAPARE

El Rio Health's Use of Kiosks and Tablets to Administer PRAPARE

El Rio Santa Cuz Neighborhood Health Center, Inc., located in Tucson, Arizona, began PRAPARE implementation in March 2017. Because patients were already using kiosks and tablets at check-in, El Rio staff felt it would be easy to use the same approach to implement PRAPARE. Along with the kiosks, staff and leadership decided to develop an electronic form in NextGen on tablets for patients to also fill out themselves instead of having patients self-administer using the paper-based tool. OTech, a technology based customization software, partnered with El Rio to build PRAPARE into a tablet system, ensuring PRAPARE questions were displayed correctly and that PRAPARE data was populated directly into El Rio's NextGen Electronic Health Record (EHR). Staff piloted and deployed this innovation to two of El Rio's largest health center sites and received feedback from staff and patients before spreading to other sites. El Rio has since rolled out PRAPARE to nine more location sites and continues to expand PRAPRE implementation with standard staff trainings and engagement opportunities.

IT Staff Involved in the Deployment of PRAPARE Using Kiosks and Tablets

The IT department at El Rio had a team of people dedicated to the testing and implementation of PRAPARE in kiosks and tablets with roles ranging from Data Analysts to Support Technologists.

El Rio's IT Department

Data Analysts	confirmed that information was populated into correct tables within the EHR
Network Technologists	verified that there were no barriers to the technology working at different sites
IT Trainers	worked closely with OTech for configuration and trained all staff as well as implemented a plan for onboarding staff. The trainers were present for all Go Lives and continued to provide ongoing support to all sites
Support Technologists	deployed the kiosks and tablets

Best Practices and Lessons Learned

The staff at El Rio gathered feedback from staff and best practices as they tested and implemented PRAPARE within tablets and kiosks. El Rio was committed to utilizing the technology platform to collect PRAPARE data and so they wanted to ensure that they had processes and procedures in place for smoother adoption. Before spreading to other location sites, El Rio provided more training and support to staff. This included having technical and operational processes embedded for a period of days until it was assured that staff were following the correct procedures and workflows. The Community Health Advisors and IT team worked collaboratively to identify best practices and lessons learned to ensure workflows all ultimately led to address patients' needs and to ensure that any issues with workflows or technological tools were identified and fixed quickly. Lastly, leadership quickly learned that staff were very interested in visualizing the impact of their implementation efforts by seeing data and metrics to show utilization at the individual site level and not just at the aggregate organizational level. Key staff members felt that it was imperative to see directly how their work was impacting the overall goal of addressing needs for their patients. El Rio staff continues to work through solutions in a timely manner and educate staff on PRAPARE to ultimately improve patient health and well-being by providing community resources to those in need.

El Rio Health's Use of Kiosks and Tablets to Administer PRAPARE (Arizona)

- Involve IT staff from the beginning
- Gather feedback at all times
- Identify "Super Users"
- Develop a resource book

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La Clínica

PRAPARE

La Clinica's Use of PRAPARE with Formerly Incarcerated Populations

La Clínica de La Raza, Inc. (La Clínica) is a Federally Qualified Health Center providing comprehensive health care to underserved populations in Alameda, Contra Costa, and Solano Counties. The diverse and low-income communities in these counties face barriers to accessing care related to cost, linguistic isolation, and inaccessibility of health care providers. To meet the needs of these low-income communities, La Clínica has been at the forefront of developing culturally and linguistically responsive patient-centered health care services that reduce barriers to care for over 47 years.

In recognition of the high need for integrated services for those recently released from prison in Solano County, La Clínica established a Transitions Clinic in 2016. Modeled after and part of the Transitions Clinic Network based out of San Francisco and funded by a local managed care plan as well as the Board of State and Community Corrections, La Clínica's Transition Clinic provides comprehensive, integrated clinical care, care coordination, referrals, and case management services tailored to the formerly incarcerated population, who often experience significant economic and societal obstacles that may prevent them from obtaining gainful employment, stable housing, and a supportive social network. La Clínica decided to implement PRAPARE at their Transitions Clinic to better understand the socioeconomic obstacles and barriers that their patients face and to target appropriate services, referrals, and interventions.

PRAPARE Implementation

La Clínica has a Memorandum of Understanding with the Solano County Sheriff's Office that allows the community health worker (CHW) to receive a list of individuals that are being released. La Clínica also receives referrals from case managers at different prisons and parole agencies in the area. The CHW is able to establish a relationship with the inmate before their release date by connecting via webcam through a confidential iWeb visit to identify the needs of the individual. The CHW is then able to schedule a primary care appointment.

At La Clínica's Transitions Clinic, a community health worker (who had also been formerly incarcerated) administers the PRAPARE screening tool at intake in a conversational way to build rapport and trust with patients. Because the community health worker had also been formerly incarcerated, they are able to relate to patients' experiences and understand how some questions can trigger unresolved trauma. During the conversation, the CHW provides coordinated support services and referrals to other community resources. Given the need to build trusting and lasting relationships with individuals who were recently incarcerated, La Clínica ensures to allocate sufficient time at the intake process, even up to an hour if needed.

After administering PRAPARE, the patient visits with the medical provider to receive primary care services. The Transitions Clinic team (consisting of a medical provider, a CHW, and a Community Health Education Supervisor) works closely together to coordinate care and provide case management. The CHW attends collaborative meetings, community events, and outreach events and visits halfway homes and shelters to promote the services provided at the Transitions Clinic.

La Clínica's Transitions Clinic care team (right to left): Dr. Ann Finkelstein, MD & Provider Champion and MaDonna Garcia-Crowley, Community Health Worker

La Clinica's Use of PRAPARE with Formerly Incarcerated Populations (California)

- Connection pays off
- Attract patients with incentives
- Establish a champion
- Schedule kick-off meetings

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RiverStone Health's Incorporation of PRAPARE Data for Risk Stratification and Scoring

Located in Billings, Montana, RiverStone Health Clinic began PRAPARE implementation in November 2016. A multi-disciplinary team-based approach was utilized to plan the implementation of PRAPARE and to test, evaluate, and revise the clinical workflow that would be used by all sites.

To expand the utility of the standardized socioeconomic data collected via PRAPARE, they incorporated PRAPARE data with other clinical outcomes data to create a more holistic patient risk score to use for care management and transformation.

Multi-Disciplinary Workflow to Respond to Socioeconomic Needs Identified by PRAPARE

At RiverStone Health, patients (age 18 and older) are asked to complete PRAPARE on an annual basis upon check-in. Providers and the clinical staff work together to address positive screening responses to the questions regarding patients who either have high stress level responses, feel physically or emotionally unsafe, or do not have a support system. If the patient screens positive for any social risks, the patient will be connected with the Team Care Manager at the time of their appointment for assistance. All completed PRAPARE forms are entered into the patient's care plan into the Electronic Health Record by the Care Manager. This allows for data tracking and recording of the patients' socioeconomic concerns.

To have a more seamless workflow to respond to needs, RiverStone Health color-coded PRAPARE questions to alert staff implementing PRAPARE as to which staff are most appropriate to respond to certain needs. A positive screen indicated in the yellow section notifies the medical assistant that the Care Coordinator should see the patient after their visit to address those particular needs. A positive screen in the orange section, on the other hand, indicates that a clinical and/or behavioral health team member should be involved to help address risks related to stress, safety, and domestic violence, and social isolation.

Page 1 of the RiverStone Health PRAPARE Tool

RiverStone Health's Incorporation of PRAPARE Data for Risk Stratification and Scoring (Montana)

- Responding to Socioeconomic Needs
- Creation of Windows One Note Program
- Staff Educational Opportunities to Learn About Various Community Services
- Development of a Risk Stratification Model that Incorporates PRAPARE Data

Valley-Wide Health Systems' Linkage of PRAPARE with Enabling Services and Care Coordination Tracking Tools (Colorado)

- Work with IT staff
- Find value in data
- Start Now!
- Be willing to be flexible and creative
- Small steps matter!

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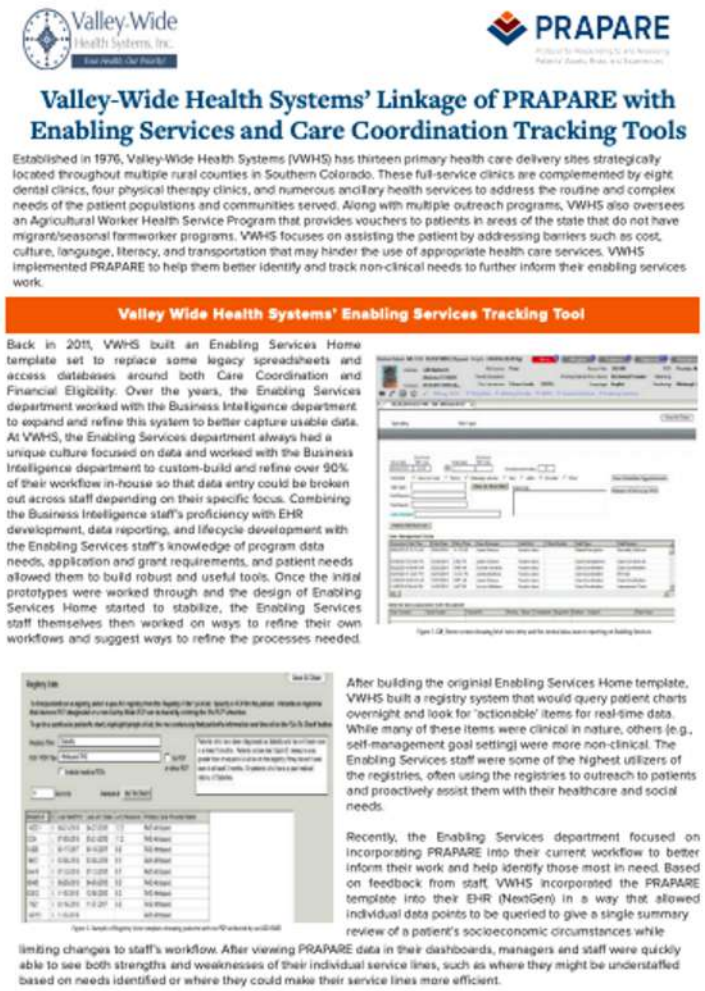

Valley-Wide Health Systems, Inc.

PRAPARE

Valley-Wide Health Systems' Linkage of PRAPARE with Enabling Services and Care Coordination Tracking Tools

Established in 1976, Valley-Wide Health Systems (VWHS) has thirteen primary health care delivery sites strategically located throughout multiple rural counties in Southern Colorado. These full-service clinics are complemented by eight dental clinics, four physical therapy clinics, and numerous ancillary health services to address the routine and complex needs of the patient populations and communities served. Along with multiple outreach programs, VWHS also oversees an Agricultural Worker Health Service Program that provides vouchers to patients in areas of the state that do not have migrant/seasonal farmworker programs. VWHS focuses on assisting the patient by addressing barriers such as cost, culture, language, literacy, and transportation that may hinder the use of appropriate health care services. VWHS implemented PRAPARE to help them better identify and track non-clinical needs to further inform their enabling services work.

Valley Wide Health Systems' Enabling Services Tracking Tool

Back in 2011, VWHS built an Enabling Services Home template set to replace some legacy spreadsheets and access databases around both Care Coordination and Financial Eligibility. Over the years, the Enabling Services department worked with the Business Intelligence department to expand and refine this system to better capture usable data. At VWHS, the Enabling Services department always had a unique culture focused on data and worked with the Business Intelligence department to custom-build and refine over 90% of their workflow in-house so that data entry could be broken out across staff depending on their specific focus. Combining the Business Intelligence staff's proficiency with EHR development, data reporting, and lifecycle development with the Enabling Services staff's knowledge of program data needs, application and grant requirements, and patient needs allowed them to build robust and useful tools. Once the initial prototypes were worked through and the design of Enabling Services Home started to stabilize, the Enabling Services staff themselves then worked on ways to refine their own workflows and suggest ways to refine the processes needed.

After building the original Enabling Services Home template, VWHS built a registry system that would query patient charts overnight and look for "actionable" items for real-time data. While many of these items were clinical in nature, others (e.g., self-management goal setting) were more non-clinical. The Enabling Services staff were some of the highest utilizers of the registries, often using the registries to outreach to patients and proactively assist them with their healthcare and social needs.

Recently, the Enabling Services department focused on incorporating PRAPARE into their current workflow to better inform their work and help identify those most in need. Based on feedback from staff, VWHS incorporated the PRAPARE template into their EHR (NextGen) in a way that allowed individual data points to be queried to give a single summary review of a patient's socioeconomic circumstances while limiting changes to staff's workflow. After viewing PRAPARE data in their dashboards, managers and staff were quickly able to see both strengths and weaknesses of their individual service lines, such as where they might be understaffed based on needs identified or where they could make their service lines more efficient.

PRAPARE

Valley-Wide Health Systems, Inc.

AAPCHO

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NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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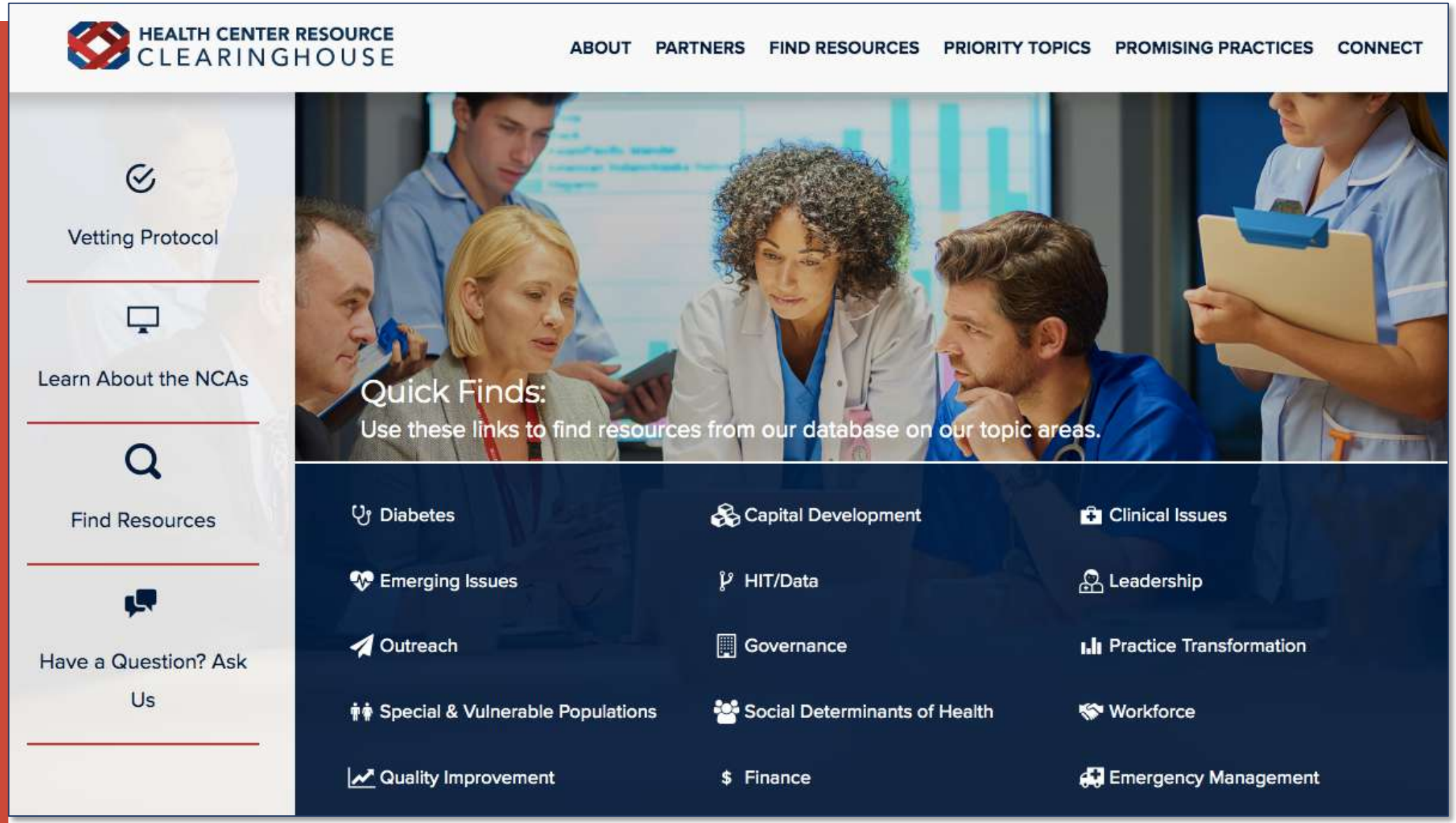

Website: www.healthcenterinfo.org

AAPCHO

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AAPCHO

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**

Health Outreach Partners

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
- Outreach and enrollment
- Transportation
- Collaboration
- Needs assessment

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**

HEALTH CENTER RESOURCE CLEARINGHOUSE

AAPCHO

Health Outreach Partners

MHP Salud OUTCOMES-DRIVEN EXPERIENCED INNOVATIVE

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

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**