# TWO SIDES OF THE SAME COIN: ADDRESSING SOCIAL DETERMINANTS OF HEALTH AND ENABLING SERVICES DATA COLLECTION

**April 25, 2019**
**1:30 p.m. EDT**

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

AAPCHO
Association of Asian Pacific Community Health Organizations

# Overview

**Purpose:**

Standardized data collection on SDoH and ES are two sides of the same coin and provide the foundation for health centers to succeed in a value-based pay environment by not only helping them address root causes of poor health, but also by highlighting the value of the health center model.

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

- Explain the importance of tracking health center interventions in addressing patients' social determinants of health risks.
- Describe the role of Primary Care Associations (PCAs) and health centers in identifying patient social risks and promoting a standardized protocol to track enabling services.
- Identify resources available for PCAs and health centers to implement an enabling services data collection protocol within their own organizations.

# NCA Introductions

**Kristen Stoimenoff, MPH**
*Interim CEO*
HOP

**Brett Poe**
*Research Associate*
NHCHC

**Albert Ayson, MPH**
*Senior Program Manager*
AAPCHO

**Diana Lieu**
*Senior Manager*
HOP

**Joe Lee, MSHA**
*Training & Technical Assistance Director*
AAPCHO

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# PCA & CHC Guest Speakers

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Upper Great Lakes Family Health Center

**Nashia Choudury, MPH**
*Associate Director of Operations & Enabling Services*
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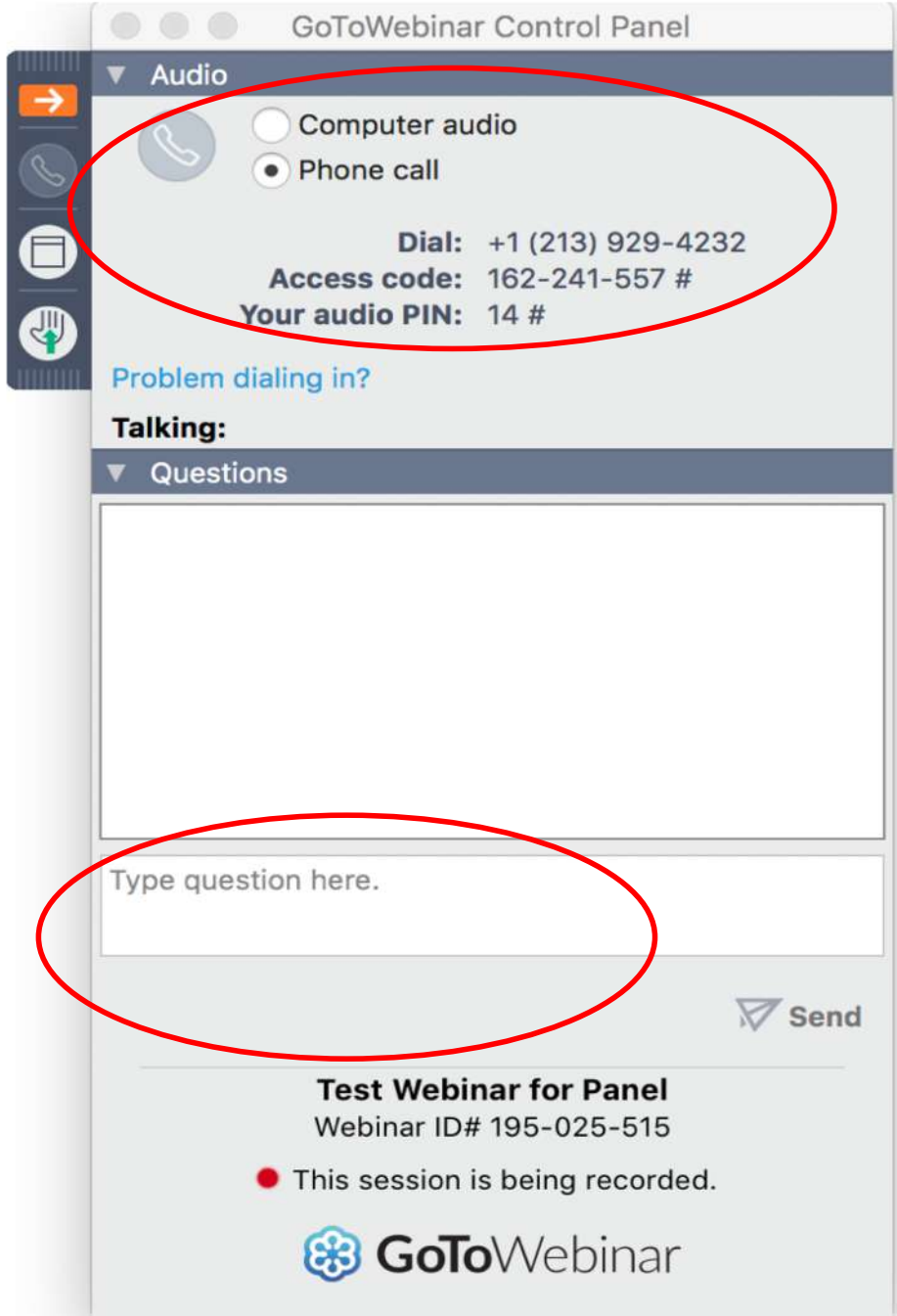
# Agenda

1) Welcome & Introductions
2) Enabling Services Accountability Project
3) NCA Partnership: Enabling Services Data Collection
4) PCA Perspectives
5) Health Center Perspective
6) Q&A/Closing

# Using GoToWebinar

- All participants in Listen Only mode
- Connect to audio via telephone or computer, not both
- Type questions or comments into the “Question” box on your Control Panel.



# ENABLING SERVICES ACCOUNTABILITY PROJECT

# AAPCHO's Enabling Services Accountability Project

**PARTICIPATING CENTERS:**

- Charles B. Wang Community Health Center (New York, NY)
- International Community Health Services (Seattle, WA)
- Kalihi-Palama Health Center (Honolulu, HI)
- Waianae Coast Comprehensive Health Center (Waianae, HI)

*Acknowledgement: New York Academy of Medicine (NYAM) , National Association of Community Health Centers (NACHC), et al.

# AAPCHO's Enabling Services Accountability Project (cont.)

## Goals

Develop standardized enabling services (ES) data collection protocols

Describe utilization of ES at health centers

Evaluate the impact of ES on health access, outcomes, and utilization of primary care

Disseminate findings to health centers and policymakers to guide effective resource allocation

Facilitate research and expansion opportunities to other health centers and networks

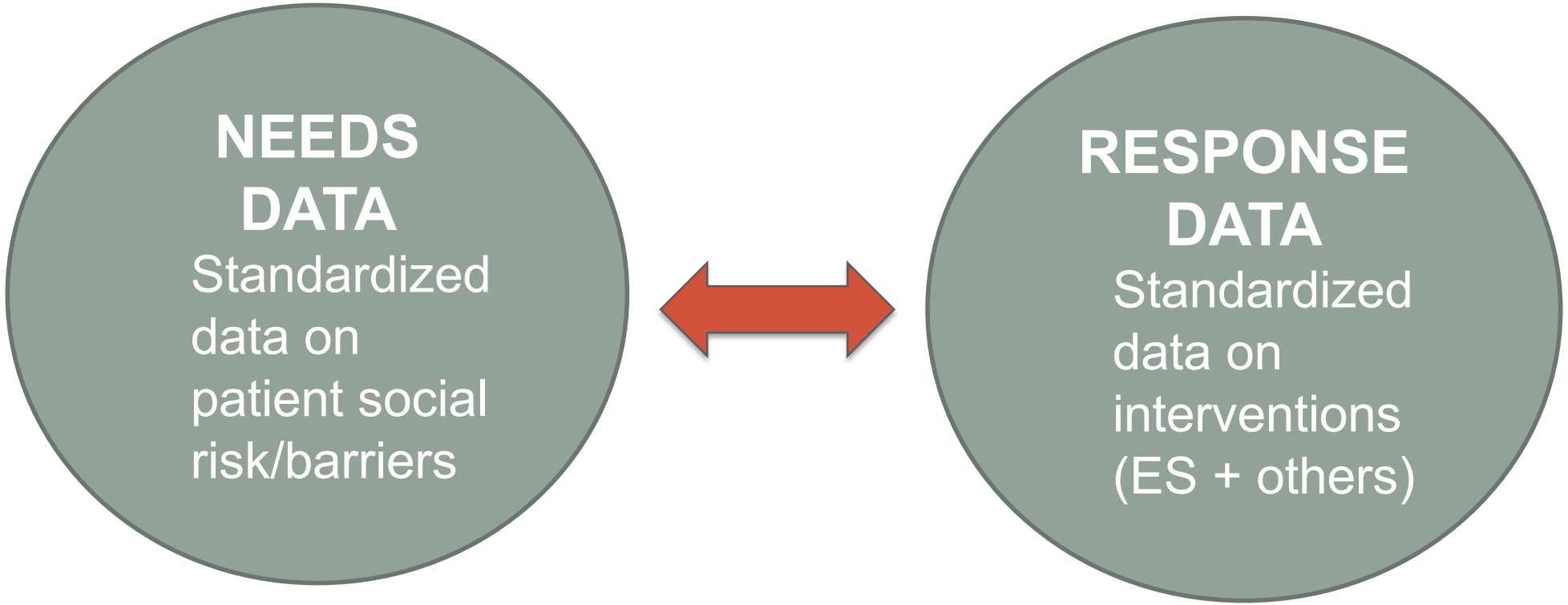
# Definitions

- **Enabling Services:** Non-clinical services that are specifically linked to a medical encounter or the provision of medical services for a patient at your health center. *"Enabling" patients to improve access and health outcomes.*
- Standardized collection allows for better tracking of these unique services across health centers for national evaluation and advocacy

**15 categories of services**

- *Social Services*
- *Case Management*
- *Referral – Health*
- *Referral - Social*
- *Financial Counseling*
- *Health Education, 1-1*
- *Health Ed, 2-12*
- *Health Ed, 13+*
- *Supportive Counseling*
- *Interpretive Services*
- *Outreach*
- *Inreach*
- *Transportation – Health*
- *Transportation – Social*
- *Other*

| 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<br>*Individual<br>*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 |




**BOTH are necessary to:**

- ✓ Demonstrate health center value to payers
- ✓ Seek adequate financing
- ✓ Better target and/or improve services
- ✓ Achieve integrated, value-driven delivery system and reduce total cost of care

# NCA PARTNERSHIP: ENABLING SERVICES DATA COLLECTION

# What Are Enabling Services?

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

# NCA Partnership

- Training of Trainers Approach
- T/TA Examples
- Categories
- Implementation Packet:

http://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/

- Meeting with PCA/HCCN Partners (Dec 2017)

# PCA/HCCN Virtual Convening: Major Themes

- What is the value of this work?
- What are the biggest barriers to implementation?
- How is your organization helping?
- How should/could PCAs, HCCNs, and NCAs use this data?
- How should/could PCAs, HCCNs, and NCAs support ESDC?

# Findings and Recommendations

- Value of ES – sets health centers apart
- Tracking varies greatly; ES likely underreported
- Importance of using ES data to show ROI
- Value of toolkit & structured trainings
- Value of linking to PRAPARE

# PCA PERSPECTIVES

Iowa PRIMARY CARE ASSOCIATION

# Tracking Enabling Services



# Our History

- Partnership with AllianceChicago to purchase their customized Centricity EHR content
- AllianceChicago had health center in Hawaii that requested enabling services content, based on AAPCHO work
- Opportunity to work with AAPCHO to implement enabling services data collection within two Iowa health centers using AllianceChicago content
- Learned that implementation of PRAPARE (or other SDOH screening tool) first helps demonstrate the value proposition for collecting enabling services . . .
- Same two health centers then served as pilots for testing and implementing the PRAPARE tool

Iowa PRIMARY CARE ASSOCIATION
INConcertCare expanding our capacity to care
iowahealth+

# Where We're Headed Next

- We now have six health centers at different stages of implementation of PRAPARE across Iowa
  - Over 24,000 unique patients have been screened with the PRAPARE tool across the state
- Capturing SDOH has made obvious the need to capture enabling services in a standardized way as had the opportunity to implement Medicare CCM programs
- The Iowa PCA and its member health centers are focused on:
  1. A process for determining if health centers have the ability to capture enabling services in a consistent way in their current HIT environments
  2. An evaluation of vendors that specialize in connecting health care providers with community-based services and ensure a closed referral loop with technology

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April 2019

# mpca

THE VOICE OF
COMMUNITY HEALTH CENTERS

April 2019

# The MPCA Mission & Vision

## Our Mission:

To enhance integrated care through community health centers while influencing policy at the state and national level

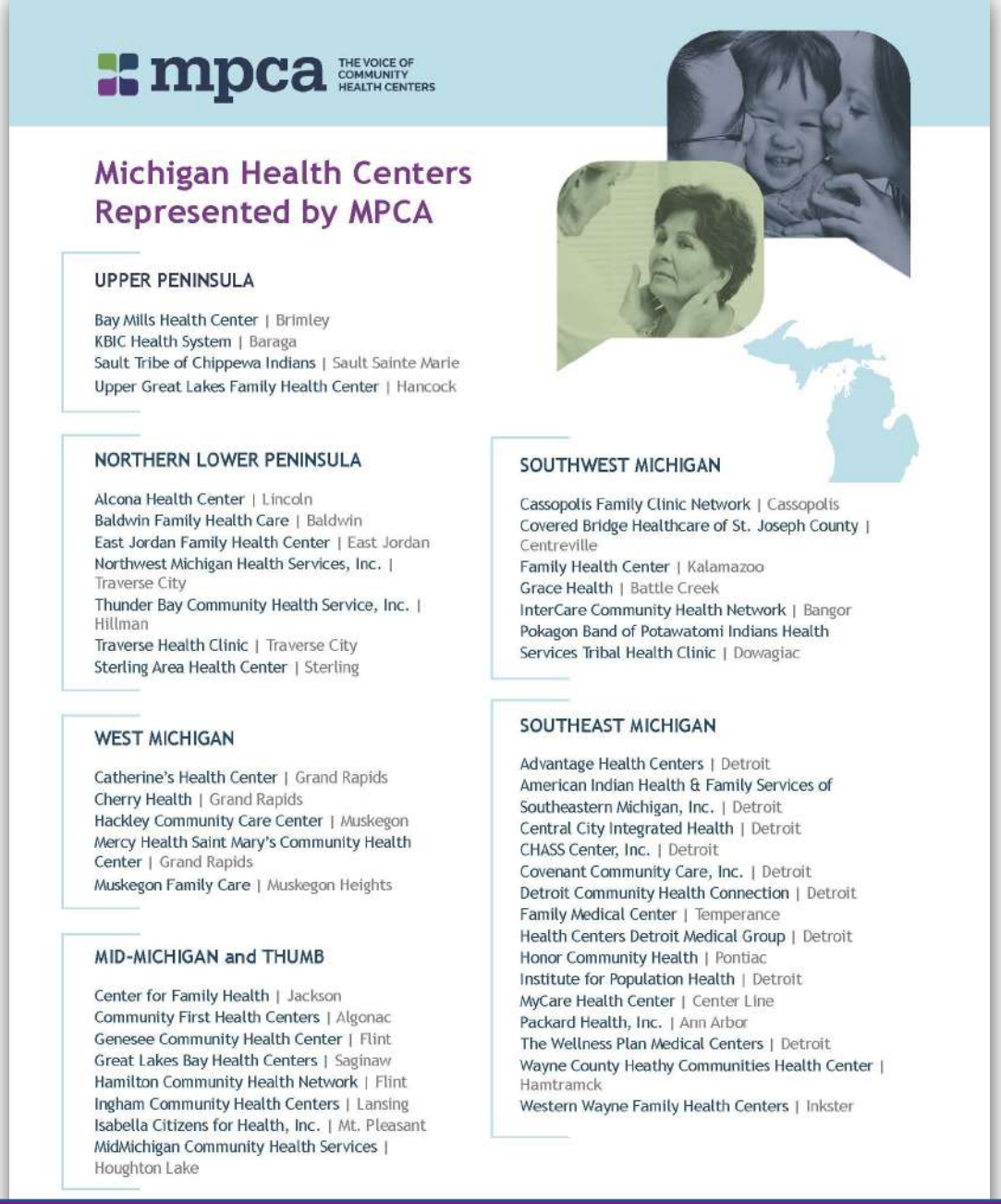
## Our Vision:

Quality Integrated Care for All

# Michigan Health Centers

# Michigan Health Center Sites

- 45 Health Center organizations
  - 38 Health Centers
  - 3 Health Center Look-Alikes
  - 5 American Indian Health Service Providers
- Serving more than 700,000 patients at over 300 sites in both rural and urban communities across Michigan



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## Michigan Health Centers Represented by MPCA

### UPPER PENINSULA

Bay Mills Health Center | Brimley
KBIC Health System | Baraga
Sault Tribe of Chippewa Indians | Sault Sainte Marie
Upper Great Lakes Family Health Center | Hancock

### NORTHERN LOWER PENINSULA

Alcona Health Center | Lincoln
Baldwin Family Health Care | Baldwin
East Jordan Family Health Center | East Jordan
Northwest Michigan Health Services, Inc. | Traverse City
Thunder Bay Community Health Service, Inc. | Hillman
Traverse Health Clinic | Traverse City
Sterling Area Health Center | Sterling

### WEST MICHIGAN

Catherine's Health Center | Grand Rapids
Cherry Health | Grand Rapids
Hackley Community Care Center | Muskegon
Mercy Health Saint Mary's Community Health Center | Grand Rapids
Muskegon Family Care | Muskegon Heights

### MID-MICHIGAN and THUMB

Center for Family Health | Jackson
Community First Health Centers | Algonac
Genesee Community Health Center | Flint
Great Lakes Bay Health Centers | Saginaw
Hamilton Community Health Network | Flint
Ingham Community Health Centers | Lansing
Isabella Citizens for Health, Inc. | Mt. Pleasant
MidMichigan Community Health Services | Houghton Lake

### SOUTHWEST MICHIGAN

Cassopolis Family Clinic Network | Cassopolis
Covered Bridge Healthcare of St. Joseph County | Centreville
Family Health Center | Kalamazoo
Grace Health | Battle Creek
InterCare Community Health Network | Bangor
Pokagon Band of Potawatomi Indians Health Services Tribal Health Clinic | Dowagiac

### SOUTHEAST MICHIGAN

Advantage Health Centers | Detroit
American Indian Health & Family Services of Southeastern Michigan, Inc. | Detroit
Central City Integrated Health | Detroit
CHASS Center, Inc. | Detroit
Covenant Community Care, Inc. | Detroit
Detroit Community Health Connection | Detroit
Family Medical Center | Temperance
Health Centers Detroit Medical Group | Detroit
Honor Community Health | Pontiac
Institute for Population Health | Detroit
MyCare Health Center | Center Line
Packard Health, Inc. | Ann Arbor
The Wellness Plan Medical Centers | Detroit
Wayne County Heathy Communities Health Center | Hamtramck
Western Wayne Family Health Centers | Inkster

Source: *American Journal of Public Health* 106, No. 11 (Nov. 1, 2016); pp. 1981-1989

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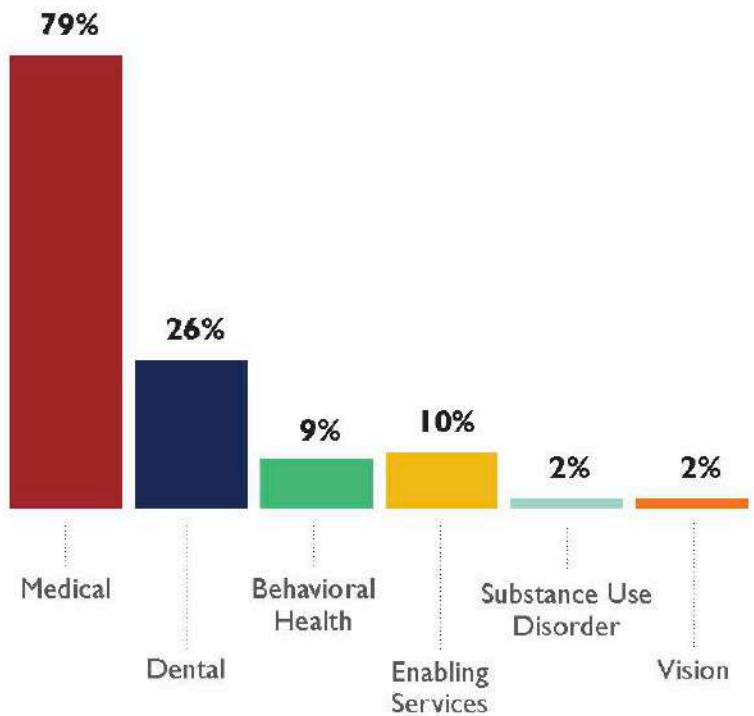
# State Summary: Who Do We Serve?

## % OF PATIENTS BY SERVICE TYPE




## AGE OF PATIENTS

- **29%** 0-19
- **35%** 20-44
- **28%** 45-64
- **8%** 65+

## RACE & ETHNICITY

- **2%** American Indian/Alaska Native
- **1%** Asian
- **28%** Black/African American
- **13%** Hispanic/Latino
- **1%** Native Hawaiian/Other Pacific Islander
- **55%** White

## PATIENT INCOME

- **69%** below 100% FPL
- **92%** at or below 200% FPL

## INSURANCE SOURCE

- **15%** Uninsured
- **54%** Medicaid
- **12%** Medicare
- **19%** Private

# Social Determinants of Health and Enabling Services

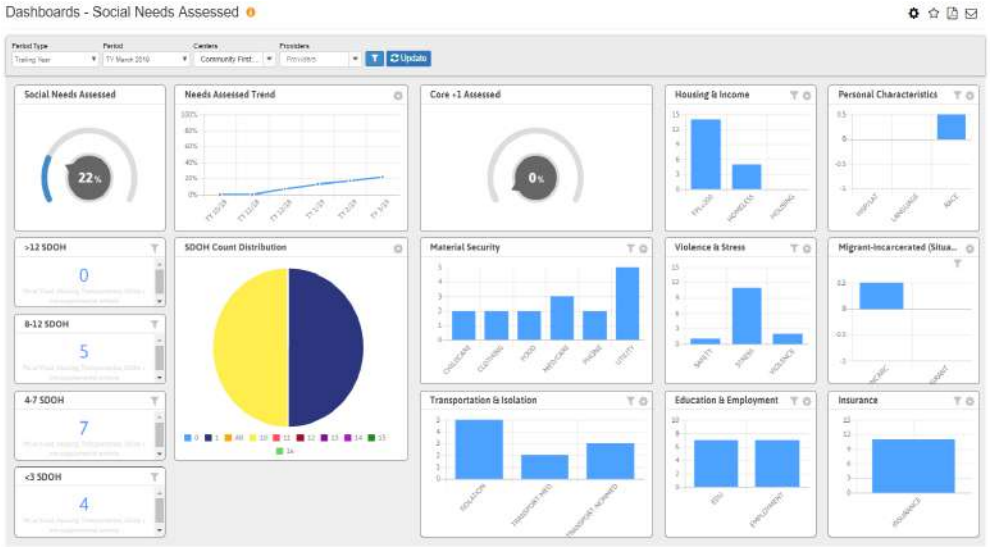
# MPCA Support

- Partnerships with social services organizations
- Branding to increase awareness of comprehensive primary care
- Advocacy
- Outreach and enrollment network
- Community Health Workers network
- Medical-legal partnerships
- Food insecurity
- PRAPARE implementation
- Patient perspectives pilot project

# A Look into the Future

- Build and strengthen partnerships
- Continue to advocate for health centers and enabling services
- Support data collection of social determinants of health
- Support health centers in implementing PRAPARE tool
- Risk stratification
- Workforce support
- Alternative Payment Methodology

# Azara Walkthrough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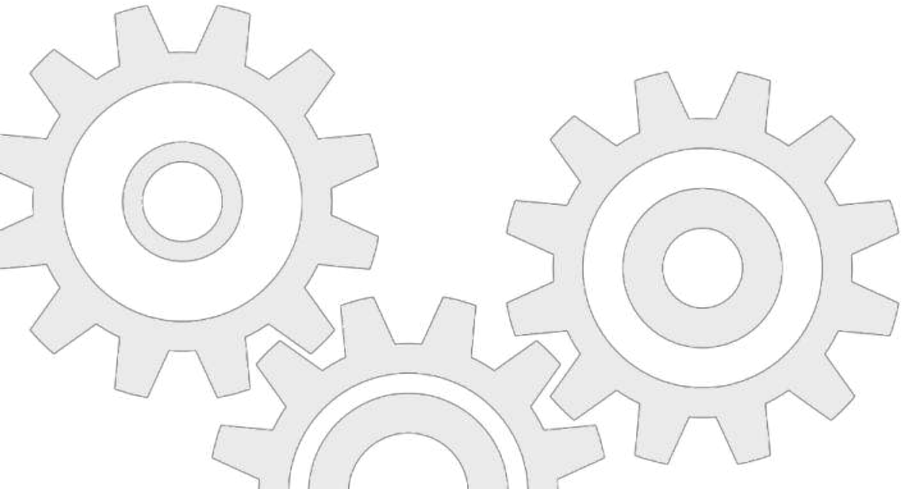
Improving Patient Outcomes Through Data

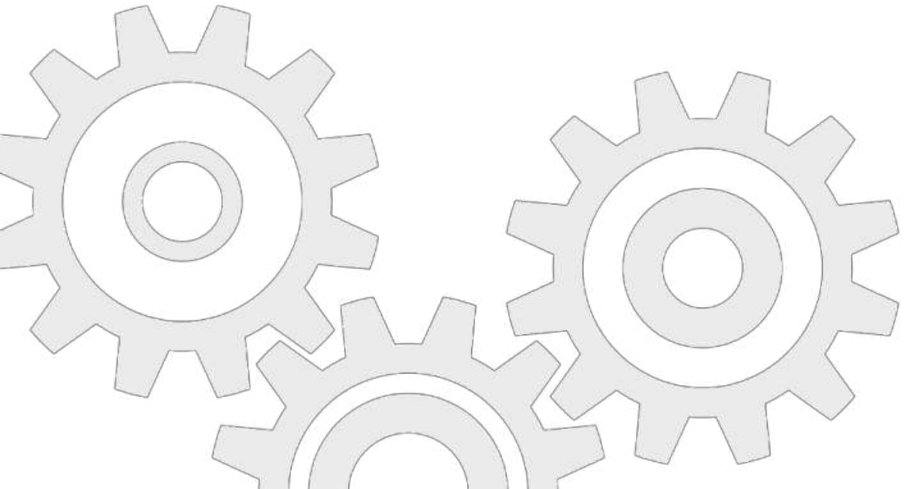
# Social Determinants of Health: Understanding Your Population



March 21, 2019

# CONFIDENTIAL





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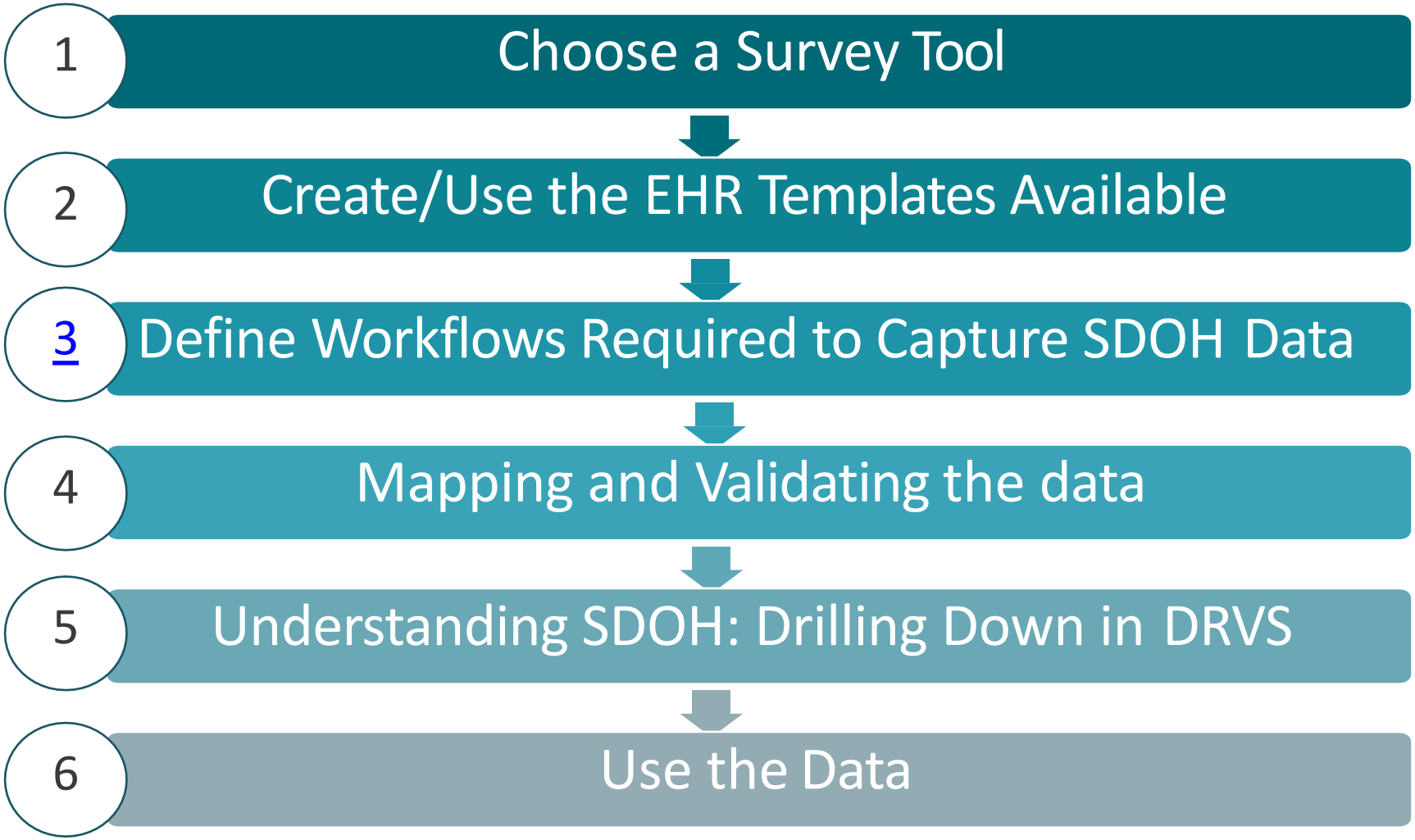
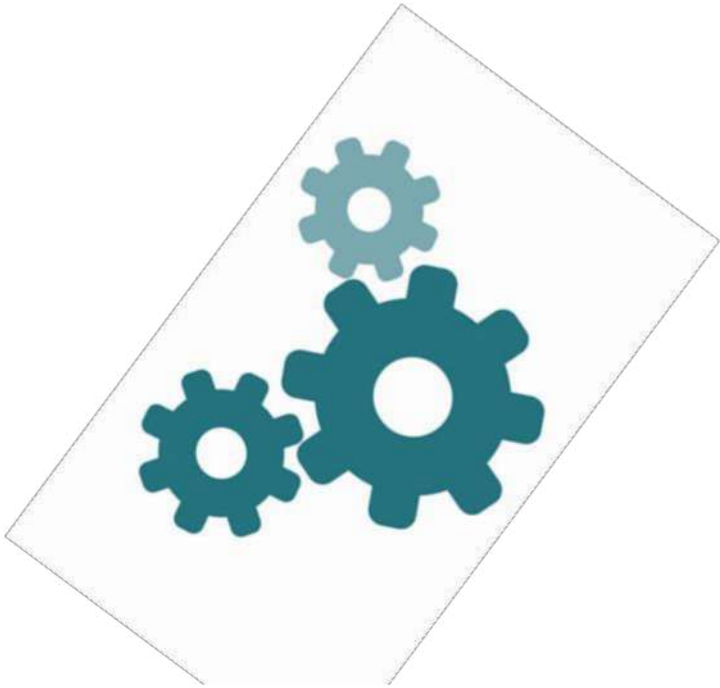
# SDOH Start to Finish



# Understanding SDOH

## Drilling Down in DRVS

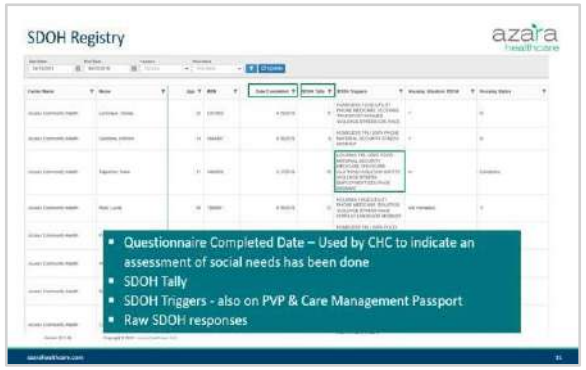


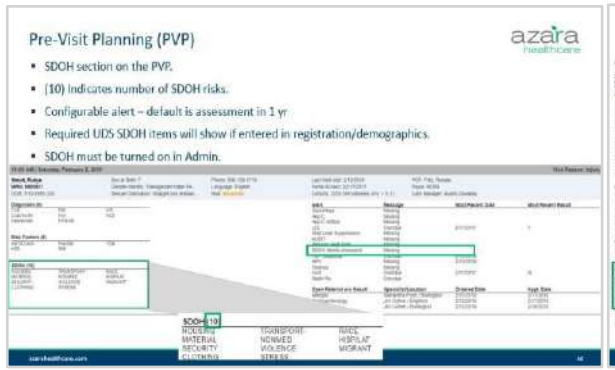
# Drilling Down in DRVS

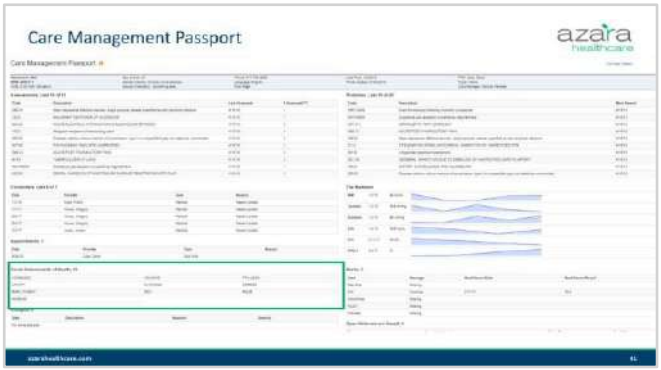
**Population Focused**

**Individual Focused**

Dashboard → Registry → PVP → CMP

# Social Determinants of Health (SDOH) in DRVS

- Available on PVP and Care Management Passport
- Filtering by SDOH Triggers (e.g., values)
  - Available on all measures and reports via the "Additional Filters" icon.
  - Reflect SDOH triggers active *during* the selected measurement period for the given report/measure.
- SDOH Filter
  - A list of available SDOH triggers, as seen on the PVP.
  - Filter works as an "AND" statement. For example, if two triggers are chosen, the patient must have *both* triggers.
- SDOH Count Filter
  - A numerical filter displaying the count of active SDOH triggers for patients.

# Social Needs Assessed | Screened – Core – Results

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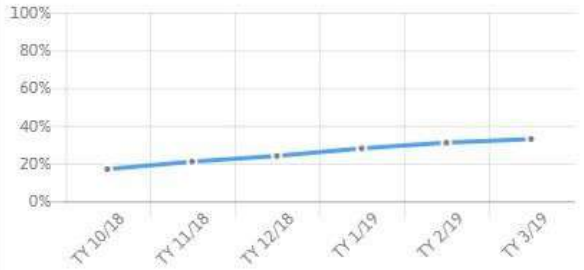
Dashboards - Social Needs Assessed

Period Type: Trailing Year | Period: TY March 2019 | Centers | Providers | Update

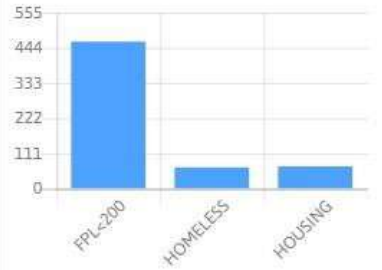
**Social Needs Assessed**


**Needs Assessed Trend**

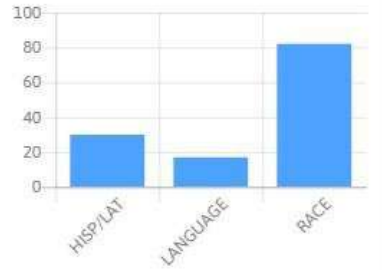



**Core +1 Assessed**


**Housing & Income**




**Personal Characteristics**




**>12 SDOH**

3

Pts w/ Food, Housing, Transportation, Utility + one supplemental criteria

**8-12 SDOH**

80

Pts w/ Food, Housing, Transportation, Utility + one supplemental criteria

**4-7 SDOH**

942

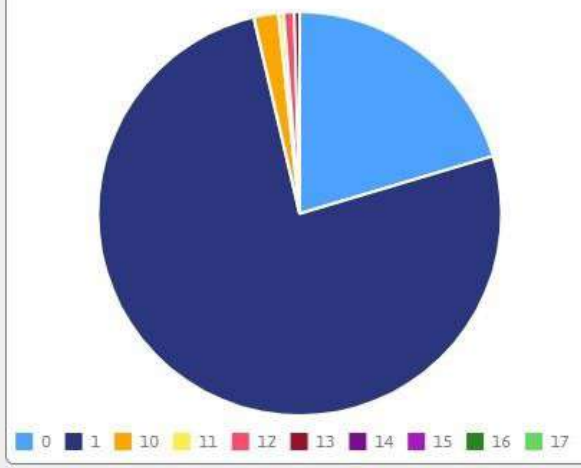
Pts w/ Food, Housing, Transportation, Utility + one supplemental criteria

**<3 SDOH**

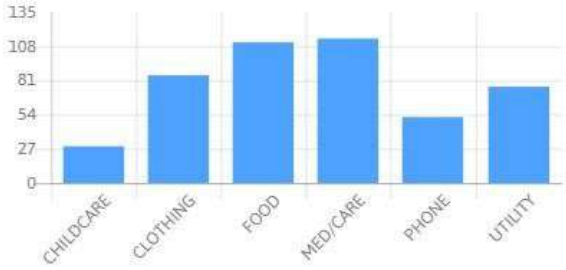
1,914

Pts w/ Food, Housing, Transportation, Utility + one supplemental criteria

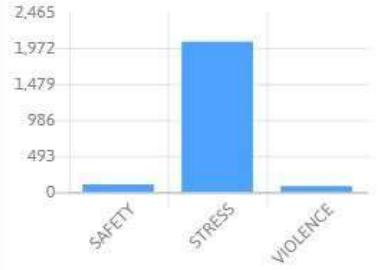
**SDOH Count Distribution**



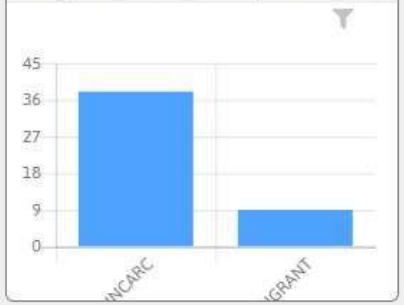

**Material Security**



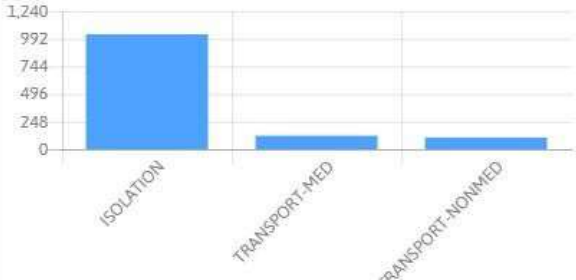

**Violence & Stress**



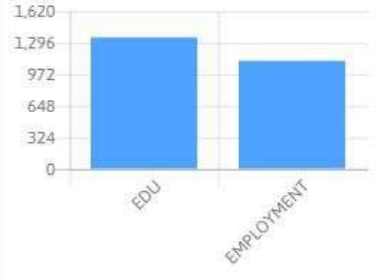

**Migrant-Incarcerated (Situati...**



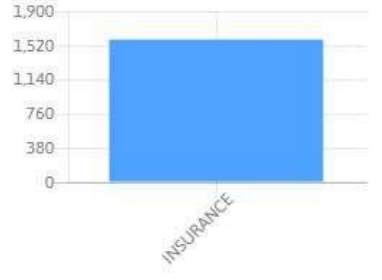

**Transportation & Isolation**



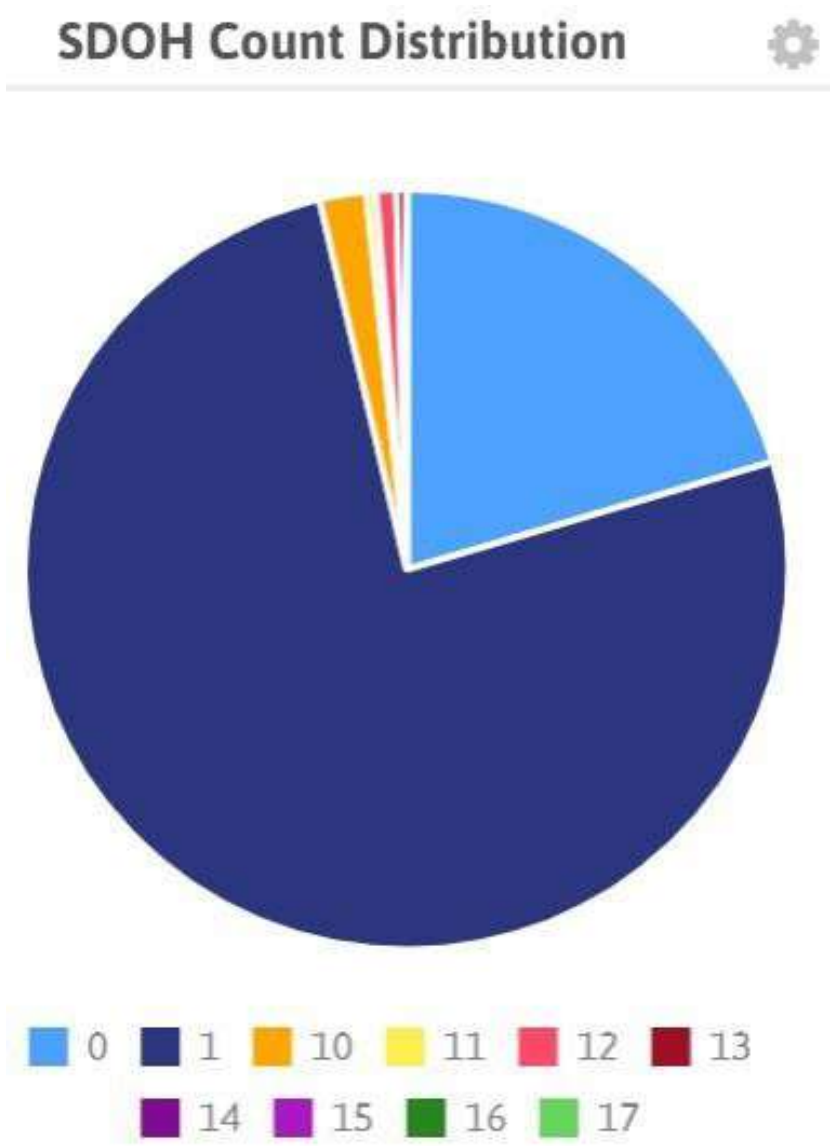

**Education & Employment**




**Insurance**



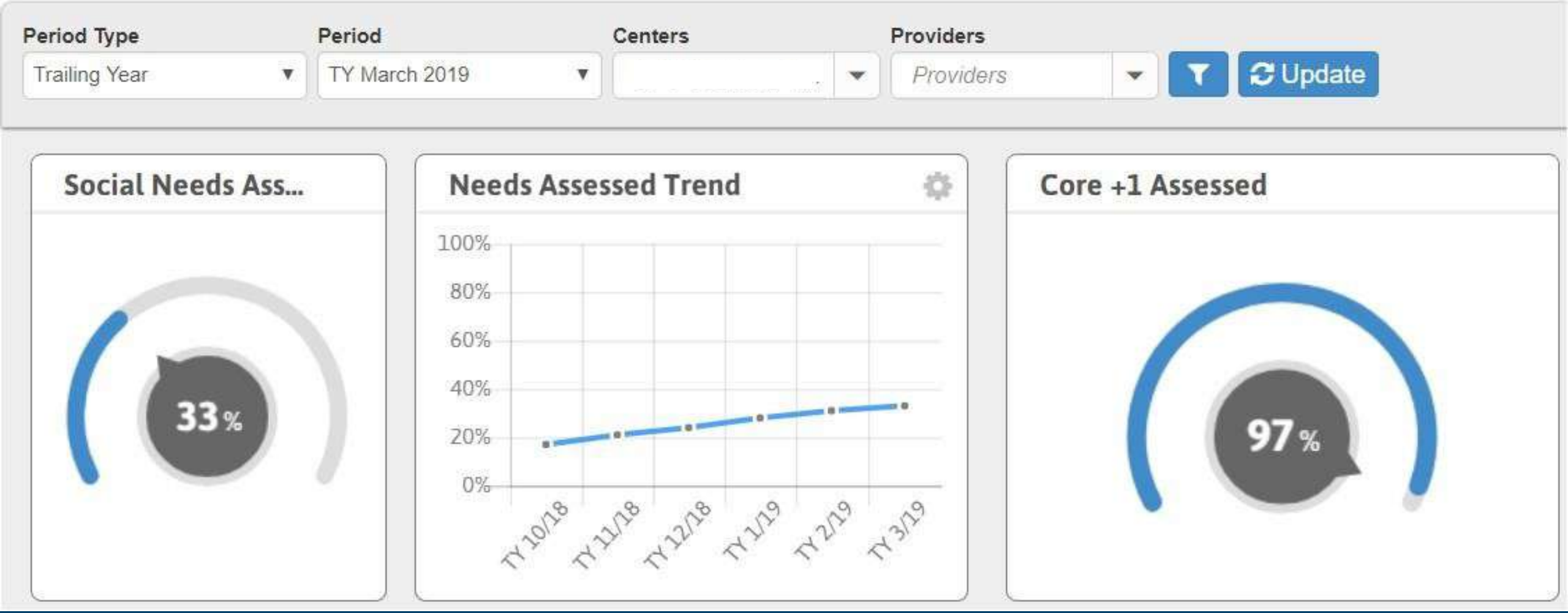
# Social Needs Assessed | Distribution and Count



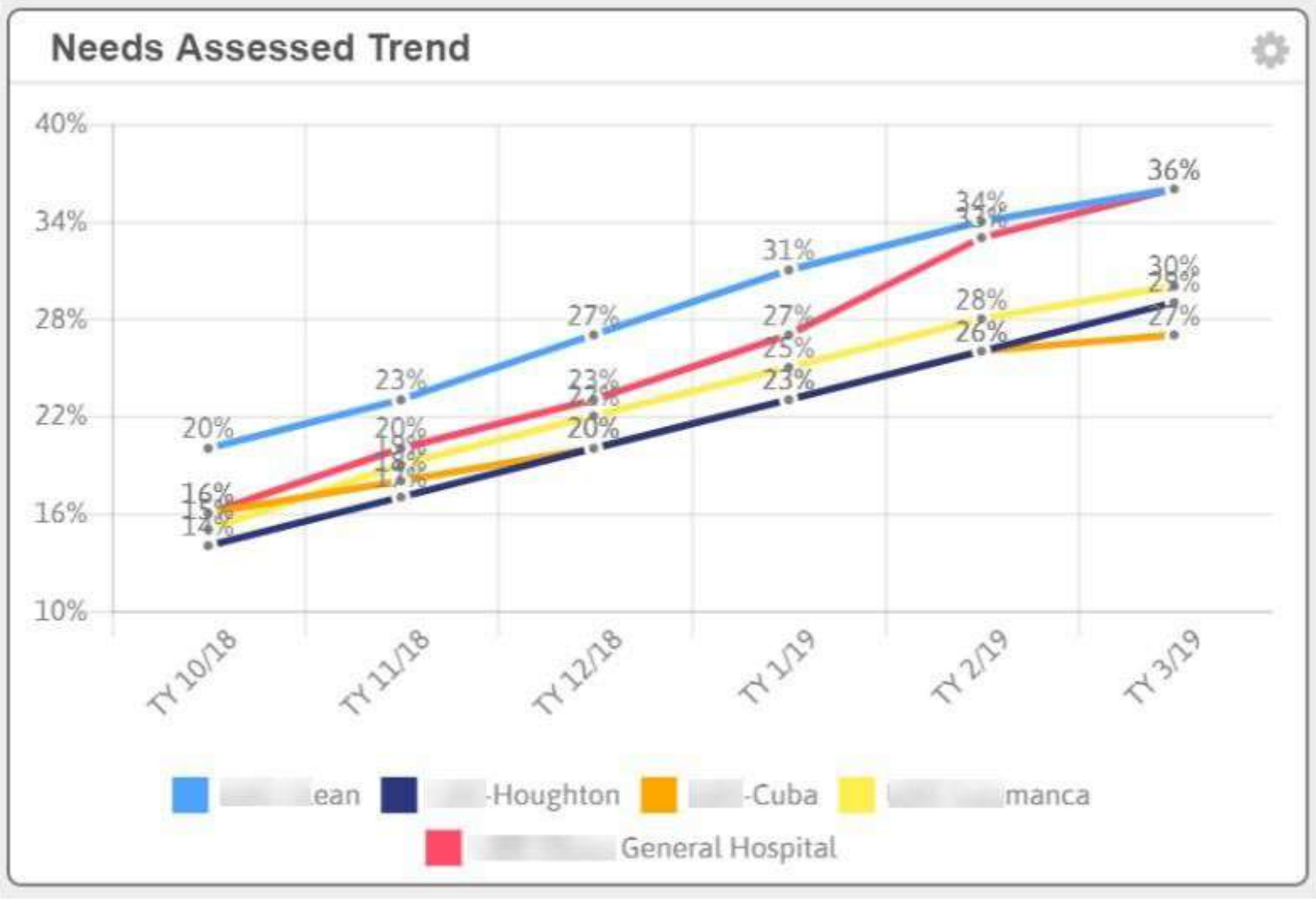

| >12 SDOH | 8-12 SDOH | 4-7 SDOH | <3 SDOH |
|---|---|---|---|
| 3 | 80 | 942 | 1,914 |
| Pts w/ Food, Housing, Transportation, Utility + | Pts w/ Food, Housing, Transportation, Utility + | Pts w/ Food, Housing, Transportation, Utility + | Pts w/ Food, Housing, Transportation, Utility + |

# Social Needs Assessed | Screening – Trend and Core Criteria

- Evaluate assessments done and completeness of assessment



# Trendline by Location



# Social Needs Assessed | Criteria by Domain

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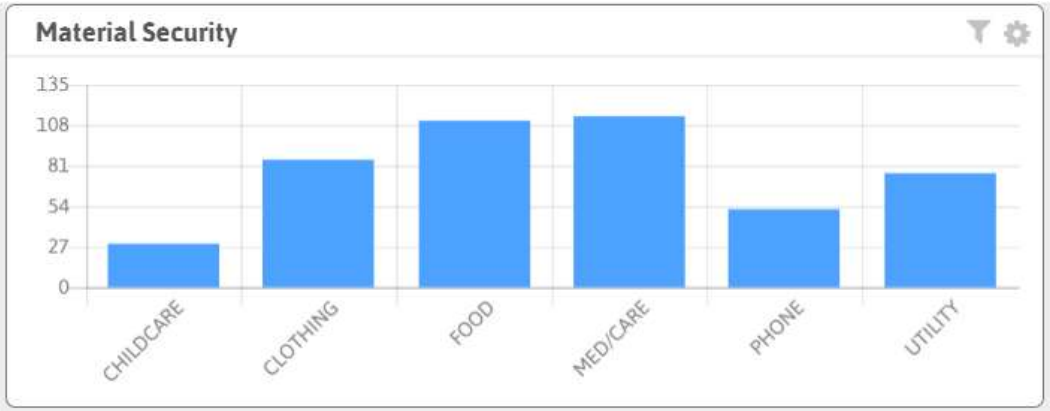
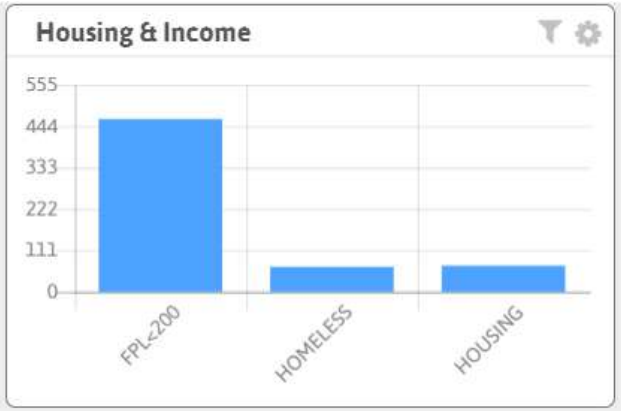
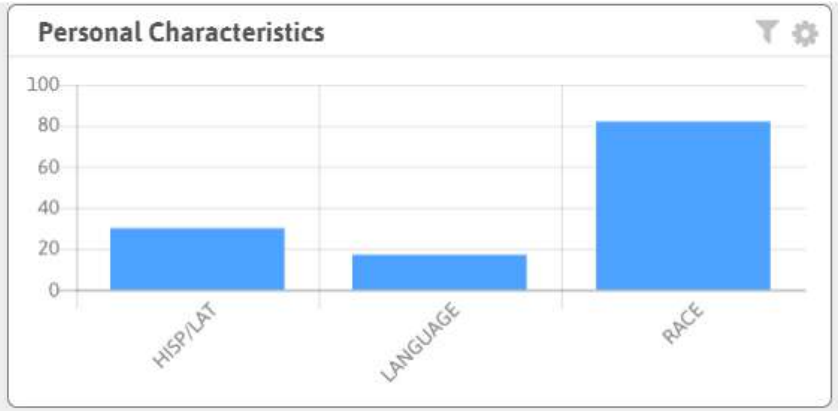
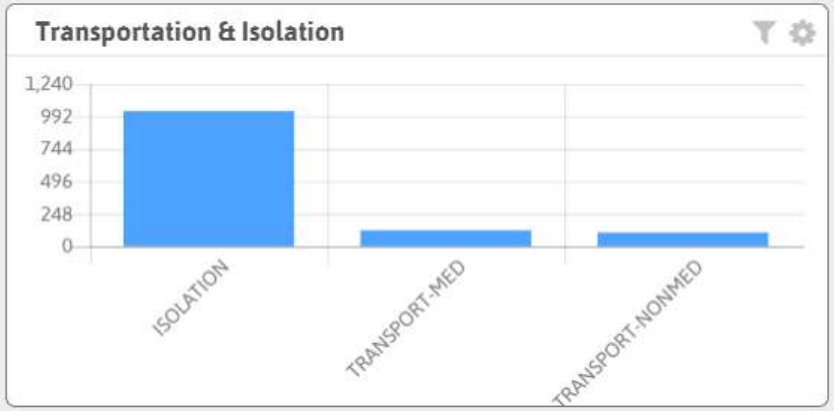
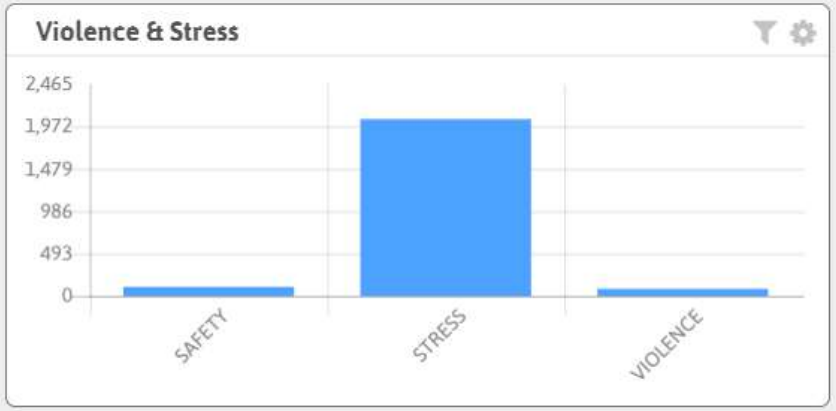
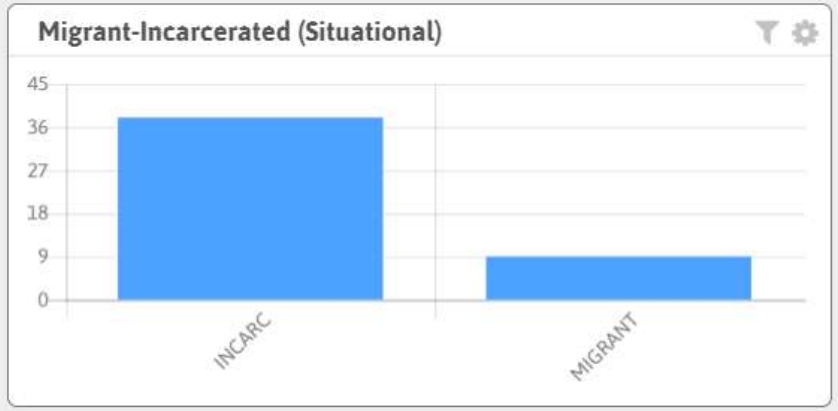


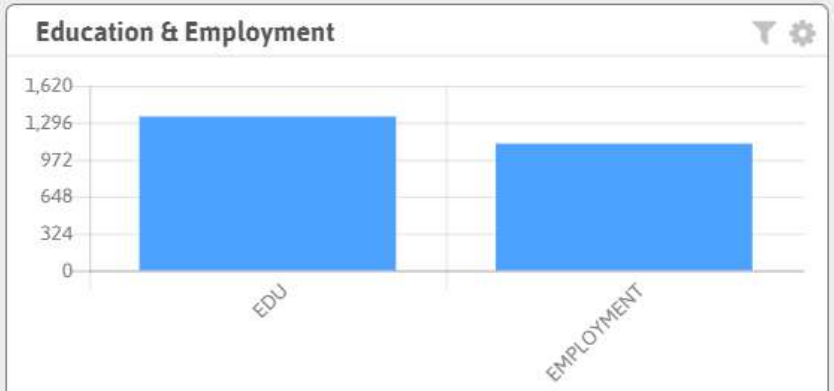



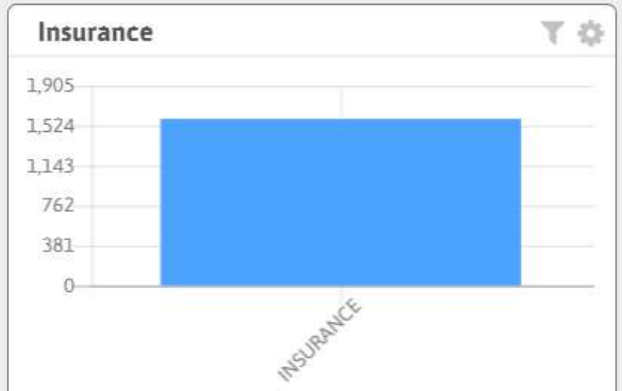



# SDOH Registry

Start Date: 04/13/2018 | End Date: 04/20/2018 | Centers | Providers | Update

| Center Name | Name | Age | MRN | Date Completed | SDOH Tally | SDOH Triggers | Housing Situation SDOH | Housing Status |
|---|---|---|---|---|---|---|---|---|
| Access Community Health | Lamoreux, Hosea | 35 | 8357620 | 4/16/2018 | 11 | HOMELESS FOOD UTILITY PHONE MED/CARE CLOTHING TRANSPORT-NONMED VIOLENCE STRESS EDU RACE | Y | N |
| Access Community Health | Quintona, Anthony | 14 | 5044887 | 4/16/2018 | 6 | HOMELESS FPL<200% PHONE MATERIAL SECURITY STRESS MIGRANT | Y | N |
| Access Community Health | Tappeiner, Nidia | 31 | 5468538 | 2/17/2018 | 15 | HOUSING FPL<200% FOOD MATERIAL SECURITY MED/CARE CHILDCARE CLOTHING ISOLATION SAFETY VIOLENCE STRESS EMPLOYMENT EDU RACE MIGRANT | N | Conditions |
| Access Community Health | Rodi, Lucile | 59 | 7998681 | 4/16/2018 | 12 | HOUSING FOOD UTILITY PHONE MED/CARE ISOLATION VIOLENCE STRESS RACE HISP/LAT LANGUAGE MIGRANT | Not Homeless | Y |
| Access Community Health | Fu | | | | | HOMELESS FPL<200% FOOD | | |
| Access Community Health | W | | | | | | | |
| Access Community Health | R | | | | | | | |
| Access Community Health | Ca | | | | | | | |

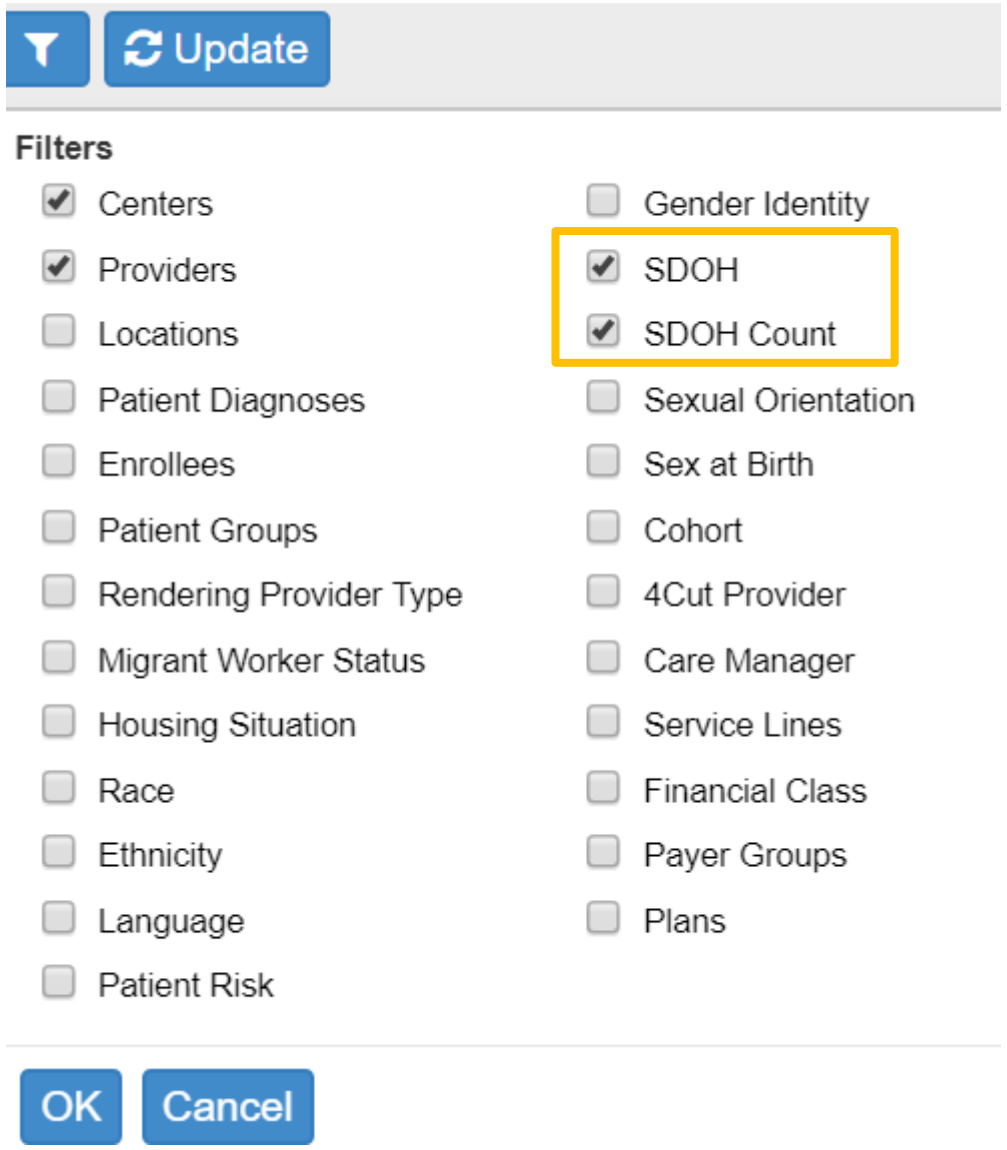
- Questionnaire Completed Date – Used by CHC to indicate an assessment of social needs has been done
- SDOH Tally
- SDOH Triggers - also on PVP & Care Management Passport
- Raw SDOH responses

Version 22.2.66

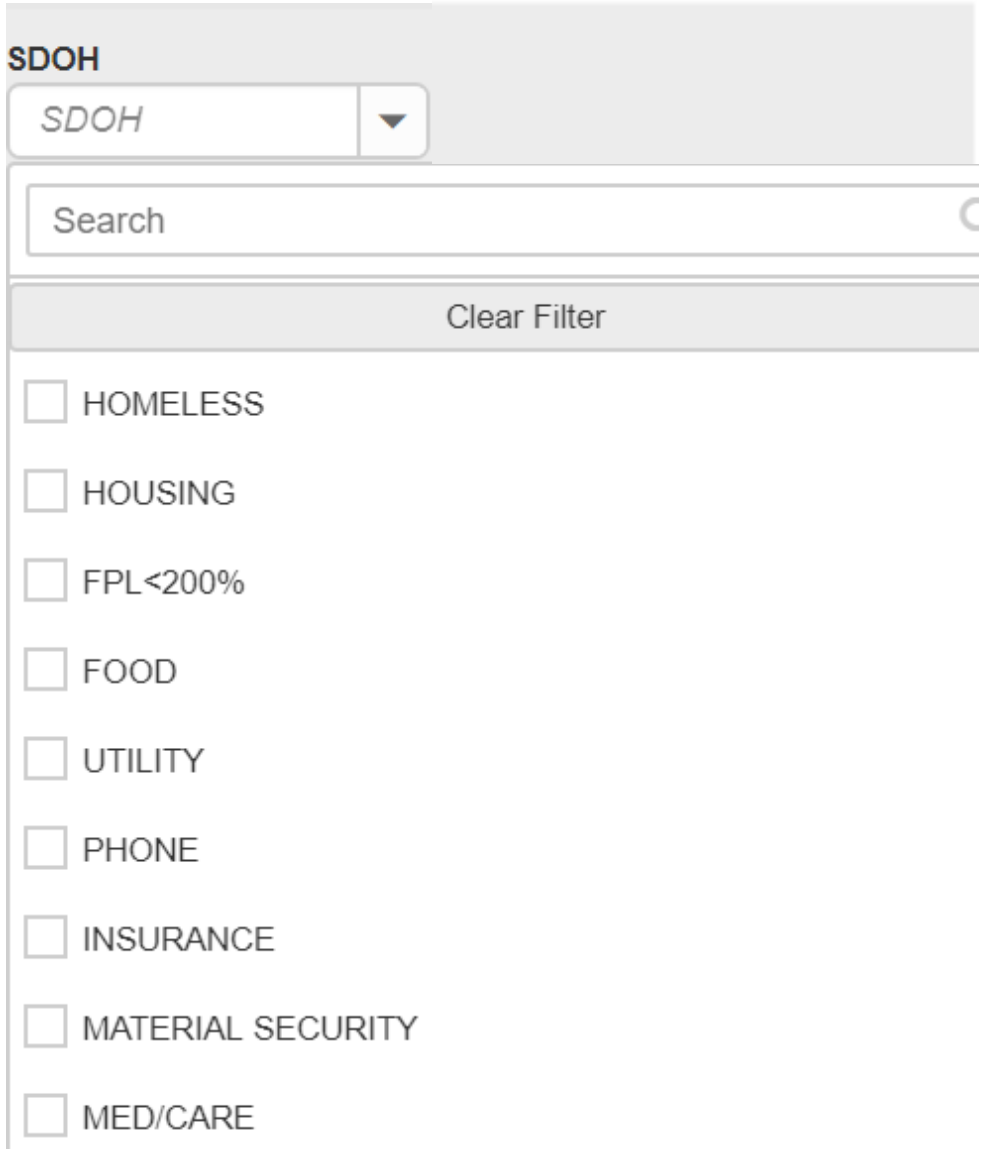
# SDOH Triggers and Raw Data

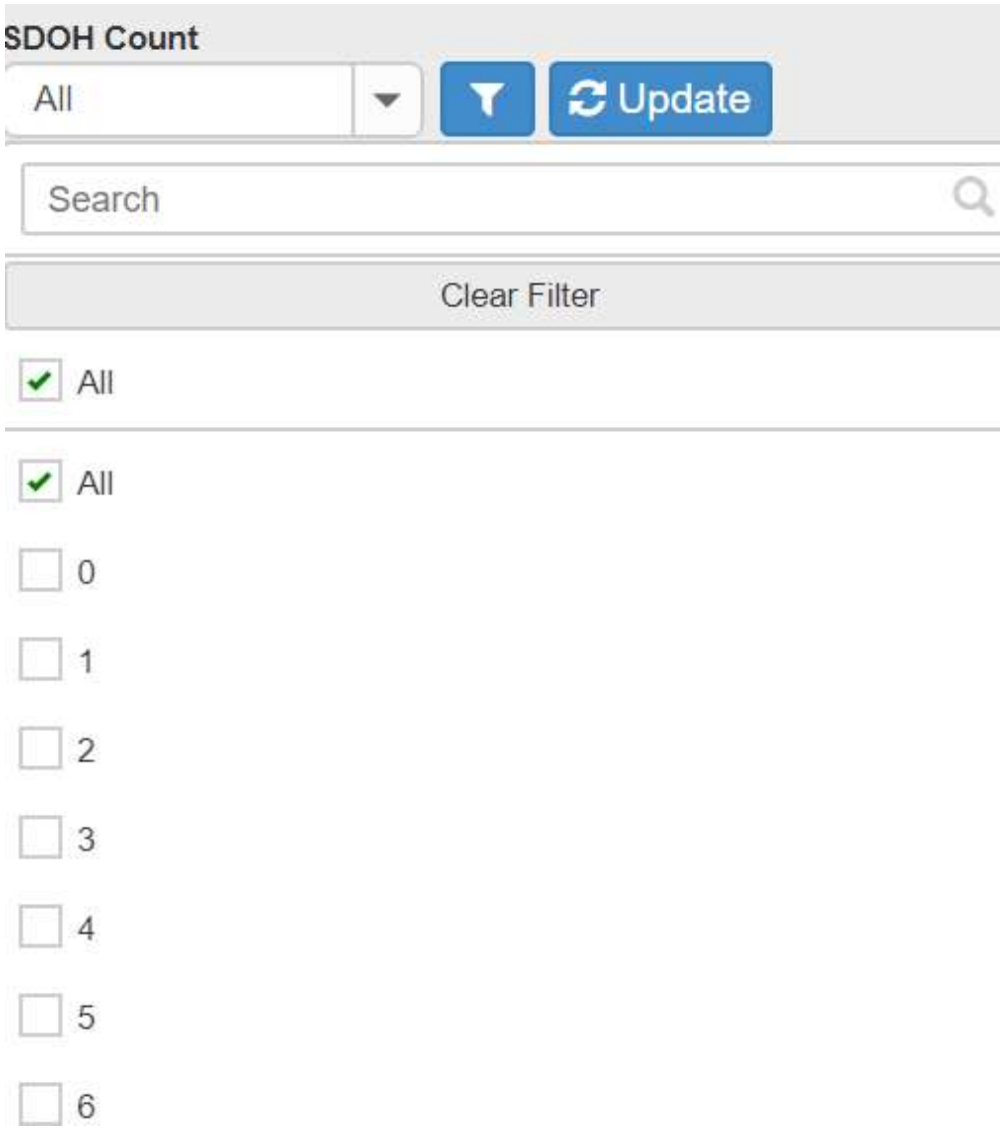
| SDOH Tally | SDOH Triggers |
|---|---|
| 10 | HOMELESS HOUSING FPL<200% PHONE MED/CARE ISOLATION SAFETY STRESS EMPLOYMENT EDU |
| 9 | FPL<200% FOOD UTILITY MED/CARE CLOTHING ISOLATION STRESS EMPLOYMENT EDU |
| 8 | HOUSING FPL<200% UTILITY PHONE STRESS EMPLOYMENT EDU INCARC |
| 7 | FPL<200% PHONE ISOLATION STRESS EMPLOYMENT EDU INCARC |

# Accessing the SDOH Filters

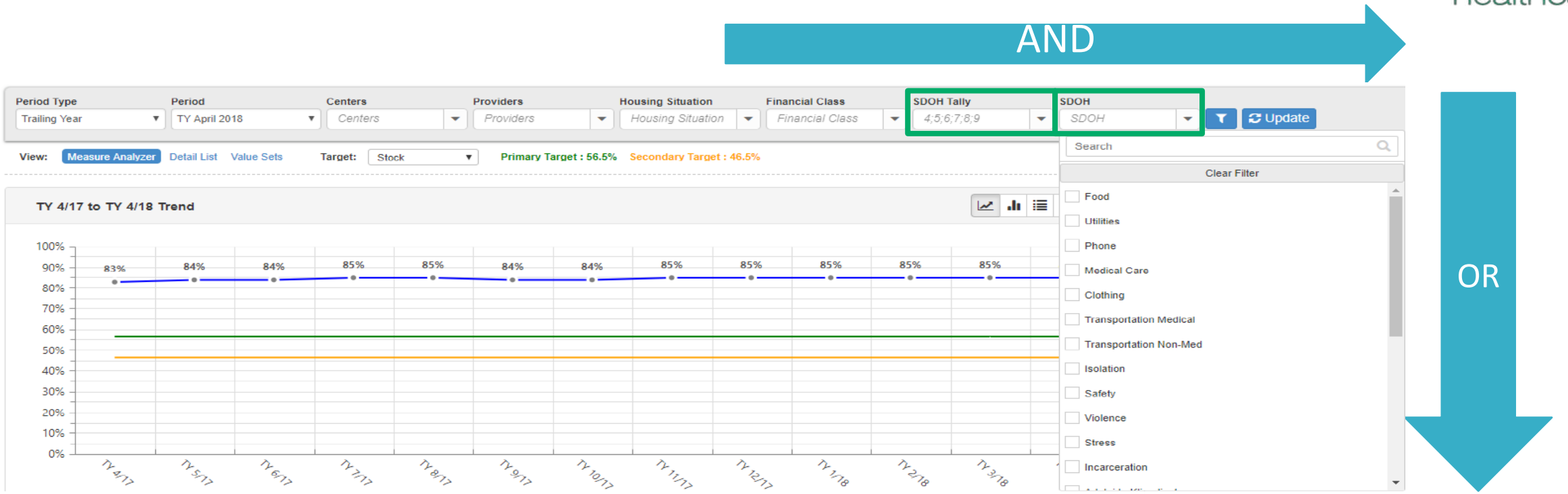


# SDOH Filters



# SDOH Filter Functionality




- Ability to filter by SDOH criteria and SDOH Count
- Patient must fit all filter types added to appear.
  - Period **AND** Housing Situation **AND** Financial Class, etc.
  - Applies to patient characteristics (not locations/providers)
- Patient can fit any filter within a specified filter type.
  - Food **OR** Utilities **OR** Phone, etc.

# A1c >9 or Untested = 32%

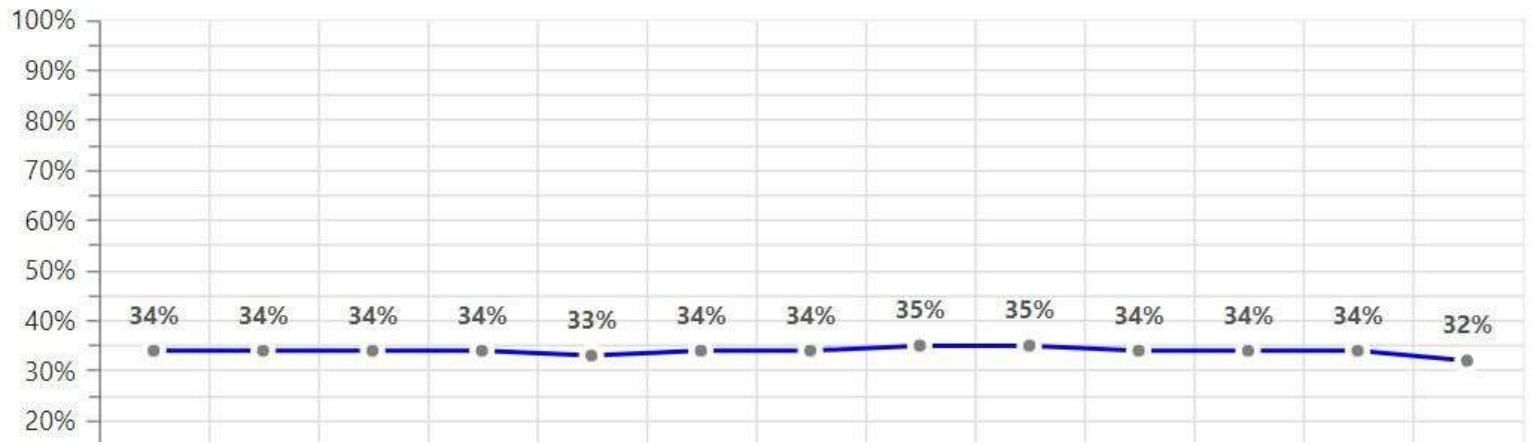
## Diabetes A1c > 9 or Untested (NQF 0059)

Period Type: Trailing Year | Period: TY July 2018 | Centers | Providers | SDOH | Service Lines | Financial Class

Update

View: Measure Analyzer | Detail List | Value Sets  Target: 2018 UDS 330 Goal  Primary Target : 29.0%  Secondary Target : 39.0%  ← Back to dashboard

### TY 7/17 to TY 7/18 Trend




### TY 7/18 Result

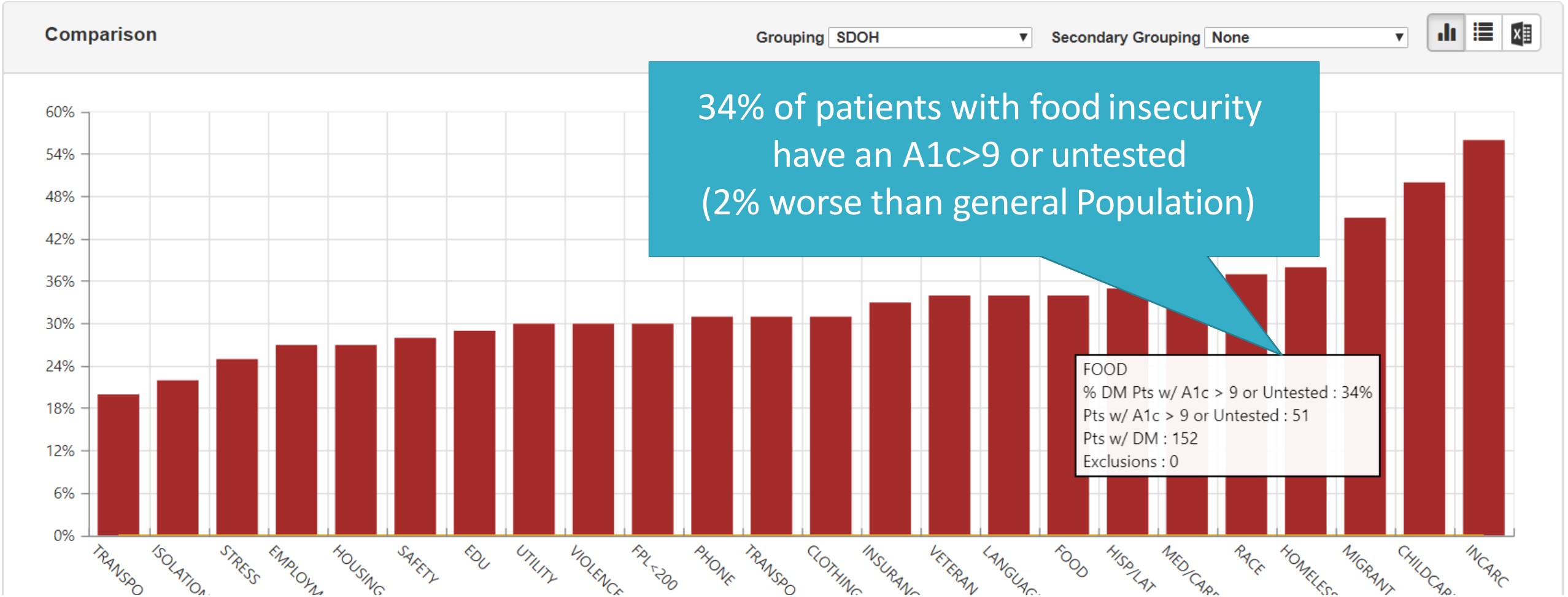
Selected : 32%
32%

Best Center : 19%
19%

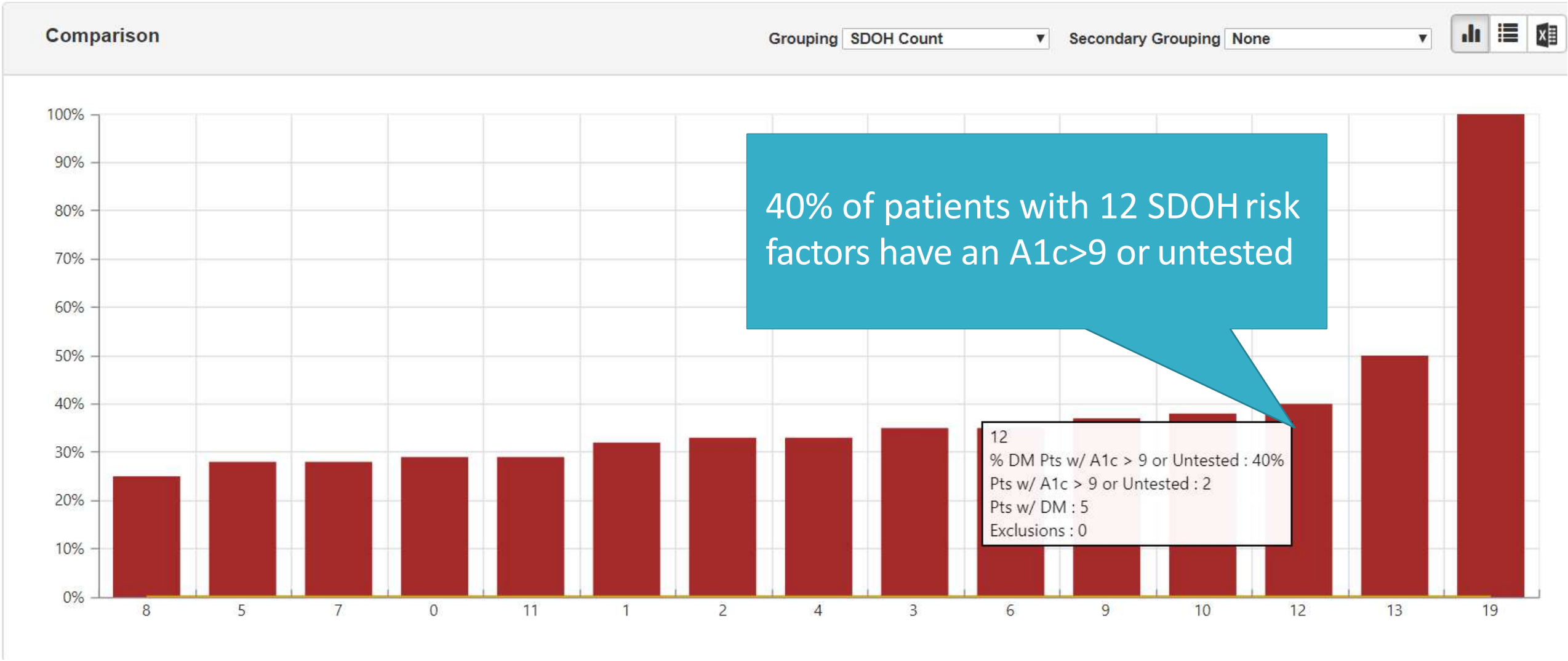
Network Average : 32%
32%

Center Average
32%

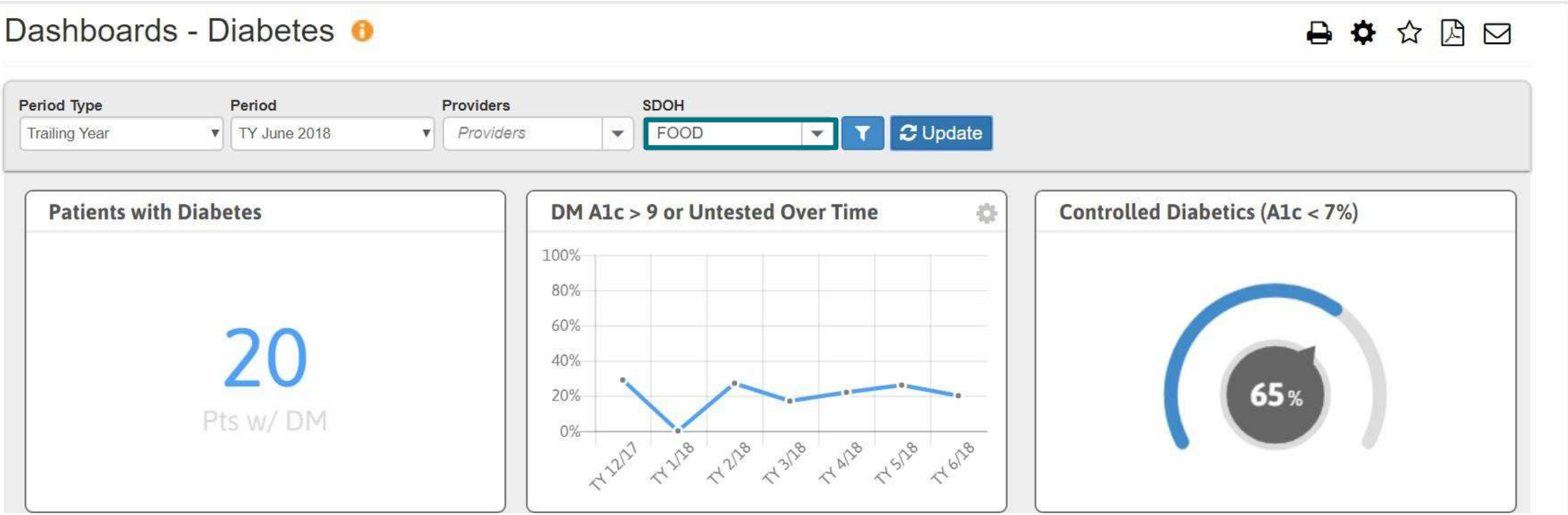
# Diabetes >9 or Untested by SDOH Risk



# DM >9 or Untested by # SDOH Risks

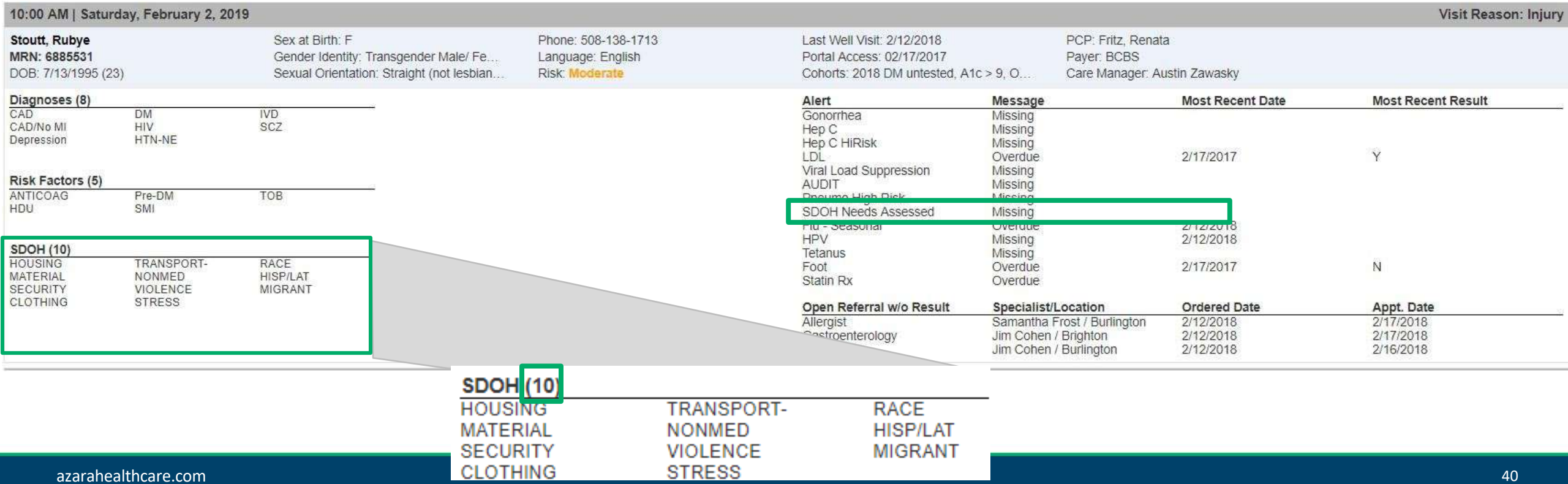


# DM Dashboard with SDOH Filter



# Pre-Visit Planning (PVP)

- SDOH section on the PVP.
- (10) Indicates number of SDOH risks.
- Configurable alert – default is assessment in 1 yr
- Required UDS SDOH items will show if entered in registration/demographics.
- SDOH must be turned on in Admin.



# Care Management Passport

## Care Management Passport

Find New Patient

| | | | | |
|---|---|---|---|---|
| **Reichmann, Neil** | Sex at Birth: M | Phone: 617-765-2559 | Last Phys: 1/2/2018 | PCP: Cote, David |
| **MRN: 2262171** | Gender Identity: Choose not to disclose | Language: English | Portal Access: 01/02/2018 | Payer: Aetna |
| DOB: 3/18/1960 (58 years) | Sexual Orientation: Something else | Risk: **High** | | Care Manager: Narcisa Perrette |

### Assessments, Last 10 of 18

| Code | Description | Last Assessed | # Assessed TY |
|---|---|---|---|
| 296.24 | Major depressive affective disorder, single episode, severe, specified as with psychotic behavior | 4/16/18 | 1 |
| 152.0 | MALIGNANT NEOPLASM OF DUODENUM | 4/16/18 | 1 |
| 303.02 | ACUTE ALCOHOLIC INTOXICATION IN ALCOHOLISM, EPISODIC | 4/16/18 | 3 |
| 153.2 | Malignant neoplasm of descending colon | 4/16/18 | 1 |
| 250.00 | Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled | 4/16/18 | 2 |
| 307.80 | PSYCHOGENIC PAIN, SITE UNSPECIFIED | 4/16/18 | 1 |
| G89.12 | ACUTE POST-THORACOTOMY PAIN | 4/16/18 | 2 |
| A15.0 | TUBERCULOSIS OF LUNG | 4/16/18 | 3 |
| 424148004 | Substance use cessation surveillance (regime/thera | 4/16/18 | 1 |
| K02.53 | DENTAL CARIES ON PIT AND FISSURE SURFACE PENETRATING INTO PULP | 4/16/18 | 1 |

### Problems, Last 10 of 22

| Code | Description | Most Recent |
|---|---|---|
| 308110009 | Direct fundoscopy following mydriatic (procedure) | 4/16/18 |
| 424148004 | Substance use cessation surveillance (regime/thera | 4/16/18 |
| G47.411 | NARCOLEPSY WITH CATAPLEXY | 4/16/18 |
| G89.12 | ACUTE POST-THORACOTOMY PAIN | 4/16/18 |
| 296.24 | Major depressive affective disorder, single episode, severe, specified as with psychotic behavior | 4/16/18 |
| I21.3 | ST ELEVATION (STEMI) MYOCARDIAL INFARCTION OF UNSPECIFIED SITE | 4/16/18 |
| 401.9 | Unspecified essential hypertension | 4/16/18 |
| I63.139 | CEREBRAL INFARCTION DUE TO EMBOLISM OF UNSPECIFIED CAROTID ARTERY | 4/16/18 |
| V65.3 | DIETARY SURVEILLANCE AND COUNSELING | 4/16/18 |
| 250.00 | Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled | 4/16/18 |

### Encounters, Last 5 of 7

| Date | Provider | Type | Reason |
|---|---|---|---|
| 1/2/18 | Ryan, Frank | Medical | Needs Update |
| 7/7/17 | House, Gregory | Medical | Needs Update |
| 6/8/17 | House, Gregory | Medical | Needs Update |
| 5/4/17 | House, Gregory | Medical | Needs Update |
| 3/2/17 | Jones, James | Medical | Needs Update |

### The Numbers

| | | | |
|---|---|---|---|
| BMI | 1/2/18 | **24** lb/m2 | |
| Systolic | 1/2/18 | **101** mmHg | |
| Diastolic | 1/2/18 | **94** mmHg | |
| LDL | 1/2/18 | **122** mg/dL | |
| A1c | 2/11/17 | **10.4%** | |
| PHQ-9 | 6/8/17 | **11** | |

### Appointments, 1

| Date | Provider | Type | Reason |
|---|---|---|---|
| 4/28/18 | Cote, David | Sick Visit | |

### Social Determinants of Health, 10

| | | |
|---|---|---|
| HOMELESS | HOUSING | FPL<200% |
| UTILITY | CLOTHING | STRESS |
| EMPLOYMENT | EDU | RACE |
| MIGRANT | | |

### Alerts, 5

| Alert | Message | Most Recent Date | Most Recent Result |
|---|---|---|---|
| Pap Anal | Missing | | |
| A1c | Overdue | 2/11/17 | 10.4 |
| Gonorrhea | Missing | | |
| AUDIT | Missing | | |
| Prenatal | Missing | | |

### Allergies, 0

| Start | Description | Reaction | Severity |
|---|---|---|---|
| No active allergies | | | |

### Open Referrals w/o Result, 4

# Hypertension – SDOH Transportation Insecure (TY April 2018)

## BP < 140/90 - Transportation Insecure


## HTN Control


## HTN BP Control - Transportation Insecure

| Pts w/ HTN | 14 | |
|---|---|---|
| Pts w/ BP <140/90 | 11 | 79% |
| Pts w/ BP >= 140/90 | 3 | 21% |
| Pts w/ no BP Taken | 0 | 0% |

## Risk Level of HTN Pts

| Patient Risk | Denominator | % Total |
|---|---|---|
| Low | 2 | 0% |
| Moderate | 3,359 | 85% |
| High | 570 | 15% |
| **Totals** | **3,931** | |

## Patients with Hypertension

3,931

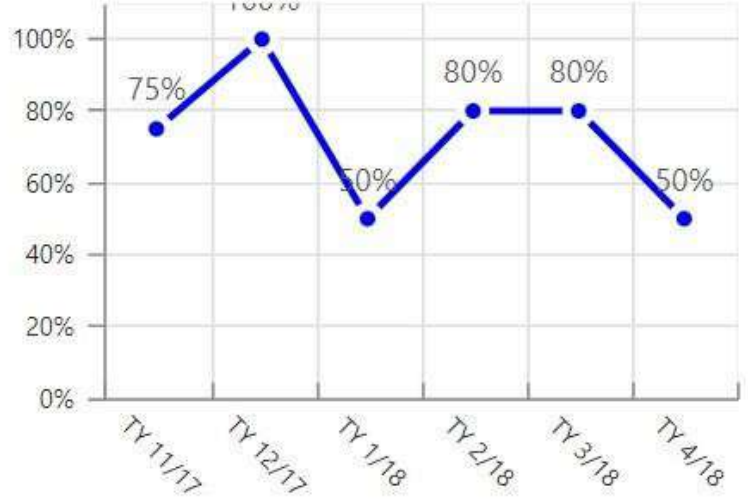
Pts w/ HTN

## BP Control by Age - Transport Insecure

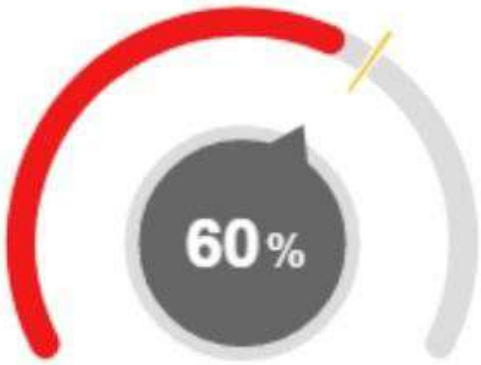
| Age | Result | Num | Denom |
|---|---|---|---|
| 20-34 | 100% | 1 | 1 |
| 35-44 | 0% | 0 | 1 |
| 45-64 | 82% | 9 | 11 |
| 65 + | 100% | 1 | 1 |

# Hypertension – SDOH Transportation Insecure + Homeless

## BP < 140/90 - Transportation Insecure




## HTN Control




## HTN BP Control - Transportation Insecure

| Pts w/ HTN | 2 | |
|---|---|---|
| Pts w/ BP <140/90 | 1 | 50% |
| Pts w/ BP >= 140/90 | 1 | 50% |
| Pts w/ no BP Taken | 0 | 0% |

## Risk Level of HTN Pts

| Patient Risk | Denominator | % Total |
|---|---|---|
| Moderate | 109 | 75% |
| High | 37 | 25% |
| **Totals** | **146** | |

## Patients with Hypertension

146

Pts w/ HTN

## BP Control by Age - Transport Insecure

| Age | Result | Num | Denom |
|---|---|---|---|
| 45-64 | 50% | 1 | 2 |

# Questions?


Need to Know More?

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# HEALTH CENTER PERSPECTIVE

# PRAPARE Screening Implementation

Upper Great Lakes Family Health Center

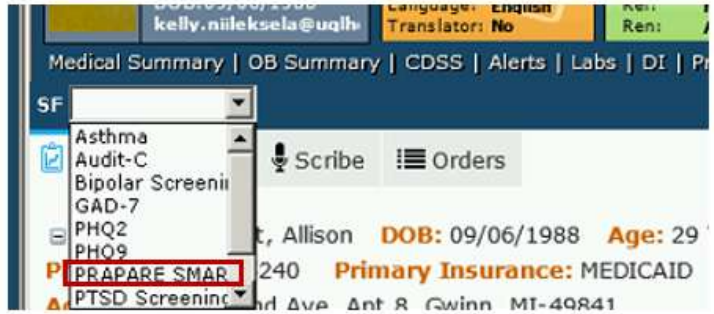
# Quick Facts

- Upper Great Lakes Family Health Center
  - 24,792 patients in 2018
  - Services in 4 counties in the Upper Peninsula of Michigan
- Service Lines
  - 9 Family Practice clinics
  - 1 OB/GYN Clinic
  - 1 Pediatric Clinic
  - 2 Dental Clinics
  - Behavioral Health
  - Care Management Services

# PRAPARE Screening Implementation: Phase 1

- Initial focus on care management & care coordination patients
- Care management eligible patients are identified by provider, nurse, and in team huddles
- PRAPARE screening embedded into care management/care coordination workflows
- Care managers, coordinators, and community health workers trained in providing enabling services.

4. Once the visit is created, go to the visit's **Progress Notes**
5. Reconcile the patient's medication list by selecting **Current Medication:**
   a. Review each existing medication with the patient.
   b. Communicate any significant medication changes to the patient's PCP via Telephone Encounter
   c. Refer to 'Managing Patient Medications' document if needed
6. Select the **SF** dropdown on the bottom left corner of the navigation panel, then select PRAPARE SMART FORM.




Revised 5.8.

5

INITIAL MICARE VISIT WORKFLOW

7. The PRAPARE Smart Form assesses patient's Assets, Risks, and Experiences. Fill the form out with the patient, then select Save. The completed smart form will drop into your progress note.
   a. If the patient is due for any other screenings, complete them now by using the **SF** dropdown.

# EHR Progress Note View

**Social History**

Social Determinants:

PRAPARE

Date Completed/Updated: *01/14/2019*

What is your current housing situation? *I have housing*

Are you worried about losing your housing? *No*

What is the highest level of school that you have finished? *Less than a high school degree*

What is your current work situation? *Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver)*

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply *Food,Clothing,Utilities,Phone*

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? *Yes, it has kept me from medical appointments or from getting my medications,Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living*

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings) *More than 5 times a week*

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled *Very much*

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility? *No*

Are you a refugee? *No*

What country are you from? *United States*

Do you feel physically and emotionally safe where you currently live? *Yes*

In the past year, have you been afraid of your partner or ex-partner? *No*

PRAPARE Score: *12*

Enabling Services Provided? *Yes*

Please specify *Case Management Assessment First Visit,Health Education/Supportive Counseling,Transportation to/from Referral Appoinment*

# Patient Registry (Azara) View

## Social Determinants of Health, 8

| | | |
|---|---|---|
| FPL<200% | FOOD | UTILITY |
| PHONE | CLOTHING | STRESS |
| EMPLOYMENT | EDU | |

SOCIAL DETERMINANTS OF HEALTH

- FPL<200%
- FOOD
- ISOLATION
- STRESS
- EMPLOYMENT

# PRAPARE Implementation: Phase 2

**GOAL: Implement Screening for ALL Patients**

**Challenges:**

- Increased intake time
- Screening burnout – Up to 37 questions for adult annual exams
  - AUDIT-C
  - Tobacco Screening
  - PHQ2/9
  - GAD-7
  - DAST-10
  - RAAPS (Adolescent)
- PRAPARE Screening is performed, now what?

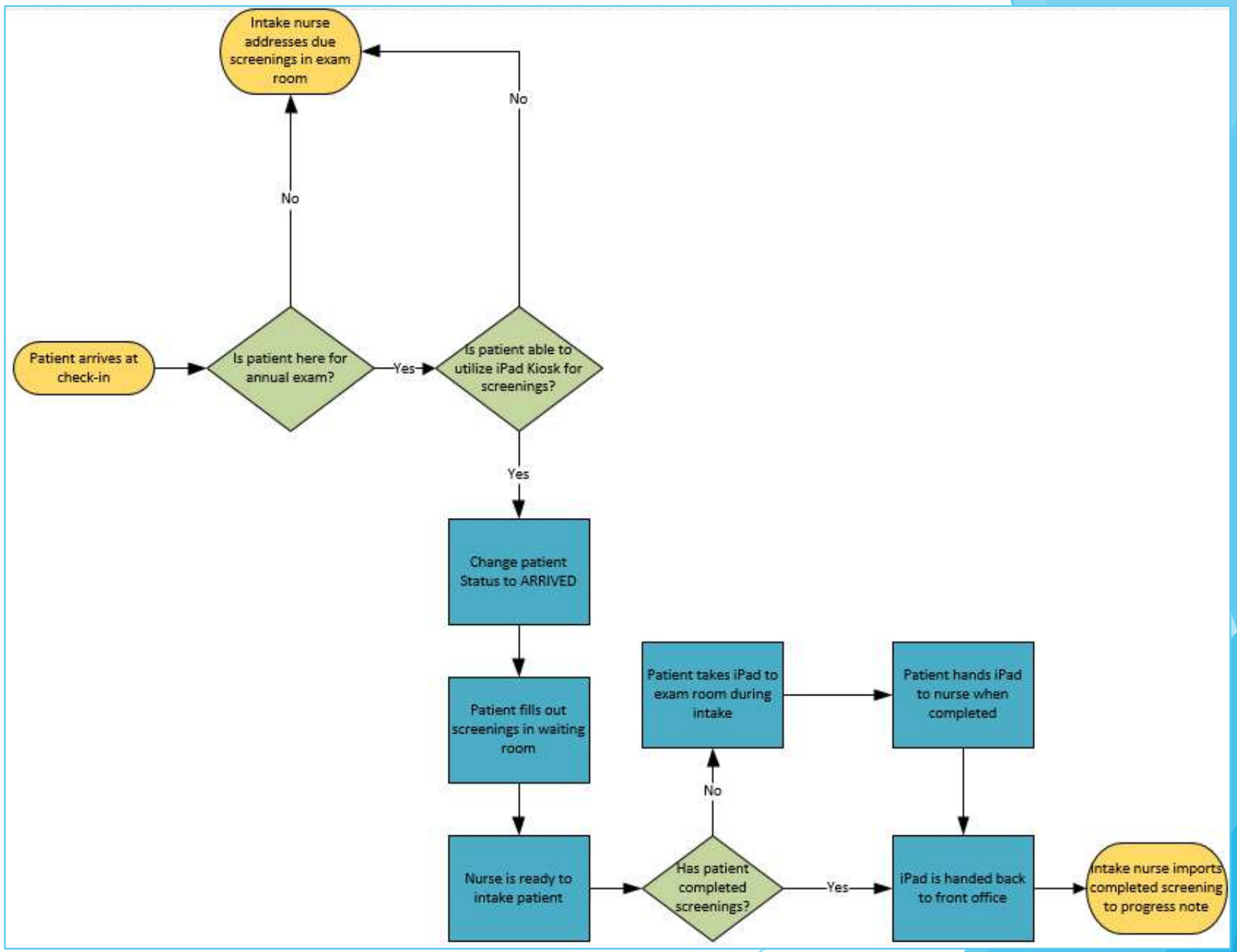
# PRAPARE Implementation: Phase 2

- Solution: Check-in Kiosk
  - Add ALL adult intake question on kiosk for patient to fill out in waiting room, including PRAPARE
  - Nurse imports filled out questionnaire into EHR
  - Structured data captured, decreased intake time
  - Start with Adult Annual Exams
- New Challenges
  - Long Lines
  - Increased time to before check-in status appears
  - Some populations unable to navigate kiosk check-in

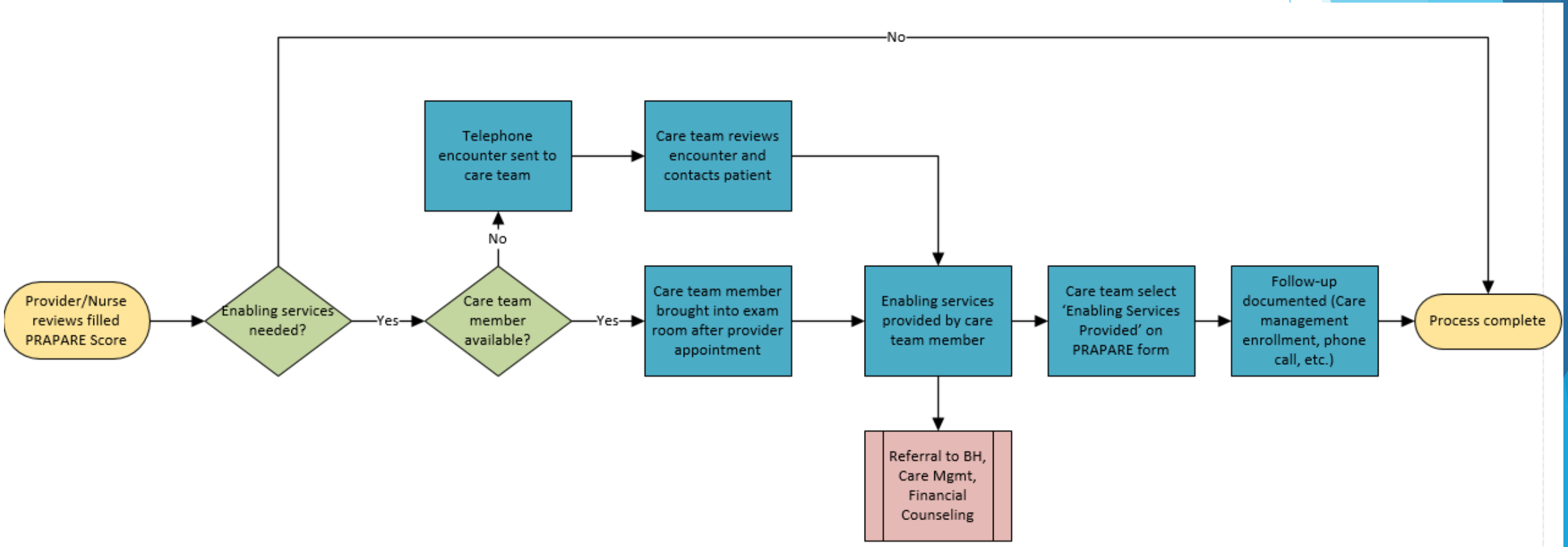
# PRAPARE Implementation: Phase 2

- Final Solution
  - Remove kiosk stand, invest in loose iPads
  - Front desk staff hand patient iPads
  - Patient fills out while waiting for intake nurse

# Condensed Workflow



# Enabling Services Process



# Next Steps

- Final Solution
  - Enabling services codes
  - Alert in Pre-Visit Planning

> Alert will trigger if Questionnaire Completed PRAPARE has not occurred in the last 1 years.

# Contact Me

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# QUESTIONS & ANSWERS

# Questions for Speakers

# Open Discussion

- **What types of non-clinical services are you already providing that may not be represented in your data reporting?** How much ROI might be missing?

- **In what areas could NCAs or PCAs improve their assistance or impact in the area of ESDC?** Are you currently supported in this area by your own local PCA?

- From the implementation example you heard today**, what stood out as the most feasible approach to introducing a new process?** What might be the biggest barrier to a similar implementation process? How might it be tailored to suit your organization?

# Resources

- **enablingservices.aapcho.org**
  - Implementation Toolkit:
  - ES Research Studies
  - Webinars
  - Health Center Training Opportunities

- **nachc.org/prapare**

# Acknowledgements

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# Partnerships

# THANK YOU & KEEP IN TOUCH!


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