SDOH SCREENING TOOLS FOR PUBLIC HOUSING RESIDENTS

LEARNING COLLABORATIVE

A Guided Tour of Screening Tools

May 4, 2021

National Center for Health in Public Housing

National Center for Health in Public Housing

The National Center for Health in Public Housing (NCHPH), a project of North American Management, is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Cooperative Agreement (NCA) for $2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

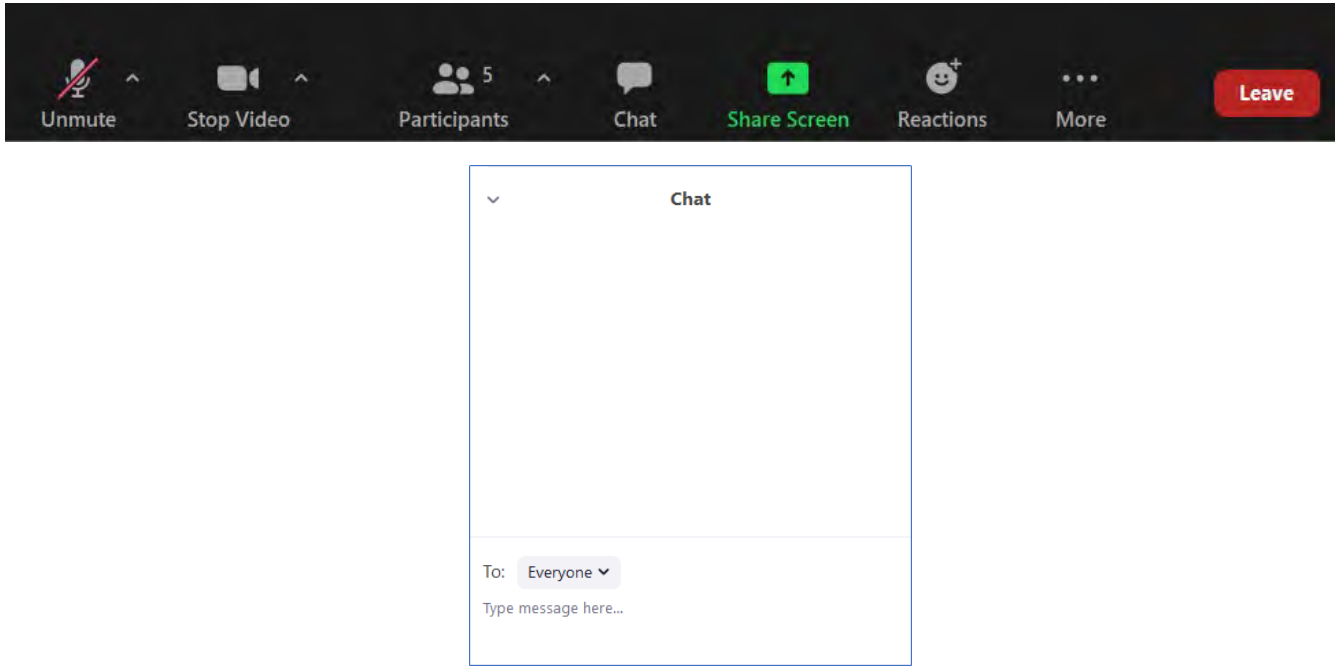
Housekeeping

- All participants muted upon entry
- Cameras on (if possible)
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email and posted to Moodle within a week after session

Icebreakers

In the Chat

- Name and role
- Health center name
- City and State



Moodle

- Materials related to LC will be available through this platform
- Visit Moodle.nchph.org select “Screening SDOH for Public Housing Residents”
- Create account
- Detailed instructions on how to access materials included in our “Welcome Packet”

Moderator and Facilitators

Saqi Maleque Cho, DrPH, MSPH
Director of Research, Policy, and Health Promotion
National Center for Health in Public Housing
saqi.cho@namgt.com

Abdin Noboa-Rios, PhD
President
Innovative Consultants International, Inc.
abdin.noboa@namgt.com

Guest Speaker

- Joe Lee, MSHA
- Association of Asian and Pacific Community Health Organizations
- PRAPARE Guru

Agenda

- Recap of Session 1
- Additional Domains to Consider
- Criteria for Choosing a Standardized Screener
- Comparison of Common Screening Tools
- Guest Speaker Joe Lee to discuss PRAPARE tool
- Handouts/Resources
- Q&A

NCHPH
National Center for Health in Public Housing

Guiding Questions

1. What is the range and diversity of screening tools and how do they compare?
2. How can determination be made about the adequacy of screening tools and their quality?
3. Among the various screening tools, how does PRAPARE rank?

Guide to Screening Tools

- Learning Objectives
  - Compare the most common SDOH screening tools.
  - Determine the best SDOH screening tool(s) for your patient population and needs.
  - Describe the PRAPARE tool and evaluate its potential application at your health center.

Review of Session #1 (part one)

Key concepts covered.

- 1. SDOH just recently entered the field of health.
- 2. The health field has changed in significant ways.
- 3. Our social environment has more to do with health than clinical care.
- 4. The effects of SDOH strongly impacts all communities, yet more strongly affects low-income and public housing communities.
- 5. Issues around race and culture relate fully to the social determinants of health.
- 6. There are helpful processes and methods on how to make the SDOH model work more effectively.

It is this latter point that we want to cover in greater depth today.

Recap (cont'd)

- Race/ethnicity
- Education
- Financial resource strain (food insecurity/ housing insecurity)
- Stress
- Depression
- Physical activity
- Tobacco use and exposure
- Alcohol use
- Social connections and social isolation
- Exposure to violence: Intimate partner violence
- Neighborhood and community compositional characteristics

NCHPH
National Center for Health in Public Housing

Why Is Digital Health Literacy and Broadband Access Important to the Health of Public Housing Residents?

DIGITAL HEALTH LITERACY IS THE ABILITY TO SEEK, FIND, UNDERSTAND, AND APPRAISE HEALTH INFORMATION FROM ELECTRONIC SOURCES

Digital Disparities

- Low-income individuals are less likely to have adopted or utilize a digital health communications system to track, monitor, or maintain their health.
- Elderly populations with low education are more likely to have lower levels of digital literacy.
- Patients with low health literacy are less likely to use health information technology tools.
- Disabled Americans are about three times as likely as those without a disability to say they never go online.

eHealth Literacy Scale (eHEALS)

"It's not only access to housing, food, pharmacy, but also things like lacking broadband service or text-messaging services; those can have severe impact on the patient engagement side."

CIO, SBH Health Systems

The eHealth Literacy Scale (eHEALS) is an 8-item scale developed to measure consumers' combined knowledge, comfort, and perceived skills at finding, evaluating, and applying electronic health information to health problems.

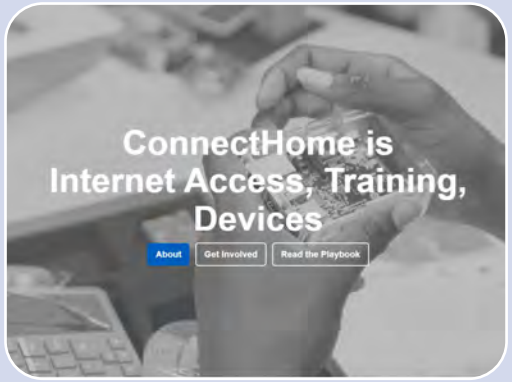
Poll Question #1:

Do you screen for digital health literacy and/or broadband access?

PHPCs may consider the following metrics on digital literacy and broadband access:

1. DO YOU CURRENTLY HAVE ACCESS TO HIGH SPEED INTERNET ON A COMPUTER OR TABLET IN YOUR HOME?
2. DO YOU USE A SMARTPHONE FOR ACCESSING THE INTERNET?
3. DO YOU VISIT A SCHOOL OR LIBRARY WHEN YOU NEED INTERNET ACCESS?
4. HOW COMFORTABLE ARE YOU WITH FINDING HEALTH INFORMATION OR ACCESSING PATIENT PORTALS?

Partner with other organizations to improve digital health literacy and broadband access



HUD developed a new pilot initiative called ConnectHome that engages PHAs, city municipalities, and private sector stakeholders to close the digital divide by providing digital literacy training, broadband access, and digital devices.

The Richmond Library and Cultural Services Department's Literacy for Every Adult Program (LEAP) created The Digital Health Literacy Project to provide low-income Richmond, VA residents with tools and skills needed to access online information to improve their health.

IC-Health Consortium, which consists of 14 partners from seven countries in Europe, developed a series of 35 open access online courses (MOOCs) in eight languages.

How Lawyers Help Address Patients' Social Needs

I-HELP™	How Lawyers Can Help
Income & Insurance	Food stamps, disability benefits, cash assistance, health insurance
Housing & utilities	Eviction, housing conditions, housing vouchers, utility shut off
Education & Employment	Accommodation for disease and disability in education and employment settings
Legal status	Assistance with immigration status (e.g. asylum applications); Veteran discharge status upgrade; Criminal background expungement
Personal & family stability	Domestic violence, guardianship, child support, advanced directives, estate planning

The Social Determinants of Health Academy

Bringing lawyers onto the health center care team to promote patient & community health (NCMLP's Health Center MLP Toolkit, October 2020)

Poll question at the end of the session

- Would you like more information on digital health literacy, broadband access, or Medical Legal Partnerships?

- If so, I can add it to Moodle.

Standardized Screeners Currently Used (UDS 2019)

- None ~38%
- PRAPARE ~32%
- Accountable Health Communities Screening Tools ~6%
- Well Child Care Evaluation Community Resources Advocacy Referral Education (WE CARE) ~4%
- Upstream Risks Screening Tool and Guide ~ <1%
- More than one standardized screener ~12%

Common Screening Tools

- Accountable Health Communities Tool
- Health Begins
- Health Leads
- MLP IHELLP Questionnaire
- PRAPARE
- Safe Environment for Every Kid (SEEK)
- Survey of Wellbeing for Young Children (SWYC)
- We Care
- AAFP-Tool
- AccessHealth
- BMC-Thrive
- WellRx
- IHELP
- NC Medicaid

Criteria for Choosing a Standardized Screener

IOM Criteria for Domains

1. Strength of the evidence

2. Usefulness of the domain

3. Availability of a reliable and valid measure(s) of the domain.

4. Feasibility

5. Sensitivity

6. Accessibility of data from another source.

NC Health and Human Services

- Domains linked to health outcomes
- Questions must be brief
- Validated questions
- Align with existing tools

Criteria for Choosing a Standardized Screener

- Domains
- Length of assessment
- Reading level
- Languages available
- Cost
- Integration into EHRs
- Flexibility
- Resources needed to implement screening tool
- Rating or ranking

Housing insecurity/ Homelessness

AHC-Tool	BMC-Thrive	MLP IHELLP	Medicare Total Health Assessment Questionnaire	NC-Medicaid	PRAPARE	WellRx	iHELP	We Care
What is your living situation today? I have a steady place to live I have a place to live today, but I am worried about losing it in the future I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)	**Do you currently live in a shelter or have no steady place to sleep at night?** Yes/ No **Do you think you are at risk of becoming homeless?** Yes/ No	**Are you living in section 8/public housing?** Yes/No	**Which of the following best describes your current living situation?** Live independently in own home (may get some help with meals, household chores, and personal care) Live in home with a relative or friend who helps with meals and household chores Live in a senior/retirement or Assisted Living facility where meals and household help are routinely provided by paid staff (or could be if requested) Live in a facility such as a nursing home which provides meals and 24-hour nursing care Other	**Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?** Yes/ No **Are you worried about losing your housing?** Yes/ No	**What is your housing situation today**? I have housing I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park) I choose not to answer this question **Are you worried about losing your housing?** Yes/No	**Are you homeless or worried that you might be in the future?** Yes/No	**Do you have any concerns about being evicted or not being able to pay the rent?** **Do you have any concerns about not being able to pay your mortgage?**	**Do you think you are at risk of becoming homeless?** Yes/No **If YES, would you like help with this?** Yes No Maybe later **If yes, is this an emergency?** Yes/No
8th grade	7th grade	8th grade	College	5th grade	8th grade	2nd grade	7th grade	9th grade

The Accountable Health Communities Health-Related Social Needs Screening Tool

Topics Covered	No. of Items	Reading Level	Languages	Completion Time	Cost	Flexibility	EHR
Food Insecurity, Housing, Safety, Transportation, Utilities	10	8th grade	Multiple	Less than 5 min	Free	Supplemental domains: Disabilities, Education, Financial Strain, Social Support, Health Behaviors, Mental Health Paper-based and electronic, staff-administered and self-screened	NextGen, EPIC, eClinicalWorks, Allscripts,

Guest Speaker

PRAPARE

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

SDOH Screening Tools for Public Housing Residents Learning Collaborative:

A Guided Tour of Screening Tools - PRAPARE

Joe Lee, MSHA

Director of Strategic Initiatives and Partnerships

AAPCHO

National Center for Health in Public Housing Learning Collaborative

May 4, 2021

NATIONAL ASSOCIATION OF Community Health Centers

AAPCHO ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

OPCA Oregon Primary Care Association

About AAPCHO

- The Association of Asian Pacific Community Health Organizations (AAPCHO) was formed in 1987
- National association of 32 community health organizations serving Asian Americans, Native Hawaiians, and Pacific Islanders
- Dedicated to improving the health status and access of medically underserved communities
- Bureau of Primary Health Care funded National Health Center Training and Technical Assistance Partner (NTTAP) to provide training and technical assistance to health centers

PRAPARE

Our PRAPARE Partnership

Vivian Li
Research Project Manager/Analyst
AAPCHO

Rosy Chang Weir
Director of Research
AAPCHO

Michelle Proser
Director of Research
NACHC

Jason Patnosh
Associate VP, Partnership and Resource Development
NACHC

Nalani Tarrant
Deputy Director, Research Projects
NACHC

Albert Ayson, Jr.
Associate Director, T/TA
AAPCHO

Joe Lee
Director of Strategic Initiatives and Partnerships
AAPCHO

Sarah Halpin
Program Associate
NACHC

Yuriko de la Cruz
SDOH Manager
NACHC

Stephanie Castano
Transformation Manager
Oregon PCA

PRAPARE

Learning Objectives

At the conclusion of this session, participants will be able:

1. To **learn about PRAPARE** (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) and its **design factors** to identify patient barriers and social needs
2. Promote **SDOH data collection strategies** including workforce development and health IT infrastructure
3. To learn **how standardized data** on Social Determinants of Health (SDOH) can **impact different levels of care, align with national healthcare priorities, and generate innovation**

Learning Objective #1

To learn about PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) and its design factors to identify patient barriers and social needs

PRAPARE

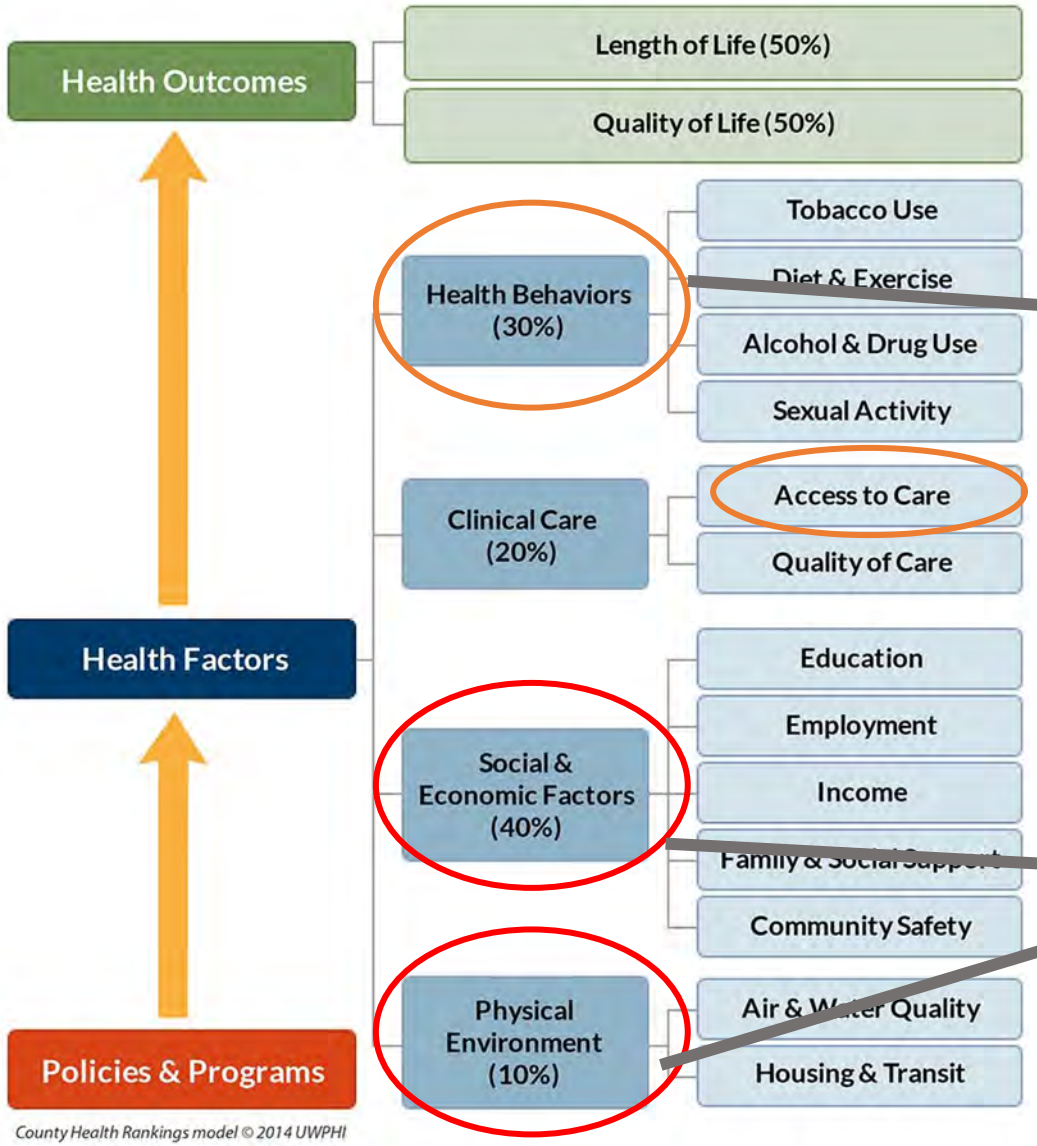
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Why Focus on Social Determinants of Health?

The Social Determinants of Health are the conditions that impact our health and well-being: the circumstances which we are born, grow up, live, work and age.

"Where we live, learn, work and play can have a greater impact on how long and how well we live than medical care."

Source: The Robert Wood Johnson Foundation, Commission to Build a Healthier America (2008-2009)

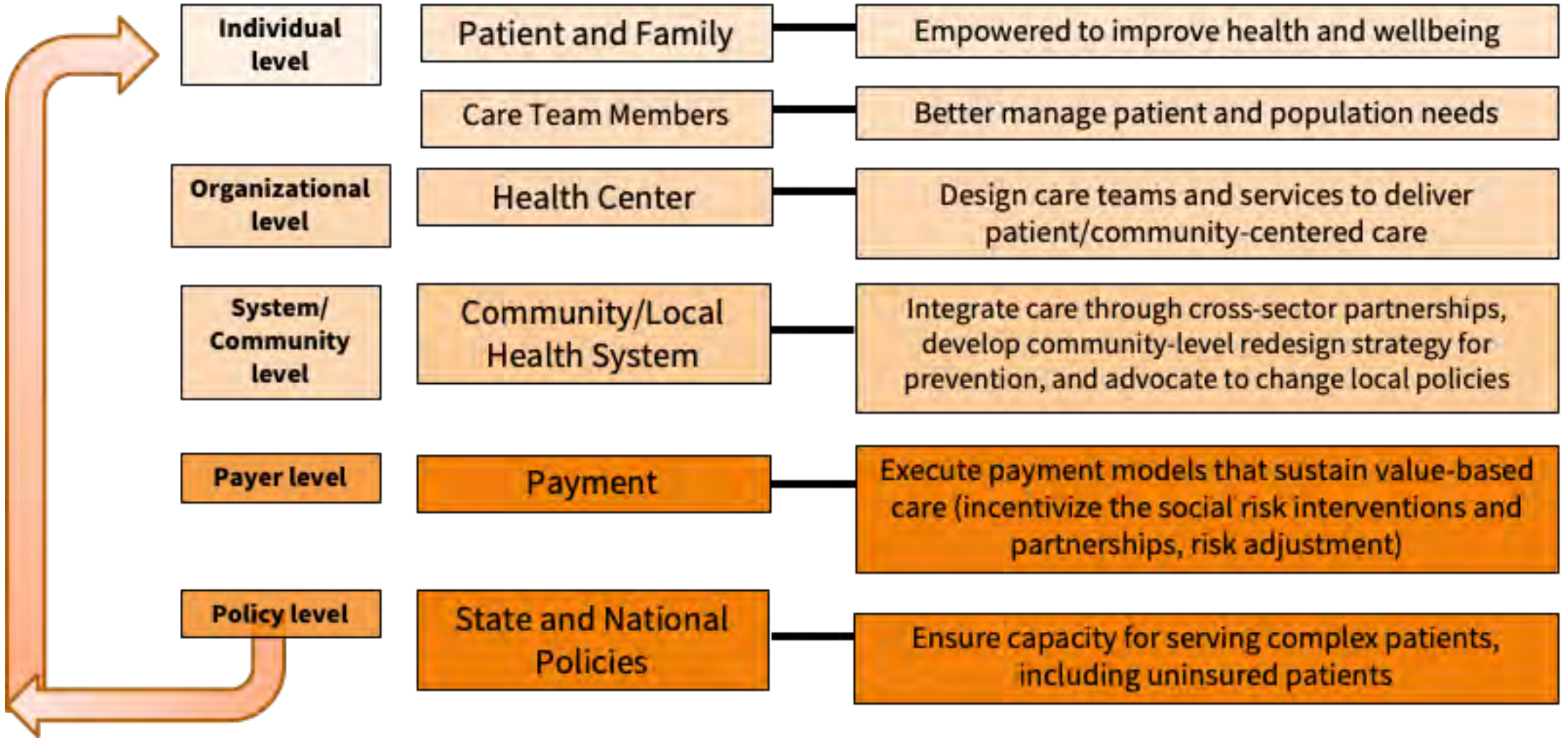


Impacted by the social determinants of health

Social determinants of health

PRAPARE

Why Collect Standardized Data on SDOH?



PRAPARE

Why Collect Standardized Data on SDOH?

INDIVIDUAL Level	Build new or expand existing services in-house for same-day use as clinic visit (children's book corner, food banks, clothing closets, wellness center, transportation shuttle, etc.)	Ensure prescriptions and treatment plan match patient's socioeconomic situation (all)
POPULATION Level	Build partnerships with local organizations (transportation partnerships)	Guide work of local foundations (ex: New York housing)
	Use for Population Segmentation/Risk Stratification	Streamline care management plans for better resource allocation (ex: Hawaii)
System and Policy Level	Inform health delivery redesign (ex: Medicaid and Medicare ACO discussions)	Calculate ROI for social determinant interventions and revenue generated from reducing no-show rates
	Use data for "seat at the table" with payers to discuss sustainable payment and APM	

PRAPARE

Publication pending. Do not quote or distribute without permission from NACHC, AAPCHO, or OPCA.

What is PRAPARE?

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

PRAPARE

What is PRAPARE?

A national standardized patient risk assessment protocol built into the EHR designed to engage patients in assessing and addressing social determinants of health.

www.nachc.org/prapare

PRAPARE

PRAPARE Assessment Form Questions

Core	
1. Race*	10. Education
2. Ethnicity*	11. Employment
3. Veteran Status*	12. Material Security
4. Farmworker Status*	13. Social Isolation
5. English Proficiency*	14. Stress
6. Income*	15. Transportation
7. Insurance*	16. Housing Stability
8. Neighborhood*	
9. Housing Status*	

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

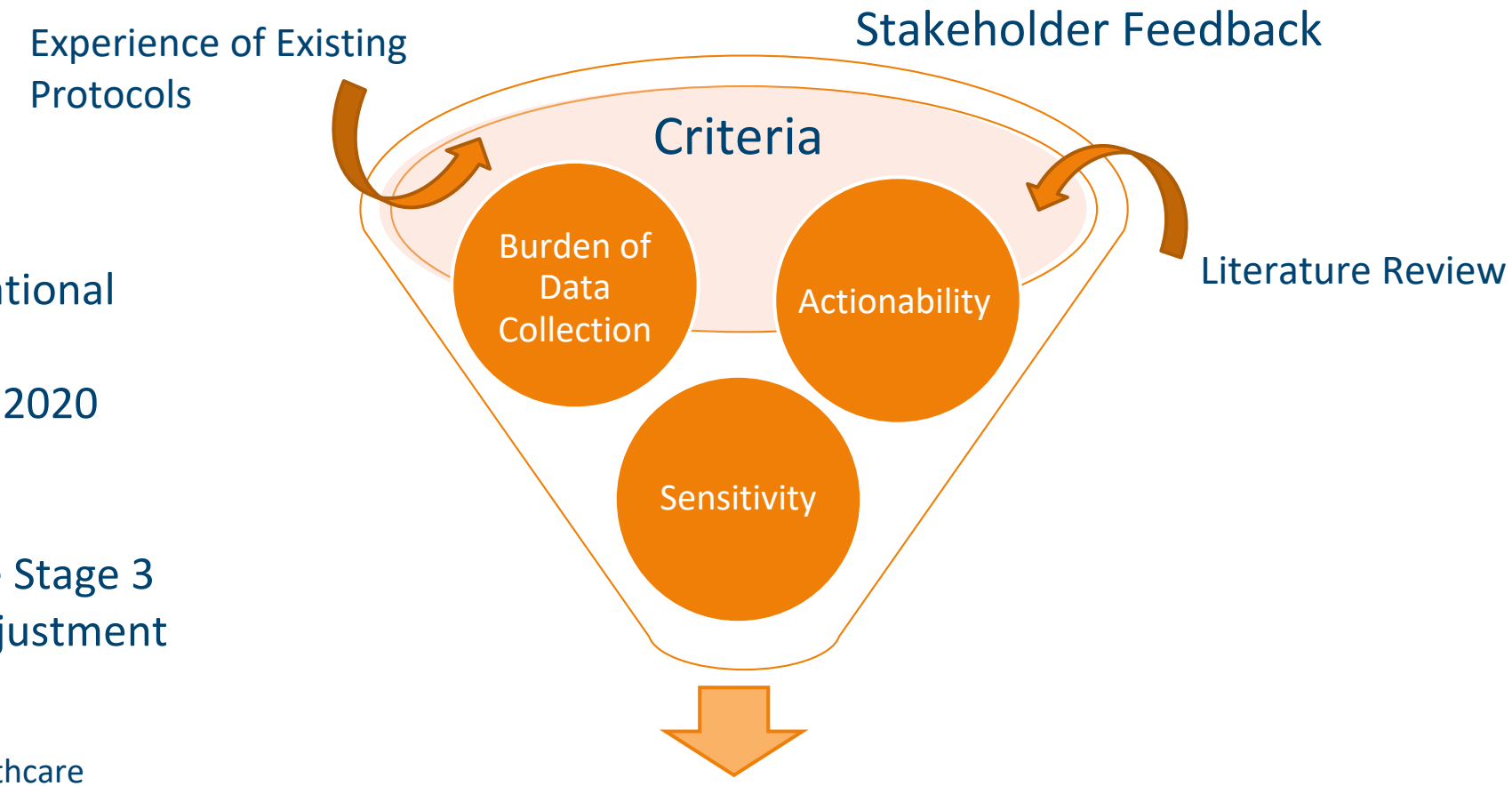
Optional Granular	
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

Find the tool at www.nachc.org/prapare

PRAPARE

PRAPARE's Evidence-Based and Stakeholder-Driven Development Process



Alignment with National Initiatives:

- Healthy People 2020
- ICD-10
- IOM
- Meaningful Use Stage 3
- NQF on Risk Adjustment

Note: Accountable Healthcare Communities Tool did not exist in 2014

PRAPARE

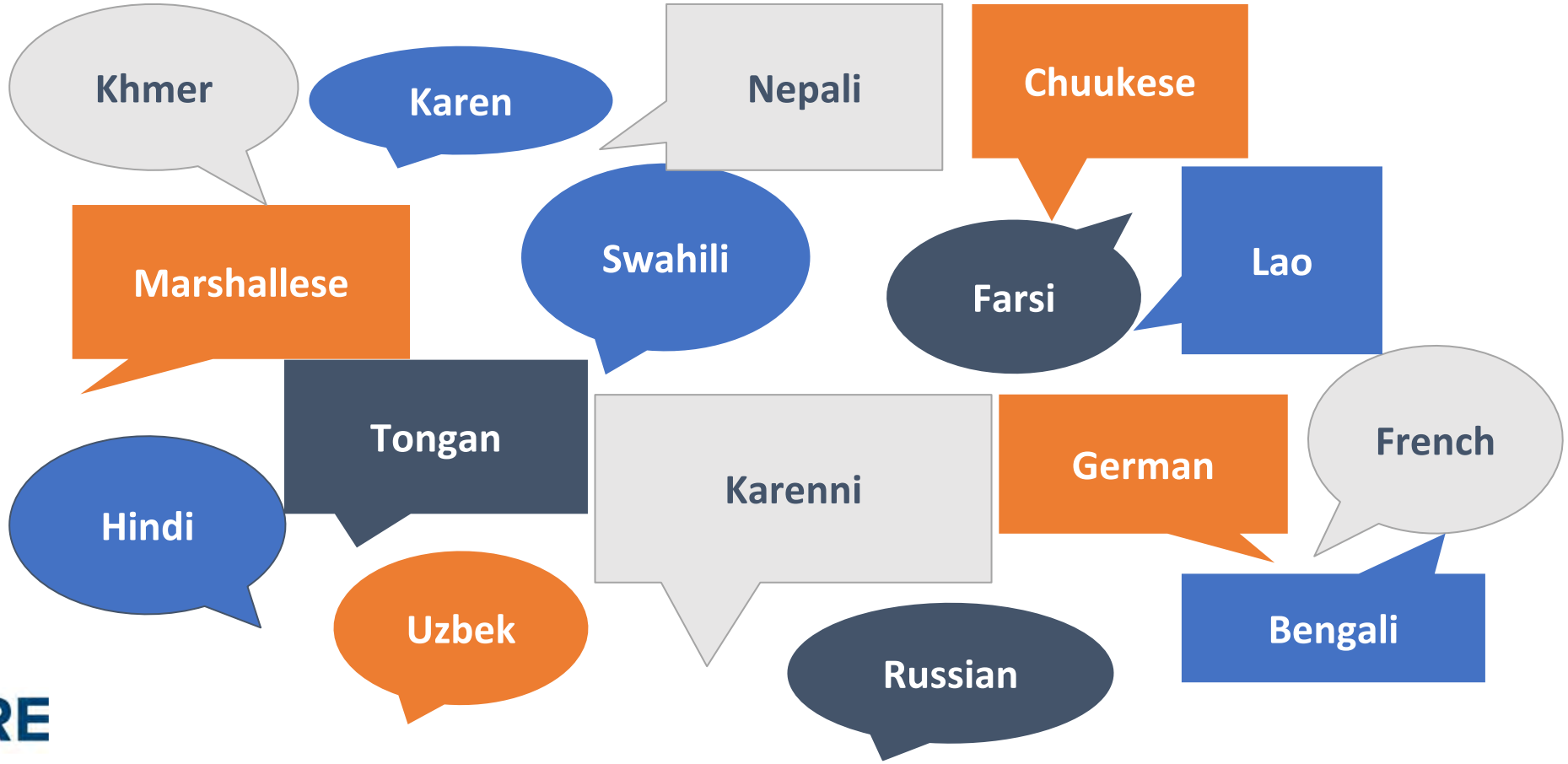
Why PRAPARE?

- **STANDARDIZED and WIDELY USED**
  - Measures linked with standardized codes
  - Dominant SDH risk screening tool, used by health centers in every state
    - *Medicaid Access and Coverage to Care in 2018: Results from the Institute for Medicaid Innovation's 2019 Annual Medicaid Managed Care Survey*
- **EVIDENCE-BASED and STAKEHOLDER-DRIVEN**
  - Developed and tested by health centers
- **FREE EHR Templates**
- **FREE PRAPARE Implementation and Action Toolkit**
  - Accompanying resources, BPs, & lessons learned to guide users on PRAPARE implementation
- **WORKFLOW AGNOSTIC**
  - Can fit within existing workflows and be combined with other tools/data
- **PATIENT-CENTERED and ACTIONABLE**
  - Meant to facilitate conversations and build relationships with patients
  - Standardize the need rather than the question

PRAPARE

PRAPARE is Now in 26 Languages!

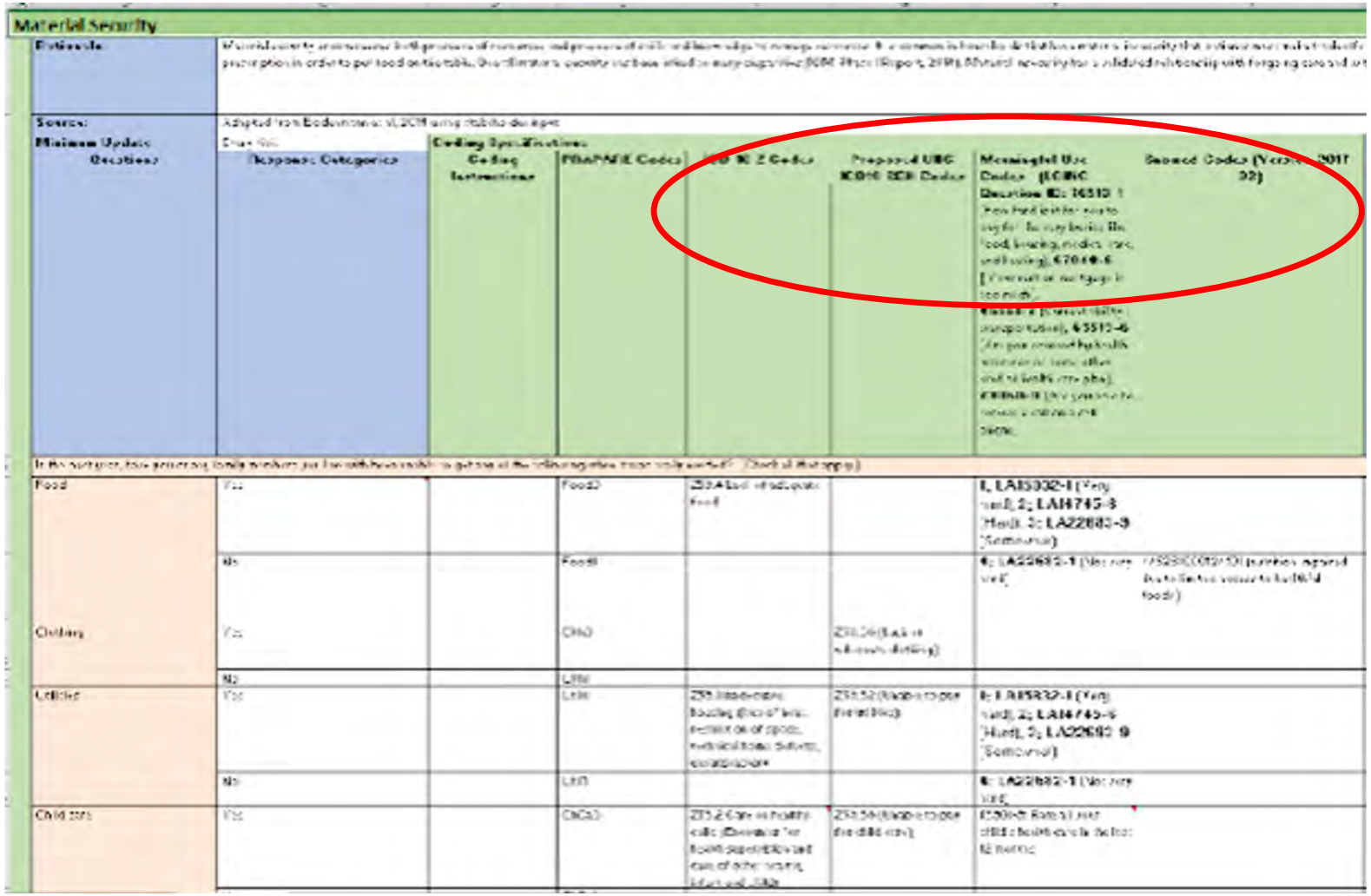
- Validated at community health centers for comprehension and cultural competence
- New additions include:



PRAPARE

Updated PRAPARE Coding and Data Dictionary

- Crosswalks include ICD-10, LOINC, SNOMED
- Many PRAPARE EHR templates have used crosswalks to map PRAPARE measures to ICD-10 codes
- New proposed codes for PRAPARE in LOINC and ICD-10
- PRAPARE Data Documentation available in Toolkit



PRAPARE EHR Templates

- **FREE EHR Templates Available:**
  - NextGen*
  - eClinical Works
  - athenaPractice (formerly GE Centricity)*
  - Epic
  - Cerner*
  - Greenway Intergy
  - Athena

Available for FREE after signing EULA at www.nachc.org/prapare

* Automatically map to ICD-10 Z codes so you can easily add relevant Z codes to problem or diagnostic list

- **In Development:**
  - Allscripts
  - Meditech

70% of all health centers

Current 7 + New EHRs = 85-95% of all health centers

Recorded demos of each PRAPARE EHR template available at www.nachc.org/prapare

PRAPARE

💡 Polling Question 💡

- **Which Electronic Health Record (EHR) does your organization currently support in your SDOH screening T/TA for health centers? Please check multiple EHRs if your organization supports and/or partners with more than one EHR system. [Select all that apply]**

__NextGen

__eClinicalWorks

__athenaPractice (formerly GECentricity)

__Epic

__Greenway Success EHS

__Greenway Intergy

__Cerner

__Allscripts

__Athena

__Other (use chat box)

PRAPARE

Learning Objective #2

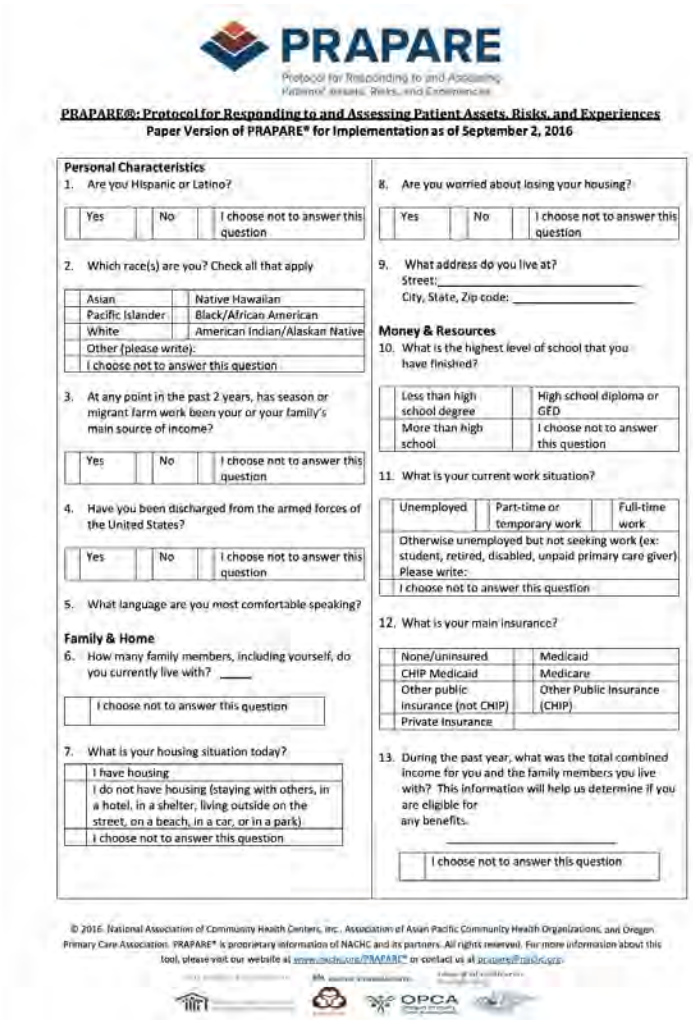
Promote SDOH data collection strategies including workforce development and health IT infrastructure

PRAPARE

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

Documenting PRAPARE SDOH – Paper Tool

The PRAPARE tool can be used as a paper handout to use for administration or to help educate and guide implementation (1-pager front and back)



PRAPARE

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

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

Yes	No	I choose not to answer this question

2. Which race(s) are you? Check all that apply

Asian	Native Hawaiian
Pacific Islander	Black/African American
White	American Indian/Alaskan Native
Other (please write):	
I choose not to answer this question	

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

Yes	No	I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

Yes	No	I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? ____

I choose not to answer this question

7. What is your housing situation today?

I have housing
I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
I choose not to answer this question

8. Are you worried about losing your housing?

Yes	No	I choose not to answer this question

9. What address do you live at?
Street: _____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

Less than high school degree	High school diploma or GED
More than high school	I choose not to answer this question

11. What is your current work situation?

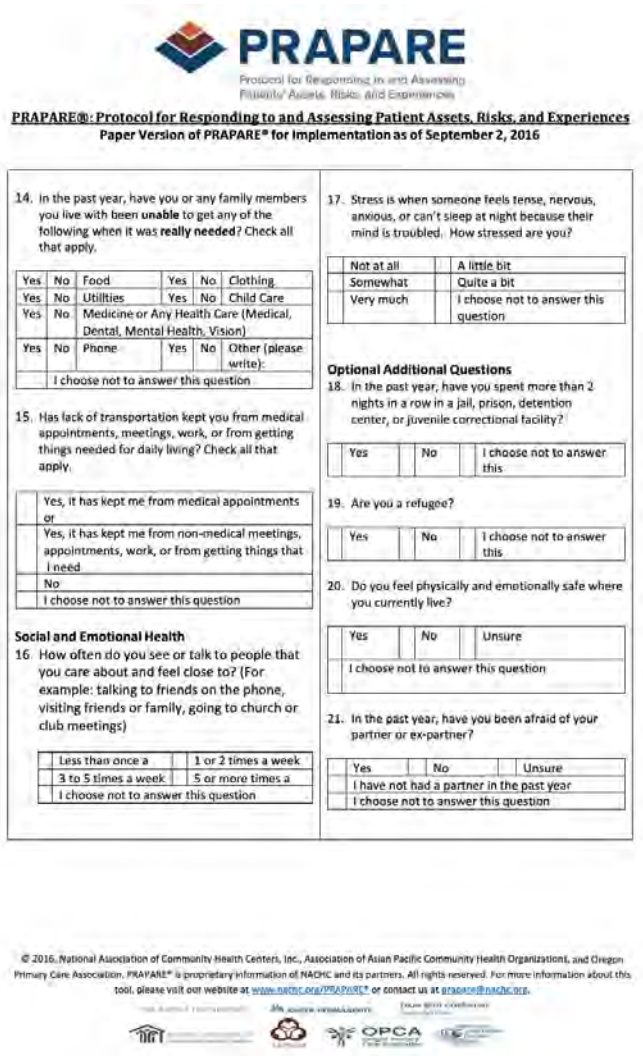
Unemployed	Part-time or temporary work	Full-time work
Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:		
I choose not to answer this question		

12. What is your main insurance?

None/uninsured	Medicaid
CHIP Medicaid	Medicare
Other public insurance (not CHIP)	Other Public Insurance (CHIP)
Private Insurance	

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

I choose not to answer this question



PRAPARE

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

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

14. 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.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
I choose not to answer this question					

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

Yes, it has kept me from medical appointments or
Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
No
I choose not to answer this question

Social and Emotional Health

16. 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)

Less than once a	1 or 2 times a week
3 to 5 times a week	5 or more times a
I choose not to answer this question	

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

Not at all	A little bit
Somewhat	Quite a bit
Very much	I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

Yes	No	I choose not to answer this

19. Are you a refugee?

Yes	No	I choose not to answer this

20. Do you feel physically and emotionally safe where you currently live?

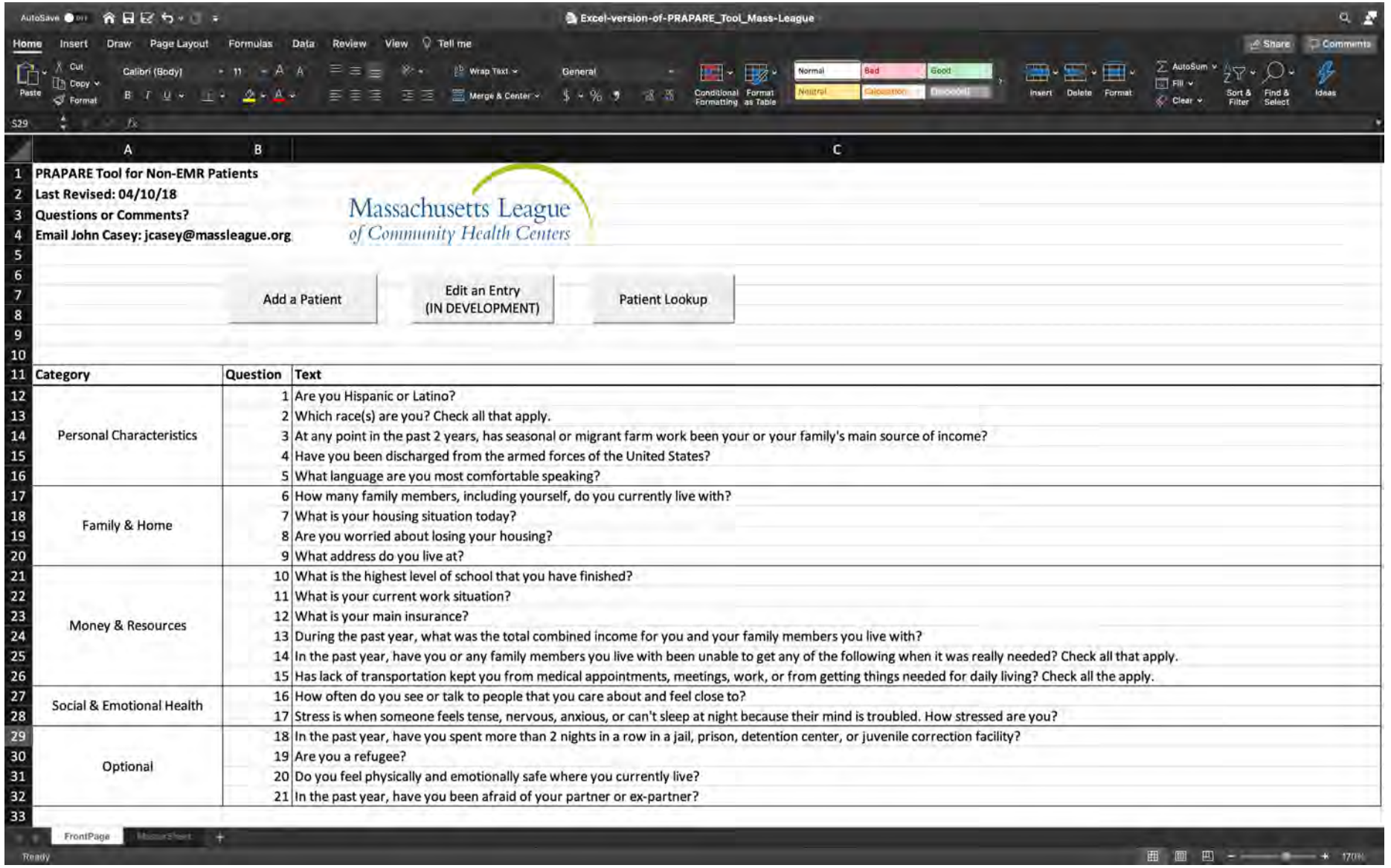
Yes	No	Unsure
I choose not to answer this question		

21. In the past year, have you been afraid of your partner or ex-partner?

Yes	No	Unsure
I have not had a partner in the past year		
I choose not to answer this question		

Documenting PRAPARE SDOH – Excel Template

We are working with several other vendors to develop additional PRAPARE EHR templates. For those who use an EHR where a PRAPARE template doesn't currently exist, we also have an Excel file template that allows you to collect standardized PRAPARE data in Excel until a PRAPARE EHR template is developed [PRAPARE Data Collection Excel Template]



Category	Question	Text
Personal Characteristics	1	Are you Hispanic or Latino?
	2	Which race(s) are you? Check all that apply.
	3	At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?
	4	Have you been discharged from the armed forces of the United States?
	5	What language are you most comfortable speaking?
Family & Home	6	How many family members, including yourself, do you currently live with?
	7	What is your housing situation today?
	8	Are you worried about losing your housing?
	9	What address do you live at?
Money & Resources	10	What is the highest level of school that you have finished?
	11	What is your current work situation?
	12	What is your main insurance?
	13	During the past year, what was the total combined income for you and your family members you live with?
	14	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.
	15	Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all the apply.
Social & Emotional Health	16	How often do you see or talk to people that you care about and feel close to?
	17	Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
Optional	18	In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correction facility?
	19	Are you a refugee?
	20	Do you feel physically and emotionally safe where you currently live?
	21	In the past year, have you been afraid of your partner or ex-partner?

PRAPARE

PRAPARE Assessment Form Questions

Core	
1. Race*	10. Education
2. Ethnicity*	11. Employment
3. Veteran Status*	12. Material Security
4. Farmworker Status*	13. Social Isolation
5. English Proficiency*	14. Stress
6. Income*	15. Transportation
7. Insurance*	16. Housing Stability
8. Neighborhood*	
9. Housing Status*	

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

Optional Granular	
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

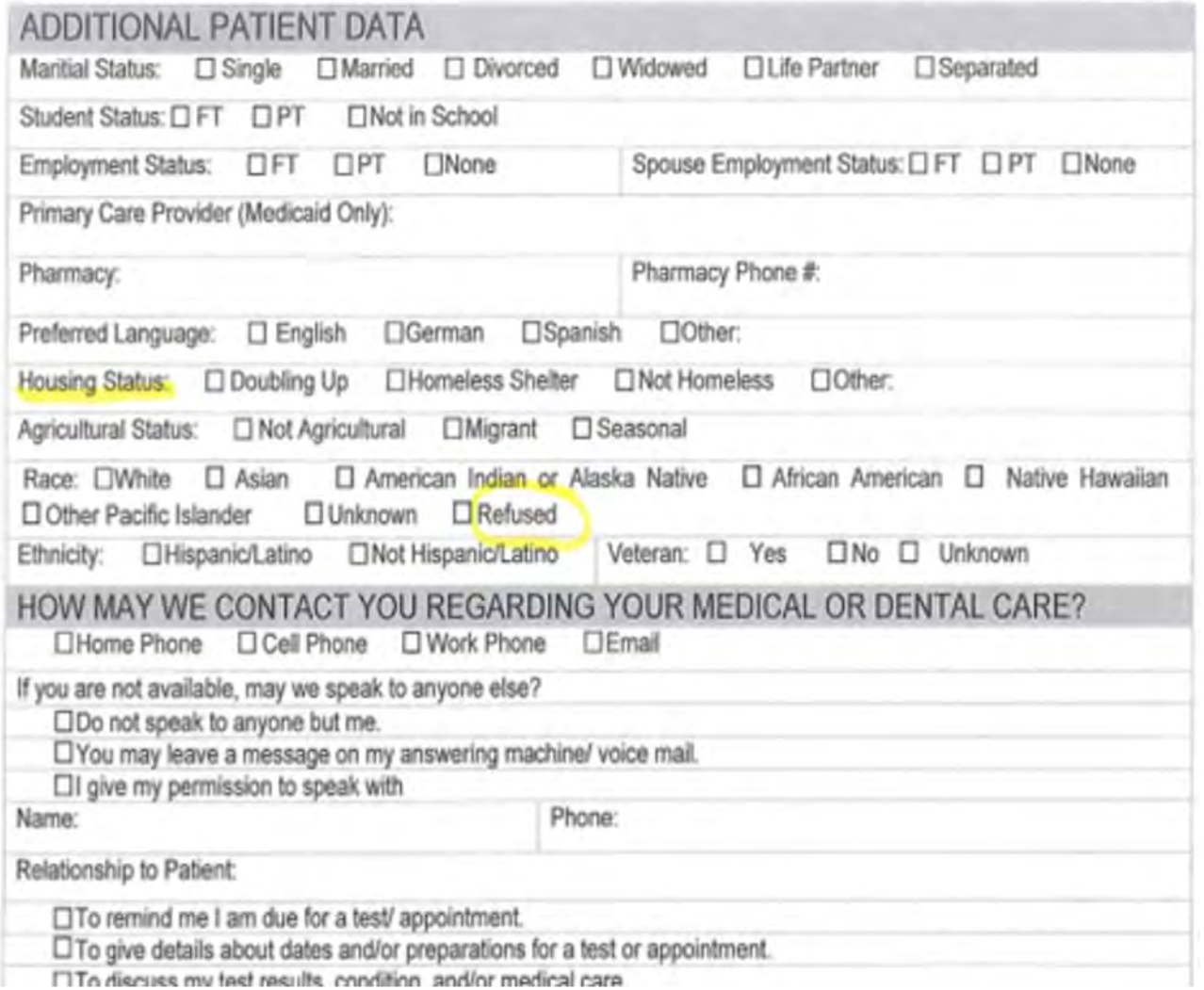
* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

Find the tool at www.nachc.org/prapare

PRAPARE

Crosswalking Your Data to Avoid Double Documentation

- Review your intake forms
- Are there areas where you already collect information that is also in PRAPARE?
  - Income verification forms
  - Self-management forms
- Many PRAPARE EHR templates automatically map to practice management system and/or demographics section and auto-populate that into PRAPARE template
- Don’t need to double-document!!



ADDITIONAL PATIENT DATA

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Separated

Student Status: ☐ FT ☐ PT ☐ Not in School

Employment Status: ☐ FT ☐ PT ☐ None | Spouse Employment Status: ☐ FT ☐ PT ☐ None

Primary Care Provider (Medicaid Only):

Pharmacy: | Pharmacy Phone #:

Preferred Language: ☐ English ☐ German ☐ Spanish ☐ Other:

Housing Status: ☐ Doubling Up ☐ Homeless Shelter ☐ Not Homeless ☐ Other:

Agricultural Status: ☐ Not Agricultural ☐ Migrant ☐ Seasonal

Race: ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Unknown ☐ Refused

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino | Veteran: ☐ Yes ☐ No ☐ Unknown

HOW MAY WE CONTACT YOU REGARDING YOUR MEDICAL OR DENTAL CARE?

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

If you are not available, may we speak to anyone else?

☐ Do not speak to anyone but me.

☐ You may leave a message on my answering machine/ voice mail.

☐ I give my permission to speak with

Name: | Phone:

Relationship to Patient:

☐ To remind me I am due for a test/ appointment.

☐ To give details about dates and/or preparations for a test or appointment.

☐ To discuss my test results, condition, and/or medical care

PRAPARE

QI Process: Intake Form Modification Process

Quality Improvement Process

1) Add new question to General Patient Information Form: ***"Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed from daily living? Check all that apply."***
2) EHR Integration
3) SDOH Response Strategy

Core	
1. Race*	10. Educ
2. Ethnicity*	11. Empl
3. Veteran Status*	12. Mate
4. Farmworker Status*	13. Socia
5. English Proficiency*	14. Stress
6. Income*	15. Transportation
7. Insurance*	16. Housing Stability
8. Neighborhood*	
9. Housing Status*	

ence

is

Optional Granular

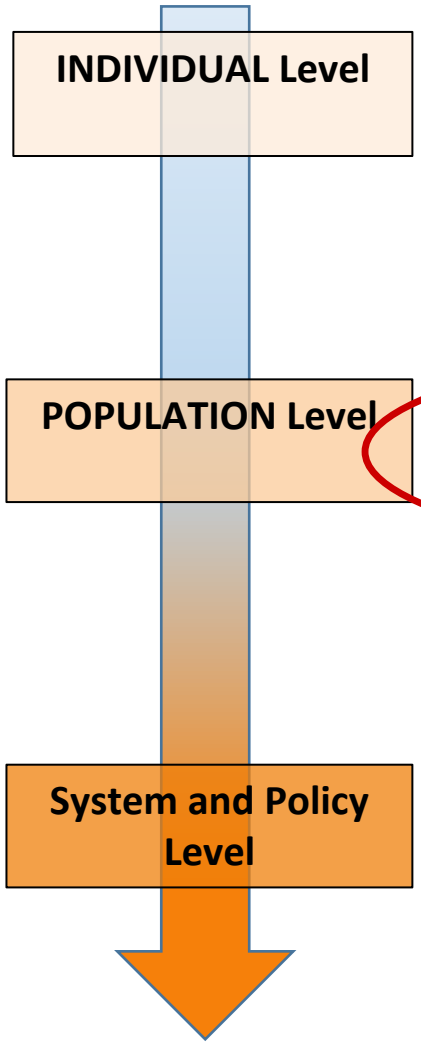
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

Find the tool at www.nachc.org/prapare

PRAPARE

QI Process: Intake Form Modification Process



	Build new or expand existing services in-house for same-day use as clinic visit (children's book corner, food banks, clothing closets, wellness center, transportation shuttle, etc)	Ensure prescriptions and treatment plan match patient's socioeconomic situation (all)
POPULATION Level	Build partnerships with local organizations (transportation partnerships)	Guide work of local foundations (ex: New York housing)
	Use for Population Segmentation/Risk Stratification	Streamline care management plans for better resource allocation (ex: Hawaii)
System and Policy Level	Inform health delivery redesign (ex: Medicaid and Medicare ACO discussions)	Calculate ROI for social determinant interventions and revenue generated from reducing no-show rates
	Use data for "seat at the table" with payers to discuss sustainable payment and APM	

PRAPARE

Publication pending. Do not quote or distribute without permission from NACHC, AAPCHO, or OPCA.

SDOH Data Collection: Five Rights Framework

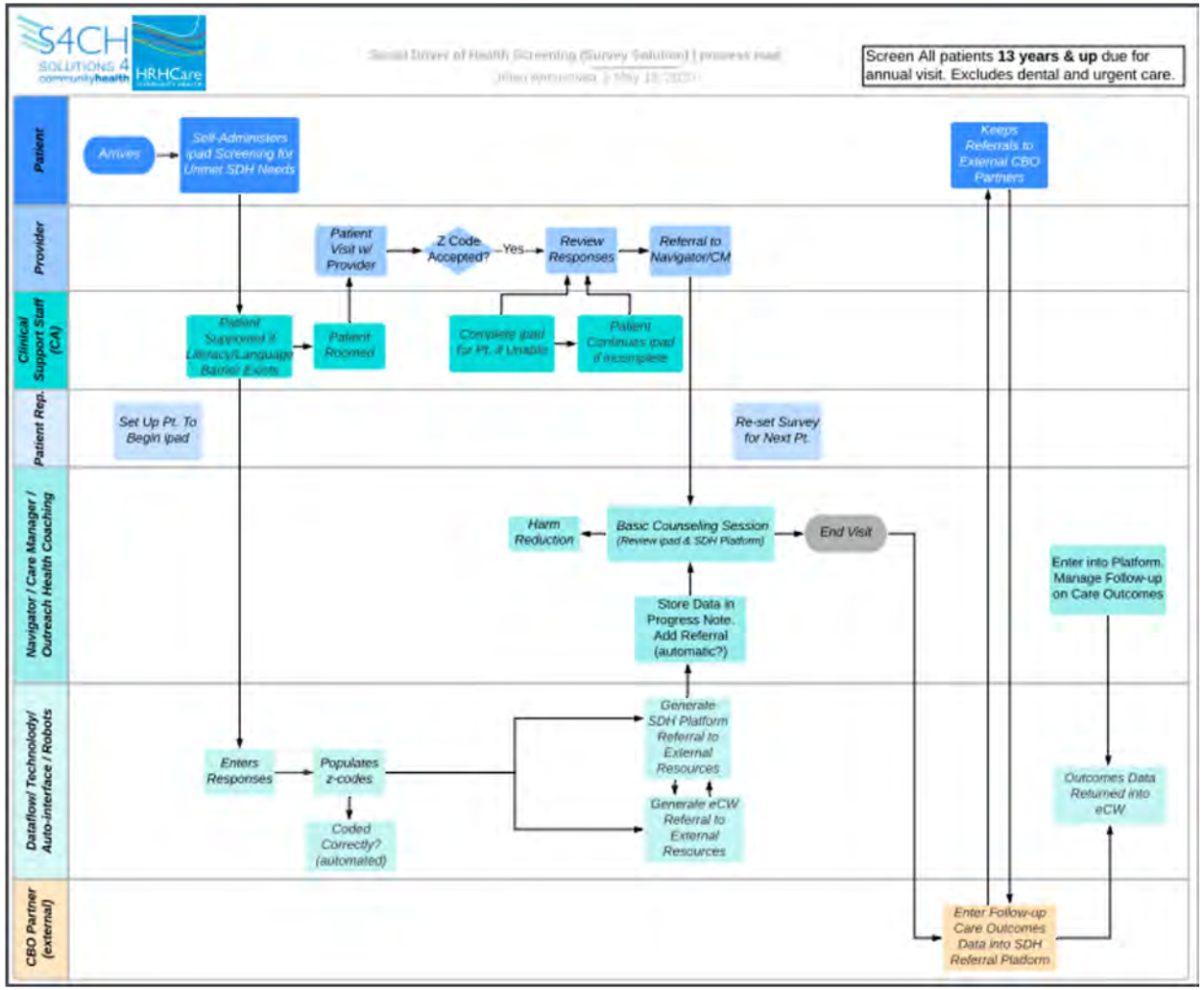
PRAPARE

SDOH Data Collection: Five Rights Framework

5 Rights	Workflow Considerations
Right Information--WHAT	What information in PRAPARE do you already routinely collect? • Part of registration • Part of other health assessments or initiatives
Right Format--HOW	How are we collecting this information and in what manner are we collecting it? • Self-Assessment • In-person with staff
Right Person--WHO	Who will collect the data? Who has access to the EHR to input the data? Who needs to see the information to inform care? Who will respond to needs identified? • Providers and other clinical staff • Non-Clinical Staff
Right Time--WHEN	When is the right time to collect this information so as to minimize disruption to clinic workflow? • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?
Right Place--WHERE	Where are we collecting this information? Where do we need to share and display this information? • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?

PRAPARE

SDOH Data Collection Process – Swimlane Diagram



Acknowledgements: Community Health Care Association of New York State (CHCANYS) and HRHCare

PDF: https://files.constantcontact.com/b6bde37a401/88fa3464-eed6-4898-8a63-0e4ad81aa8bf.pdf

PRAPARE Strategies for Implementation

Health centers already committed to using other SDH tools (AHC, homegrown)	Do crosswalk that maps other tools with PRAPARE to show similarities & differences Message importance of standardized data
Competing Priorities	Message how PRAPARE will add value to other initiatives (PCMH, ACO Participation, Payment Reform, etc.)
How do we implement this without increasing visit time?	Find "Value-Added" time, whether in waiting room, during rooming process, or after clinic visit

Inability to Address SDH	Message: "Have to start somewhere and do the best we can with what we have. Collecting information will help us figure out what services to provide."
Staff Turnover at both CHC and PCA and HCCN	Involve multiple staff from PCA/HCCN and CHC in PRAPARE training so that work can continue despite turnover.
Fitting PRAPARE into Workflow	Incorporate into other assessments to encourage completion (Health Risk Assessment, Depression Screening, PAM, etc)

PRAPARE

Learning Objective #3

To learn how standardized data on Social Determinants of Health (SDOH) can impact different levels of care, align with national healthcare priorities, and generate innovation

PRAPARE

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

Opportunities to Leverage PRAPARE and SDOH Data

Delivery System Transformation Activities (VBP, Shared Savings, etc.)

Payment Reform Efforts

Payers Interested in Social Determinants Data Collection (e.g., Medicaid, private, etc.)

PCMH and QI Initiatives

Data Sharing and Aggregation Opportunities (e.g., HIE, CIE, etc.)

State Foundation Interests in Social Determinants or Related Topics (Opioids, etc.)

Community Health Worker Initiatives

Quality Incentives that Reward for Social Determinant Data Collection

PRAPARE

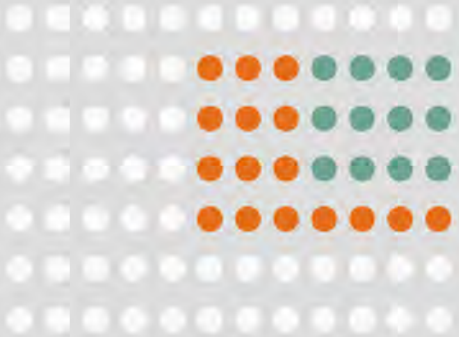
Using PRAPARE and SDOH Data for Care Planning & Population Health Management

10,000 PEOPLE
POPULATION

Use analytics to piece together target population characteristics.

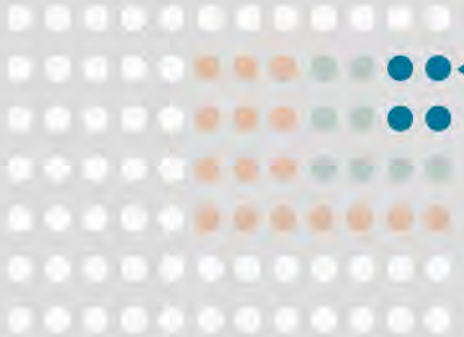
May require multiple data sources and analytic processes.

SUB-POPULATION(S)



- 834 diabetics
- 223 with HbA1c >9

TARGET POPULATION



- 56 out of the 223 diabetics with HbA1c >9 who also:
  - Missed 2 appointments in the last 6 months
  - Live below 100% FPL
  - Are non-native English speaker
  - Have a co-occurring mental health diagnosis
  - Did not graduate from high school

Understanding Their Needs

- Empathic inquiry and community data ***(PRAPARE)***

Responding to Their Needs

- Redesigning care teams
- Developing strong
- Community partnerships
- Expanding social determinants of health/upstream interventions

Demonstrating Impact

- Metrics of success
- Understanding cost and ROI

PRAPARE

Health Center Performance & Accountability

76% of health centers could receive financial incentives for achieving certain clinical care targets

58% of health centers participating in a financial incentive program use an SDOH screening tool*

Source: Commonwealth Fund 2018 National Survey of Federally Qualified Health Centers, https://www.commonwealthfund.org/publications/surveys/2019/apr/2018-national-survey-federally-qualified-health-centers

*Preliminary finding based on NACHC analysis

PRAPARE

IN-HOUSE OR PARTNERSHIPS?

Health Center Resources

Many Resources

Few Resources

Local Community Resources

Create Services In-House

- **People:** Deliver skills training on how to discuss SDOH (i.e. empathic inquiry)
- **Process:** Create opportunities for staff and leadership to message the value of addressing SDOH

Form Coalitions with Community Partners; Advocate for Policy and Environmental Change

- **People:** Build and staff a resource desk and community resource guides
- **Process:** Build and sustain effective community partnerships
- **Technology:** Track referrals to non-clinical services and measure intervention impact

Raise Awareness to Strengthen Staff, Patient, and Partner Knowledge of SDOH

- **People:** Deliver skills training on how to discuss SDOH (i.e. empathic inquiry)
- **Process:** Create opportunities for staff and leadership to message the value of addressing SDOH

Partner with Community-Based Organizations & Leaders

- **People:** Set up volunteer programs at CHC for community volunteers
- **Processes:** Focus public health/grant funds to support partnership development with local community organizations
- **Technology:** Track referrals to non-clinical services and measure intervention impact

Siouxland CHC's Interventions To Address Food Insecurity for Patients with Diabetes (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)

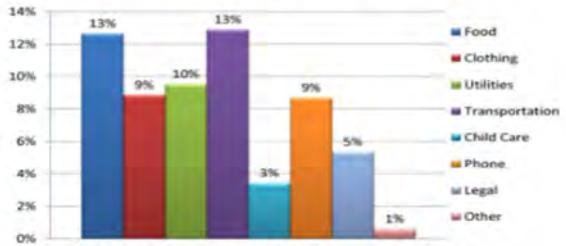
When patients arrive at SCHC or Siouxland Community Health of Nebraska, SCHC's satellite clinic in South Sioux City, they receive a paper PRAPARE, Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences, questionnaire to help identify any needs they might have. In the last 12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

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



Does not include anyone answering "No" or Refusing to Answer.

PRAPARE

Siouxland Community Health an iowahealth center

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

Siouxland CHC's Interventions To Address Food Insecurity for Patients with Diabetes (Iowa)

Voices for Food/Grow an Extra Row

Partner with state extension office program to provide fresh produce donated by community gardeners to patients in need at health center

Demonstration Garden Boxes at Health Center

Healthy Cooking Classes

Partner with YMCA to provide cooking class at local grocery store

Grocery Store Tours

Partner with local grocery store to provides dietician-led tour of grocery store

Increased staff knowledge of community food pantries, soup kitchens, and other resources

PRAPARE

Siouxland Community Health an iowahealth center

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

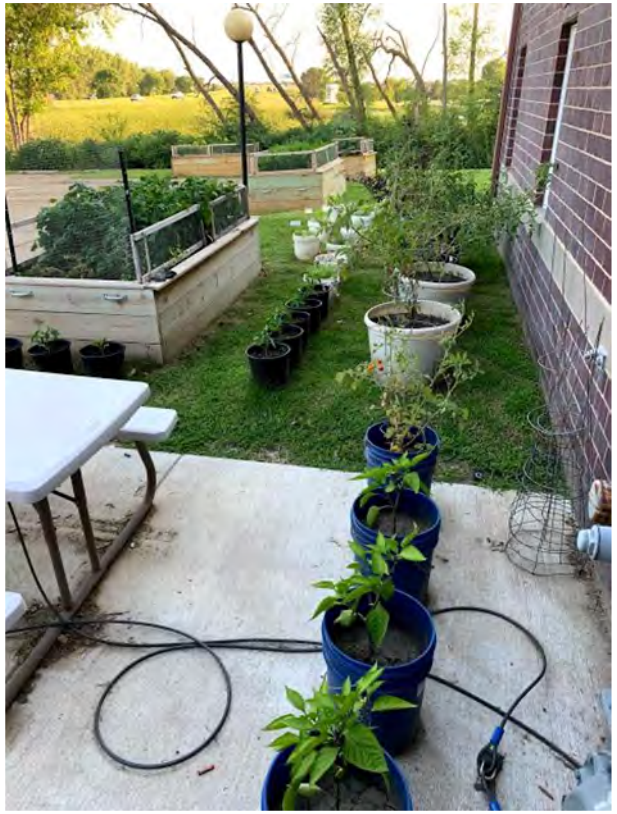
Siouxland CHC's Interventions To Address Food Insecurity for Patients with Diabetes (Iowa)

PRAPARE

Siouxland Community Health
an iowahealth center

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

Siouxland CHC's Interventions To Address Food Insecurity for Patients with Diabetes (Iowa)

PRAPARE

Siouxland Community Health
an iowahealth center

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

PRAPARE IMPLEMENATION AND ACTION TOOLKIT

www.nachc.org/prapare

Chapter 1: Understand the PRAPARE Project

Chapter 2: Engage Key Stakeholders

Chapter 3: Strategize the Implementation Process

Chapter 4: Technical Implementation with EHR Templates

Chapter 5: Develop Workflow Models

Chapter 6: Develop a Data Strategy

Chapter 7: Understand and Evaluate Your Data

Chapter 8: Build Capacity to Respond to SDH Data

Chapter 9: Respond to SDH Data with Interventions

Chapter 10: Track Enabling Services

PRAPARE

Thank you for participating! What questions do you have?

Joe Lee, MSHA
E-mail joelee@aapcho.org

Albert Ayson, Jr., MPH
E-mail: aayson@aapcho.org

Twitter: @prapare_sdoh

Join our Listserv
Email: prapare@nachc.org

PRAPARE

Resources

PRAPARE

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

PRAPARE SDOH & COVID-19
Fact Sheet

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!

PRAPARE

NEW! Research Publication

NEW

Publication in the Journal of Health Care for the Poor and Underserved: Collecting Social Determinants of Health Data in the Clinical Setting: Findings from National PRAPARE Implementation

The Protocol of Responding and Assessing Patient Assets, Risks, and Experiences (PRAPARE) team was recently published in the Journal of Health Care for the Poor and Underserved! The study revealed that nationally, health center patients face an average of 7.2 out of 22 social risks and demonstrate a high prevalence of social determinants of health (SDH) risks—key findings that can be critical for informing social interventions and upstream transformation to improve health equity for underserved populations.

Access now: available here

ORIGINAL PAPER

Collecting Social Determinants of Health Data in the Clinical Setting: Findings from National PRAPARE Implementation

Rosy Chang Weir, PhD
Michelle Proser, PhD, MPP
Michelle Jester, MA, PMP
Vivian Li, MS
Carlyn M. Hood-Ronick, MPA, MPH
Deborah Gurewich, PhD

Abstract: **Background.** The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) is a nationally recognized standardized protocol that goes beyond medical acuity to account for patients' social determinants of health (SDH). *Aims.* We described the magnitude of patient SDH barriers at health centers. **Methods.** Health centers across three PRAPARE implementation cohorts collected and submitted PRAPARE data using a standardized data reporting template. We analyzed the scope and intensity of SDH barriers across the cohorts. **Results.** Nationally, patients faced an average of 7.2 out of 22 social risks. The most common SDH risks among all three cohorts were limited English proficiency, less than high school education, lack of insurance, experiencing high to medium-high stress, and unemployment. **Conclusions.** Findings demonstrated a high prevalence of SDH risks among health center patients that can be critical for informing social interventions and upstream transformation to improve health equity for underserved populations.

Key words: Social determinants of health, community health center, vulnerable populations, health equity, complex patients, safety net, underserved populations, social risk factors.

There is growing consensus over the past few decades that a wide array of social and community-level risk factors—such as food insecurity, homelessness, lack of transportation, and unemployment—drive health and wellbeing as well as health care expenditures.[1] Health care providers face increasing expectations to lower health

ROSY CHANG WEIR and VIVIAN LI are affiliated with the Association of Asian Pacific Community Health Organizations. MICHELLE PROSER and MICHELLE JESTER are affiliated with the National Association of Community Health Centers. CARLYN M. HOOD-RONICK is affiliated with the Oregon Primary Care Association. DEBORAH GUREWICH is affiliated with the Center for Healthcare Organization & Implementation Research, VA Boston Healthcare System. Please address all correspondence to Rosy Chang Weir, Director of Research, Association of Asian Pacific Community Health Organizations, 101 Callan Avenue, Suite 400, San Leandro, CA 94577; phone: 510-272-9536 x107, email: rcweir@aapcho.org.

© Meharry Medical College Journal of Health Care for the Poor and Underserved 31 (2020): 1018–1035.

PRAPARE

PRAPARE Use Among Medicaid MCOs

Source: Institute for Medicaid Innovation, 2019 Annual Medicaid MCO Survey, https://www.medicaidinnovation.org/_images/content/2019_Annual_Medicaid_MCO_Survey_Results_FINAL.pdf

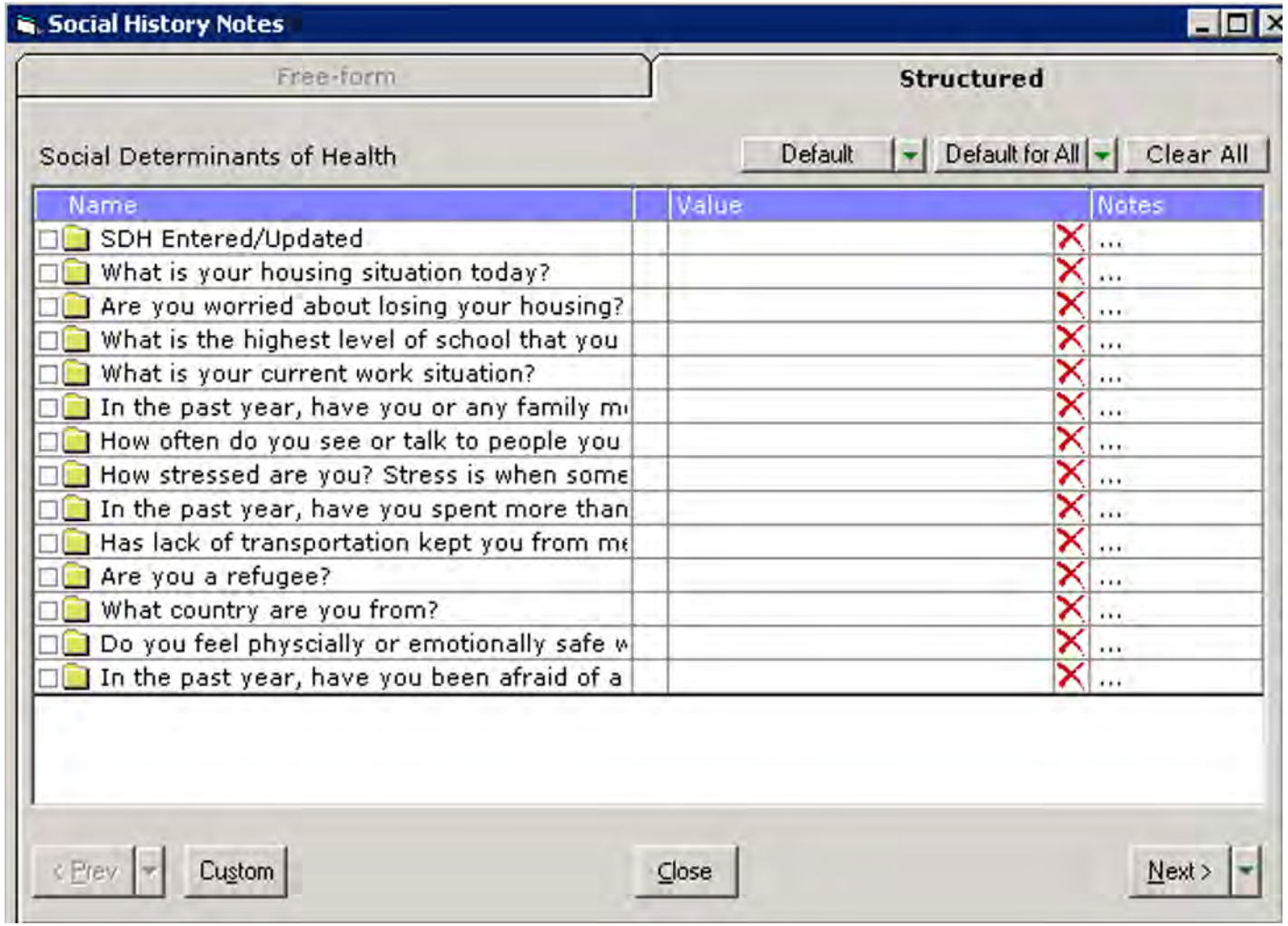
Table 57. Most Common Social Determinant of Health Screening Tools Used by Medicaid Managed Care Organizations, 2018

Screening Tool	Percentage of Medicaid MCOs
Protocol for Responding to and Assessing Patient Assets, Risks and Experiences (PRAPARE)	36%
Centers for Medicare and Medicaid Services (CMS) Accountable Health Communities Health-Related Social Needs Screening Tool	29%
Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)	22%
American Community Survey	15%
Arizona Self Sufficiency Matrix	0%
Self-Sufficiency Outcomes Matrix, OneCare Vermont, CHCS version	0%
Social Determinants Screening Tool, AccessHealth Spartanburg, CHCS version	0%
Social Needs Screening Toolkit, HealthLeads USA	0%
The EveryOne project: Advancing health equity in every community, Toolkit by American Academy of Family Physicians (AAFP)	0%
Other (e.g., internally developed, adapted versions of other tools)	50%
None	15%

PRAPARE

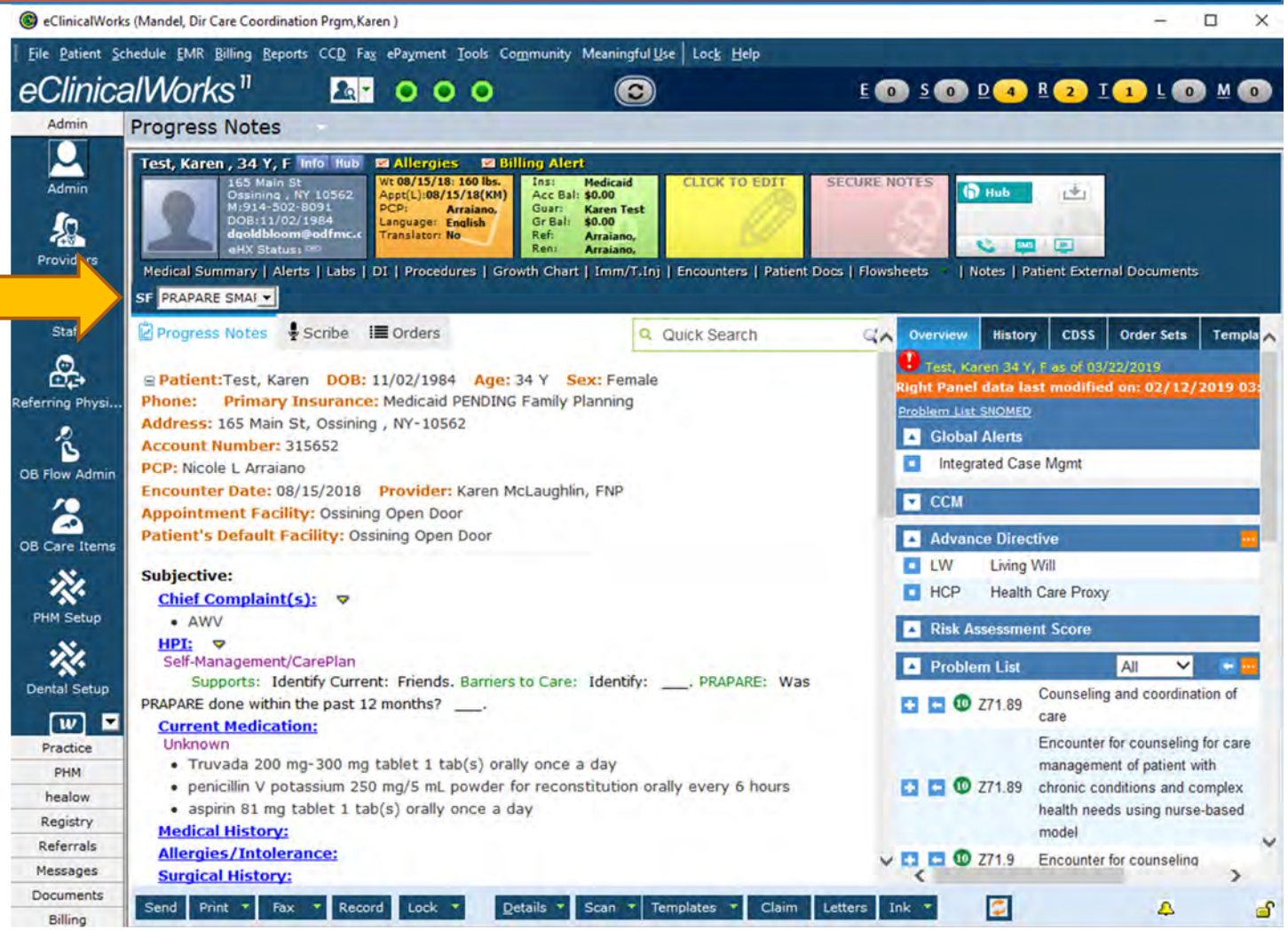
EHR Example #1: eClinicalWorks - Social History Notes

Instructions or the PRAPARE eCW Configuration guide available in Chapter 4 of PRAPARE Implementation and Action Toolkit at www.nachc.org/prapare

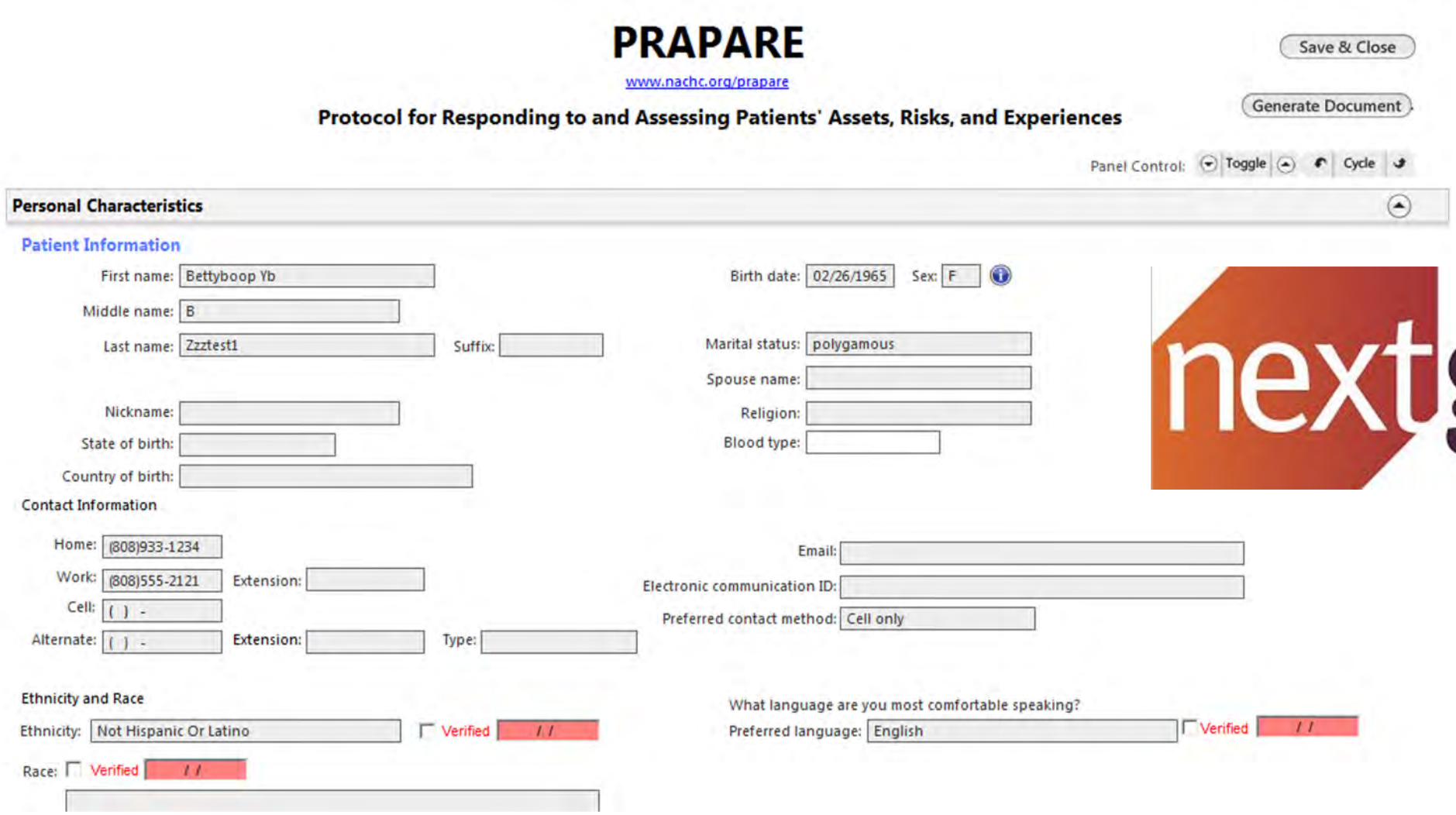


EHR Example #1: eClinicalWorks - Smart Form

PRAPARE eCW Smart Form available in Chapter 4 of PRAPARE Implementation and Action Toolkit at www.nachc.org/prapare

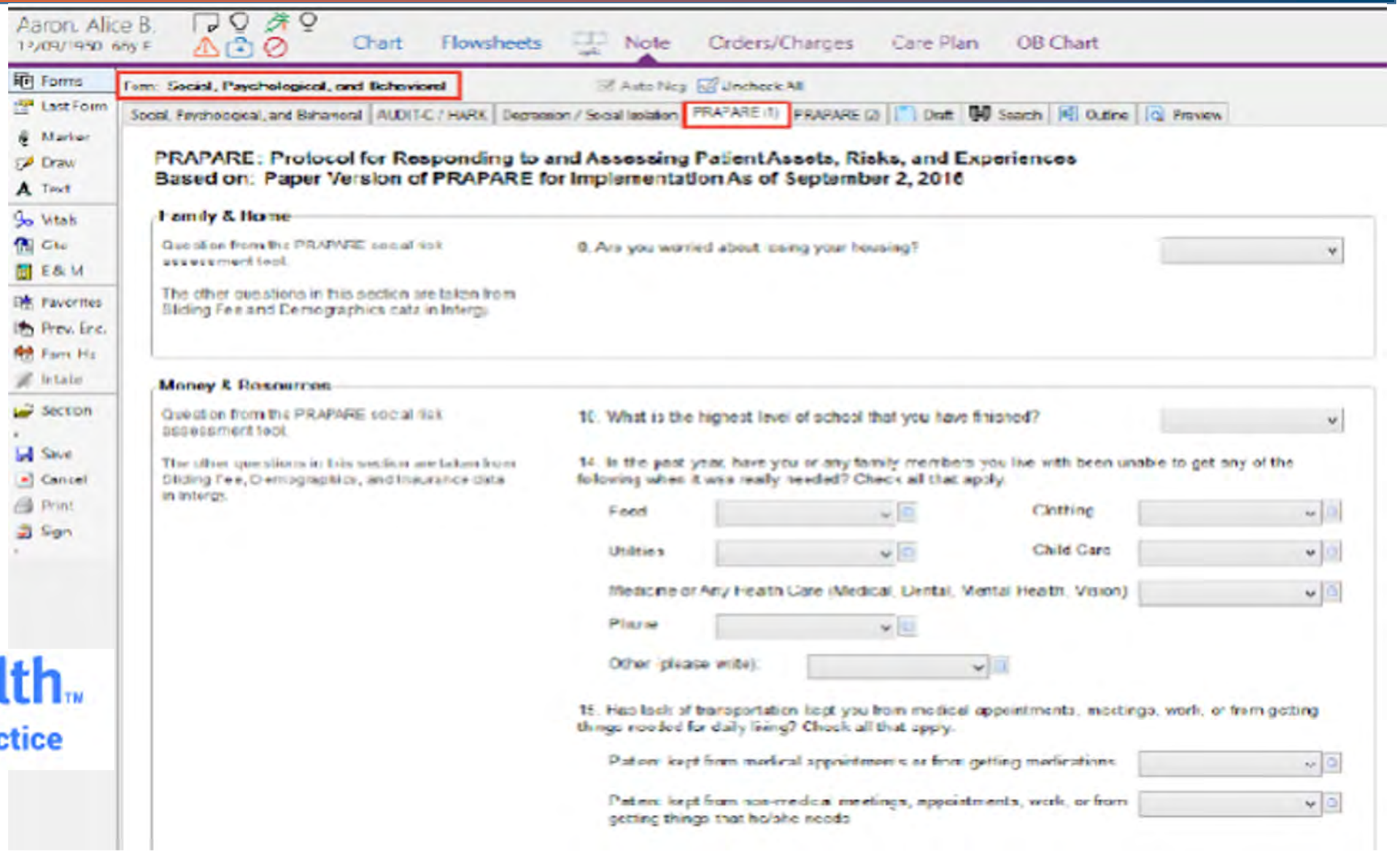


EHR Example #2: NextGen Template



EHR Example #3: Greenway Intergy Template

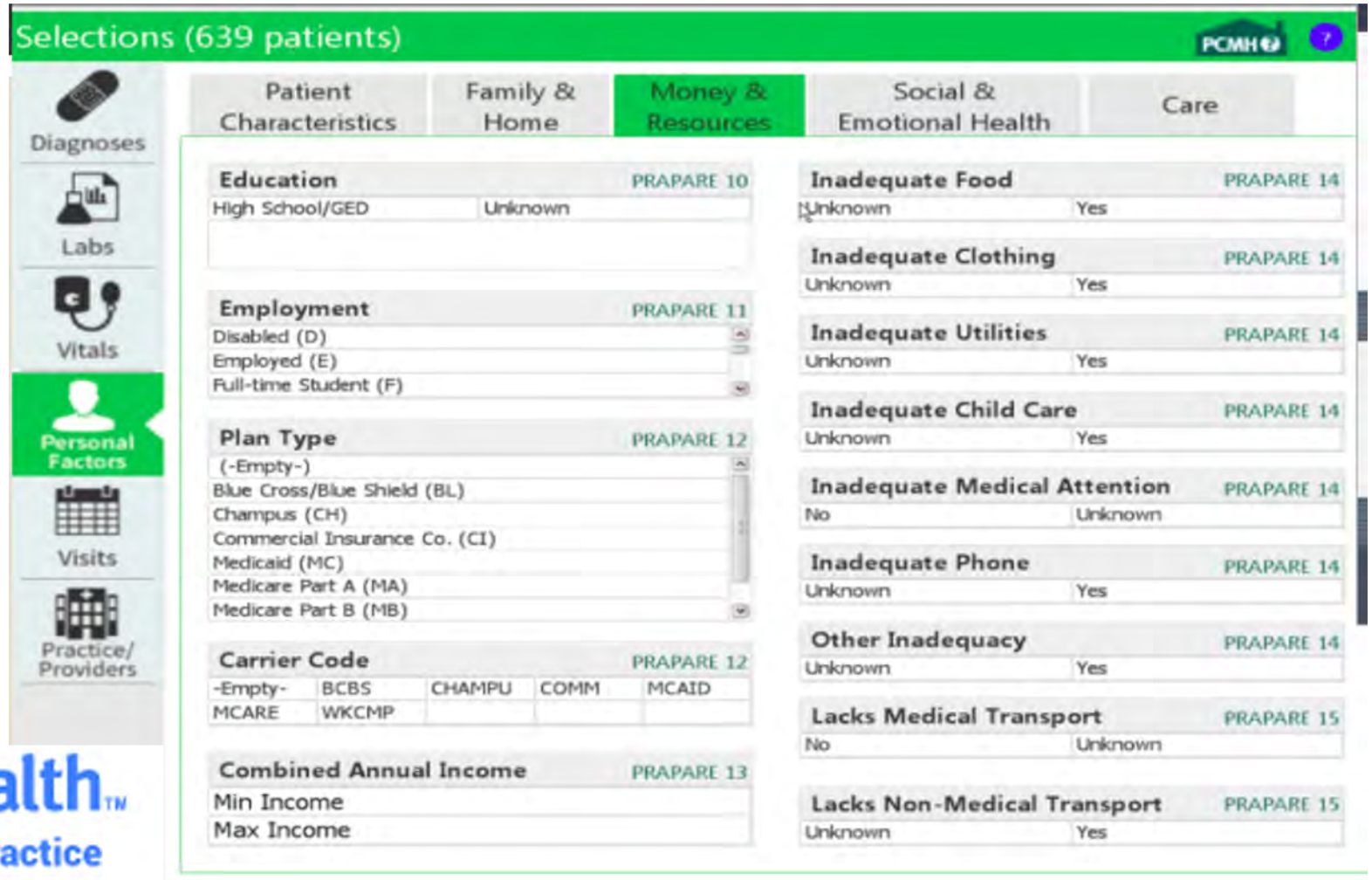
- Need Intergy 11 or higher
- Some data in demographics as usual
- Other data in PRAPARE template
- Health Choice Network has crosswalk



Greenway Health™
Putting Possibility into Practice

PRAPARE

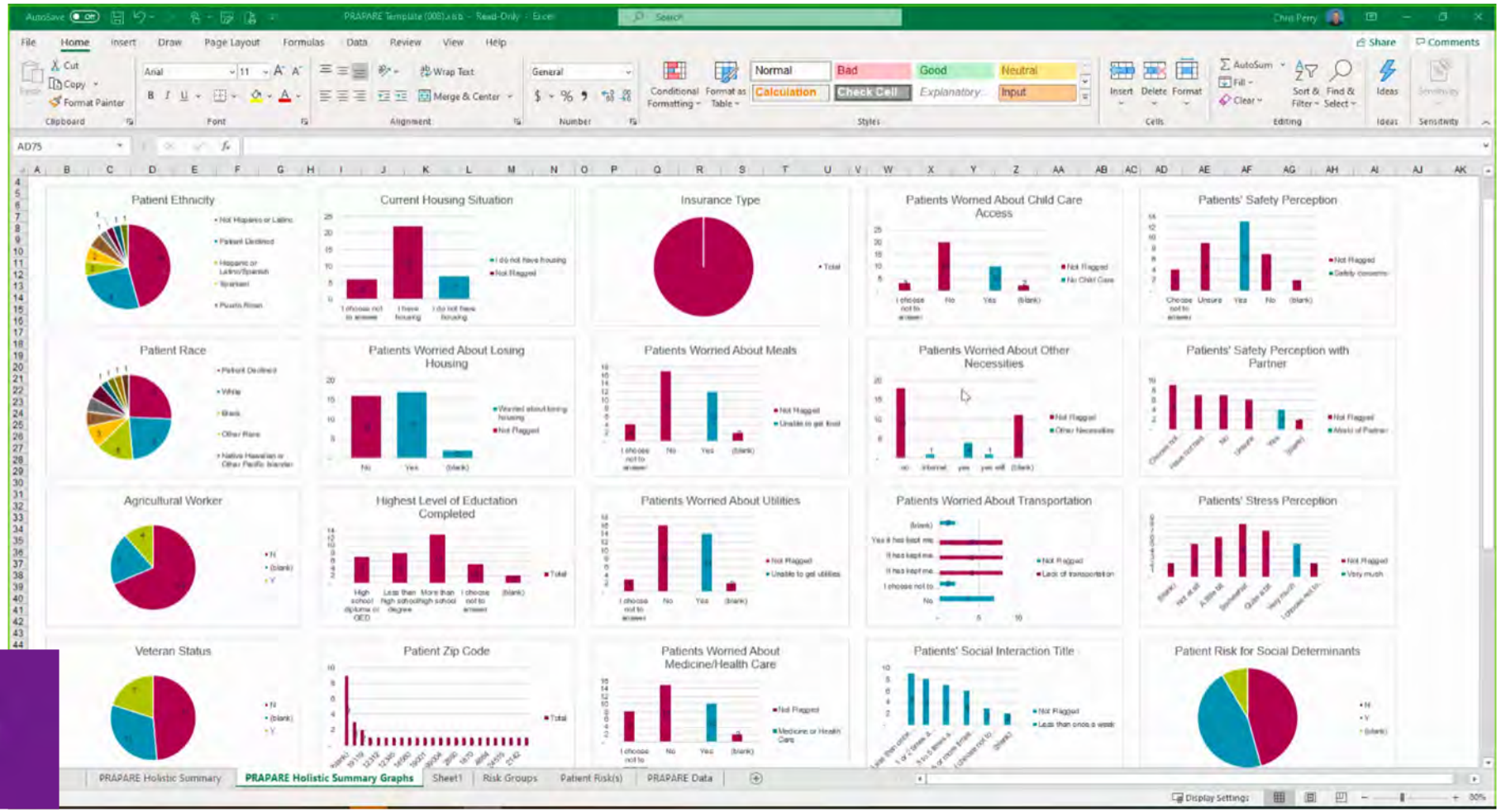
EHR Example #3: Greenway Intergy PRAPARE Report



GreenwayHealth™
Putting Possibility into Practice

PRAPARE

EHR Example #4: Athena (Pilot Phase)



athenahealth

PRAPARE

Q&A

Please unmute yourself to ask a question

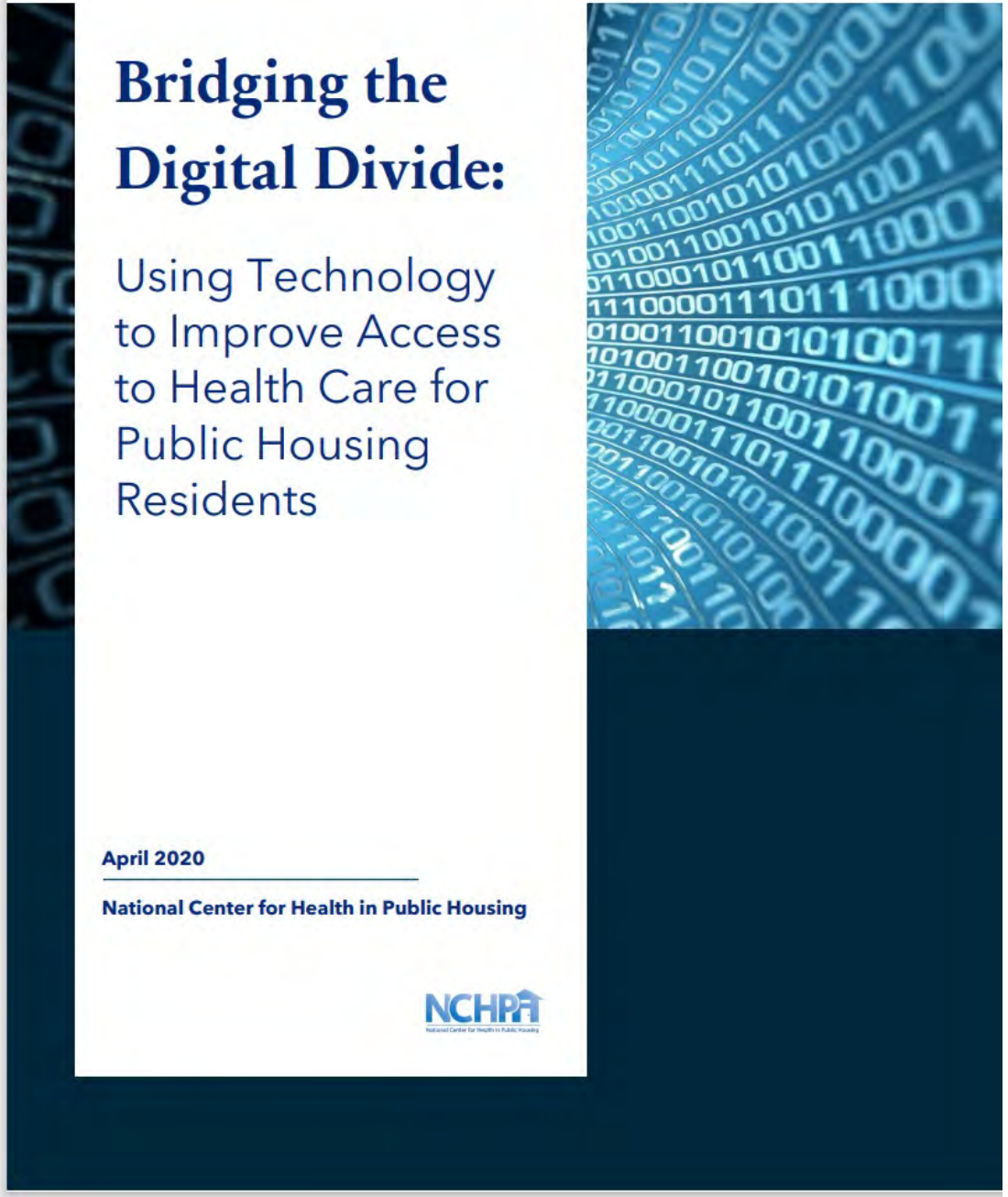
Next Session

Session 3:

- May 18th at 2pmET-3pmET
- Remembering the Goal: Implementing a Screening Process with Whole Families in Mind
- Guest Speaker Dr. Christina Bethell

Resources

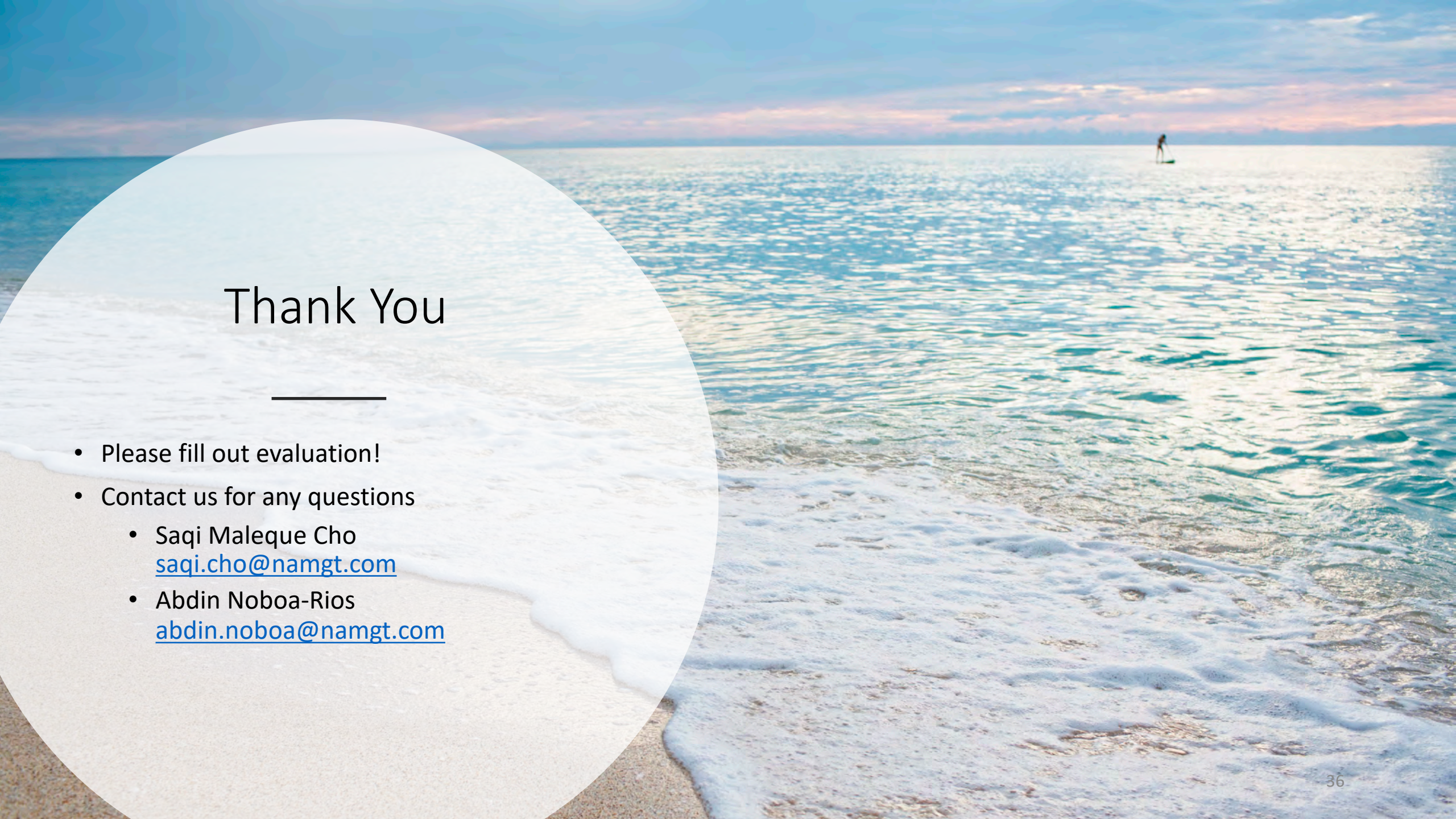
- The Screening Technical Assistance & Resource Center (STAR Center) seeks to improve the health, wellness, and development of children through practice and system-based interventions to increase rates of early childhood screening, counseling, referral, and follow-up for developmental milestones, perinatal depression, and social determinants of health. Screening Time! This site provides a variety of resources to assist you with the screening process for maternal depression, developmental concerns, and social determinants of health.
- The Social Interventions Research and Evaluation Network (SIREN) Evidence & Resource Library has expanded to include both peer-reviewed publications and other types of resources such as webinars and screening tools/toolkits on medical and social care integration.
- Kaiser Permanente and SIREN's Systematic Review of Social Risk Screening Tools



- Digital needs and challenges of public housing residents
- Risks and benefits of using technology to improve patient care
- Recommendations on how to prepare health centers and patients to optimize digital tools, improve access to care, and enhance efforts through partnerships to bridge the digital divide

Evaluation Poll

- Answer the poll...
- Add to the chat **to Organizer**
  - Which aspects of this learning collaborative session did you find most useful?
  - How could this learning collaborative session be improved in the future?



Thank You

- Please fill out evaluation!
- Contact us for any questions
  - Saqi Maleque Cho
    saqi.cho@namgt.com
  - Abdin Noboa-Rios
    abdin.noboa@namgt.com