Aligning Social Needs Data and Social Interventions Coding for Health Equity

December 10, 2020

Housekeeping

- Webinar will be recorded
- Relevant resources and next steps will be emailed after
- Tips on Zoom and features for engaging with us and each other
- New realities: kiddos, furry friends, unstable internet, renovations, etc.

Agenda

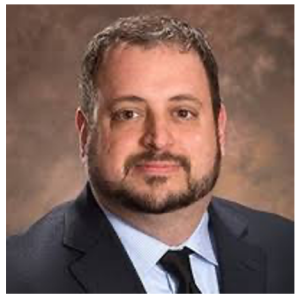
Topic	Timing in EST
Opening and Housekeeping • Yuriko de la Cruz, NACHC	3:00pm
PRAPARE Social Interventions Protocol & Impact of Social Interventions Documentation • Rosy Chang Weir & Vivian Li, AAPCHO	3:05pm
Under One Roof: A Combined Community Health Center and Community Action Agency Addresses Social Risk Factors • Martin "Marty" Sabol, Director of Health Services, Nasson Health Care/York County Community Action Corporation	3:20pm
La Maestra's Circle of Care® Addressing Social Determinants • Corinne Hanson, Chief Development Officer, La Maestra Community Health Centers	3:40pm
Q&A • Albert Ayson, AAPCHO	4:00pm
Closing & Resources	4:15pm

Learning Objectives

1. Identify and review existing social interventions data collection protocols and provide technical expert insight for national standardization.
2. Provide on-the-ground perspective and recommendations for integrating social interventions including the social service referral loop in alignment with the social service sector.
3. Foster discussion around best practices and lessons learned in existing processes, use cases, scenarios, workflows, and reporting to document SDOH interventions.

Project Team at NACHC & AAPCHO

Michelle Proser
Director of Research
NACHC



Jason Patnosh
Associate VP, Partnership & Resource Development
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Program Associate
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Yuriko de la Cruz
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Vivian Li
Research Project Manager/Analyst
AAPCHO

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

Today's Guest Speakers

Martin "Marty" Sabol,
Director of Health Services
Nasson Health Care/York County Community Action Corporation
(Sanford, ME)

Corinne Hanson
Chief Development Officer
La Maestra Community Health Centers
(San Diego, CA)

Acknowledgements

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

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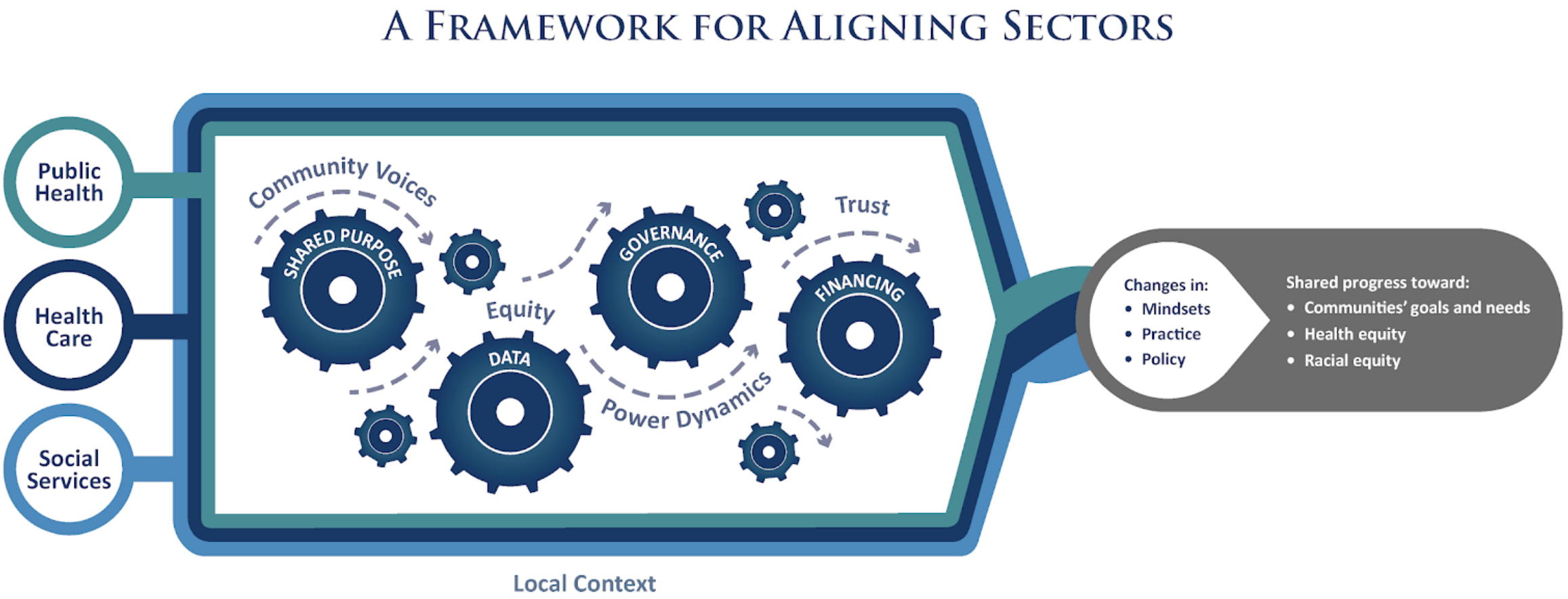
RWJF Theory of Change Alignment Framework



"Assessing and Addressing Social Determinants of Health During COVID-19" – Webinar Series

The goal of the series is to:

- Provide an overview, relevant updates, and promising practices on how community health centers are leveraging resources, including their workforce, technology, and external partners to assess and address their patients' SDOH needs.
- Demonstrate how health centers are using the SDOH data to develop new and/or stronger collaborations with community partners to provide social interventions during the COVID-19 pandemic.

"Assessing and Addressing Social Determinants of Health During COVID-19" – Webinar Series

Session #1:

Adapting SDOH Data Collection Workflows during COVID-19

Slides (click here)

Webinar Recording (click here)

Session #2:

Practical Strategies for Social Risk Screening during COVID-19

Slides (click here)

Webinar Recording (click here)

NEW! Q&A with the Panelists (click here for recording)

Session #3:

Emerging Strategies to Address SDOH Through Community Referrals and Cross-Sector Partnerships

Slides (click here)

Webinar Recording (click here)

PRAPARE Social Interventions Protocol

Rosy Chang Weir, AAPCHO
Vivian Li, AAPCHO

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What are social interventions?

Social Interventions = Non-clinical services that address non-medical, health-related social determinant of health needs

-Adapted from National Academies of Sciences, Engineering, and Medicine report, 2019

Social Interventions Protocol - First Draft

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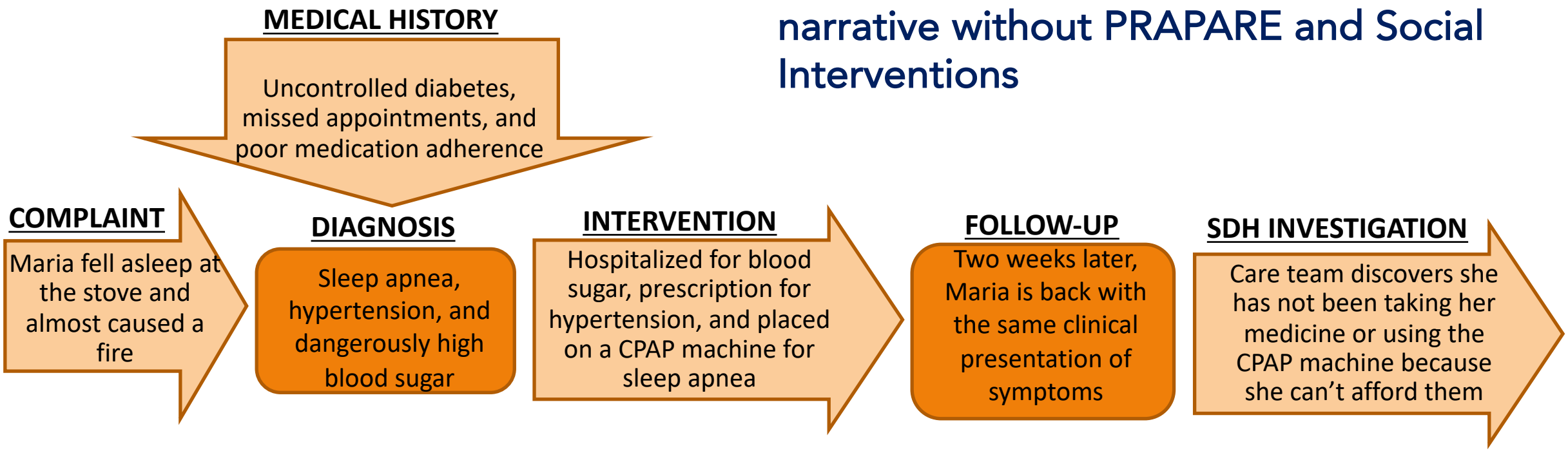
PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Social Interventions Data Collection Protocol

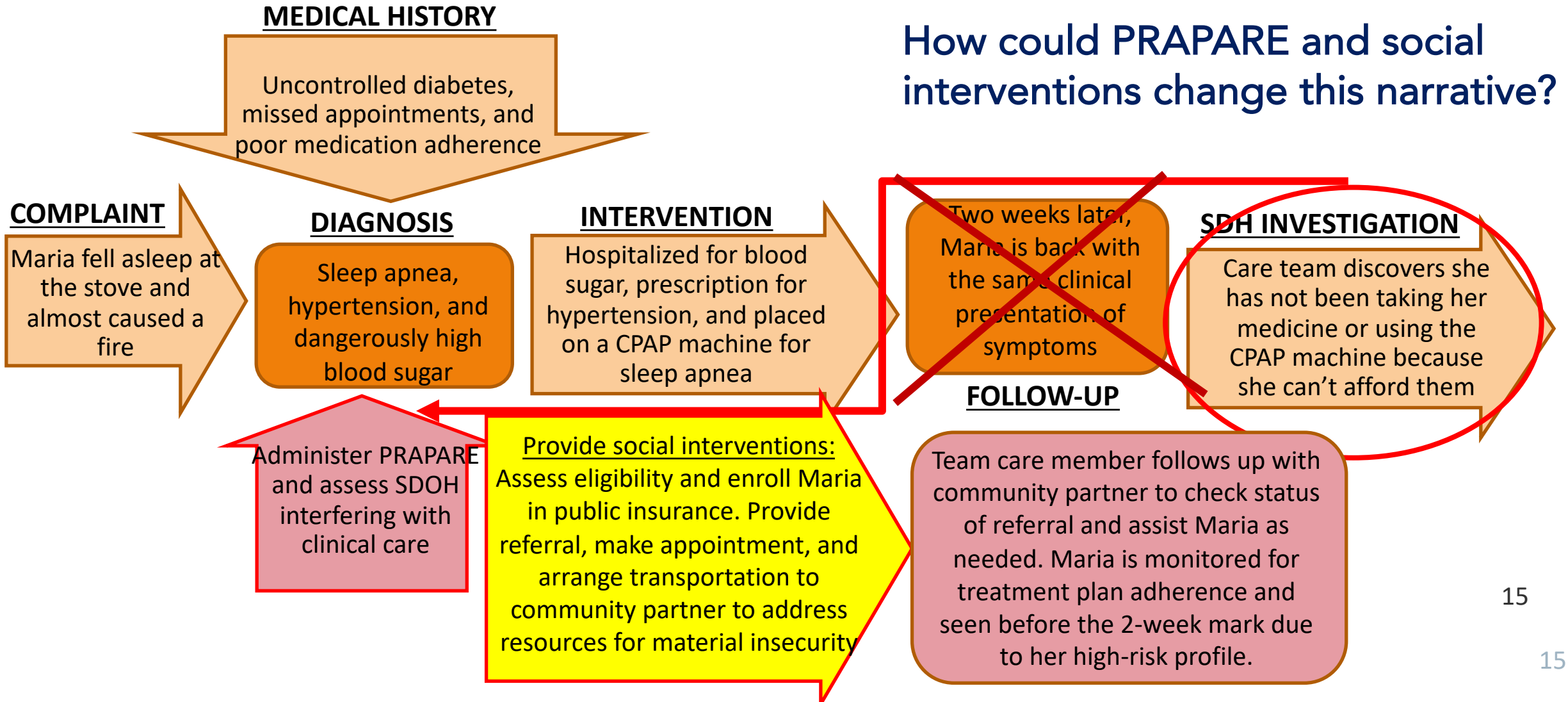
Table of Contents

USE CASE:
Care Narrative *without* PRAPARE & Social Interventions Documentation

Maria's Story: Example of a care narrative without PRAPARE and Social Interventions



USE CASE:
Care Narrative *with* PRAPARE & Social Interventions Documentation



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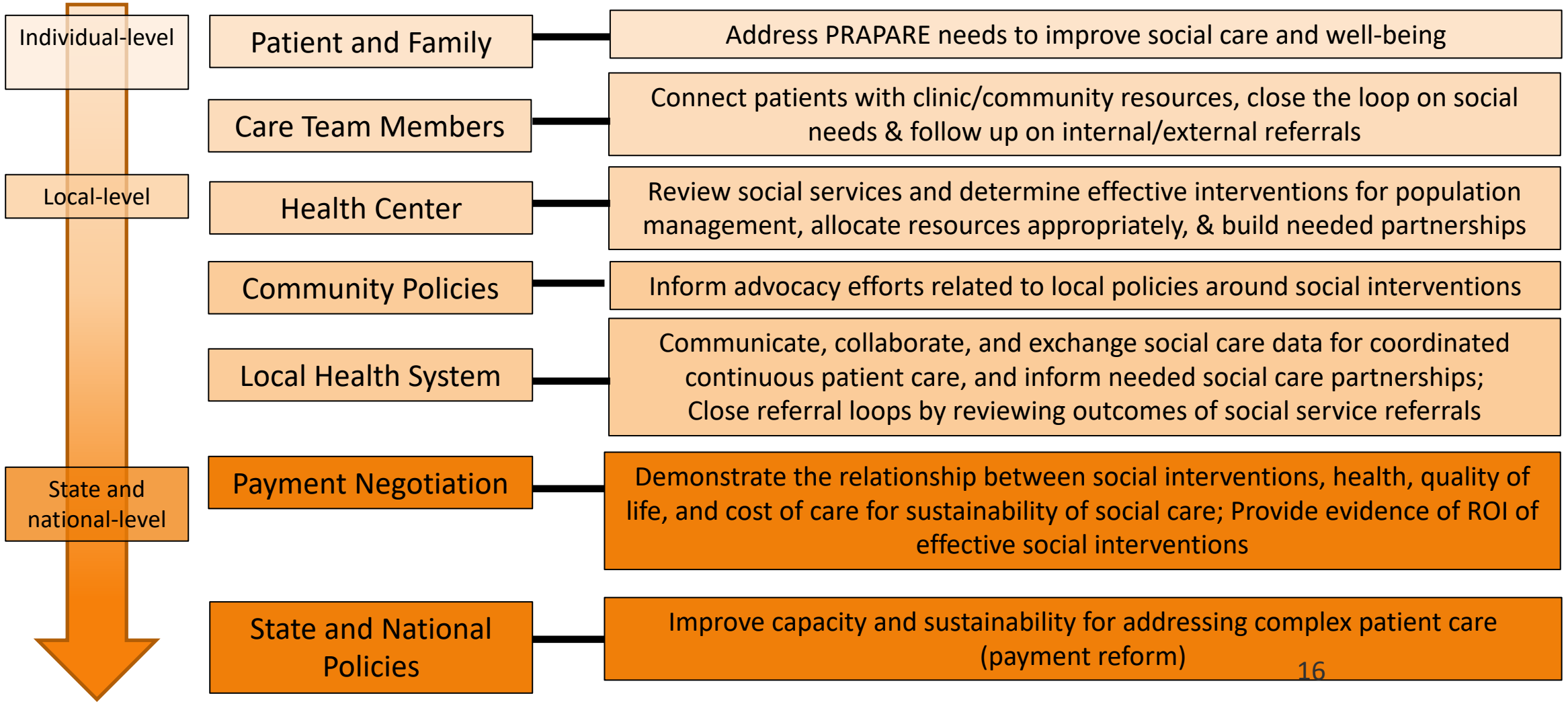
Use Cases for Social Interventions from Patient to Policy Level



PRAPARE

Social Intervention Response Categories

Code	Social Intervention Response
SI-RE	Racial/Ethnic Support Services
SI-FW	Farmworker Support Services
SI-VN	Veteran Support Services
SI-IN	Interpretation Services
SI-HS	Housing Support Services
SI-FC	Financial Counseling/Eligibility Assistance
SI-ED	Education Support Services
SI-EM	Employment Support Services
SI-FD	Food Support Services
SI-UT	Utilities Support Services
SI-CC	Child Care Support Services
SI-MH	Medicine or Health Care Support Services

Code	Social Intervention Response
SI-CL	Clothing Support Services
SI-PH	Phone Support Services
SI-OM	Other Material Security Support Services
SI-MT	Medical Transportation Services
SI-NMT	Non-Medical Transportation Services
SI-SI	Social Integration Support Services
SI-ST	Mental Health Support Services
SI-IN	Incarceration Support Services
SI-RF	Refugee Support Services
SI-ST	Safety Support Services
SI-DV	Domestic Violence Support Services

Social Interventions: Supplementary Documentation

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

Social Interventions Documentation Workflow Example

If referral provided, document Social Service Closed Loop Referral Status

Document PRAPARE positive response(s)

Under each positive response, document the PRAPARE Social Intervention Response(s)

Under the Social Intervention category, document the PRAPARE Social Intervention Activity Code(s)

Document the Social Intervention Supplementary data (e.g. visit length, provider type)

PRAPARE data is transmitted to referral dept/organization

Care Team member follows up to track and close the social service referral loop

Re-assess PRAPARE based on PRAPARE guidelines (see Toolkit)

Close the social service referral loop

Impact of Social Interventions Documentation

Rosy Chang Weir, AAPCHO

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Social need and intervention response data go hand in hand

NEED DATA
Standardized data on patient social needs

+

RESPONSE DATA
Standardized data on interventions

=

BOTH are necessary to:

- Demonstrate value to payers
- Advocate for upstream investments
- Seek adequate financing to ensure interventions are sustainable
- Achieve integrated, value-driven delivery system and reduce total cost of care

Examples of Reporting Metrics

- Number of SDOH screens and corresponding social interventions by month, by category & provider type
- Number of SDOH interventions addressed compared to number of PRAPARE needs
- Top patient SDOH needs that lack community resources/interventions
- Mean length of time spent on social interventions, by category & provider type
- Summary of patient referral status (e.g., completed, lost to follow up etc.) by social intervention, by organization

Outcomes of Social interventions Tracking

- ✓ Reduction in missed appointments
- ✓ Reduction in ER visits and hospitalizations
- ✓ Improvement in appropriate, preventive care
- ✓ Improvement in quality indicators such as A1C and overall health outcomes

Next Steps

- Finalize PRAPARE Social Interventions protocol with input from TEP and stakeholders
- Conduct PDSAs with organizations
- Pilot protocol with organizations and develop resources for national data collection

Under One Roof: A Combined Community Health Center and Community Action Agency Addresses Social Risk Factors

Martin Sabol, *Director of Health Services*,
Nasson Health Care/York County Community Action Corporation

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Under One Roof: A Combined Community Health Center and Community Action Agency Addresses Social Risk Factors

Martin Sabol
Director of Health Services
Nasson Health Care
York County Community Action Corporation
Sanford, Maine
December 10, 2020

NASSON Health Care

Outline

- Our organization
- Early work with SDOH
- Screening, Diagnosis and Referral
- Social Service Intervention
- Next Steps

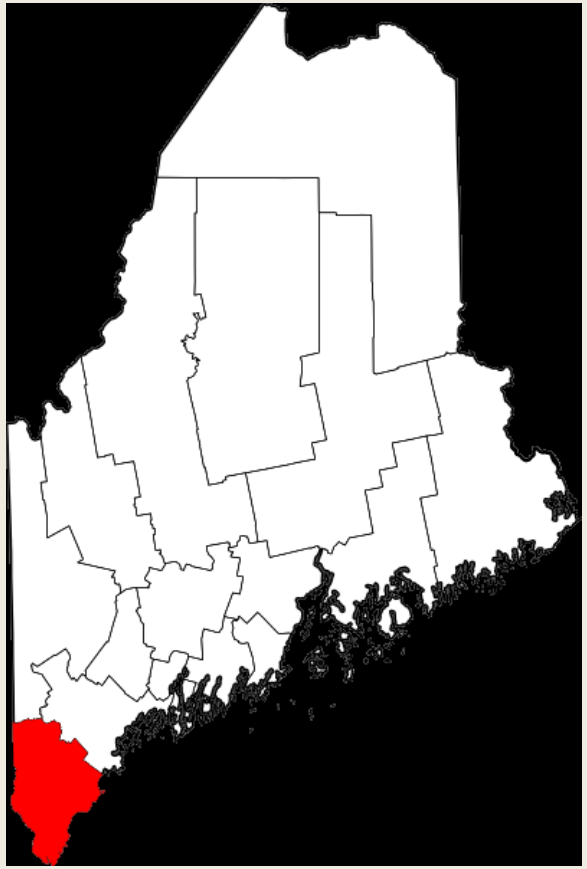
NASSON Health Care

York County Community Action

- Founded in 1964.
- The mission of York County Community Action Corporation is to alleviate the effects of poverty, attack its underlying causes, and to promote the dignity and self-sufficiency of the people of York County, Maine.

NASSON Health Care

Service Area



NASSON Health Care

Programs

- Head Start
- Transportation
- WIC
- LIHEAP/Weatherization
- Economic Opportunity
- Nasson Health Care

NASSON Health Care

NASSON
Health Care

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Health Care

Nasson Health Care

- 5 Sites
- 7,500 active patients
- 18 providers
- Medical, BH, Dental
- CHC, HCH, PHPC, School-based

NASSON Health Care

Early Work with Social Determinants of Health

- Disappointing quality metrics
- Risk stratification
- Clinical integration
- Agency program integration
- PRAPARE Pilot

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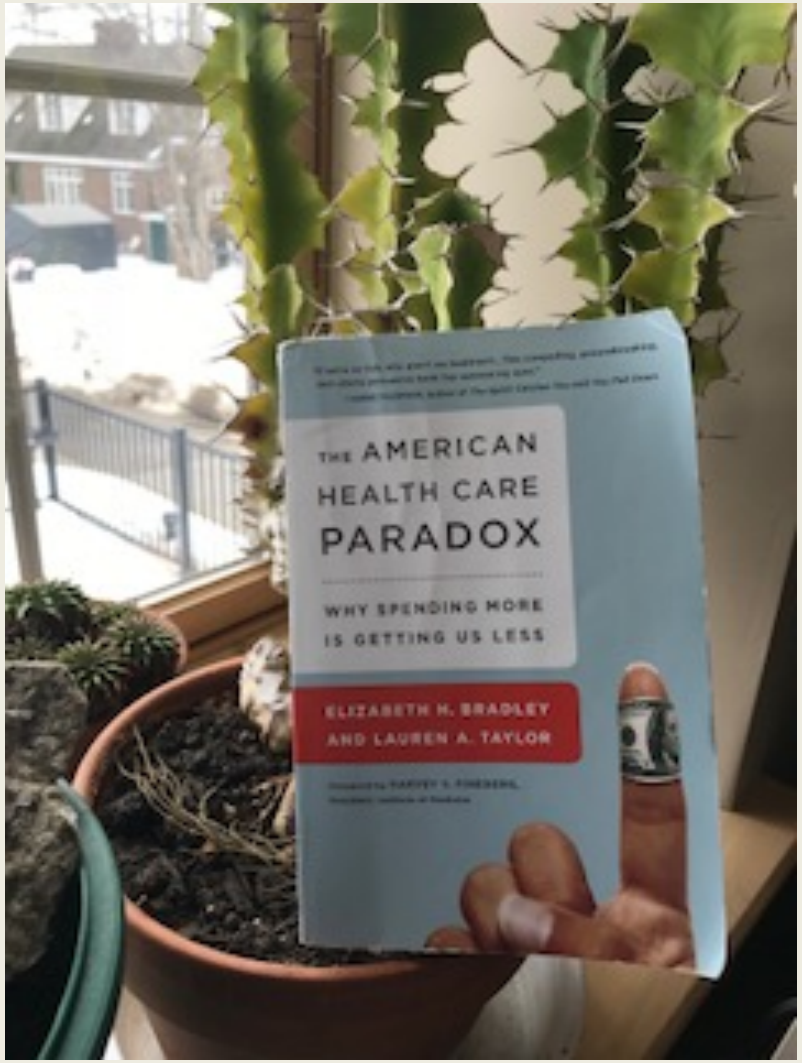

NASSON Health Care

Workflow – Health Center

- »Screen
- »Evaluate
- »Diagnose – ICD 10 Codes
- »Treat/Refer
- »Measure
- »Report

NASSON Health Care

Workflow – Social Services

- Department of Economic Opportunity houses generalist social workers who are able to triage SDOH referrals after more in-depth social needs assessment and/or provide one-on-one coaching support
- Workflow:
  - SDOH referral received by social worker. Social Worker reviews notes from the provider.
  - Social Worker utilizes “Asset Building Matrix” to assess patient needs across domains including housing, child care, financial, education, food insecurity, and more.
  - Social Worker develops “Pathway Plan” with patient that outlines steps to address needs. This could include securing housing or food or any other need that was identified.
  - Social Worker meets with patient regularly to work on “Pathway Plan” and provide assistance such as food vouchers or other benefits that may be needed.
  - Social Worker tracks all meetings, services, and outcomes with patient and provides consult notes back to health center provider.

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IT Support

- NextGen/OSIS
  - PRAPARE template
  - Links to other fields/templates
- Agency database
  - Track referrals and outcomes
  - Count/report on unique individuals using agency services

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Next Steps

- Standardize/codify social service interventions
- Assign cost/value and bring to payor negotiations
- Address both acute and chronic needs
- Use data to make case for community and regional solutions
- Integrate better with health risk assessments, e.g. Medicare Wellness, well-child, caries risk assessment

NASSON Health Care

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NASSON Health Care

La Maestra's Circle of Care® Addressing Social Determinants

Corinne Hanson, *Chief Development Officer,*
La Maestra Community Health Centers

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La Maestra's Circle of Care®
Addressing Social Determinants

Presented by:
Corinne Hanson,
Chief Development Officer

LA MAESTRA
COMMUNITY HEALTH CENTERS
City Heights · El Cajon · National City · Lemon Grove

About La Maestra

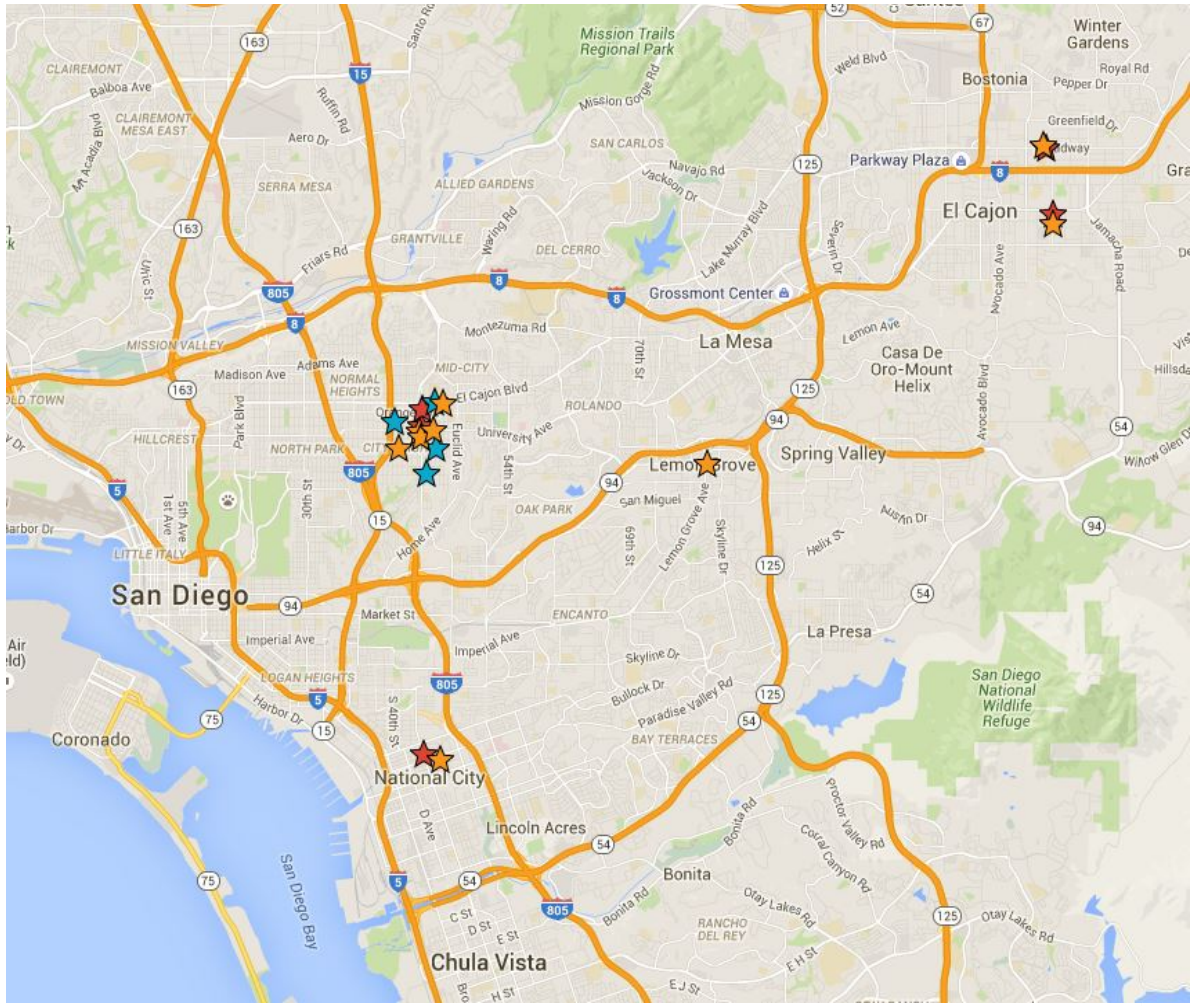
Our Mission: "To provide quality healthcare and education, improve the overall well-being of the family, bringing the underserved, ethnically diverse communities into the mainstream of our society, through a caring, effective, culturally and linguistically competent manner, respecting the dignity of all patients."

History: Clinic formed in 1990 under La Maestra Amnesty Center. The need for culturally competent healthcare was identified by Student Council representing over 12,000 students who participated in legal residency and citizenship programs, ESL, VESL, job training at LMAC.

First Clinic, opened 1990

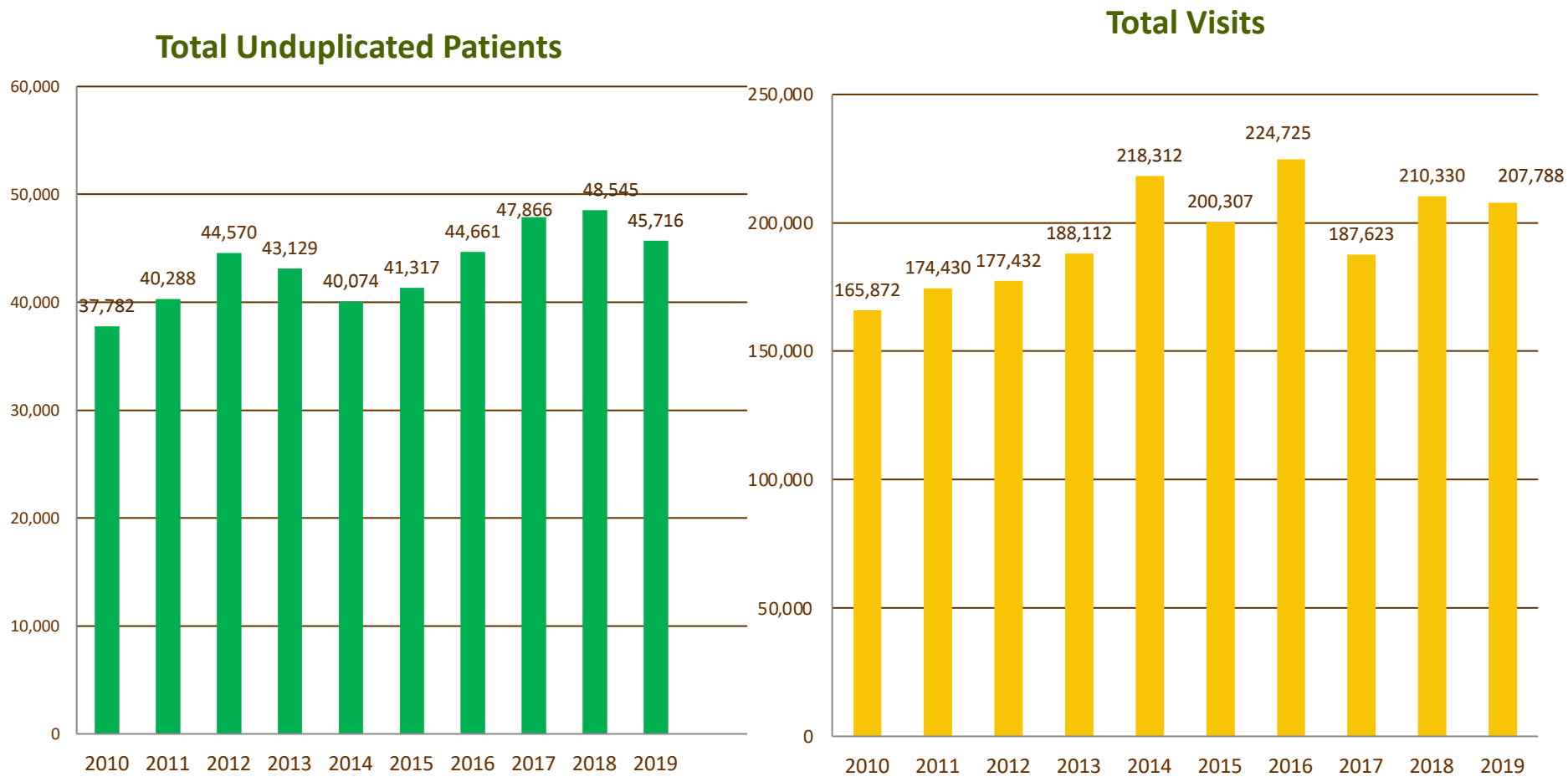
LEED Certified Gold Health Center, opened 2010

Locations



- Five medical and ten dental suites in San Diego County, plus three school-based clinics in the communities of:
  - City Heights
  - El Cajon
  - National City
  - Lemon Grove
- Mental health services onsite & via telehealth
- Substance abuse (MAT)
- Digital imaging – mammo, X-ray, ultrasound, dexa and CT scan
- Mobile clinic – medical, dental, optometry, telehealth
- Mobile mammo coach

Annual Number of Patients & Visits



57% of patients indicated they were best served in a language other than English in 2019

Serving the Culturally Diverse Community

- One of the most culturally diverse health centers in California – sites are in refugee resettlement areas and along US-Mexican border.
- At least 57% of patients prefer to communicate in a language other than English
- Staff come from the cultures served, ensuring cultural and linguistic competency. Many staff are patients and then become employees
- More than 30 languages and dialects spoken by 500+ employees
- *Medically Trained Cultural Liaisons* provide valuable, ongoing support, education to local residents and identify new needs

Innovative Models at La Maestra

- ***La Maestra's Circle of Care®* -** All services and programs have elements focusing on education, case management, social services – *Integrated approach*
- *Medically Trained Cultural Liaison (MTCL)* model
- School-based clinics, mobile clinics, Hope clinic for homeless, onsite substance abuse services including MAT. Individuals
- Telehealth i.e. alternative access points and bringing services to residents where they live, work, learn, play and worship
- Electronic and cloud-based programs/case management, mobile app, Quick Base, PRAPARE
- Specialty care in the medical home via telehealth and partnerships
- Digital imaging
- Contemporary management team model

La Maestra's Circle of Care®

Standardized Social Needs Screenings

La Maestra has been building onsite social services programs for all patients for decades.

The organization recently began to standardize its model for assessing patients' social needs. La Maestra uses a modified PRAPARE template. Having a standard, structured way to collect social needs data has resulted in the following benefits:

- Improvements in identify patients in need of social services
- Improvements in data tracking, and
- Has empowered staff to make appropriate social service referrals.

Social Needs Screening Tool

What is PRAPARE?
La Maestra began implementing PRAPARE in 2017 with grant funding for a pilot program.

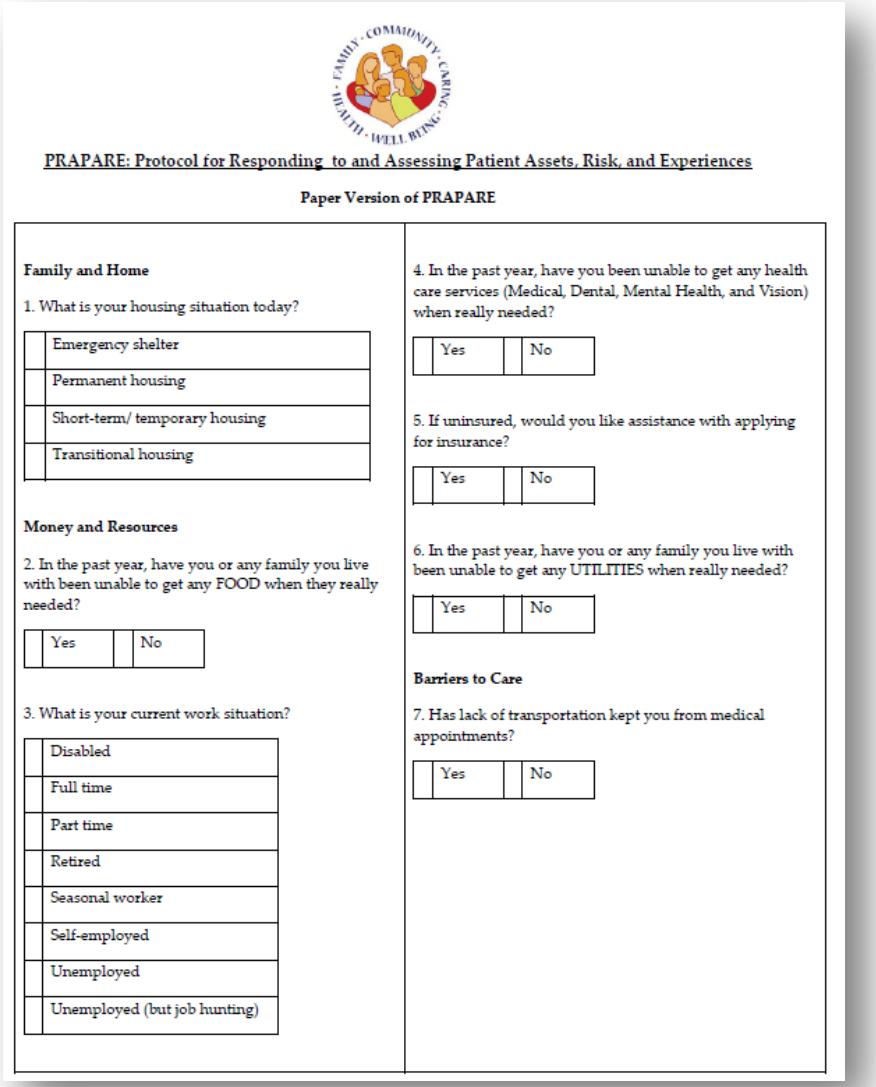
Workflow:

Patient typically receive a hardcopy of the PRAPARE tool. Due to COVID-19 the tool can be emailed and the organization is working on setting up the tool in Quick Base.

During the medical appointment, the Provider reviews the PRAPARE responses. This can be done via a telephonic or telemedicine visit.

The Provider determines whether a social service referral is needed and notifies the Referral Department.

Case managers from the Referral Department then respond to the patient (either in-person or by telephone) and ensure the



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

Paper Version of PRAPARE

Family and Home

1. What is your housing situation today?

- Emergency shelter
- Permanent housing
- Short-term/ temporary housing
- Transitional housing

Money and Resources

2. In the past year, have you or any family you live with been unable to get any FOOD when they really needed?

Yes | No

3. What is your current work situation?

- Disabled
- Full time
- Part time
- Retired
- Seasonal worker
- Self-employed
- Unemployed
- Unemployed (but job hunting)

4. In the past year, have you been unable to get any health care services (Medical, Dental, Mental Health, and Vision) when really needed?

Yes | No

5. If uninsured, would you like assistance with applying for insurance?

Yes | No

6. In the past year, have you or any family you live with been unable to get any UTILITIES when really needed?

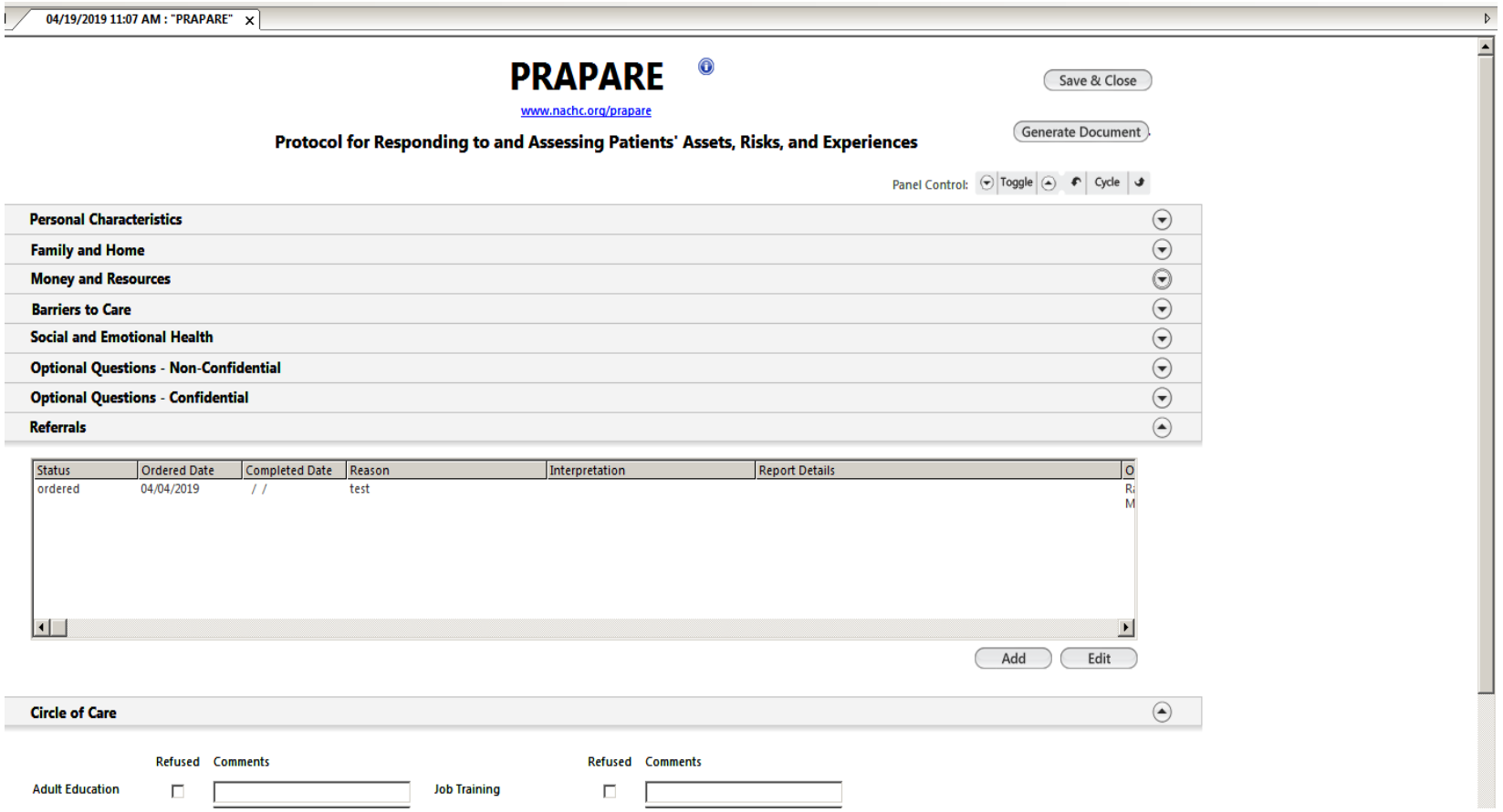
Yes | No

Barriers to Care

7. Has lack of transportation kept you from medical appointments?

Yes | No

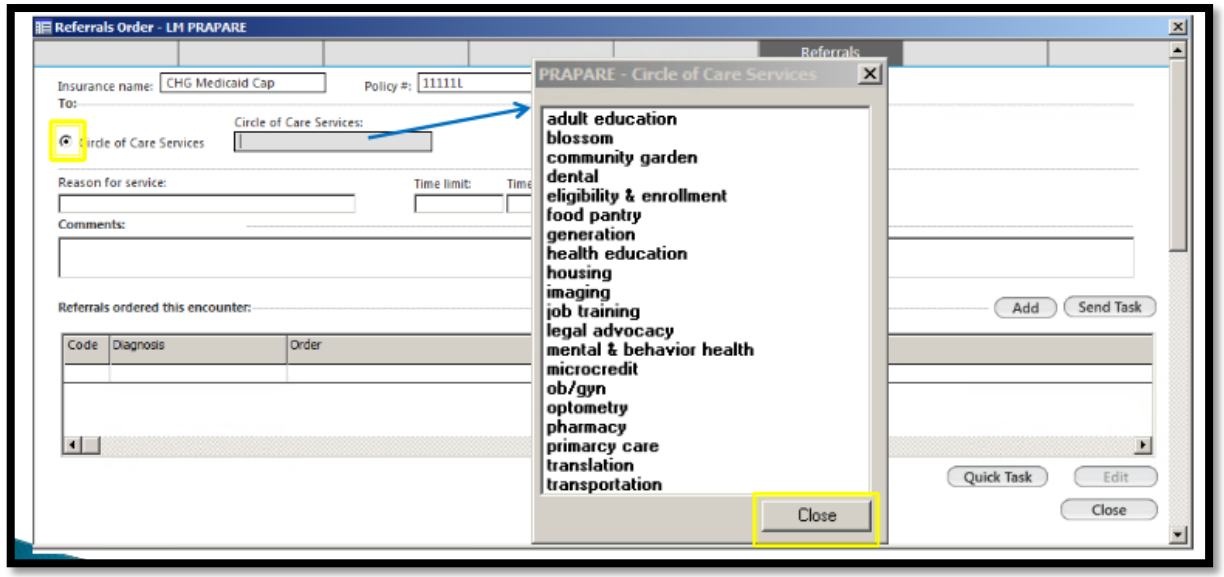
Leveraging La Maestra's EHR



Leveraging EHR continued

Social Needs Screening

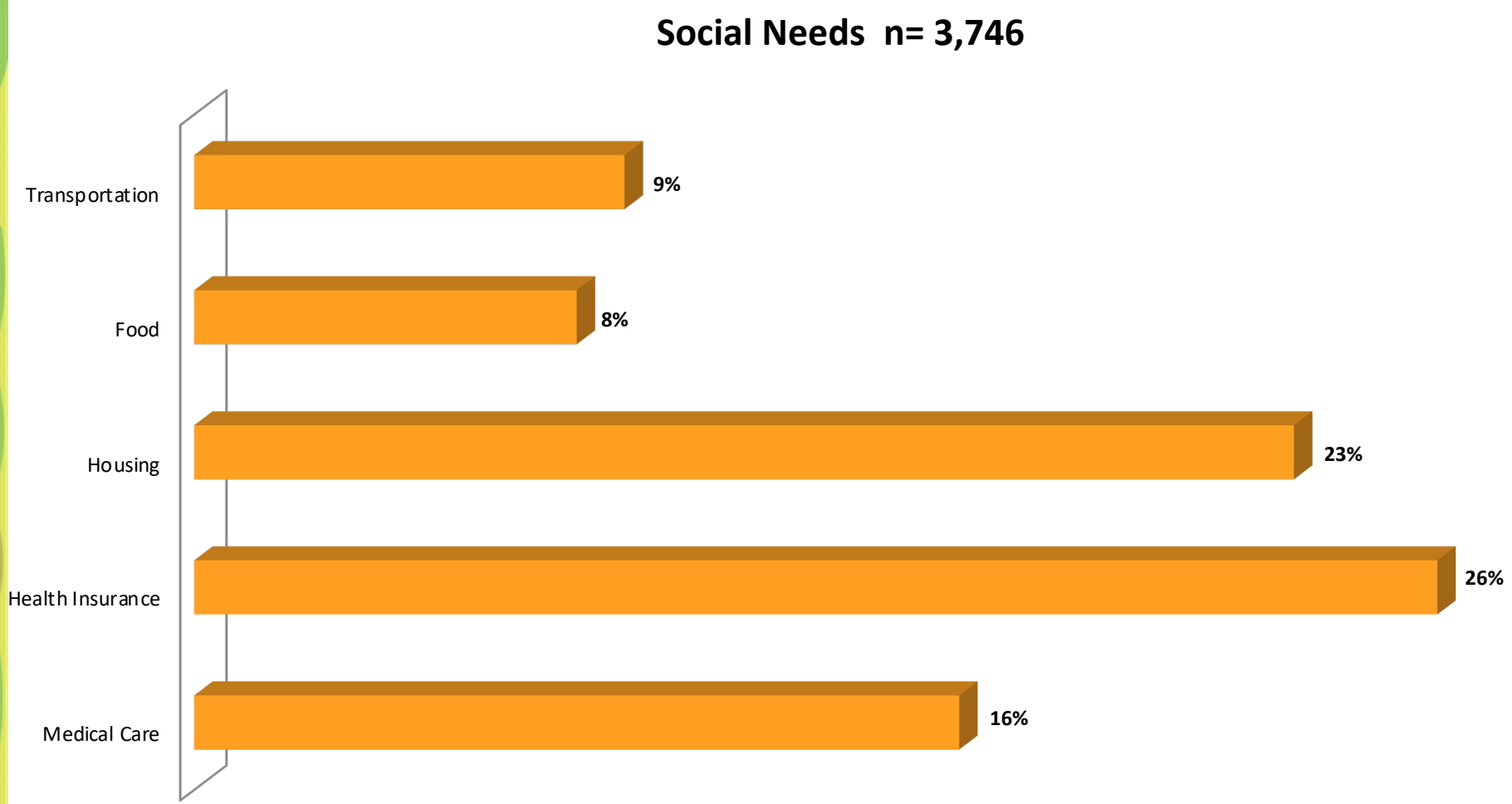
PRAPARE responses are documented in EHR using the NextGen PRAPARE template. This template maximizes shared fields within the database so users can avoid double data entry.



Referrals

- La Maestra electronically tracks the status of internal social service referrals using NextGen (see image).
- When a patient requires services beyond the scope of La Maestra's and partner referral network, Case Managers review a local community resource directory developed by 2-1-1 San Diego to identify appropriate patient resources.
  - Case managers phone the external referral organizations/patients up to three times to ensure that the patient completes the referral.

Social Needs Documented



Challenges and Next Steps

Results:	• In a recent study, La Maestra screened 3,746 patients for social services using the PRAPARE tool
	• Top needs were:
	  ○ Medical Care
	  ○ Health Insurance
	  ○ Food
	  ○ Housing
	  ○ Transportation

Challenges:	• Consistent Funding
Next Steps:	• Developing and implementing a marketing campaign to ensure patients are aware of in-house social services; • Analyzing social needs data to inform the development of strategic community partnerships; • Working with 2-1-1 San Diego to participate in the Community Health Information Exchange and begin electronically referring patients to external orgs.

Q&A and Closing

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Questions & Discussion

Next Steps

- Webinar recording and slides will be posted
- Please complete evaluation
- Share topics for future webinars

Join us again next week!

Building Cross Sector Partnerships to Address SDOH: Design Sprints

Thursday, December 17, 2020 | 3:00pm ET

- NACHC and AAPCHO, with support from the Robert Wood Johnson Foundation, are convening a series of rapid cycle, peer driven training and technical assistance cohorts to better align health centers and community based social services to improve health equity. Working towards building successful ecosystems within impacted communities, this effort aims to foster community wellness and activation, addressing core issues such as structural racism and poverty as factors. This innovative approach to tackling these foundational challenges will bring stakeholders together through exchange of information and ideas by using a human-centered design framework and facilitation.

More Information and to Register

We appreciate your time and commitment!

Have any questions or feedback?

E-mail: prapare@nachc.org
Website: www.nachc.org/prapare

Twitter: @prapare_sdoh
Join our Listserv

PRAPARE Related Resources

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PRAPARE IMPLEMENATION AND ACTION TOOLKIT

www.nachc.org/prapare

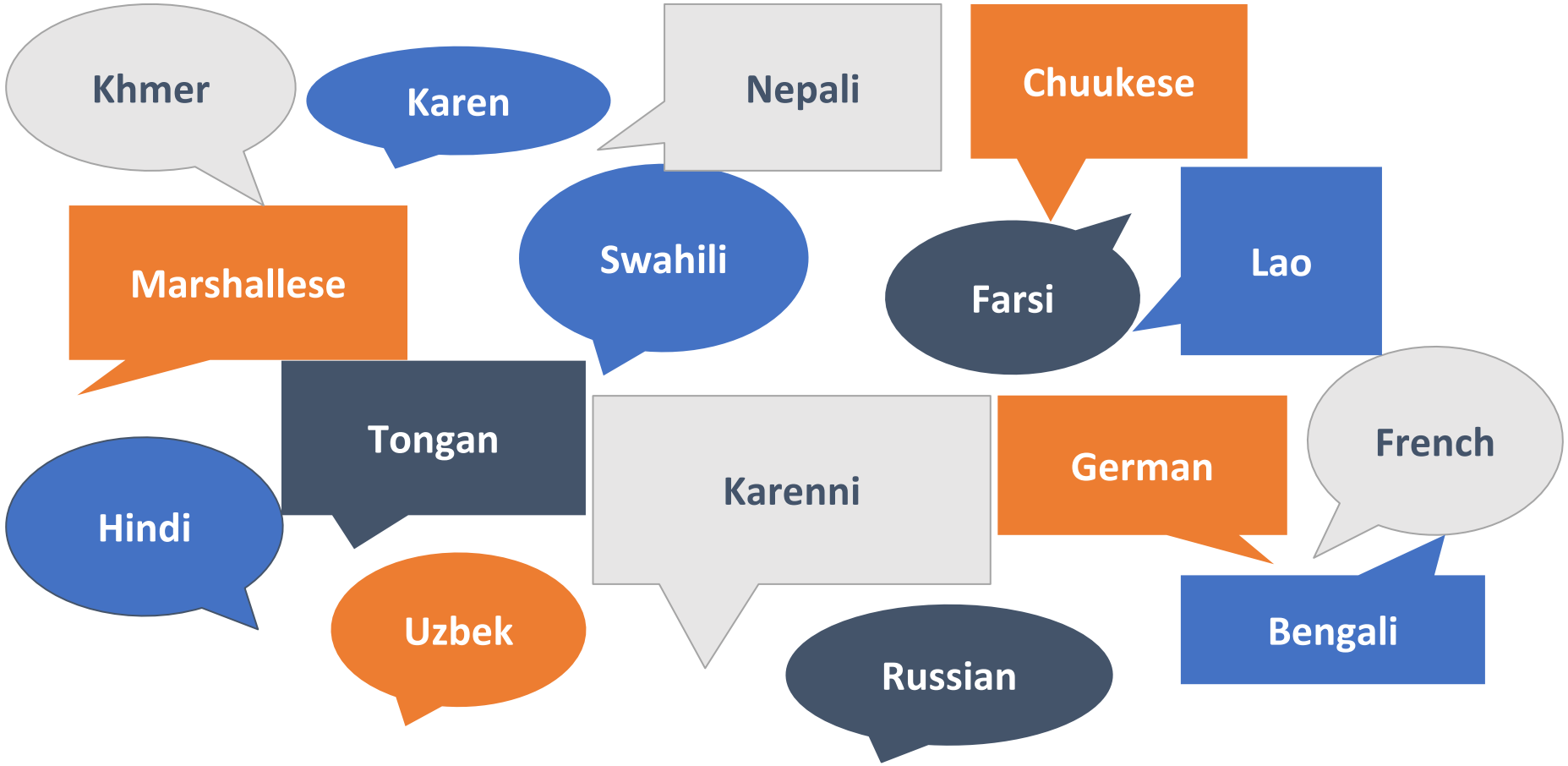
Chapter 1: Understand the PRAPARE Project
Chapter 2: Engage Key Stakeholders
Chapter 3: Strategize the Implementation Process

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 is Now in 26 Languages!

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



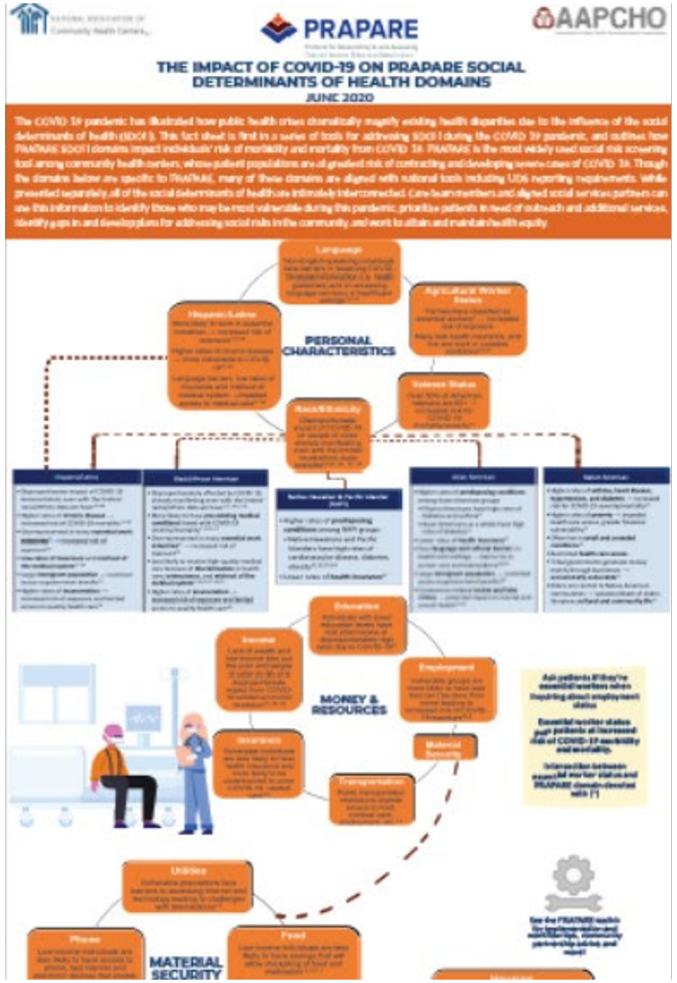
PRAPARE SDOH & COVID-19 Fact Sheet

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!



Appendix

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Social Intervention Response: Activity Codes

Code	Social Intervention Activity	Definition
AM001	Assessment	Social assessment used as a follow-up to a positive PRAPARE response or social need that includes the use of an acceptable instrument measuring socioeconomic status, wellness, or other non-medical health status.
CM001	Social Care Management	An encounter with a patient or their household or family member in which a comprehensive patient-centered social care plan is developed or monitored to address a positive PRAPARE response or social need. The care plan focuses on supporting patients in meeting social service needs of the patients and may include a follow-up plan to close the social service loop.
RF001	Referral	Facilitation of a visit with a patient to a social service provider. Includes re-referrals if necessary.
RF002	Follow up on Social Service Closed Loop, Referral Status	Follow up with a patient who was previously referred to an external organization or other department. Please indicate care team follow-up status of social intervention using the following categories: 0 = Patient social need was not met and requires follow-up to address social need (select reason) a. Patient has not yet followed up with referral dept/organization b. Patient unable to be served at referral dept/organization c. Patient lost to follow up d. Other, please specify:_____ 1 = Patient social need was met through social intervention 2 = Patient no longer needs service a. Patient used different organization b. Patient chose not to use referral resource c. Patient situation changed and no longer needs service d. Patient requested not to be called again e. Other, please specify:_____ 3 = Other, please specify:_____

Social Intervention Response: Activity Codes

Code	Social Intervention Activity	Definition
EA001	Eligibility Assistance	Counseling of a patient and assessing the patient's eligibility of a program to address a social need.
ED001	Education	The provision of learning experiences in an encounter designed to help individuals improve their social health, including describing appropriate use of social services, teaching self-management approaches, explaining how to prevent injuries for patients, and other promoting behaviors to address social needs.
SC001	Supportive Counseling	The provision of support to patients to mitigate distress or concerns regarding issues affecting their social wellbeing. This would include listening to patient concerns and providing encouragement when appropriate.
IN001	Interpretation	Provision of interpreter services by a third party (other than the service provider) intended to reduce barriers to a limited English-proficient (LEP) patient or a patient with documented limitations in writing or speaking skills sufficient to affect the outcome of an encounter.
OT001	Outreach	Providing information about social services to engage patients to address social need(s) including checking in with a patient to close the social service loop in order to ensure appropriate and timely social service.
TR001	Transportation	Providing transportation assistance to a patient requiring transport to receive appropriate social services.
OT001	Other Social Intervention Activity: Please Specify (OPTIONAL)	If the social intervention does not fall into the above categories, please enter free text name and description of other social intervention. This is REQUIRED if the social intervention service type field "Other" is marked.