NATIONAL ASSOCIATION OF
Community Health Centers®

PRAPARE and Addressing SDoH: Integration Is Not As Hard As You Think

Wednesday, April 27, 2022

THE NACHC MISSION

America’s Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

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Acknowledgements

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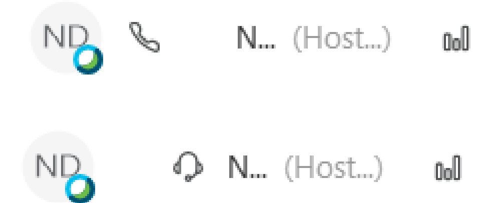
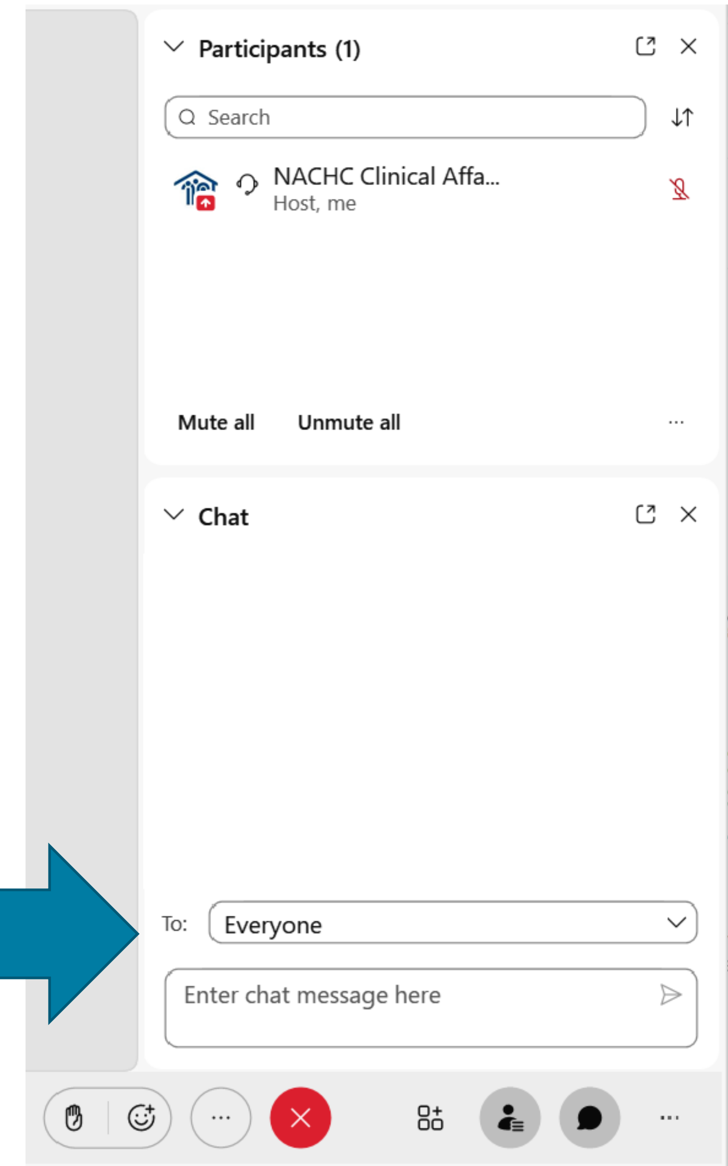


ASKING QUESTIONS VIA CHAT BOX

1. **The chat feature** is available to ask questions or make comments anytime.

2. **Click the chat button** at the bottom of the WebEx window to open the chat box on the bottom righthand side of the window.

3. **Choose "EVERYONE",** as appropriate.
   - Type your question.
   - Click ***"Enter"*** to send your question.



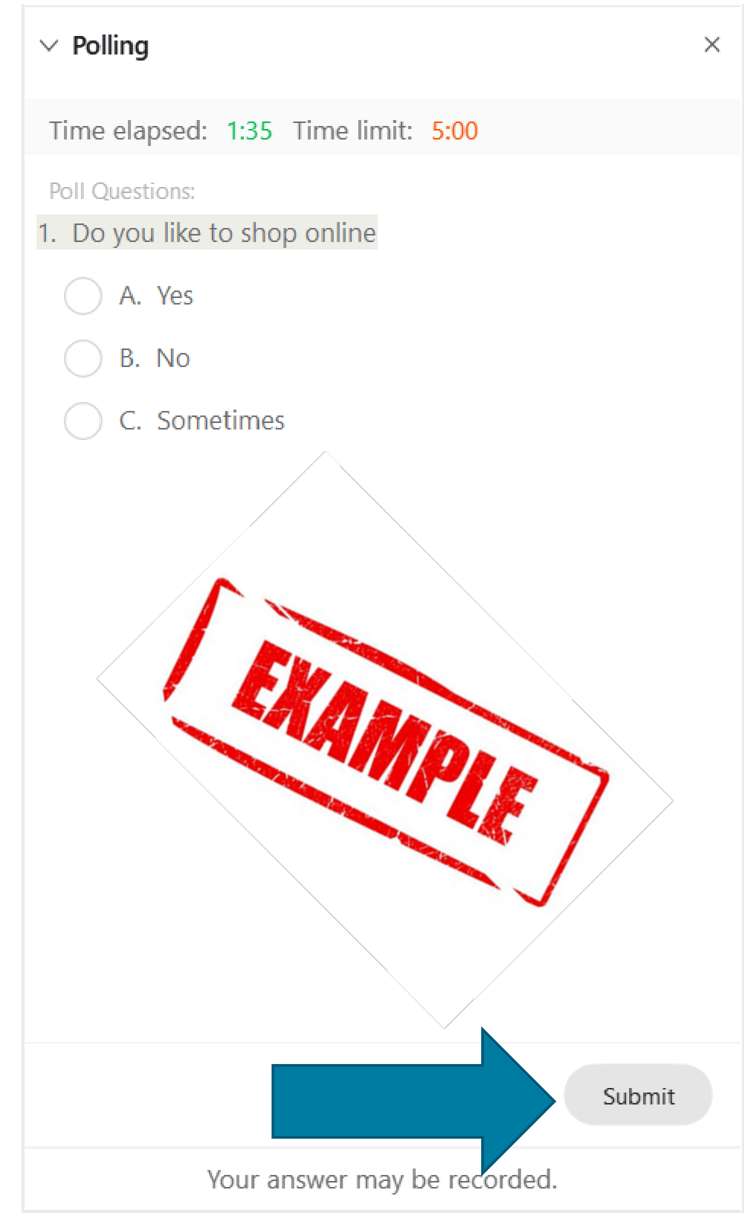
Friendly Reminders

- Today's Event is being **RECORDED**
- Please keep your audio line **MUTED**
- The **CHATBOX** is open for the duration of this event
- Questions from the **CHAT BOX** will be answered after the presentation is completed.
- We will have **POLLING QUESTIONS** for you to vote on today!

POLLING QUESTION

What coast are you located at?

a) West
b) Midwest
c) Southwest
d) South
e) East



Overview of PRAPARE to Assess and Address Social Needs

April 27th, 2022

Acknowledgement:
Support for this program was provided by a grant from HRSA's Bureau of Primary Health Care

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

Longstanding PRAPARE Partnership

Presenter

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

Yuriko de la Cruz, MPH, CPHQ
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Program Manager, Social Drivers of Health
Public Health Priorities Division, NACHC

Poll

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

- Is your health center currently collecting SDOH data?
  - Yes
  - No
  - Not sure
  - Not applicable (non health center staff)
- If yes, what standardized SDOH screener does your health center uses?
  - PRAPARE
  - Recommended Social and Behavioral Domains for EHRs
  - AHC Screening Tools
  - We Care
  - No standardized screener used
  - Not applicable

Definitions

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

1. **Social drivers of health:** the conditions in which people are born, grow, live, work, and age. These conditions are shaped by the distribution of money, power, and resources.
2. **Social risk factors:** specific adverse social conditions that are associated with poor health.
3. **Social needs:** patient's role in identifying and prioritizing social interventions.
4. **Population health:** the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Source: AAFP https://www.aafp.org/news/practice-professional-issues/20190610sdohterms.html

Why are Social Drivers of Health Important?

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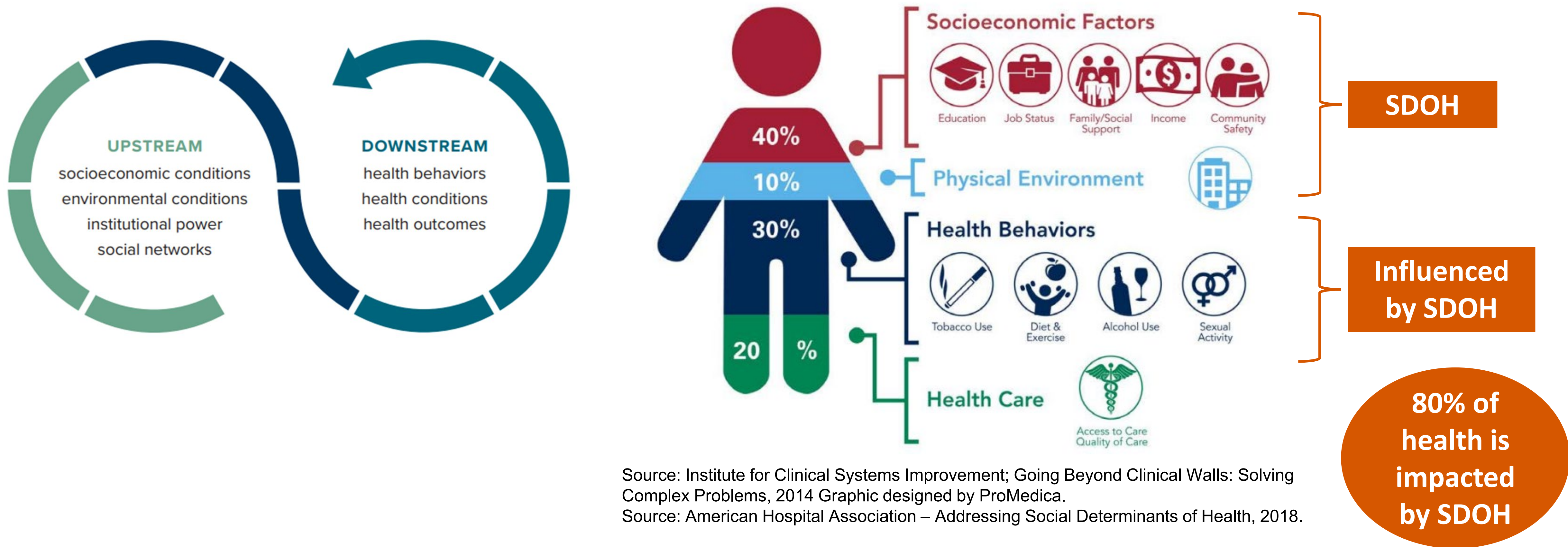
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Social drivers of health (SDOH): the conditions in which people are born, grow, live, play, work, and age. These conditions are shaped by the distribution of money, power, and resources.



Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.
Source: American Hospital Association – Addressing Social Determinants of Health, 2018.

Building Capacity to Respond to SDOH Needs

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

+

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PEOPLE

- Do you have staff time that can be dedicated to social determinants-focused initiatives at your organization?
- Are there specific roles (e.g., Community Health Worker) focused on addressing a patient's social needs?

PROCESSES

- Do you have referral workflows in place for connecting patients with resources to address their social determinant needs?
- Have you formed partnerships with external organizations (e.g., local food bank, employment agency, etc.)?

TECHNOLOGY

- Does your EHR support or systematize social services?
- Are you able to share data with external organizations?

Why Collect Standardized Data on SDOH?

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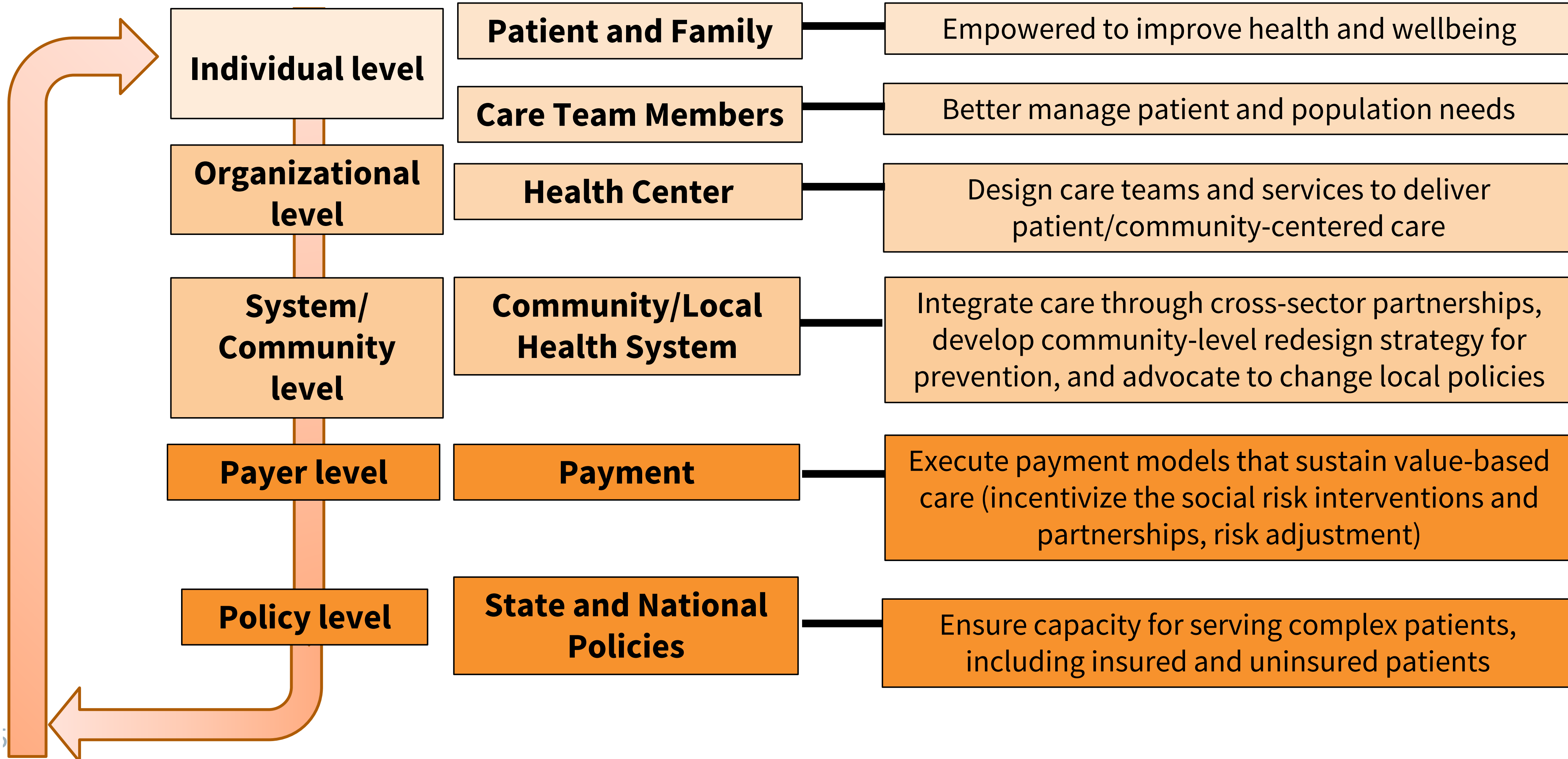

What is PRAPARE?

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

A national **standardized** patient risk assessment **tool** designed to **engage patients** in assessing and addressing social drivers of health

What does PRAPARE Measure?

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*	

* UDS measures are automatically populated into PRAPARE EHR templates.

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?**

Find the tool at www.prapare.org

Why use PRAPARE to collect SDOH?

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ACTIONABLE

STANDARDIZED and WIDELY USED

EVIDENCE-BASED and STAKEHOLDER-DRIVEN

DESIGNED TO ACCELERATE SYSTEMIC CHANGE

PATIENT-CENTERED

Opportunities to Leverage PRAPARE

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

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

Payment Reform Efforts

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

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

PCMH and QI Initiatives

Quality Incentives that Reward for Social Determinant Data Collection

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

Community Health Worker Initiatives

National SDOH Screening 2020-UDS

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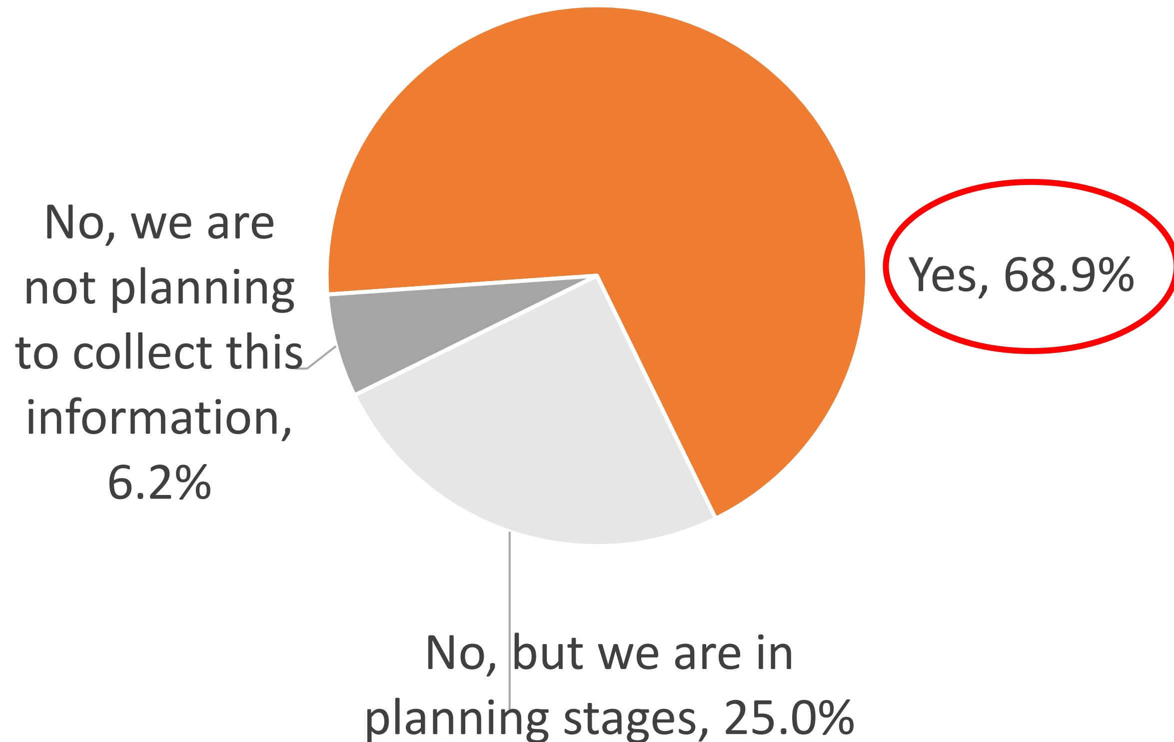

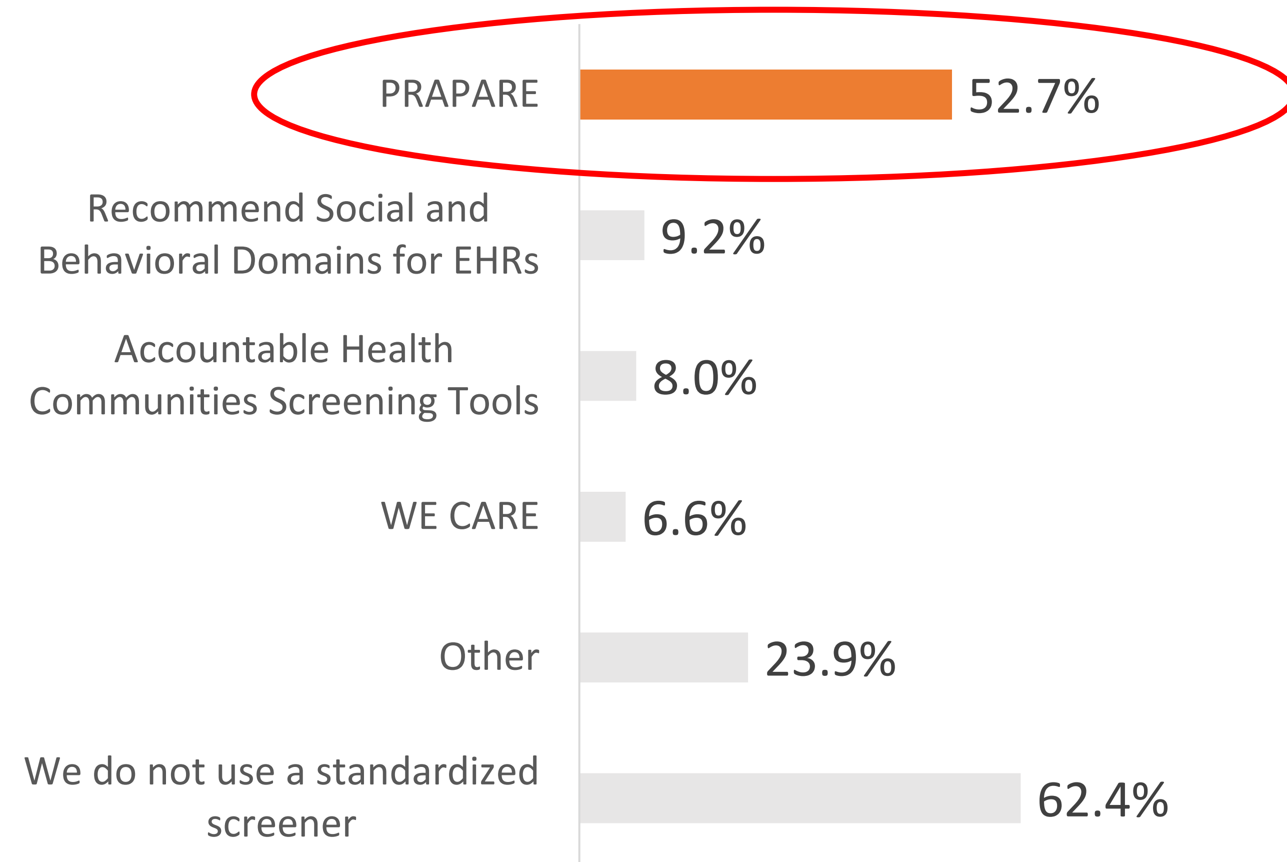

PRAPARE Reach

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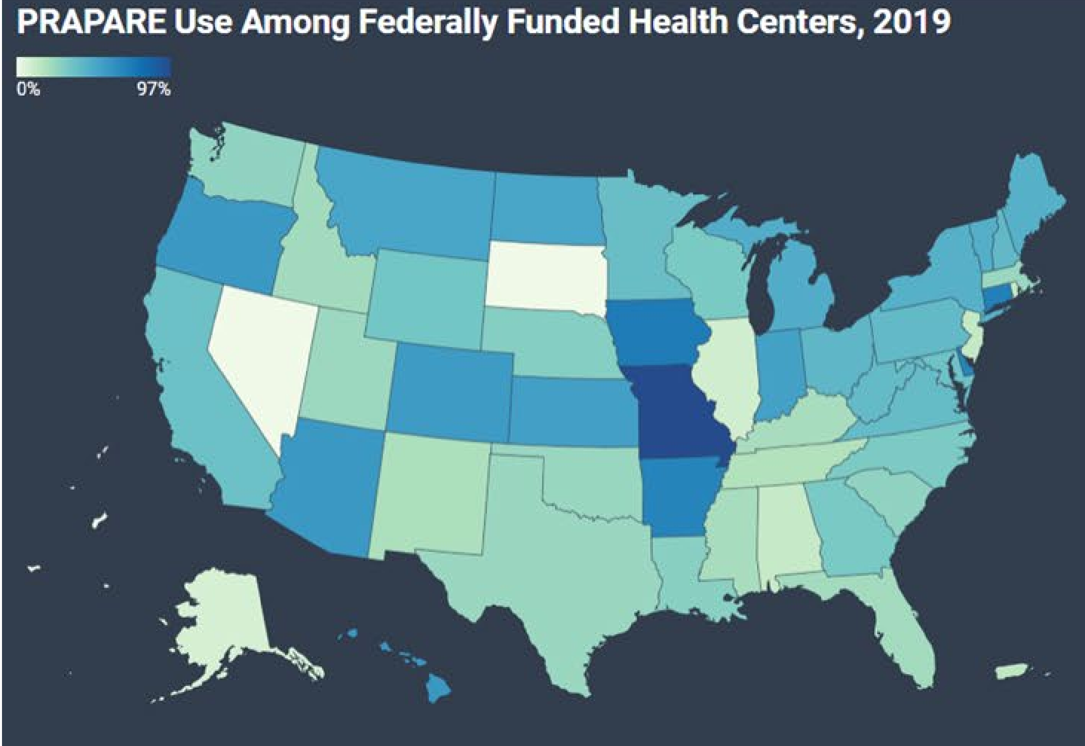
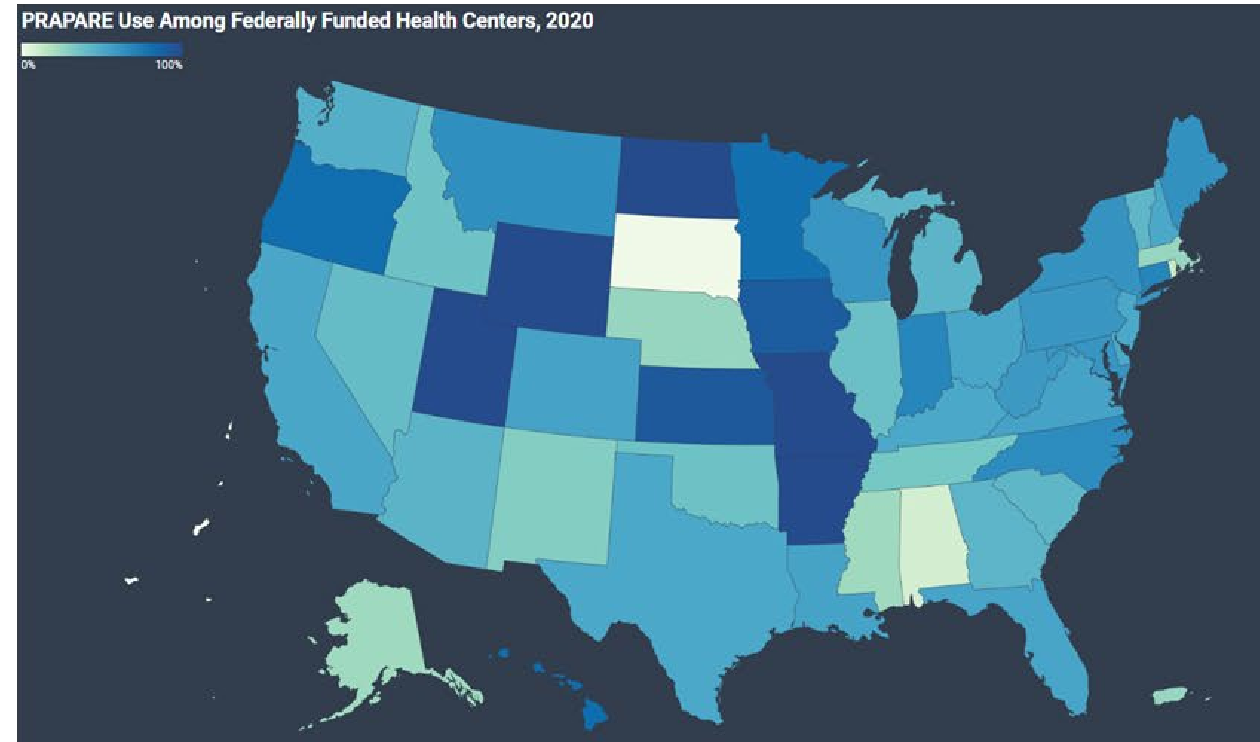
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences





Note: Percentages reflect PRAPARE use among federally funded health centers that report screening for social risk. Excludes Health Center Program Look-Alikes and may underestimate the true volume of federally funded health centers using PRAPARE. For example, data may not capture all health centers accessing PRAPARE through some Electronic Health Records or other Health Information Technology platforms and does not capture health centers using parts of PRAPARE.

Map: © National Association of Community Health Centers and the Association of Asian Pacific Community Health Organizations, October 2021. For more information, email prapare@nachc.org
Source: 2020 Uniform Data System, Bureau of Primary Health Care, Health Resources and Services Administration, DHHS.

Action Steps to Engage Stakeholders

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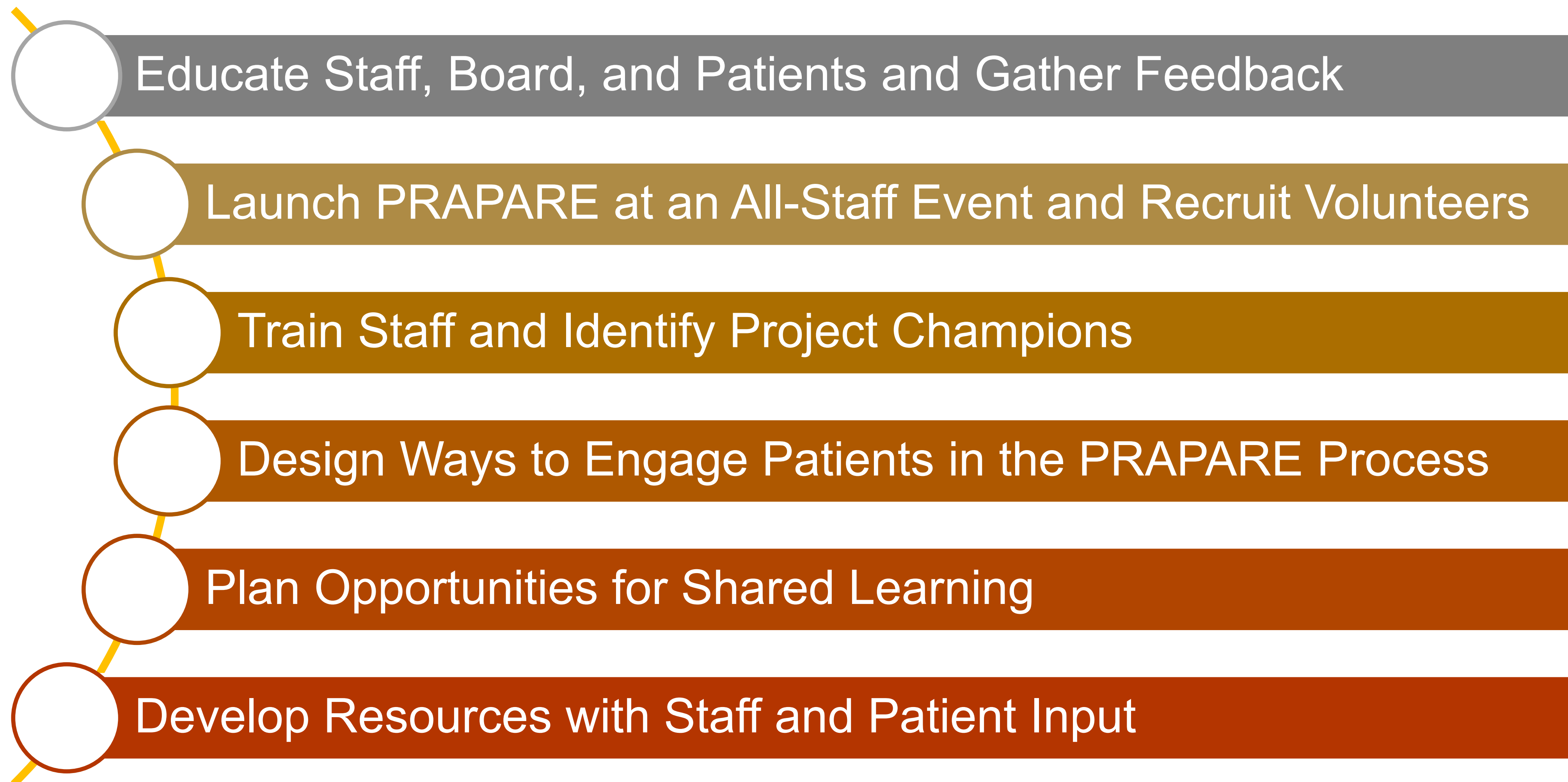

Common Challenges and Messaging Solutions

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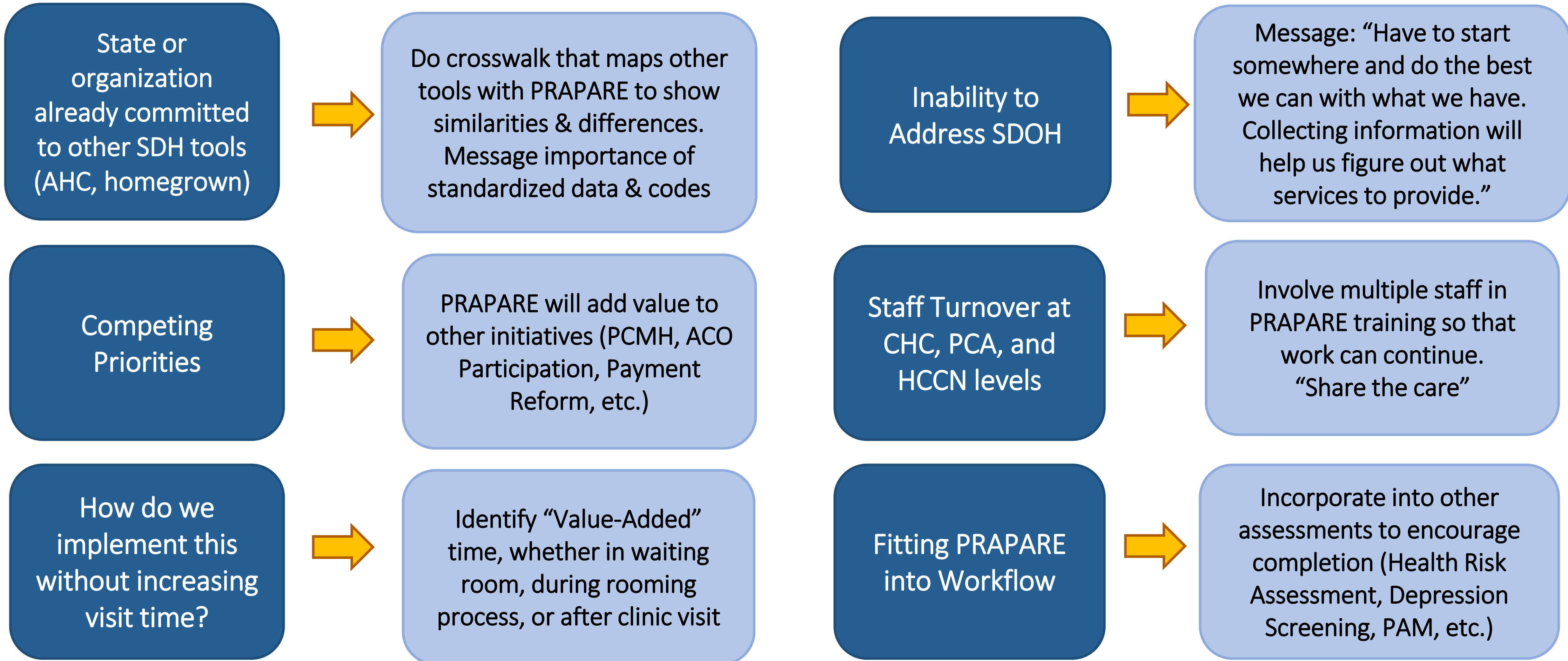
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences



Five Rights Framework to Plan Workflow

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THE RIGHT INFORMATION

WHAT sociodemographic information is already being collected that PRAPARE can align with rather than duplicate? How will intervention or resource information be organized so that it is readily available and standardized for all when needs are identified by PRAPARE?

IN THE RIGHT FORMAT

HOW will the PRAPARE tool be administered to patients to ensure it accurately and respectfully captures the patients' social determinants of health?

WITH THE RIGHT PEOPLE

WHO will collect the PRAPARE data and who will address the social determinant needs identified?

VIA THE RIGHT CHANNELS

WHERE will PRAPARE data be collected and how will it be shared with the appropriate care team members to inform care appropriately and address needs identified?

AT THE RIGHT TIMES

WHEN in the patient visit does it make sense to administer the PRAPARE tool and when is the best time to address the identified needs?

5 RIGHTS	WORKFLOW CONSIDERATIONS	RESPONSE WORKFLOW CONSIDERATIONS
Right Information: WHAT	**What information in PRAPARE do you already routinely collect?** • Part of registration • Part of other health assessments or initiatives	**What information and resources do you have to respond to social determinants data?** • Update your community resource guide and referral list with accurate information • Track referrals, interventions, and time spent
Right Format: HOW	**How are we collecting this information and in what manner are we collecting it?** • Self-Assessment? • In-person with staff?	**How will intervention and community resource information be stored for use and presented to patients?** • Searchable database of resources (in-house or via partner)? • Printed resource for patients to take with them? • Warm hand-off for referrals?
Right Person: WHO	**Who will collect the data? Who has access to the EHR? Who has contact with the population of focus? Who needs to see the information to inform care?** • Providers and other clinical staff? • Non-Clinical Staff?	**Who will respond to social determinants data?** • By a dedicated staff person? • By any staff person who administers PRAPARE with the patients? • By the provider?
Right Channel: 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?	**Where will referrals and/or resource provisions take place?** • In private office? • In the exam room?
Right Time: WHEN	**When is the right time to collect this information so as to not disrupt clinic workflow?** • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?	**When will referrals take place?** • Immediately after need is identified? • After the patient sees the provider? • At the end of the visit?

Workflow Models

- No Wrong Door Approach
- Non-Clinical Staff (Before or After Visit)
- Clinical Staff (During Visit)
- Care Coordinators
- Chronic Disease Management Team
- Interpreters
- Self-Assessment
- Administering via email

PRAPARE and Addressing SDOH: Integration Is Not As Hard As You Think

Presented By:

Sonia Deal, RN, MSN/MHA, CHCEF, PCMH CCE

Assistant Vice President of Clinical Integration

OBJECTIVES

- Clinical Leaders and their care teams will:
  - Understand the importance of actively integrating public/population health issues with primary care practice.
  - Be familiar with PRAPARE and an innovative approach of how to integrate PRAPARE into primary care practice.
  - Be able to determine how to build community referrals to respond to the needs of their patients and communities.

AFFINIA
HEALTHCARE™
Inspired by the Patients We Serve

Affinia Healthcare

- Federally Qualified Health Center (FQHC) in St. Louis, MO
- 11 clinical and sattellite sites (including 3 school-based health centers)
- 5 health centers within 20 minute proximity of downtown St. Louis
- Approximately 43,000 patients served annually

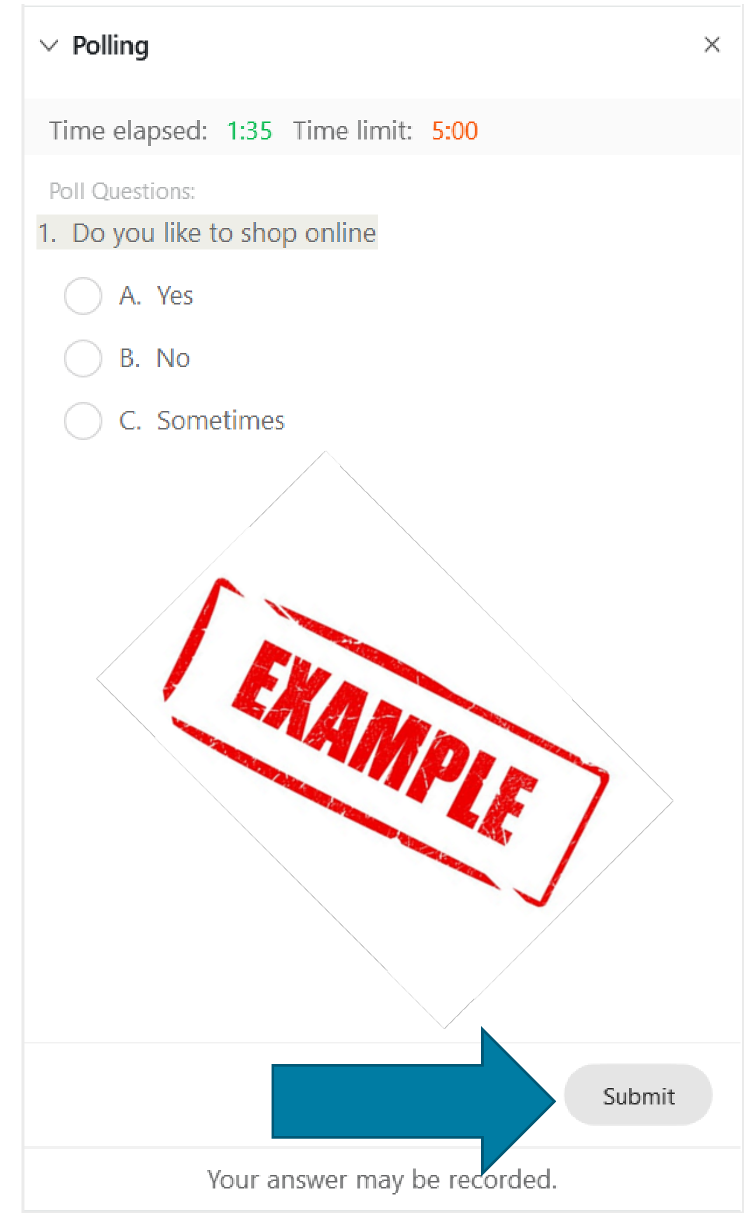
POLLING QUESTION

Do you work for facilities or organizations where CHWs are employed and/or integrated?

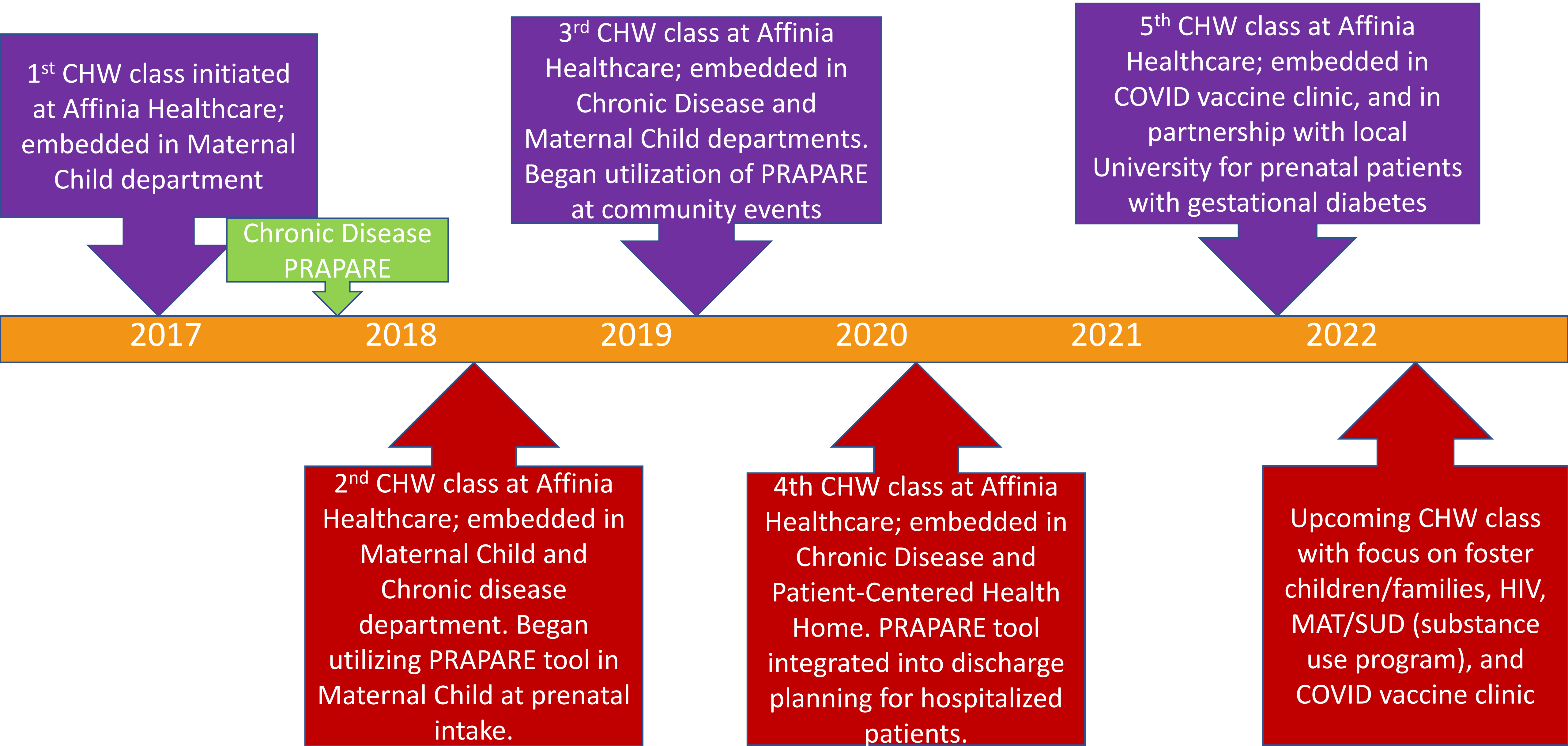
a) Yes

b) No

c) Beginning implementation



HISTORY OF CHW INTEGRATION



CHW INTEGRATION VIDEO INTERVIEW

CANDACE HENDERSON, AAS, RMA, CHW-C

LEAD COMMUNITY HEALTH WORKER (CHW)

ADDRESSING SDOH

SDoH	Community Partnership/Referrals
Income/Education/Employment	Partnered with SLATE, St. Louis workforce, and other work force agencies to refer patients/community members for job training and employment opportunities
Legal	Partnered with Legal Services of Eastern Missouri (LSEM) on a Medical Legal Partnership (MLP)
Material Insecurity	Partnered with St. Louis DiaperBank to provide emergency and monthly diapers before, during, and after the pandemic. Partnered with Junior League for baby items. Partnered with Helping Hand Me Downs for clothing, furniture, and job opportunities. Partnered with Integrated Health Network (IHN), United Way 211 and Urban League for utility assistance and other services
Insurance	Affinia Healthcare has an internal Outreach department that assists patients and community members with applying for Medicaid, and other insurances under the Affordable Care Act.

AFFINIA
HEALTHCARE®
Maternal Child

ACE PAINT
Kids Corner
SUPER ACTIVITY SET
TEMPERATURE
Sign - In
Sign - In
Sign - In

Lansinoh
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Inspired by the Patients We Serve
COOKING
MATTERS

ADDRESSING FOOD INSECURITY

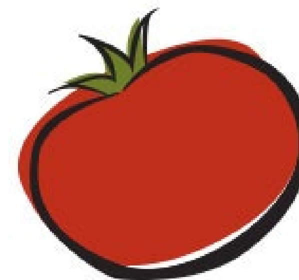
SDoH	Community Partnership/Referrals
Food Insecurity	Partnered with St. Louis Foodbank, Operation Food Search, and St. Louis MetroMarket, and Link market for food pantries, weekly distribution of fresh produce bags, and weekly food distribution during and after the pandemic

ST LOUIS METROMARKET
ST. LOUIS
METRO
MARKET
FOOD IS MEDICINE
EAT TO LIVE
ST. LOUIS
METRO
MARKET

SALAD DRESSING
St.
CLUB
BELLPEPPER

Operation Food Search at Affinia

- **Build Nutrition IQ**
  - Cooking Matters 6-week Course
  - Cooking Demonstrations & Nutrition Presentations
  - Grocery Store Tours
- **Topic Focus:** preparing dishes at home utilizing heart healthy & affordable ingredients to help improve dietary outcomes for patients who present with hypertension



Operation Food Search

ADDRESSING HOUSING AND TRANSPORTATION

SDoH	Community Partnership/Referrals
Housing	Partnered with IHN and United Way 211 for housing and rental assistance Partnered with Equal Housing Opportunity Council (EHOC) to prevent termination/eviction of housing
Transportation	Purchased cab and bus vouchers to provide for patients in health center, at homeless shelters, in the community, etc.

ADDRESSING MEDICAL AND MENTAL HEALTH

SDoH	Community Partnership/Referrals
Medical Needs	Affinia Healthcare provides comprehensive services, including, Holistic medicine, pain programs, OB-GYN, Pediatrics, Internal Medicine, Psychiatry, Optometry, Audiology, Podiatry, Chiropractic, Urgent Care, Case Management, School-based health centers, Immunizations, etc.
Domestic/Partner Violence	Partnered with Women's Safe House
Stress and Mental Health	Affinia Healthcare has integrated behavioral/mental health services for children and adults. Psychiatry services are also offered internally.
Substance Use	Affinia Healthcare has integrated Behavioral Health Consultants, and a Medication Assisted Treatment program at 2 sites Partnered with Salvation Army residential treatment facility and Assisted Recovery Centers of America (ARCA) for ongoing substance use treatment

CHRONIC DISEASE TEAM

HYPERTENSION EDUCATION CLASSES

CHALLENGES

- Supply vs demand of resources: Not enough resources for everyone in need.
- Patients looking for resolve if question answered. (Supply of resources vs. demand of need)
- Staff uncomfortable with asking questions. (Questions are personal and intrusive)
- Patient uncomfortable with answering questions. (Partially due to mistrust of the medical and legal system)

SUCCESSES

- The team is able to gather information to better assist patients with their needs.
- The organization has been able to utilize the data to focus on community partnerships.
- 10,000 of community members and patients were assisted with consistent weekly food and diapers throughout the pandemic.
- Affinia Healthcare has been able to increase the amount of patients who were home bound through diaper and food delivery.
- Throughout the pandemic, Affinia Healthcare and the CHW team was able to shift to assist patients with medical needs in the community.

PEARLS

- Don’t think of the PRAPARE tool as 20+ questions. Break the questions down into a “motivational interview” style conversation.
- Have more than one way to ask a question. Patients may not understand the way a question was asked.
- Know your audience. Words may have different meanings in different cultures.
- Involve staff during planning phase. (We’re working on this now). Staff oftentimes are able to give valuable feedback on how to integrate questions into existing workflow.
- Team Approach. Involve all departments. The PRAPARE tool is a tool that is not just clinically-focused. All departments can assist with gathering information, making it easier to obtain complete information.

Q&A

Resources

PRAPARE

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

PRAPARE Resources

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

- PRAPARE Tool
- PRAPARE Readiness Assessment Tool
- PRAPARE Implementation and Action Toolkit
- Free PRAPARE Electronic Health Record Templates
- Available in 26 languages
- PRAPARE YouTube Channel
- Frequently Asked Questions
- Coding- Crosswalks include ICD-10, LOINC, SNOMED
  - PRAPARE Data Documentation (January 2020)

Responding to SDOH Needs During COVID

Given the ongoing social needs of the communities you serve, **we hope to understand your efforts to assess and address social drivers of health (SDOH).**

Our goal is to continue to learn more about the circumstances in which communities are currently operating and how we can advance our support of organizations in responding to social needs during COVID-19.

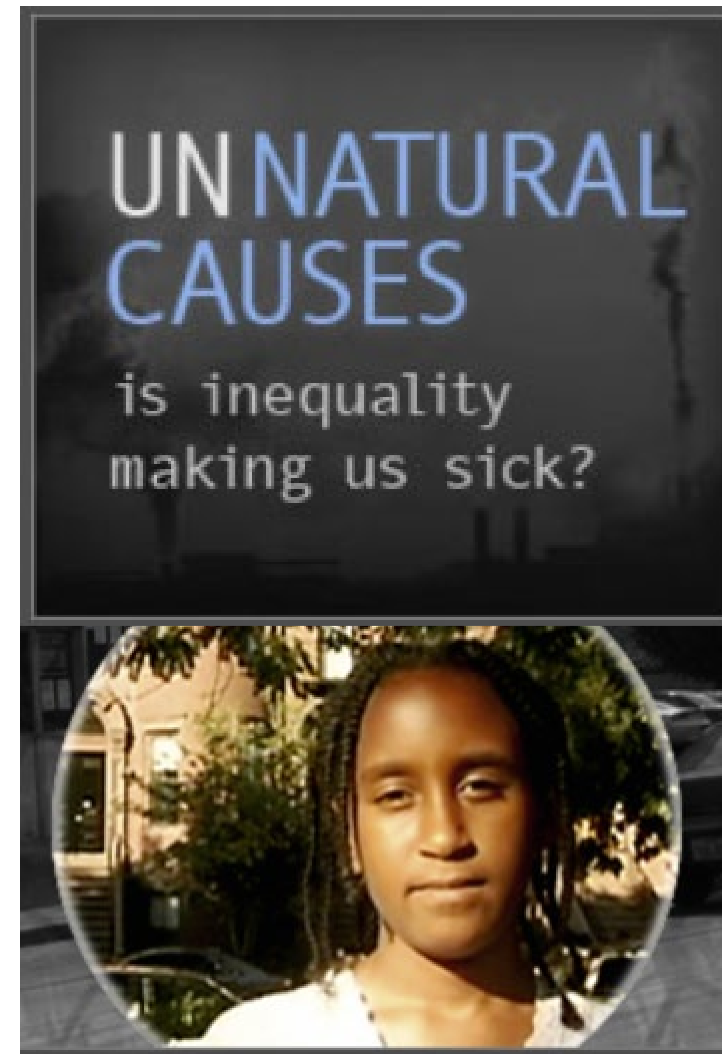
Questions include:

- Assessing + addressing SDOH needs within special and vulnerable populations
- The use of funding from the American Rescue Plan Act to address SDOH needs
- Initial thoughts on your organization's ability to address SDOH needs once the public health emergency declaration expires

Complete the Needs Assessment: https://www.surveymonkey.com/r/SDOHCOVID3

Health Equity Community of Practice

- Utilize PBS documentary series, “Unnatural Causes”
- Over 7 months, host live webinar session per month
- Utilize online discussion forums to continue the conversation
- Affinity groups may be created to allow for a deeper dive in a specific topic
- Create community agreements to allow for brave, courageous conversations
- Session 1: May 18th, 3pm ET
- Visit www.prapare.org for more information



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Q&A

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