NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Risk Stratification & Social Drivers of Health

February 13, 2024

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.

NATIONAL ASSOCIATION OF Community Health Centers®

Agenda

Welcome

Elevate Journey

Social Drivers of Health

- ***WHAT, WHY, HOW***
- **Melissa Mitchell, CEO, HealthLinc, *Elevate Featured Health Center***
- **Nālani Tarrant, Director of SDOH, NACHC**

Risk Stratification

- ***WHAT, WHY, HOW***

Q&A and Discussion

Closing

NACHC Quality Center

Cheryl Modica
Director,
Quality Center

Cassie Lindholm
Deputy Director,
Quality Center

Holly Nicholson
Deputy Director, Learning
and Development

Tristan Wind
Manager,
Quality Center

Rachel Barnes
Specialist,
Quality Center

Elevate Journey

Your transformation journey begins here!

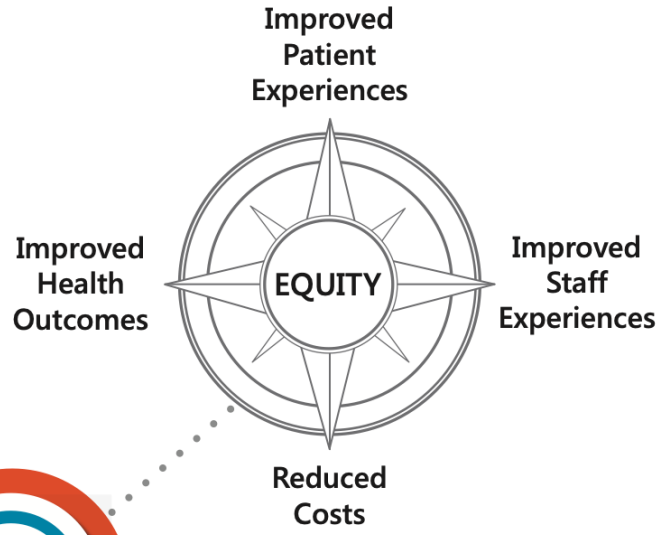
STEP 1 - ENGAGE
Register for Elevate and participate in the **FREE** health center learning community. Invite others

STEP 2 – ASSESS
Measure transformation progress using the Value Transformation Framework (VTF) Assessment

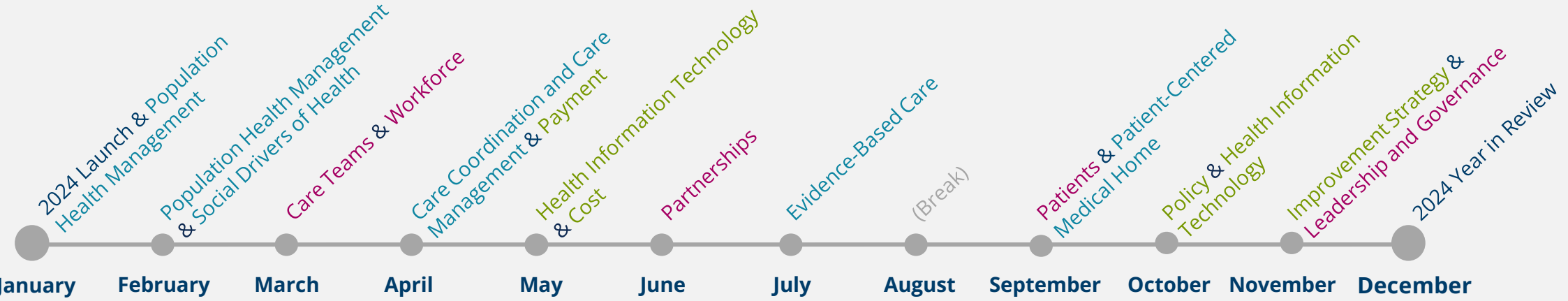
STEP 3 – PLAN
Incorporate transformation efforts into your Improvement Strategy

STEP 4 – TRANSFORM
Apply the VTF and suite of transformation tools and resources

STEP 5 – REASSESS
Measure transformation progress over time using the VTF Assessment; monitor, adjust, and improve



Transform Together Through Monthly Learning Forums



- ✓ Invite additional staff from your organization to register for Elevate.
- ✓ Block calendar for monthly learning forums (2nd Tuesday, 1-2 pm ET). Registration emails will be sent out one month prior.

- ✓ Complete **VTF Assessment** and share results with PCA/HCCN.

- ✓ Plan transformation efforts; incorporate into your health center improvement strategy.

- ✓ Attend monthly learning forums.
- ✓ Log in to NACHC Learning Hub to access free Elevate resources.
- ✓ Initiate and continue transformation efforts!

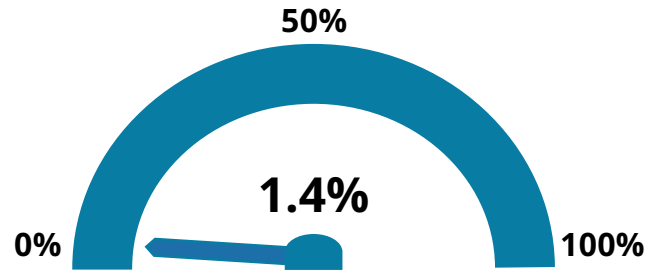
- ✓ Reassess; Share **VTF Assessment** results with PCA/HCCN.

*Schedule of Monthly Learning Forum Topics may be adjusted by the Quality Center as needed.

Elevate Data Dashboard

Health Centers that have taken the VTF Assessment YTD
10

Individuals Registered for Elevate	Health Centers Registered for Elevate	PCAs/HCCNs/NTTAPs Registered for Elevate	Public Health Partners Registered for Elevate
5394	728	79	48



YTD VTF Assessment Scores

Health Information Technology 2.90	Improvement Strategy 3.40	Policy 2.80	Payment 2.80	Cost 2.80
Population Health Management 3.00	Patient-Centered Medical Home 3.20	Evidence-Based Care 3.50	Care Coordination and Care Management 3.20	Social Drivers of Health 2.70
Patients 3.00	Care Teams 2.90	Leadership 2.60	Workforce 2.40	Partnerships 3.60

Complete VTF Assessments ➡ Access FREE Resources

Complete 3+ VTF Assessments:

Health center is eligible for a 6-month trial membership to an online document management platform to support health center OSV preparation and ongoing compliance!

Save the Date:

March 25, 2024, 1-2pm ET

RegLantern Information Session for Health Center Compliance Tool Trial Subscription Register here!

REGLANTERN

RegLantern Continuous Compliance Tool

- Cloud-based platform that helps health centers move toward continuous HRSA compliance
- FTCA Application Tool
- Allows health centers to compile and organize all documents demonstrating compliance in one place
- Embedded with checklists, alerts, and reminders
- Allows a health center to share documents with on-site reviewers during Operational Site Visit (OSV) through Citrix ShareFile integration
- Access to exclusive discounts for health centers interested in continuing subscription after trial period.
- Free Form 5A Review

Elevate Featured Health Centers: 2023 Health Center Quality Leaders!

ESPERANZA health centers

mainlinehealth systems, inc.

SOUTHSIDE
Your Community Health Services

St. Croix Regional
Family Health Center

care resource
Your Community's Source for Healthcare

MVHC

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

CAMILLUS HEALTH CONCERN

RHG
RURAL HEALTH GROUP
healthcare that fits your family

OneWorld
Community Health Centers, Inc.

WAIMĀNALO
HEALTH CENTER

AudubonArea
Community Care Clinic, Inc.

Population Health Management

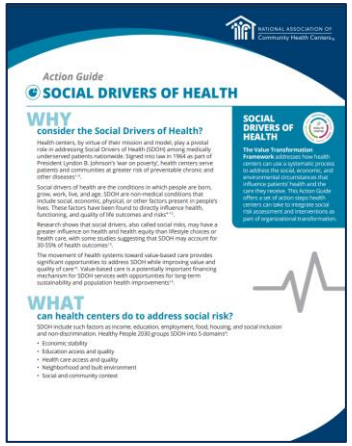
&

Social Drivers of Health

Population Health Management & SDOH

Social Drivers of Health: The social, economic, and environmental circumstances that influence patients' health and the care they receive.

SDOH Interventions



SDOH Action Guide

Empanelment

Matching every patient to a primary care provider and care team.

SDOH Assessment

Risk Stratification

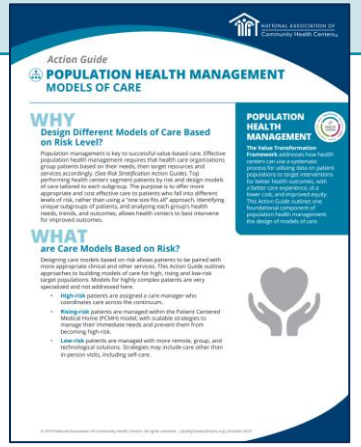
Segmenting patients into groups of similar complexity and care needs.

Models of Care

Care models based on risk for patients to be paired with more appropriate care team members and services.

Empanelment Action Guide Microlearning

Risk Stratification Action Guide Microlearning



Models of Care Action Guide

Social Drivers of Health

WHY consider Social Drivers of Health?

The conditions in which people are born, grow, work, live, and age, have an important influence on health outcomes.

These non-medical factors are referred to as social drivers of health (SDOH) and can influence health equity in positive and negative ways.

Examples of SDOH include:

- Income
- Education
- Unemployment and job insecurity
- Food insecurity
- Housing, basic amenities and the environment
- Social inclusion and non-discrimination

WHY consider Social Drivers of Health?

SDOH have an important influence on health inequities, or the unfair and avoidable differences in health status.

Health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.*

Research shows that the social drivers can be more important than health care or lifestyle choices in influencing health.

SDOH account for between 30-55% of health outcomes!*

* "Social determinants of health." World Health Organization. 2023. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

WHY consider Social Drivers of Health?

Health centers can play a pivotal role in addressing SDOH:

Social Impact	Care delivery models that account for and seek to address SDOH can reduce health disparities and inequities.
Quality Impact	Considering the relationship between SDOH and health outcomes, addressing SDOH can help to improve quality measures.
Financial Impact	Movement toward value-based care can provide financial incentive to address SDOH.

WHAT can health centers do to incorporate SDOH into processes?

- ✓ Identify the SDOH impacting the population served.
- ✓ Design interventions that support patients in addressing identified social risk factors.
- ✓ Form partnerships that increase the community's ability to address social risk factors.
- ✓ Demonstrate value to payors in incorporating SDOH into care and reimbursement models.
- ✓ Provide care and services that support health equity.

SDOH in 2023 UDS Reporting

Table 3B: Demographic Characteristics

- **Race**
- **Ethnicity**
- **Patients best served in a language other than English**
- **Sexual Orientation**
- **Gender Identity**

Table 4: Selected Patient Characteristics

- **Income Level**
- **Insurance**
- **Special Populations** (Agricultural Workers, Homeless, Veterans, Accessible Public Housing)

Table 6A: Selected Diagnosis and Services Rendered

- **Human Trafficking**
  - T74.5- through T74.6-, T76.5- through T76.6-, Z04.81, Z04.82, Z62.813, Z91.42
- **Intimate Partner Violence**
  - T74.11, T74.21, T74.31, Z69.11

APPENDIX D: Health Center HIT Capabilities

- Does your health center collect data on individual patients' social risk factors, outside of the data countable in the UDS?
- How many health center patients were screened for social risk factors using a standardized screener during the calendar year?
- Which standardized screener(s) for social risk factors, if any, did you use during the calendar year?
- Of the total patients screened for social risk factors, please provide the total number of patients that screened positive for any of the following at any point during the calendar year:
  - **Food Insecurity**
  - **Housing Insecurity**
  - **Financial Strain**
  - **Lack of Transportation/Access to Public Transportation**
- If you DO NOT use a standardized screener to collect this information, please indicate why.

Tools & Resources: 2023 UDS Manual

HOW can health centers assess and respond to social risk?

STEP 1 Engage leadership and Board members in prioritizing SDOH efforts

STEP 2 Understand social risk factors in your community

STEP 3 Identify community resources to address social risks

STEP 4 Design a workflow for SDOH screening

STEP 5 Design a workflow for interventions in response to identified SDOH needs

STEP 6 Train health center staff

STEP 7 Optimize billing opportunities

STEP 8 Collect and monitor SDOH data over time; use data to inform practice transformation

STEP 9 Leverage SDOH data to drive value-based payment and reimbursement

STEP 1

ENGAGE LEADERSHIP AND BOARD MEMBERS IN PRIORITIZING SDOH EFFORTS

Engage health center leadership and Board members by highlighting the ways SDOH aligns with existing organizational priorities and how SDOH data will add value to organizational initiatives. Determine your ***WHY.***

Leadership designates a team of health center staff responsible for implementing processes for SDOH screening and providing social risk factor interventions.

This team should be interdisciplinary, including staff member representatives with varying roles and expertise:

- Provider champion
- Medical assistant/nurse
- Front office staff member
- Community health worker
- QI staff member
- IT staff member

Tools & Resources:
- NACHC Leadership Action Guide
- Examples of Messaging Resources: PRAPARE® Toolkit (page 12)

STEP 2

UNDERSTAND SOCIAL RISK FACTORS IN YOUR COMMUNITY

Build an understanding of the prevalent social risk factors in the communities served by your health center to inform strategies for the social risk interventions that may be needed by health center patients.

Health Center Needs Assessment Findings:

Factors associated with access to care and health care utilization

- Geography, transportation, occupation, transience, unemployment, income level, educational attainment

The most significant causes of morbidity and mortality

- Diabetes, cardiovascular disease, cancer, low birth weight, behavioral health, any associated health disparities

Other unique health care needs or characteristics that impact health status or access to, or utilization of, primary care

- Social factors, the physical environment, cultural/ethnic factors, language needs, housing status

Annual County Health Rankings:

Vital health factors included in this resource are high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births.

Tools & Resources:

- Health Center Compliance Manual: Chapter 3: Needs Assessment
- County Health Rankings

STEP 3

IDENTIFY COMMUNITY RESOURCES TO ADDRESS SOCIAL RISKS

Develop a resource list identifying internal and external services that staff can refer to when addressing a patient's social needs.

Resource list can include:

- Local housing organizations
- Transportation resources
- Job-training programs
- Mental health programs
- Local food banks

Include contact information (address, phone number, email and contact name).

Tools & Resources:
These organizations maintain up-to-date information on a variety of resources by community or zip code**:** findhelp.org, 211.org, and The EveryONE Project

STEP 4

DESIGN A WORKFLOW FOR SDOH SCREENING

Select an SDOH screening tool.
This can be PRAPARE® or another screening tool of your health center's choosing.

Define initial target population.
When implementing a new workflow, test the workflow on a sample target population to allow for process improvement before expanding the workflow to your entire patient population:

- Patient panels of one or two providers who are highly engaged and supportive of this new initiative
- Patients engaged in care management
- Condition specific

Tools & Resources:
- Information on workflow implementation PRAPARE® Toolkit (Chapter 5)
- Condition specific SDOH tools CDC SDOH Tools

STEP 4
CONTINUED

DESIGN A WORKFLOW FOR SDOH SCREENING

Determine *WHEN:*
For example, prior to the patient appointment, when the patient checks in at the front desk, during the rooming process, after the clinical exam, etc.

Determine *HOW:*
For example, the patient completes through electronic form (iPad/tablet, text messaging), patient completes via paper form, or staff member verbally asks the patient each question (in-person or via telehealth or phone call).

- Due to the personal nature of the screening questions a private setting is recommended to ensure the patient is comfortable and their information is protected.

Determine *HOW OFTEN:*
For example, annually, at every visit, and/or at a 'trigger event' (e.g., a certain visit type, care management enrollment, etc.).

- You may find that flexibility is needed to deliver the screening at a time when patients are most receptive to sharing their social risk information.

Determine *WHO SCREENS:*
You may find that patients are more comfortable sharing their personal social risk information with a Community Health Worker, Care Manager, or other care team member with whom they have an established care relationship.

- For details on training staff to screen for SDOH and using e*mpathic inquiry, see* ***Step 7.***

STEP 4
CONTINUED

DESIGN A WORKFLOW FOR SDOH SCREENING

Determine *HOW/WHERE TO DOCUMENT:*
Depending on the SDOH screening tool being utilized, you may be able to work with your EHR representative to implement the tool directly into your EHR.

Utilizing structured fields within your EHR for the documentation of screening results provides a consistent location for staff to document and allows for reports to be pulled from the EHR.

Z Codes, the set of ICD-10 CM codes used to identify social risk factors, may also be documented within the patient's EHR. Z codes allow for easy reporting and provide a 'common language' when sharing risk factor data with payors and other stakeholders.

Z Code Category	Definition
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Tools & Resources:
- Details on EHR PRAPARE® implementation on page 32 of the PRAPARE® Toolkit
- PRAPARE® Data Documentation Quick Sheet
- CMS SDOH Z Code Infographic

STEP 4
CONTINUED

DESIGN A WORKFLOW FOR SDOH SCREENING

Determine *HOW/WHERE TO DOCUMENT (continued):*

LOINC codes and ***SNOMED CT codes*** may also be used to capture additional details on SDOH screening questions and responses to improve data sharing and interoperability (details on next slide).

The following ***CPT codes*** may be used to document that an SDOH assessment was conducted:

	CPT	Description	Tips for Using*
SDOH Assessment	**96156**	Health behavior assessment (e.g., health-focused clinical interview, behavioral observations, validated rating scales) by a qualified healthcare professional, initial assessment	This code is used for the initial assessment of health behaviors, including screening for SDOH. It involves conducting a comprehensive interview, behavioral observations, and using validated rating scales to assess various health-related behaviors, including social determinants.
	96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.	This code is used for the administration and scoring of a patient-focused health risk assessment instrument, such as a standardized questionnaire or survey that includes SDOH screening. It involves assessing multiple health risks, including social determinants, and documenting the results.

*Use of any CPT code requires an organizational or individual license from AMA

Tools & Resources:
- PRAPARE® Data Documentation and Codification File

	LOINC	ICD-10-CM	SNOMED-CT	CPT
WHAT are these codes?	Logical Observation Identifiers Names and Codes Also referred to as 'laboratory codes'	International Classification of Diseases, Tenth Revision, Clinical Modification Also referred to as 'diagnosis codes'	SNOMED Clinical Terms	Current Procedural Terminology Also referred to as 'procedure codes'
WHO develops and maintains these codes?	Regenstrief Institute, a non-profit medical research organization associated with Indiana University Free for use	CDC's National Center for Health Statistics under authorization by the World Health Organization Free for use	SNOMED International, a not-for-profit organization Free for use	American Medical Association (AMA) Use of any CPT code requires an organizational or individual license from AMA
WHY are these codes used?	Federally mandated terminology standard/coding system for capturing: Health measurements and observations • Vital signs, lab tests and results, questions and responses for validated screening and assessment tools (e.g., PRAPARE, PHQ, etc.) Document types • Consult notes, discharge summaries, progress notes, procedures notes, etc.	Federally mandated terminology standard/coding system for capturing diseases, illnesses, injuries and health conditions	Federally mandated terminology standard/coding system for capturing all health-related concepts (e.g., clinical findings, diagnostic procedures, etc.), Includes codes that represent concepts and relationships between concepts with more specificity	Federally mandated terminology standard/coding system for billing services provided or rendered to a patient
HOW are these codes used?	Facilitate the aggregation and exchange of health measurements, observations, and documents	Insurance claims submission and processing Tracking public health conditions and assisting with population health management Identifying care gaps Clinical research	Allows the meaning of information recorded in clinical information systems (e.g., EHRs, etc.), health data & analytics platforms and interoperability solutions to be processed SNOMED-CT, together with ICD-10-CM, is the accepted standard for SDOH Assessment, Goals, and Interventions in USCDIv3 and will be required for use before Jan 1, 2026, through the ONC's HTI-1 final rule.	Insurance claims submission and processing Utilization review and comparison Identifying care gaps (i.e., indicated by the lack of a CPT code) Can be leveraged to establish clinical protocols and outreach processes
SDOH example	*PRAPARE (full assessment instrument): 93025-5* *"What is your housing situation today?": 71802-3* *"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)": LA30190-5* See PRAPARE Data Documentation and Codification File for full code set	*Unsheltered homelessness: Z59.02* See CMS SDOH Z Code Infographic and PRAPARE Data Documentation and Codification File for full code set Z55-Z65 (Also referred to as 'Z codes')	*Patient identified as experiencing unsheltered homelessness: 611141000124105* *Goal established for the patient to be stably housed: 611221000124108* *Intervention provided through a referral to housing support program: 472161000124106* See PRAPARE Data Documentation and Codification File for full code set	*Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes: 99401* See slides 28 and 31

Captures that the screening tool utilized to assess for social risk factors is valid

Captures SDOH assessment findings (less detail)

Captures SDOH assessment findings (more detail) and the reason why an intervention was provided

Captures the provision of SDOH assessments and social risk interventions

STEP 5

DESIGN A WORKFLOW FOR SOCIAL RISK FACTOR INTERVENTIONS

Determine *WHO FOLLOWS UP:*
When a social risk factor is identified through the screening process, a staff member will then assist the patient in addressing their need(s). This staff member will use the resource list developed in ***Step 3*** to connect patients to available resources and social supports.

Determine *HOW FOLLOW UP OCCURS:*

Use warm-handoffs for internal supports including behavioral health, care managers, financial counselors, etc.

Integrate external community resource referral processes into existing health center **referral tracking and follow** up policies and procedures.

Determine *HOW/WHERE DOCUMENTED:*
Utilizing structured fields within your EHR is recommended to provide a consistent location for staff to document and to allow for reports to be pulled from the EHR.

Utilize codes to track social risk interventions...

STEP 5

DESIGN A WORKFLOW FOR SOCIAL RISK FACTOR INTERVENTIONS

	CPT	Description	Tips for Using*
Addressing Food Insecurity	**97802**	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	
	97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes	
Addressing Identified Social Risks	**99401**	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	These codes used for counseling and interventions aimed at promoting health, preventing illness, and reducing risk factors. They can be used to address specific needs identified through SDOH screening **Should be reported together with applicable ICD-10-CM Z-code(s) which demonstrates the link or need for the preventive medicine counseling** Cannot be reported in addition to preventive medicine service codes 99381–99385 and 99391–99395 for comprehensive preventive medicine evaluation and management of an individual (overlapping services)
	99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	
	99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	
	99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	
	99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	
	99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes	

*Use of any CPT code requires an organizational or individual license from AMA

STEP 6

OPTIMIZE AVAILABLE BILLING OPPORTUNITIES

Optimize available billing opportunities:

- Billing opportunities for SDOH assessments and interventions will vary by payor and state.

- When qualifying, leverage Medicare care management billing opportunities, including new opportunities for *Principal Illness Navigation* and *Community Health Integration*.

Tools & Resources:
- NACHC Medicare Reimbursement Tip Sheets

STEP 7

TRAIN HEALTH CENTER STAFF

Provide training to staff on the workflow developed in *Steps 4 and 5*.

Consider each health center staff members' unique role, for example:

- How can providers champion the process and help to reinforce the 'why' with patients?
- What is the role of front office staff members (may often be the first to identify literacy or language barriers)?
- How will the health center quality staff and/or data analytics staff support workflow development/improvement and data reporting efforts?

Empathic inquiry is used to authentically connect with patients to understand their needs and priorities by building trust.

Trust between patients and care team members leads to the provision of more appropriate care and treatment plans.

Tools & Resources:
For more information on ***Empathic Inquiry*** and sample staff training curriculums, see page 50 of the PRAPARE® Toolkit.

STEP 8

COLLECT AND MONITOR SDOH DATA OVER TIME; USE DATA TO INFORM PRACTICE TRANSFORMATION

Engage the interdisciplinary team (assigned in ***Step 1***) to implement the workflow developed in ***Steps 4 and 5***. As an implementation team, regularly assess:

- The volume of SDOH screening occurring
- Types/impacts of interventions provided
- Staff and patient feedback on the workflow

Adjust the workflow, as needed, based on findings. When ready, expand the workflow beyond the initial target population.

Tools & Resources: NACHC Improvement Strategy Action Guide

STEP 8
continued

COLLECT AND MONITOR SDOH DATA OVER TIME; USE DATA TO INFORM PRACTICE TRANSFORMATION

Integrate SDOH as a component of your health center's risk stratification process.

- At the individual level, a patient's risk category is the first step towards planning, developing, and implementing a personalized care plan.
- At the population level, risk stratification allows care models to be personalized to the needs of patients within each subgroup.

Tools & Resources:
- NACHC Risk Stratification Action Guide
- PRAPARE® Risk Tally Score Quick Sheet

STEP 9

LEVERAGE SDOH DATA FOR VALUE-BASED PAYMENT AND REIMBURSEMENT

Health centers can analyze social risk data and use this information to drive program decisions and inform payment reform efforts.

- ✓ Add data to key reports for executive leadership and Boards of Directors to inform value-based care opportunities and to document strategies that will achieve better health outcomes and better reimbursement.

- ✓ Share findings with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs and advance health equity.

Featured Health Center

Melissa Mitchell
Chief Executive Officer
HealthLinc

- *Joined HealthLinc in 2008 as a Managed Care Specialist*
- *Promoted to Chief Operating Officer (2015) and Chief Innovation and Strategy Officer (2023)*
- *Became Chief Executive Officer in 2024*
- *Graduated from the Johnson & Johnson Health Care Executive Program at UCLA in 2014*
- *Currently serves on NACHC Rural Health Committee and multiple state and local boards*
- *A native of Indiana and graduate of Ball State University with a BS in communications*

Featured Health Center

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

- Northern Indiana – Corporate headquarters in Valparaiso, IN
- Twelve clinics and one mobile medical/dental clinic
- Served 44,170 patients in 2023
- 2023 Awards

- Unique fact – We span two time zones

Featured Health Center

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

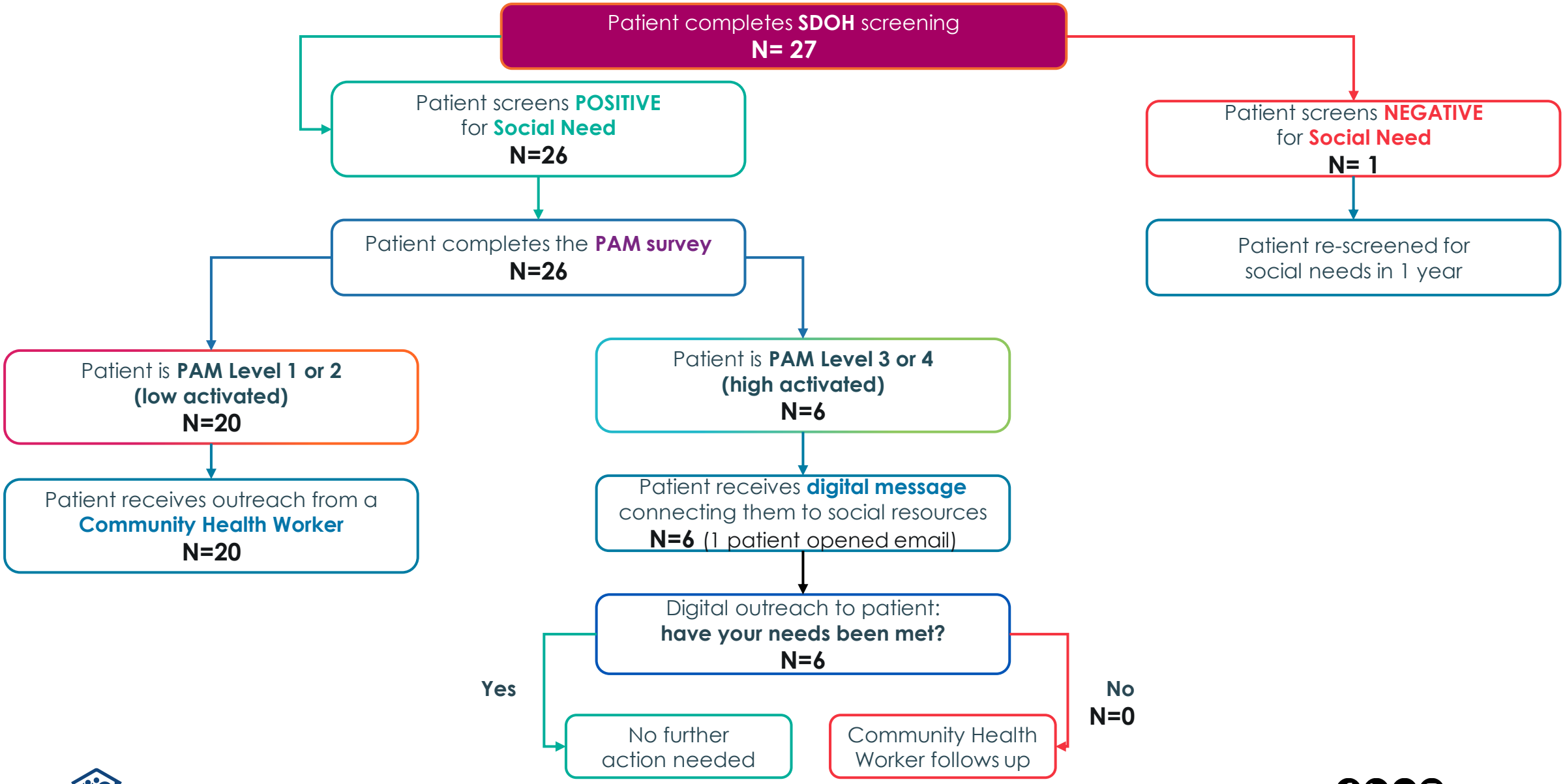
COMMUNITY HEALTH CENTER FQHC QUALITY

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

HealthLinc developed workflows to provide SDOH screening and interventions through:

- **People:**
  - We use intake staff, community health workers, LCSWs and others to review PRAPARE survey results
  - Communication is key both at the onset of the program and continuously as program capabilities change
- **Infrastructure:**
  - PRAPARE surveys done electronically at check-in and in the clinic when necessary on paper
- **Care Delivery:**
  - See next slide

SDOH SCREENING + PAM WORKFLOW WITH PILOT DATA (DEC 22 – FEB 23)



Featured Health Center

- **Outcome:**
  - Technology allowed us to increase screening by 42%
- **Lessons Learned:**
  - Patients can't focus on improving their health outcomes if they don't have their basic needs met
  - We can help them do both

NACHC SDOH Team

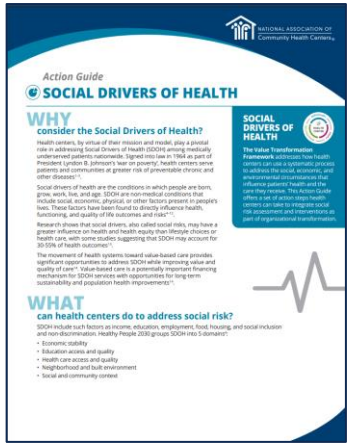
Nālani Tarrant, MPH, PMP
Director of Social Drivers of Health
National Association of Community Health Centers

- *Nālani serves as the Director of Social Drivers of Health (SDOH) at the National Association of Community Health Centers.*
- *Nālani's responsibilities encompass program development, implementation, and comprehensive evaluation, all with a dedicated focus on the Protocol for Responding to and Assessing Patients Assets, Risks, and Experiences (PRAPARE) screening tool.*
- *Her academic journey includes a bachelor's degree in Behavioral Science from Drew University, a Masters of Public Health in epidemiology from George Washington University, and the prestigious attainment of her Project Management Professional accreditation in 2017.*

Population Health Management & SDOH

Social Drivers of Health: The social, economic, and environmental circumstances that influence patients' health and the care they receive.

SDOH Interventions



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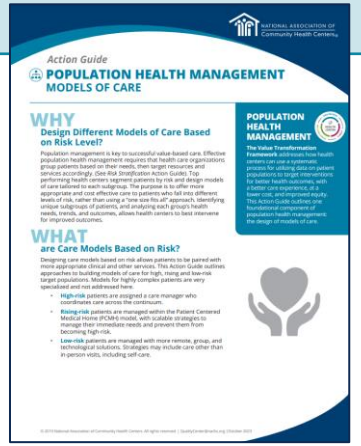


Models of Care Action Guide

Population Health

Risk Stratification

NATIONAL ASSOCIATION OF Community Health Centers®

WHAT is risk stratification?

Segmenting patients into distinct groups of similar complexity and care needs to better target care and services

Risk groups include:

1	2	3	4
LOW RISK	RISING RISK	HIGH RISK	HIGHLY COMPLEX

WHY risk stratify?

At the population level

Create care models matched to the needs of population subgroups

At the individual level

Assign a risk level and customize care and services within risk level

HOW to risk stratify?

STEP 1 Compile a List of Health Center Patients

STEP 2 Sort: Identify Risk Stratification Criteria and Assign Each Criterion a Weight

STEP 3 Stratify Patients to Segment the Population into Target Groups

STEP 4 Design Care Models and Target Interventions for Each Risk Group

STEP 1

COMPILE A LIST OF HEALTH CENTER PATIENTS

Build on empanelment work

Run reports by each PCP or PCP team

- Include established health center patients
- Include payer attributed patients who may not have had a visit at the health center yet

Develop processes for integrating payer data and provide outreach to patients to engage in care!

Tools & Resources: NACHC Empanelment Action Guide

STEP 2

SORT: IDENTIFY RISK STRATIFICATION CRITERIA

Identify the criteria to include in your risk stratification process:

- Consider reporting capabilities of your electronic health record and population health management system
- If your systems allow, use multiple criteria for a comprehensive approach
- If your systems don't allow consideration of multiple criteria, start with clinical conditions; do a 'simple' condition count

Criteria to consider:

- Clinical conditions (diagnosis)
- Social risk factors
- Utilization data (hospitalizations, ED visits)
- Clinical lab values
- High risk medications

STEP 2 CONTINUED

SORT: ASSIGN EACH CRITERION A WEIGHT

Clinical Conditions

HRSA's Uniform Data Systems (UDS), Table 6A, is a great list to work from

- Represents high cost, high prevalent conditions among health center patients
- Health centers already collecting data, and reporting on, these measures
- Add or subtract from list based upon local health conditions, patient populations, and clinical priorities

EXAMPLE *from UDS Table 6A:*

Diagnostic Category	Applicable ICD-10-CM Code	Criterion Weight
Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	2
Chronic lower respiratory diseases	J40 (count only when code U07.1 is not present), J41- through J44-, J47-	2
Asthma	J45-	2
Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	3
Hypertension	I10- through I16-, O10-, O11-	2
Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	2
Depression and other mood disorders	F30- through F39-	2

Health center determines criteria and weighting

STEP 2
CONTINUED

SORT: ASSIGN EACH CRITERION A WEIGHT

Social Drivers of Health

Consider using Qs within NACHC's PRAPARE tool: **www.prapare.org**

Assign weight to the question responses that indicate social risk.

EXAMPLE

Response to PRAPARE Question	Criterion Weight
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)	1
Yes (lack of transportation), has kept me from medical appointments	1
No (I do not feel physically and emotionally safe where I currently live)	2
Yes (I am a refugee)	3

Health center determines criteria and weighting

STEP 2
CONTINUED

SORT: ASSIGN EACH CRITERION A WEIGHT

Clinical Lab Values

In addition to looking at clinical diagnosis, lab values can be included into the risk stratification process to incorporate data on a patient's level of disease management.

EXAMPLE

Clinical Lab Values	Criterion Weight
A1C > 9	2
Blood pressure > 140/90 mmHG	3
Total cholesterol > 240 mg/dl	1
Triglycerides > 500 mg/dl	1

Health center determines criteria and weighting

STEP 2 CONTINUED

SORT: ASSIGN EACH CRITERION A WEIGHT

Medications

Medications can also be included in the risk stratification process.

Determine which medications your health center considers to be high risk.

EXAMPLE

High Risk Medications	Criterion Weight
Opioids	4
Benzodiazepines	4
Anticoagulants	4
Antipsychotics	4
Insulin	2

Health center determines criteria and weighting

STEP 2
CONTINUED

SORT: ASSIGN EACH CRITERION A WEIGHT

Utilization Data

If available, utilization data (e.g., hospitalizations and ED visits), provides a more comprehensive understanding of patient risk factors outside the walls of your health center.

EXAMPLE

Utilization Criterion	Criterion Weight
1-2 hospitalizations within the last year	2
2-3 hospitalizations within the last year	3
4 + hospitalizations within the last year	4
1-2 ED visits within the past year	2
2-3 ED visits within the past year	3
4 + ED visits within the last year	4

Health center determines criteria and weighting

STEP 2
CONTINUED

SORT: ASSIGN EACH CRITERION A WEIGHT

Using the lists of patients compiled in Step 1, assign each patient a **total risk score** representing each criterion the patient meets.

EXAMPLE

Patient A

Criterion	Criterion Weight
Heart disease (selected)	2
Asthma	2
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, in a park)	1
4 + ED visits within the last year	4
Total Risk Score	**9**

Patient B

Criterion	Criterion Weight
Diabetes mellitus	3
Overweight and obesity	2
Yes (lack of transportation), has kept me from medical appointments	1
1-2 hospitalizations within the last year	2
A1c > 9	2
Total Risk Score	**10**

STEP 3

STRATIFY: ASSIGN PATIENTS INTO TARGET GROUPS

Arrange patients from highest risk score to lowest risk score.

This can be done for the overall population, provider team, or individual provider panel, depending on size of your health center.

Risk Level	Total Risk Score *(Example)*	Estimated % patient population
Highly complex	>20	5-10%
High Risk	11-20	20-30%
Rising Risk	2-10	40-50%
Low Risk	0-1	10-20%

Patient Name	Risk Score	
Patient A	22	Highly complex
Patient B	18	High risk
Patient C	16	
Patient D	12	
Patient E	10	Rising risk
Patient F	9	
Patient G	5	
Patient H	5	
Patient I	4	
Patient J	3	
Patient K	3	
Patient L	2	
Patient M	1	Low risk
Patient N	0	
Patient O	0	

Remember: *Risk groups are a tool for targeting services, they are not a clinical diagnosis.*

STEP 3
CONTINUED

STRATIFY: SEEK PROVIDER & CARE TEAM INPUT

SEEK INPUT

from provider & care team on the patients assigned to each risk group

ADD THE PATIENT'S RISK GROUP

to their electronic health record, for care team members to easily view

DETERMINE STAFF ROLES

& responsibilities based upon care models for each risk group (Step 4) and available staff resources

STEP 4

DESIGN CARE MODELS AND TARGET INTERVENTIONS FOR EACH RISK GROUP

LOW RISK

Few or no risk factors. Stable or healthy

Focus is keeping patients engaged in the health care system without use of unnecessary services

Goals: maintain connection; support health

RISING RISK

One or several risk factors or conditions; moves in and out of stability

Focus is on managing risk factors more than disease conditions

Goals: identify and manage risk factors

HIGH RISK

Multiple risk factors or conditions

Requires structured care management and one-on-one support

Goals: chronic care management and preventive services

HIGHLY COMPLEX

Multiple complex conditions; could include psychological condition(s)

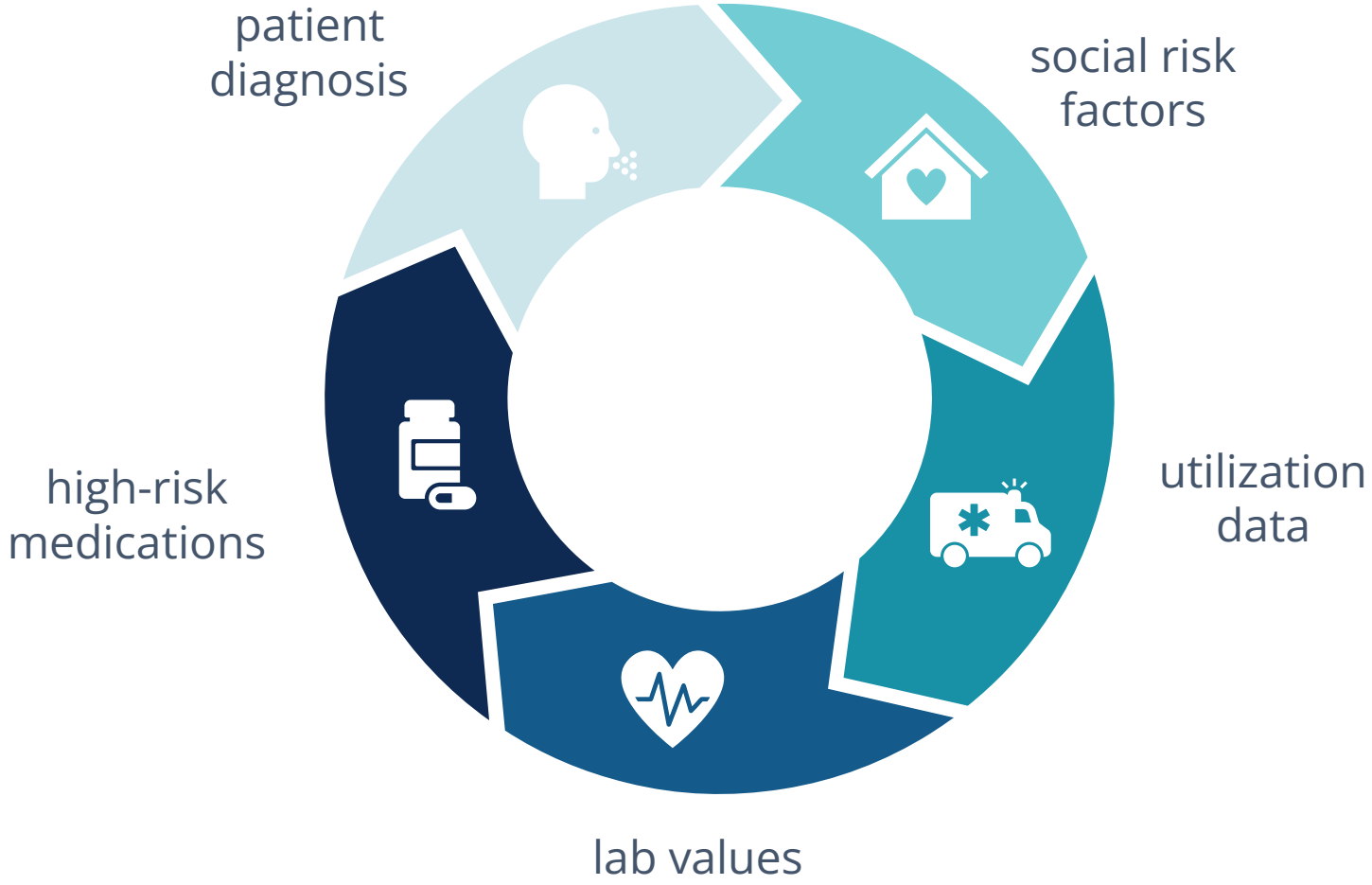
Requires intensive, pro-active care management

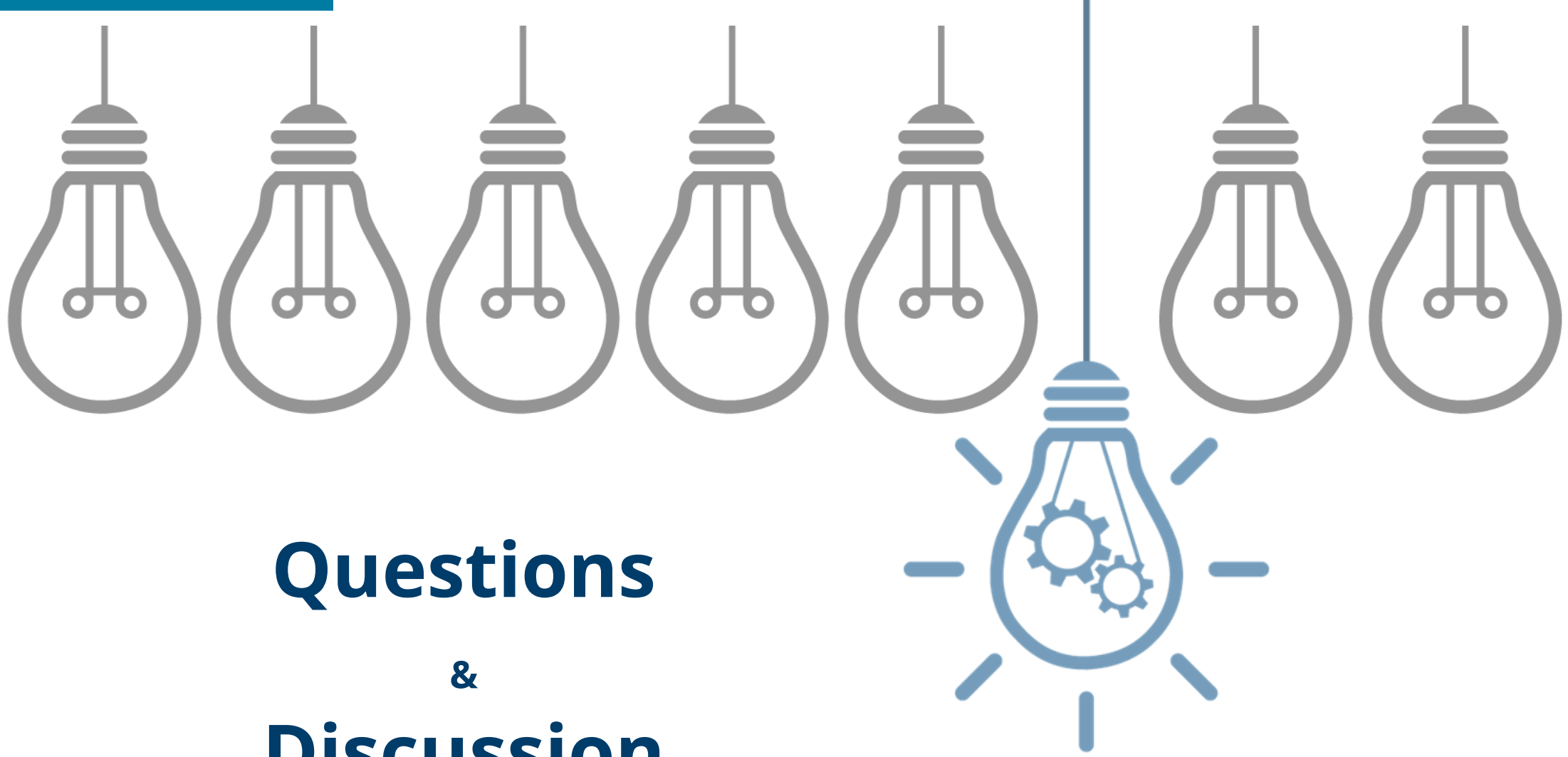
Goals: prevent high-cost emergency or acute care services

STEP 1-4

REPEAT STEPS ROUTINELY

Repeat risk stratification process routinely to capture newly empaneled health center patients, including attributed patients where possible





Questions

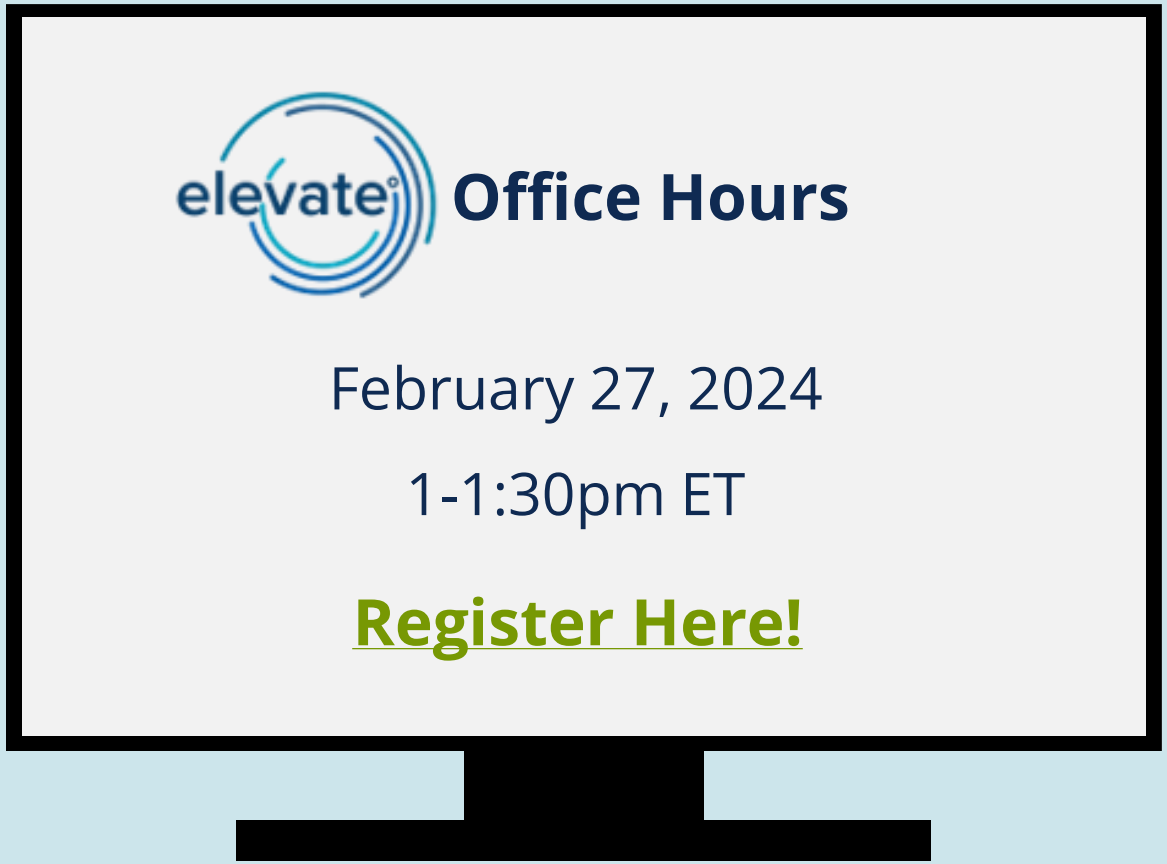
&

Discussion

Join us for Elevate Office Hours!

Join us for February Elevate Office Hours!

- Ask questions about this month's Learning Forum Topic *(Risk Stratification & SDOH)*
- Share challenges, best practices, and lessons learned
- Engage with Elevate peers across the country!



Elevate Pulse

Be on the lookout for the **Elevate Pulse** from the **NACHC Quality Center:**

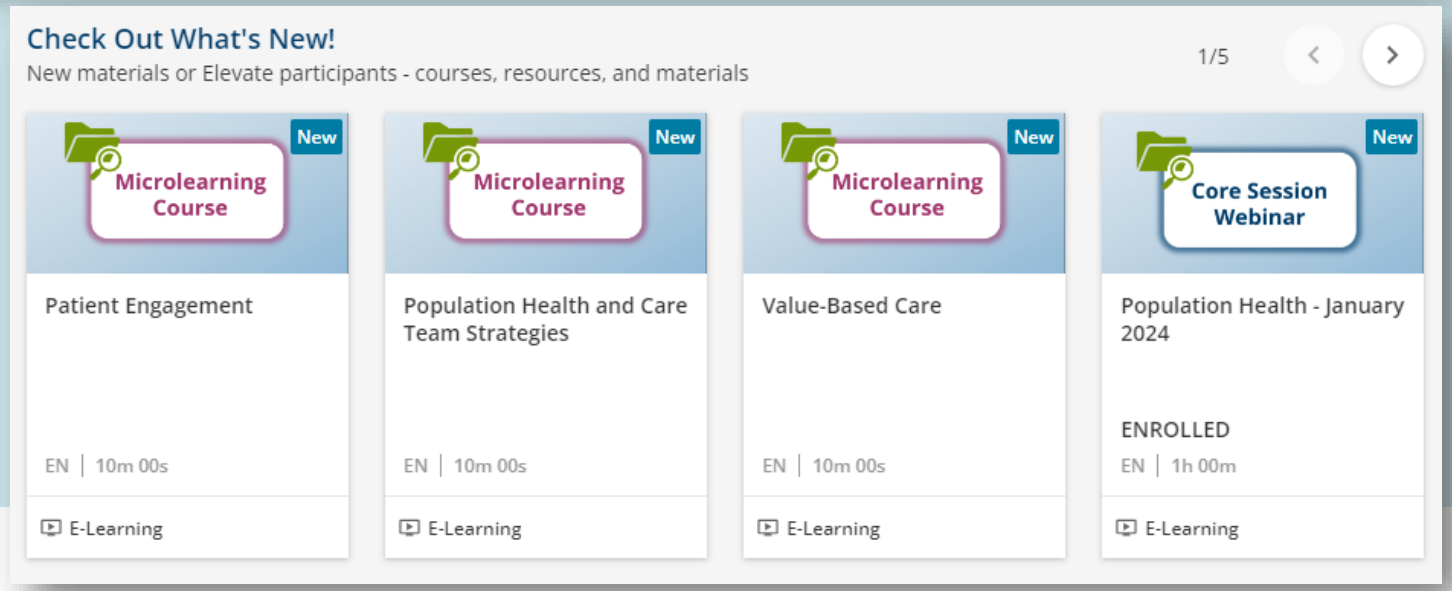
- ✓ Slides & recordings
- ✓ Tools & resources
- ✓ Upcoming opportunities

Elevate on the NACHC Learning Hub

Access dozens of

FREE resources!

Elevate on the NACHC Learning Hub



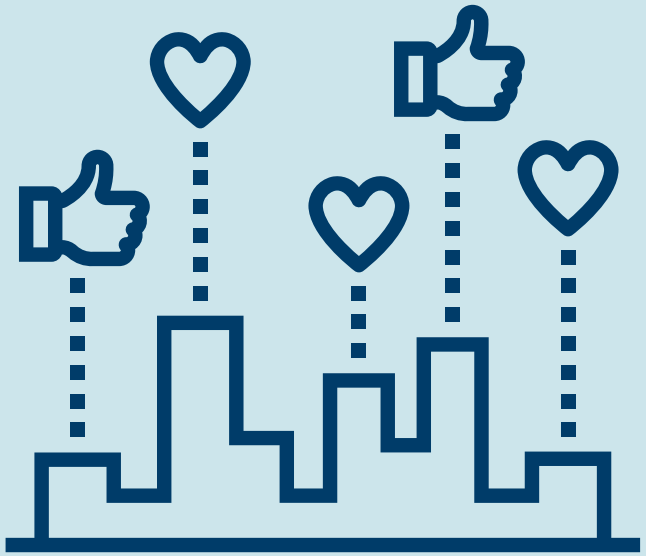
Population Health
Management Task Force

POPULATION HEALTH MANAGEMENT TASK FORCE NATIONAL LEARNING SERIES

UPCOMING WEBINARS

WEBINAR #1 Wednesday, March 6	Foundations of Population Health Management in Priority Populations
WEBINAR #2 Wednesday, March 13	Housing and HIV: Bridging the Gap between HIV and Housing in Special and Vulnerable Populations
WEBINAR #3 Wednesday, March 20	Diabetes Prevention: Food Sovereignty and Access to Ancestral, Cultural, and Healthful Foods
WEBINAR #4 Wednesday, March 27	Team-Based Approaches for Managing Complex Health Needs

REGISTER TODAY AT POPHEALTHTASKFORCE.ORG



Provide Us Feedback

FOR MORE INFORMATION CONTACT

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Next Monthly Learning Forum:

Care Teams & Workforce

elevate

March 12, 2024
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

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Together, our voices elevate° all.

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