Agenda

- Get to know each other
- Review of PRAPARE and connection to strategic plan
- Patient principles
- 4 workflows
- Discussion (throughout, please!)

Ice Breaker!

- Name
- Clinic
- Your role at the clinic
- **Are you screening for SDH?**

Social determinants of health focus as a strategic priority

OPCA shared a social determinants of health (SDH) survey w/CHCs

Purpose:
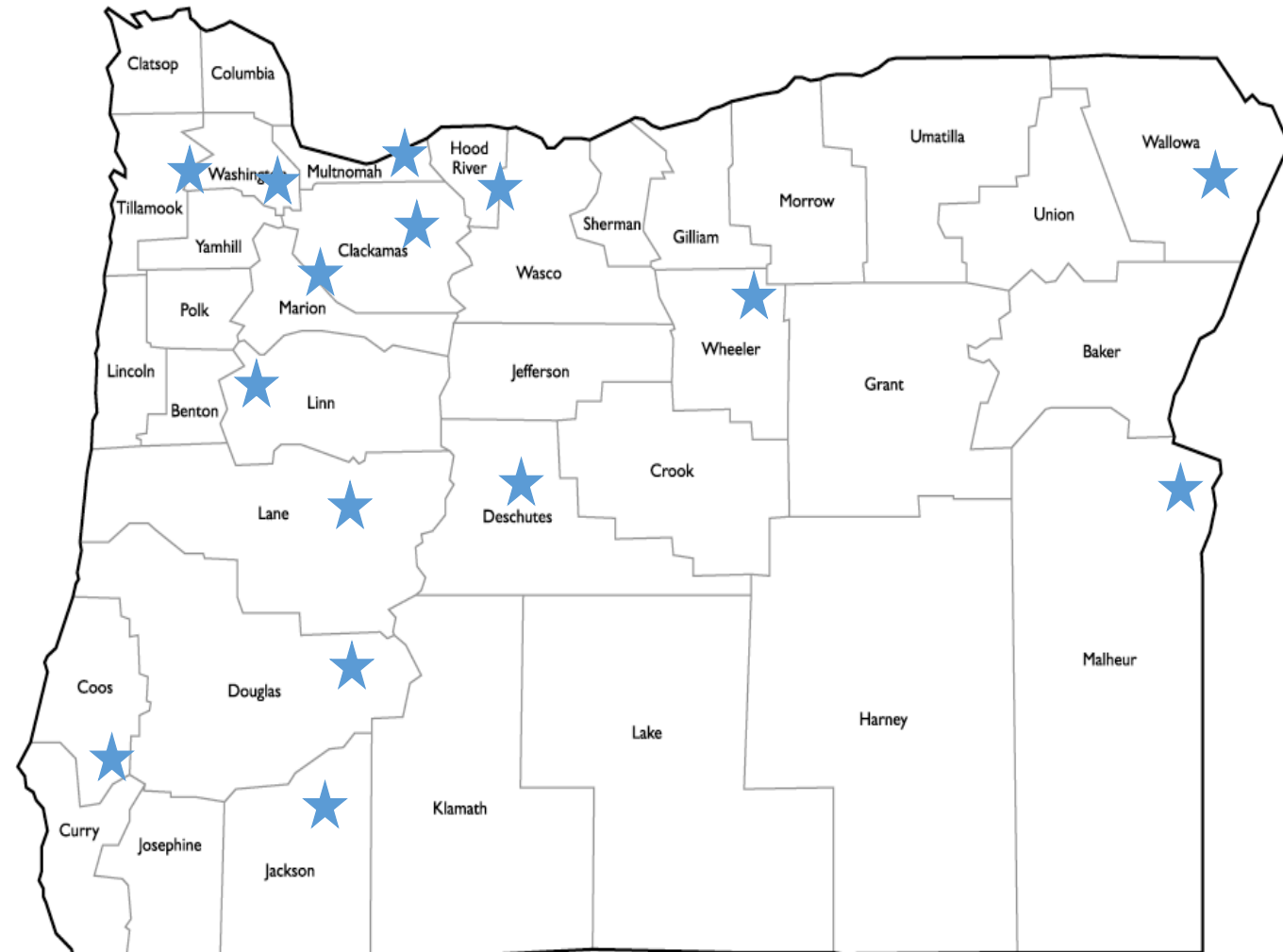Learn how CHCs in Oregon are assessing and addressing the SDH in their patient population

Total Responses: 54

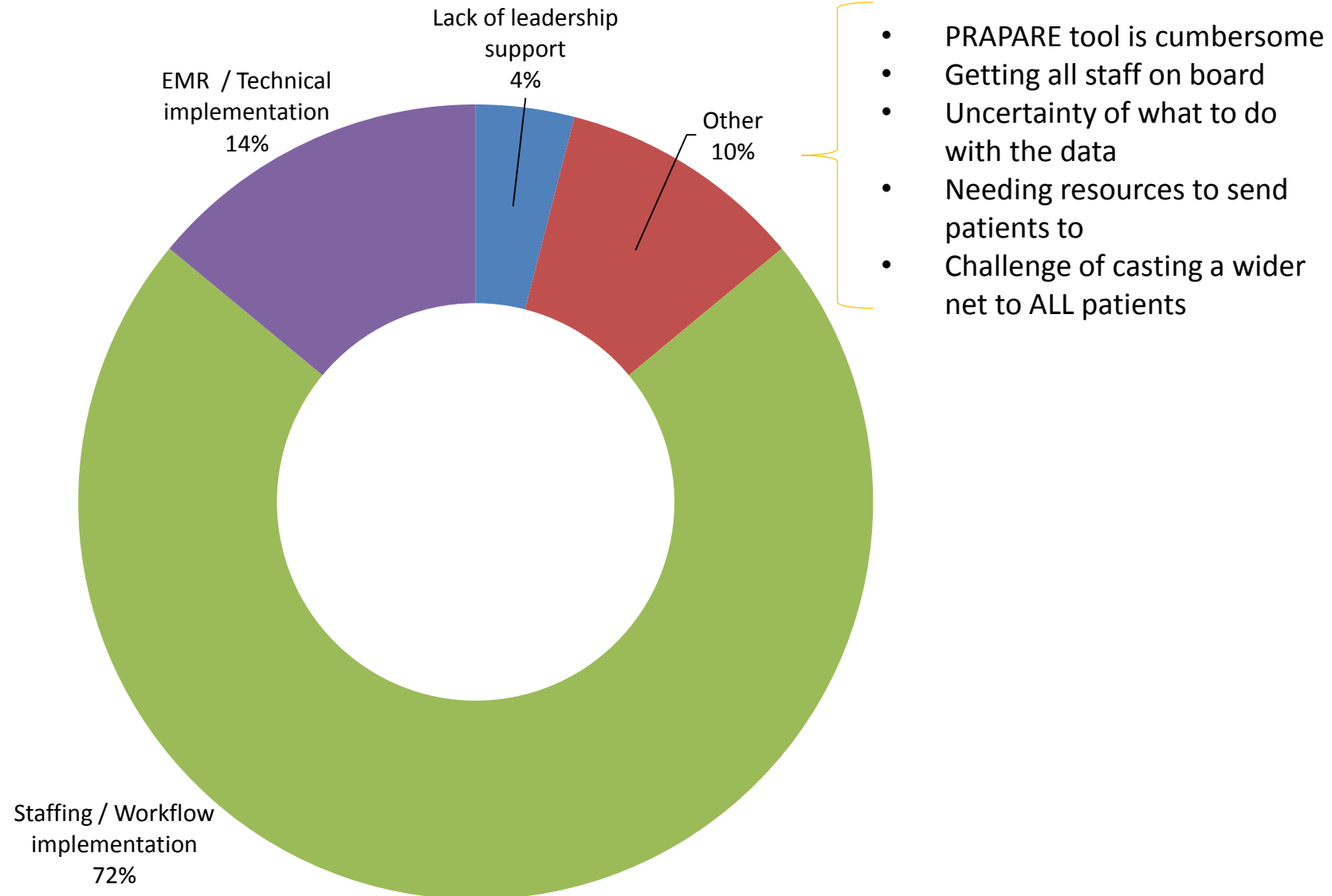26 CHCs (including OHSU Scappoose)

Key take-a-way:
Majority of respondents find it very important to understand and respond to patients' social issues.

On a scale of 1-10 (10 being the most, important), 9 was the average rating selected.

★ Health centers that responded to survey

Leading barriers to screening patients for SDH?

EMR / Technical implementation 14%

Lack of leadership support 4%

Other 10%

- PRAPARE tool is cumbersome
- Getting all staff on board
- Uncertainty of what to do with the data
- Needing resources to send patients to
- Challenge of casting a wider net to ALL patients

Staffing / Workflow implementation 72%

OPCA strategic plan 2018

Areas of work	PRACTICE/Innovation	DATA/Improvement	POLICY/Influence
Social Determinants of Health	1. Create workflows and referral pathways to utilize SDH data, and identify and share best practices to spread SDH interventions, including trauma informed practice.	1. Clinics will align around a collective SDH screening tool and utilize the data to inform care interventions.	1. Advocate for increased CCO and other investments in SDH, recognizing the integral role of CHCs as innovators in measuring and addressing social determinants needs with partners.

Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Overall Project Goal
To create, implement/pilot test, and promote a *national standardized patient risk assessment protocol* to assess and address patients' social determinants of health (SDH)

SDH screening tool + implementation/action process

Assessment Tool to Identify Needs in EHR + **Protocol to Respond to Needs**

PRAPARE domains

Core	
UDS SDH Domains	**Non-UDS SDH Domains (MU-3)**
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

Spanish and Chinese (Mandarin) translated versions
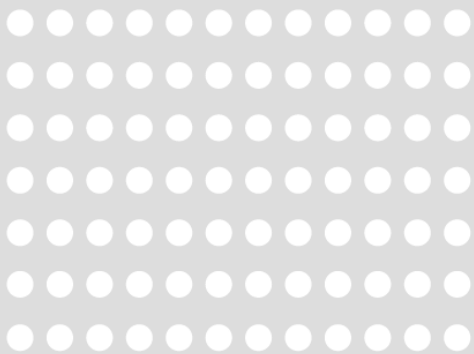
Find the tool at:
www.nachc.org/prapare
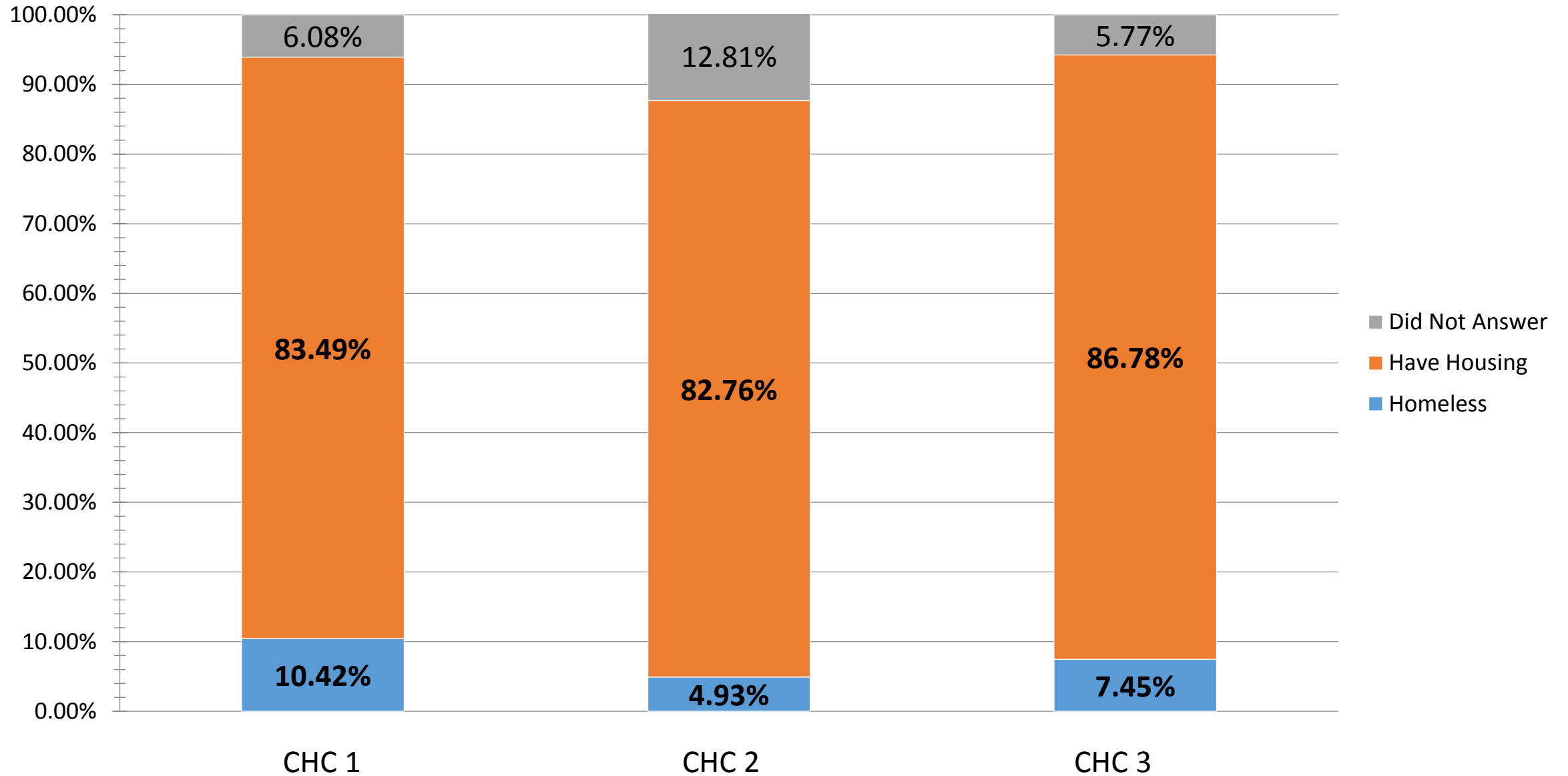
APCM and SDH screening
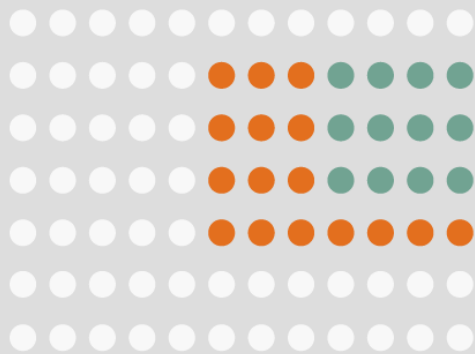
10,000 PEOPLE
POPULATION

Use analytics to piece together target population characteristics.
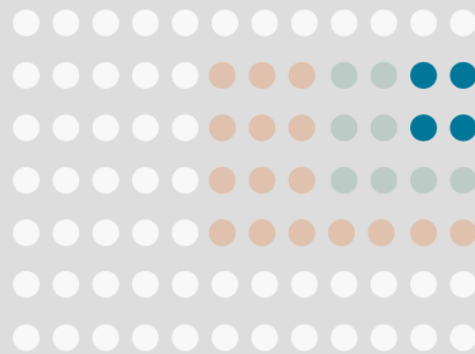
May require multiple data sources and analytic processes.

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

What is the connection to the APCM accountability requirements?

Quality
Understanding—and addressing—patient's social needs improves health outcomes (and nearly every CCO quality metric!)

Cost
Tracking SDH indicates complexity of patients, which to provide specific care for, and makes the case for enhanced funding to support more complex patients.

Access
Screening allows care team to better understand which CareSTEPS are most relevant for a particular patient (plus SDH screening counts as a CareSTEP itself!)

Population Management
Screening patients for SDH consistently allows care teams to look across patient panels at what has greatest impact on health outcomes.

Data from PRAPARE useful at all levels…

Preparing for Value-Based Pay

Individual-level		
Patient and Family	→	Improve health
Care Team Members	→	Better manage patient needs with services

Local-level		
Health Center	→	Better understand patient population
Community Policies	→	Inform advocacy efforts related to local policies around SDH
Local Health System	→	Provide comparison data for other local clinics and to inform partnerships

State and national-level		
Payment Negotiation	→	Demonstrate the relationship between patient SDH and cost of care for fair provider comparisons (risk adjustment)
State and National Policies	→	Improve health center capacity for serving complex patients (payment reform)

OPCA
Oregon Primary Care Association

Patient Centered Priorities for SDH Interviewing

1. Support autonomy and respect privacy.

Professionals should always ask permission to conduct the screening, explicitly state that patients are not required to participate, and give the option to decline to answer questions or stop the screening process at any time.

2. Provide a clear explanation for conducting the screening, how information will be used, and options for follow up.
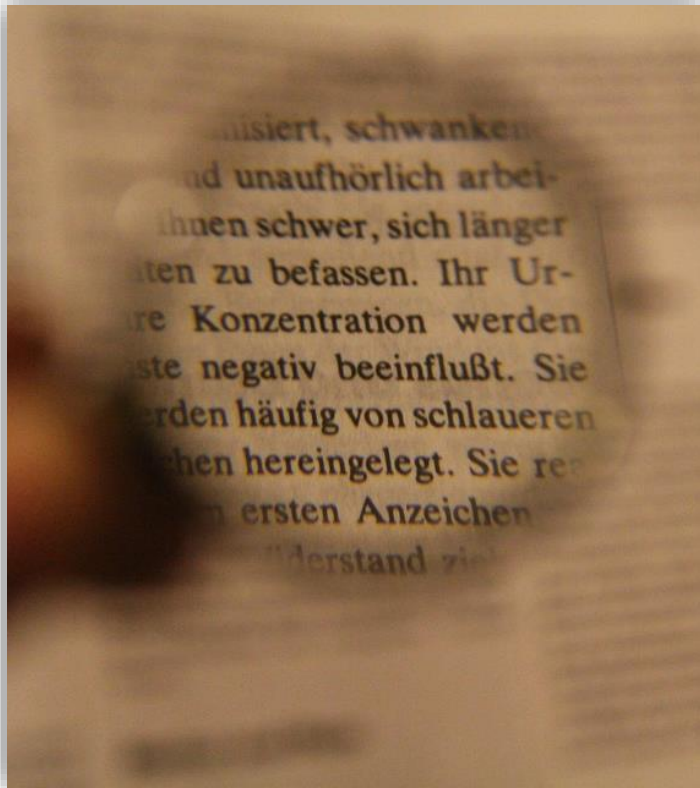
The clinic should develop and consistently share clear and transparent explanations for why SDH screening is being conducted.

3. Share power by asking about patient priorities.

Asking patients about their priorities for these needs demonstrates respect for their status as the "expert" on their own life and honors personal autonomy.

4.   Account for the stigma associated with experiencing social needs, as well as personal assumptions about the experiences and capacities of patients.

Health professionals should consider the stigma associated with poverty in America when entering into conversations about social determinants of health; it is critical to notice one's own assumptions, withhold judgment, and proactively demonstrate understanding and respect.

5. Ask patients about their strengths, interests, and assets.

Health professionals can convey respect, promote self-efficacy, and empower patients by asking about their strengths, interests, and assets.

6. Test screening workflows with patients before standardizing approach.
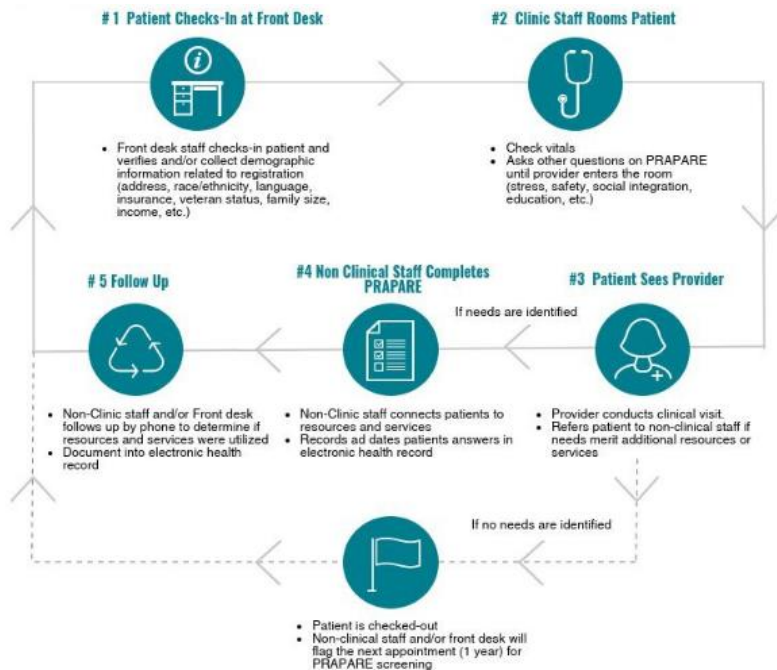
A workflow that allows the patient to fill out the screening questionnaire, either via paper or tablet, followed by a brief dialogue with a care team member may be the best way to not only respect patient's varied learning styles, but also improve likelihood of accurate data collection.

7. Ensure that information disclosed by patients through social determinants of health screening is shared with and acknowledged by all members of the care team.

If one member of the care team has asked for information, that information should be effectively documented in the medical record, visible to all team members, and accounted for across interactions with all members of the team.

8. Select a care team member with sufficient time and empathy to connect with patients about social determinants of health needs.

Given the potentially distressing nature of discussing social needs, workflows should not rush patients and staff through SDH screening and follow up.

9. Minimize patient and staff distress and trauma.

- The potential for distress should be considered for both patients and staff.

- For patients, this includes drawing on the principles of transparency, empathy, trust, collaboration, and autonomy support.

- For staff, it may include providing training on trauma and its physiological, emotional, and behavioral effects, as well as support for self-care and secondary trauma prevention.

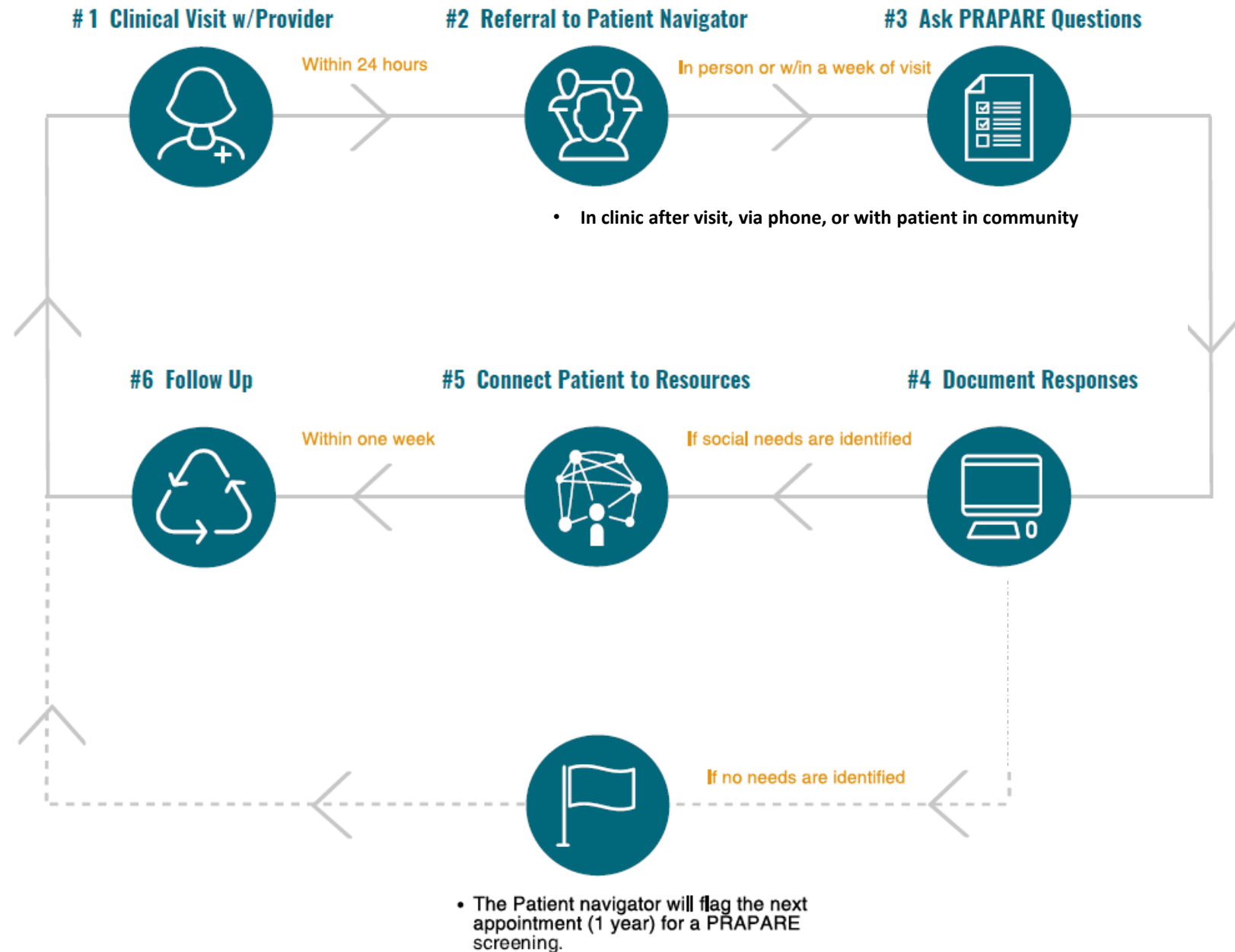# Social Determinants of Health Workflow Samples

Non-Clinical Staff **After** the Clinical Visit

Pros:
- Ensures that the staff person administering PRAPARE with the patient also addresses the needs identified by PRAPARE by referring the patient to resources.
- Non-clinical staff have more time to administer and respond to assessments.

Cons:
- Information is not available during the time of the visit.
- May be onerous on the patient's time.

#1 Clinical Visit w/Provider

Within 24 hours

#2 Referral to Patient Navigator

In person or w/in a week of visit

#3 Ask PRAPARE Questions

- In clinic after visit, via phone, or with patient in community

#6 Follow Up

Within one week

#5 Connect Patient to Resources

If social needs are identified

#4 Document Responses

If no needs are identified

- The Patient navigator will flag the next appointment (1 year) for a PRAPARE screening.
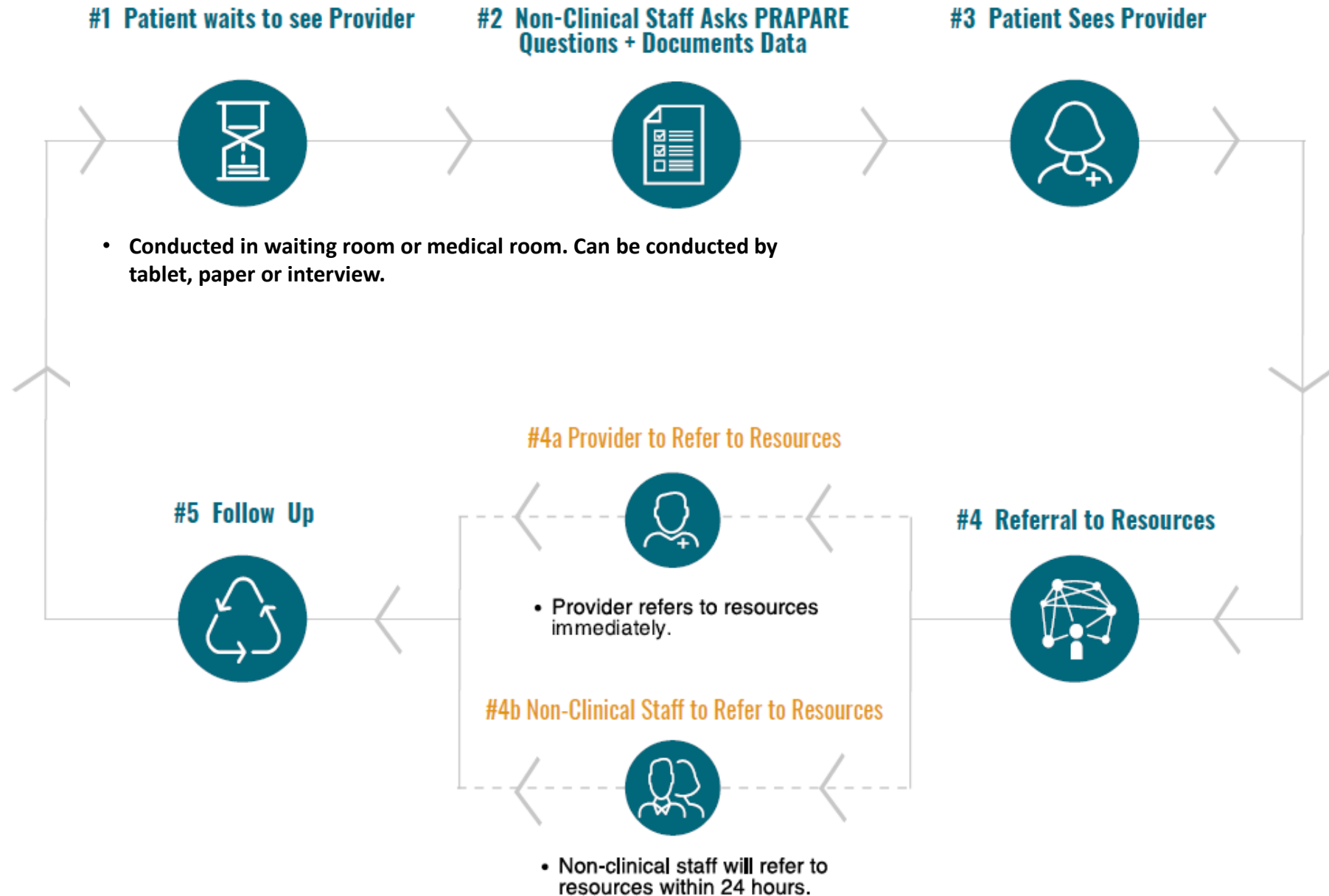
Non-Clinical Staff **Before** the Clinical Visit

Pros:

- By asking the PRAPARE questions before the clinic visit, needs identified can shape the visit and treatment plan to match the patient's circumstance and situation.
- Ensures that time is not added to the visit.
- Non-clinical staff may have more time to administer and respond to assessment.

Cons:

- May be hard to conduct the whole interview given time.
- Potential resistance from patients.

#1 Patient waits to see Provider

#2 Non-Clinical Staff Asks PRAPARE Questions + Documents Data

- Conducted in waiting room or medical room. Can be conducted by tablet, paper or interview.

#3 Patient Sees Provider

#4a Provider to Refer to Resources

- Provider refers to resources immediately.

#4b Non-Clinical Staff to Refer to Resources

- Non-clinical staff will refer to resources within 24 hours.

#5 Follow Up
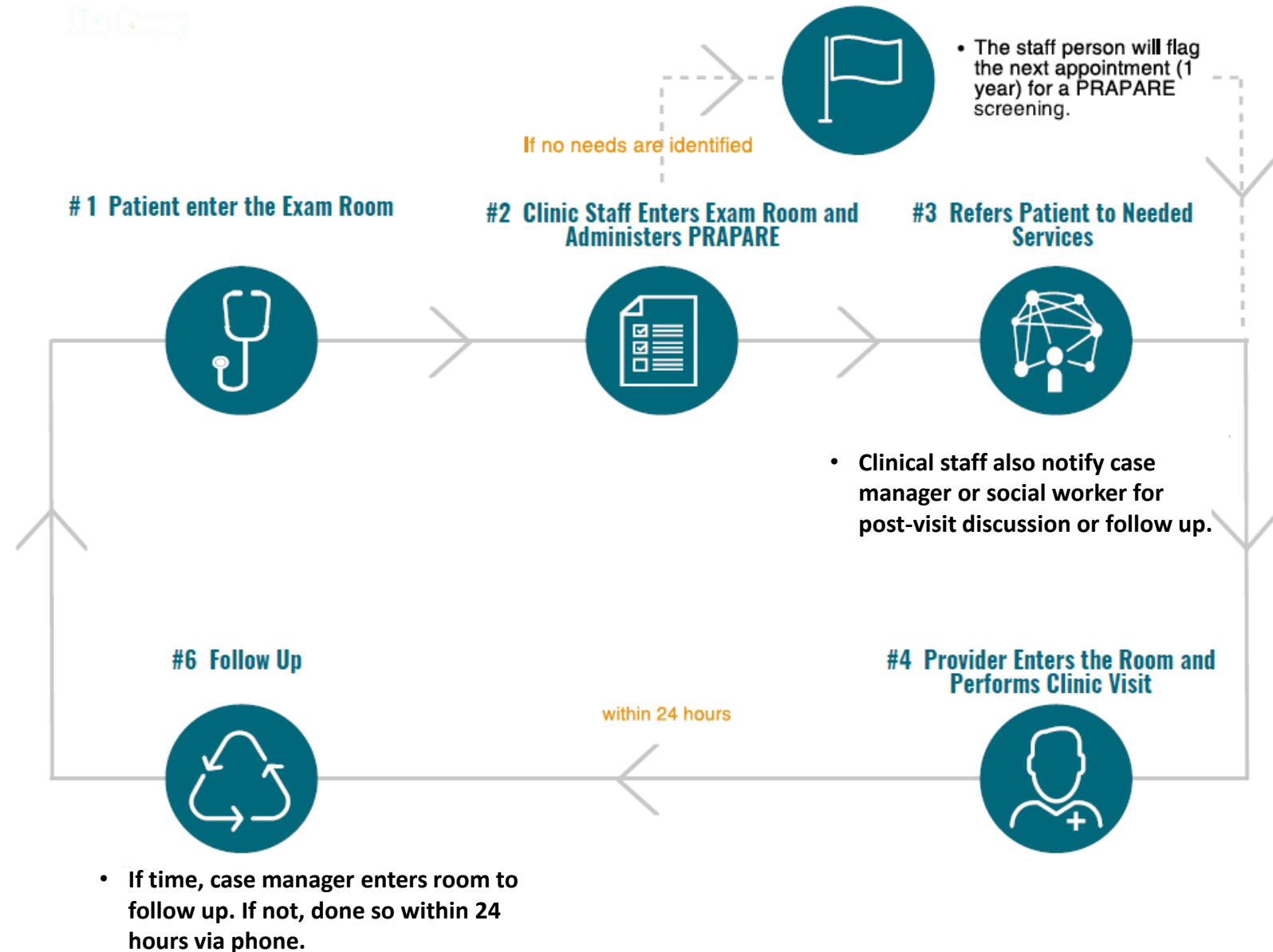
#4 Referral to Resources

Clinical Staff **During** the Clinical Visit

Pros:
- Clinical staff are trained to collect sensitive information and have experience collecting sensitive data.
- Administering PRAPARE in the exam room ensures that the information is collected in a private setting.
- Time for patient is well-utilized.

Cons:
- There is risk of not completing the administration of PRAPARE if the provider comes into the exam room.
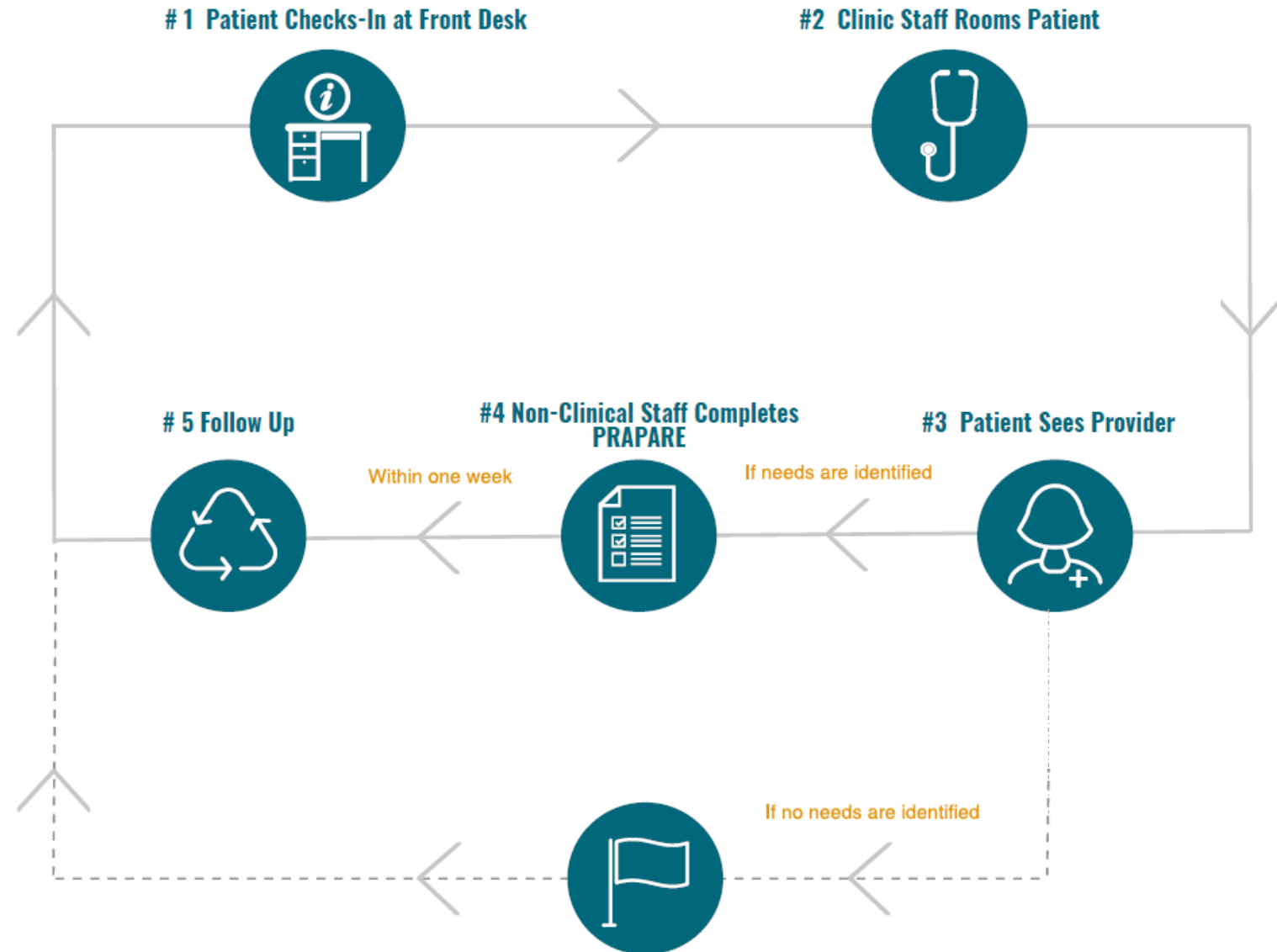- Depending on staff person screening, may not have enough time.

- The staff person will flag the next appointment (1 year) for a PRAPARE screening.

If no needs are identified

#1 Patient enter the Exam Room

#2 Clinic Staff Enters Exam Room and Administers PRAPARE

#3 Refers Patient to Needed Services

- Clinical staff also notify case manager or social worker for post-visit discussion or follow up.

#6 Follow Up

#4 Provider Enters the Room and Performs Clinic Visit

within 24 hours

- If time, case manager enters room to follow up. If not, done so within 24 hours via phone.

No "Wrong Door" Approach

Pros:
- Any staff can administer parts of PRAPARE at any time during the clinic visit and at any location within the clinic.
- By dividing the responsibility of data collection, the burden is less on everyone involved.
- Helps with staff buy-in as everyone has an opportunity and responsibility to paint a fuller picture of their patients and better meet their needs.

Cons:
- May result in duplication of questions if not entered in the electronic health record.
- No comfort created with particular care team member who is well trained.

#1 Patient Checks-In at Front Desk

#2 Clinic Staff Rooms Patient

#3 Patient Sees Provider

#4 Non-Clinical Staff Completes PRAPARE

If needs are identified

If no needs are identified

#5 Follow Up

Within one week

- Patient is checked out.
- Non-clinical staff and/or front desk will flag the next appointment (1 year) for PRAPARE screening.

Discussion Questions

- Which SDH workflow do you practice or most likely to adapt?
- What are some operational successes and challenges you've experienced with SDH workflows?
- What have patients shared about their experience with SDH interviews?
- What assistance can OPCA provide to help your health center move this work forward?

Thank you!

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