COLLECTING SOCIAL DETERMINANTS OF HEALTH DATA USING PRAPARE

TO REDUCE DISPARITIES, IMPROVE OUTCOMES, AND TRANSFORM CARE

WEBINAR AGENDA

<table>
<thead>
<tr>
<th>Topic</th>
<th>Facilitators</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of Collecting Data on the SDH</td>
<td>Michelle Proser, NACHC</td>
<td>15 mins</td>
</tr>
<tr>
<td>How We Created PRAPARE</td>
<td>Michelle Jester, NACHC</td>
<td>10 mins</td>
</tr>
<tr>
<td>Status of PRAPARE and How You Can Use PRAPARE at Your Health Center</td>
<td>Alicia Atalla-Mei, OPCA</td>
<td>10 mins</td>
</tr>
<tr>
<td>What We’ve Learned</td>
<td>Rosy Chang Weir, AAPCHO</td>
<td>15 mins</td>
</tr>
<tr>
<td>Using Data on the SDH</td>
<td>Michelle Jester, NACHC and Tuyen Tran, AAPCHO</td>
<td>15 mins</td>
</tr>
<tr>
<td>Next Steps and Q&amp;A</td>
<td>Michelle Proser, NACHC</td>
<td>25 mins</td>
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</table>
WHY IS IT IMPORTANT TO COLLECT STANDARDIZED DATA ON THE SOCIAL DETERMINANTS OF HEALTH?

- Under value-based pay environment, providers are held accountable for costs and outcomes
- Difficult to improve health & wellbeing and deliver value unless we address barriers
- Current payment systems do not incentivize approaching health holistically and in an integrated fashion
  - Providers serving complex patients often penalized without risk adjustment
WHAT IS DRIVING THE NEED TO COLLECT DATA ON THE SOCIAL DETERMINANTS OF HEALTH (SDH)?

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).

PRAPARE: PROTOCOL FOR RESPONDING TO & ASSESSING PATIENT ASSETS, RISKS, & EXPERIENCES

Assessment Tool To Identify Needs
- Paper Tool
- EHR Templates
- List of Granular Needs
- ICD-10 Z Codes
- Workflow Diagrams
- Staff Training Curriculum

Protocol to Respond to Needs
- Implementation and Action Toolkit
- Examples of Interventions
- Guidance on how to build capacity
- Appendix of Resources
- Guidance on informing policy and payment
FROM DATA TO PAYMENT: CONNECTING THE DOTS

Individual Patient Level
- Community Context
  - Upstream socio-ecological factors impact behaviors, access, outcomes, and costs
- Understand Patients
  - Inquiry & standardized data collection
  - Understand extent of patient & population complexity
- Transform Care
  - New or improved non-clinical interventions, enabling services, and community linkages
- Impact
  - Impact root causes of poor health
  - Improve outcomes, patient/staff experiences
  - Lower total cost of care
- Demonstrate Value
  - Negotiate for payment change
  - Ensure sustainability of interventions

Local Population Level
- Analyze standardized data

State and National Level

HOW DID WE CREATE PRAPARE?
IDENTIFYING CORE DOMAINS

Monitored and/or aligned with national initiatives
- HP2020
- RWJF County Health Rankings
- ICD-10
- IOM on SDH in MU Stage 3
- NQF on SDH Risk Adjustment

Collected existing protocols from the field
- Collected 50 protocols (many not validated)
- Interviewed 20 protocols
- Identified top 5 protocols

Engaged stakeholders for feedback
- Braintrust (advisory board) discussion
- Surveyed stakeholders
- Distributed worksheet to potential users for feedback

Used evidence to apply domain criteria
- Identified 15 Core Domains

Criteria:
1) Actionability
2) Alignment with National Initiatives
3) Evidence in Research
4) Burden of Data Collection
5) Sensitivity
6) Stakeholder Feedback

PRAPARE DOMAINS

<table>
<thead>
<tr>
<th>Core</th>
<th>Non-UDS SDH Domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>UDS SDH Domains</td>
<td>1. Race</td>
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<tr>
<td></td>
<td>2. Ethnicity</td>
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<td></td>
<td>6. Income</td>
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<td>7. Insurance</td>
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<td>8. Neighborhood</td>
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<td></td>
<td>9. Housing</td>
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<table>
<thead>
<tr>
<th>Optional</th>
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</thead>
<tbody>
<tr>
<td>Non-UDS SDH Domains</td>
<td>5. Safety</td>
</tr>
<tr>
<td></td>
<td>6. Domestic Violence</td>
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<td></td>
<td>10. Education</td>
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<td></td>
<td>11. Employment</td>
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<tr>
<td></td>
<td>12. Material Security</td>
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<td></td>
<td>13. Social Integration</td>
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<td></td>
<td>14. Stress</td>
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</table>

PRAPARE asks 15 questions to assess 14 core SDH domains.
- 9 domains already asked for federal health center reporting (Uniform Data System) so can be auto-populated
- 5 non-UDS domains informed by Meaningful Use Stage 3

PRAPARE has 6 optional domains.

Find the tool at: [http://www.nachc.com/research-data.cfm](http://www.nachc.com/research-data.cfm)
### CROSSWALK OF PRAPARE WITH OTHER NATIONAL INITIATIVES

<table>
<thead>
<tr>
<th>PRAPARE Domain</th>
<th>UDS</th>
<th>ICD-10</th>
<th>IOM</th>
<th>Meaningful Use (2 and 3)</th>
<th>HP2020</th>
<th>RWJF County Health</th>
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<tbody>
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<td>Education</td>
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<td>X</td>
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<tr>
<td>Stress</td>
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<td>X</td>
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</tbody>
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### VALIDATING THE TOOL

- **Selected questions to measure SDH domains**
  - Pulled from existing validated questions when possible (few validated questions exist)

- **Questions Reviewed by Health Literacy Expert**
  - To ensure language matched common reading levels

- **Performed Cognitive Testing on Questions**
  - Each pilot site performed cognitive testing with at least 10 patients

- **Pilot Tested Questions**
  - Revised as necessary after pilot testing
### PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

**Paper Version for PRAPARE for Implementation As of March 14, 2016**

#### Personal Characteristics

1. Are you Hispanic or Latino?
   - Yes
   - No
   I choose not to answer this question

2. Which race(s) are you? Check all that apply.
   - African American
   - Native Hawaiian
   - Pacific Islander
   - Other (please write)
   I choose not to answer this question

3. At any point in the past 2 years, has a season or migrant farm worker been on or near your family's main source of income?
   - Yes
   - No
   I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?
   - Yes
   - No
   I choose not to answer this question

5. What language are you most comfortable speaking?
   - English
   - Language other than English (please write)
   I choose not to answer this question

**Family & Home**

6. How many family members, including yourself, do you currently live with?
   I choose not to answer this question

#### Additional Questions

7. What is your housing situation today?
   I choose not to answer this question

8. Are you worried about losing your housing?
   - Yes
   - No
   I choose not to answer this question

9. What address do you live at?
   - Street:
   - City, State, Zipcode:

10. What is the highest level of school that you have completed?
    - Less than high school degree
    - High school diploma or GED
    I choose not to answer this question

11. What is your current work situation?
    - Unemployed
    - Part-time or seasonal work
    - Full-time work
    - Otherwise unemployed but not seeking work (e.g., retired, disabled, served a primary care giver)
    I choose not to answer this question

12. What is your main insurance?
    - None/Uninsured
    - Medicare
    - Other public
    - Other
    I choose not to answer this question

13. During the past year, what was the total combined income for you and all family members you live with? This information will help us determine if you are eligible for any benefits?
   I choose not to answer this question

14. In the past year, have you or any family members you live with been unable to get any of the following if it was really needed? Check all that apply.

   - Yes
   - No
   - Other (please write)
   I choose not to answer this question

15. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

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

16. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you? (Not at all, a little bit, quite a bit, very much)

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

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

   - Yes
   - No
   I choose not to answer this question

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

   - Yes
   - No
   I choose not to answer this question

19. Are you a refugee?

   - Yes
   - No
   I choose not to answer this question

20. What country are you from?

   - United States
   - Country other than the United States (please write)

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

   - Yes
   - No
   I choose not to answer this question

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

   - Yes
   - No
   I choose not to answer this question

23. Have you ever had a partner in the past year?

   - Yes
   - No
   I choose not to answer this question

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For more information about this tool, please contact Michelle.terner@kaiserpermanente.or or visit the "Social"
### EXAMPLES OF NEXTGEN TEMPLATES

#### SDOH Survey Template

[Image of the survey template with questions and options]

#### SDOH Survey Template

**Personal Characteristics**
1. Are you Hispanic or Latine?
2. Which sex(s) are you?
3. At any point in the past 5 years, has seasonal or migrant farm work been your or your family’s main source of income?
4. Have you been discharged from the armed forces of the United States?
5. What language are you most comfortable speaking?
6. How many family members, including yourself, do you currently live with?
7. What is your housing situation today?
8. What address do you live at? (include street and zip code)

**Money and Resources**
1. What is the highest level of school that you have finished?
2. What is your current work situation?
   - How many hours per week do you work?
   - How many job(s) do you work?
3. What is your main insurance?
   - Do you have insurance through your job?
4. Over the past year, what was the total combined income for you and the family members you live with?

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### EXAMPLES OF NEXTGEN TEMPLATES

13. In the past year, have you or any family members you live with been unable to get any of the following when you really needed it? Check all that apply.

- Yes
- No

- Food
- Clothing
- Utilities
- Rent/Mortgage payment
- Transportation
- Medical care
- Health insurance
- Other (please specify)

**Social and Emotional Health**
14. Have you had talks with people that you care about and feel close to? (e.g., talking to friends on the phone, visiting, attending church or meetings)

15. Stress is when someone feels tense, nervous, anxious, or can’t sleep at night because their mind is troubled. How often are you? (e.g., very often, fairly often, a little often, rarely)

**Optional Questions**
16. In the past year, have you spent more than 2 nights in jail, prison, detention center or juvenile correctional facility?

17. Have lack of transportation kept you away from medical appointments or from getting your medications?

18. If yes, what was your release date?

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

20. In the past year, have you been afraid of your partner or ex-partner?
WHAT IS THE STATUS OF PRAPARE?
TIMELINE OF THE PROJECT

Year 1 2014
• Develop PRAPARE tool

Year 2 2015
• Pilot PRAPARE implementation in EHR and explore data utility

Year 3 2016
• PRAPARE Implementation & Action Toolkit

Dissemination

PRAPARE PILOT TESTING IMPLEMENTATION TEAMS AND ELECTRONIC HEALTH RECORDS

Team 1
- OCHIN, Inc.
- La Clinica del Valle Family Health Center (OR)

Team 2
- Waianae Coast Comprehensive Health Center (HI)
- AlohaCare
- Altruista Health

Team 3
- Health Center Network of New York
- Open Door Family Medical Centers (NY)
- Hudson River Healthcare (NY)

Team 4
- Alliance of Chicago
- InConcertCare
- Iowa Primary Care Association
- Waikiki Health (HI)
- Peoples Community Health (IA)
- Siouxland Community Health Center (IA)

PRAPARE templates exist for 4 common EHRs that are used by 58% of all health centers.
IN DEVELOPMENT: IMPLEMENTATION AND ACTION TOOLKIT

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples of Potential Resources to Include</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Understand the Project</td>
<td>Project overview, project framework, defining risk, case studies, FAQs</td>
</tr>
<tr>
<td>Step 2: Engage Key Stakeholders</td>
<td>Messaging materials, change management guidance</td>
</tr>
<tr>
<td>Step 3: Strategize the Implementation Plan</td>
<td>Readiness assessment, PDSA materials, 5 Rights Framework, Implementation timeline, progress reports, legal documents</td>
</tr>
<tr>
<td>Step 4: Technical Implementation</td>
<td>PRAPARE paper assessment, data documentation, EHR templates, sample data dictionaries, data specifications, data warehouse and retrieval strategies, guidelines for using design and requirements documents</td>
</tr>
<tr>
<td>Step 5: Workflow Implementation</td>
<td>Workflow diagrams, data collection training curriculum, lessons learned and best practices</td>
</tr>
<tr>
<td>Step 6: Understand and Report Your Data</td>
<td>Reporting requirements, sample database, sample data outputs, sample data analyses and reports, cross-tabulating data, evaluation protocol, population-level planning, guidelines for data integration</td>
</tr>
<tr>
<td>Step 7: Act on Your Data</td>
<td>Strategy for detecting risk, report on best practices and processes for using SDH data, examples of SDH interventions, SDH response codes, linking to enabling services codes</td>
</tr>
<tr>
<td>Step 8: Use Your Data to Drive Payment and Policy Transformation</td>
<td>Strategy to engage payers, funding SDH efforts, data visualization templates</td>
</tr>
</tbody>
</table>

PRAPARE IS A NATIONAL MOVEMENT!

Use and Interest in PRAPARE

- **Health centers in 8 states are either already using PRAPARE or are planning to begin using PRAPARE in 2016**
- **Health centers, state associations, regional networks, and other health care organizations in 20+ other states interested in using PRAPARE**
## Implementing PRAPARE: Using the Five Rights Framework

<table>
<thead>
<tr>
<th>Right Information</th>
<th>• How will tool be administered to the patient to ensure that it accurately identifies the SDH the patient may have?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Person</td>
<td>• Who will collect the data and who will address the social determinants identified?</td>
</tr>
<tr>
<td>Right Intervention Format</td>
<td>• How will resource information be organized so that it is readily available and standardized for all?</td>
</tr>
<tr>
<td>Right Channel</td>
<td>• How is the appropriate care team member notified to address the SDH identified?</td>
</tr>
<tr>
<td>Right Time in Workflow</td>
<td>• When in the patient visit does it make sense to administer the tool and when is the best time to address identified SDH?</td>
</tr>
</tbody>
</table>
### SAMPLE WORKFLOWS

<table>
<thead>
<tr>
<th>Health Center</th>
<th>Who</th>
<th>Where</th>
<th>When</th>
<th>How</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHC #1</td>
<td>Non-clinical staff (enrollment assistance)</td>
<td>In exam room</td>
<td>Before provider visit</td>
<td>Administered PRAPARE with patients who would be waiting 30+ mins for provider</td>
<td>Provided enough time to discuss SDH needs</td>
</tr>
<tr>
<td>CHCs #2</td>
<td>Nursing staff and/or MAs</td>
<td>In exam room</td>
<td>Before provider enters exam room</td>
<td>Administered it after vitals and reason for visit. Provider reviews PRAPARE data and refers to case manager</td>
<td>Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info</td>
</tr>
<tr>
<td>CHC #3</td>
<td>Non-clinical staff (patient navigators, patient advocates, and community health workers)</td>
<td>In patient advocate’s office</td>
<td>After clinical visit when provider refers patient to patient navigator</td>
<td>Patient advocates administer it and then can relay to provider in office next door.</td>
<td>Wanted same person to ask question and address need. Often administer PRAPARE with other data collection effort (Patient Activation Measure) to assess patient’s ability and motivation to respond to their situation.</td>
</tr>
<tr>
<td>CHC #4</td>
<td>Medical Assistants</td>
<td>In exam room</td>
<td>Before provider</td>
<td>MAs administer PRAPARE while patient is roomed but before provider.</td>
<td>Want to get patient in to exam room as quickly as possible. However, often don’t finish because provider comes in to exam room.</td>
</tr>
<tr>
<td>CHC #5</td>
<td>Care Coordinators</td>
<td>No wrong door approach</td>
<td>No wrong door approach, but mostly as care coordinators complete chart review and HRA</td>
<td></td>
<td>Allows staff to address similar issues in real time that may arise from both PRAPARE and HRA</td>
</tr>
</tbody>
</table>

### WHAT HAVE WE LEARNED FROM PRAPARE?
WHAT WE’VE LEARNED FROM PILOT TESTING

- Easy to use: On average, takes ~9 minutes to complete form
- Staff find value in the tool: Helps them better understand patients and build better relationships with patients
- Patients appreciate being asked and feel comfortable answering questions
- Identifies New Needs, Often Leading to New Community Partnerships
- Made minor revisions to tool based on pilot testing feedback
- Emotional Toll on Staff

COMMON CHALLENGES ENCOUNTERED WHEN USING PRAPARE AND SOLUTIONS

**Challenge:** Staff and Patients Don’t Understand Why Doing PRAPARE

**Solution:** Use short script to explain to staff & patients why health center is collecting this information. Message around better understand patient and patient’s needs to provide better care

**Challenge:** Have too much going on now to add another project

**Solution:** Don’t market PRAPARE as new big initiative but as project that aligns with other work already doing (care management, ACO, enabling services, etc)

**Challenge:** How do we implement this without increasing visit time?

**Solution:** Find “Value-Added” time, whether in waiting room, during rooming process, or after clinic visit

**Challenge:** Fitting PRAPARE into Workflow

**Solution:** Incorporate into other assessments to encourage completion (Health Risk Assessment, Depression Screening, Patient Activation Measure, etc)

**Challenge:** Inability to Address SDH

**Solution:** Message “Have to start somewhere and do the best we can with what we have. Collecting information will help us figure out what services to provide.”
PERCENT OF PATIENTS WITH NUMBER OF SDH “TALLIES”

Tally Score

DATA RESULTS

- SDH risks vary by community

- Most common risks:
  - High stress
  - Having less than a high school education
  - Uninsured
  - Unemployed
  - Preference for language other than English

- But, patients are very socially integrated,
  - Half of patients in our pilot test see people that they care about more than 5+ times a week.
MATERIAL SECURITY

CORRELATION BETWEEN SDH FACTORS AND HYPERTENSION: ALL TEAMS

$r = 0.61$
# Using Data on the Social Determinants of Health

How prepared data has been used to improve care delivery and health outcomes:

| Better Understand Individual Patient’s Socioeconomic Situation | Ensure prescriptions and treatment plan match patient’s socioeconomic situation |
| Better Understand Needs of Patient Population | Refer patients to needed social services, whether in-house or through community partnership |
| Drive State and National Care Transformation | Build partnerships with local community based organizations to offer bi-directional referrals and discounts on services (ex: Iowa transportation) |
| | Streamline and expand care management plans to better allocate resources to areas most in need |
| | Inform both Medicaid and Medicare ACO discussions and care management policies |
| | Inform payment reform and APM discussions with state agencies (e.g., Medicaid) on caring for complex patients |
| | Build services in-house for same-day use as clinic visit (children’s book corner, food banks, clothing closets, wellness center, transportation shuttle, etc) |
| | Improve Community Resource Guide to ensure accuracy and appropriateness |
| | Guide work of local foundations to pay for non-clinical services and partnerships |
| | Inform advocacy efforts related to local policies around SDH |
| | Create risk score to inform risk adjustment |
| | Guide policies to incentivize integrated care with social services |
Education

Why Is Education Important?

Education is widely used measure of socio-economic status and is a significant contributor to health and prosperity. Higher education is associated with longer life span and fewer chronic conditions. Parental education is a determinant of child health outcomes.

Sample Needs Related to Education

<table>
<thead>
<tr>
<th>Global Related Needs</th>
<th>Non-CLinical Related Needs</th>
<th>Community Related Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensity and overloaded literacy (ICD-10: Z55.0)</td>
<td>Educational misplacement and discord with teachers and classmates (ICD-10: Z55.4)</td>
<td>Schooling unavailable or unattainable (ICD-20: Z55.1)</td>
</tr>
<tr>
<td>Underachievement in School (ICD-10: Z55.1)</td>
<td>Failed School Examinations (ICD-10: Z55.2)</td>
<td>Poor quality schools</td>
</tr>
<tr>
<td>Have skills needed for job but need U.S. certification/accreditation</td>
<td>Schedule problems (can't go to school due to work schedule or loss of child care)</td>
<td>Poor quality teachers</td>
</tr>
<tr>
<td>Need skills for job</td>
<td>Other problems related to education and literacy (ICD-10: Z55.8)</td>
<td></td>
</tr>
</tbody>
</table>

* Please note that this list is not exhaustive but only includes common examples of needs.

Ways to Address Education Risk in a CLINICAL Setting

- Ensure receipt of meth patient's literacy level
- Check literacy levels in clinic, encourage youth to stay in school
- Provide books at pediatric check-ups and encourage caregivers or older siblings to read to/with younger members of the family

Simple, Low-Cost Ways to Ameliorate Education Risk in a NON-CLINICAL Setting

- Offer on-site parent training for literacy, math, reading, financial literacy, computer skills, and more

APPENDIX A – RESOURCES

IDENTIFYING AND CONNECTING PEOPLE TO COMMUNITY RESOURCES AND SERVICES

2-1-1
Developed By: United Way
Free and confidential service that helps people across the U.S. find the local resources they need related to health, food, disaster assistance, housing, jobs, reentry, human trafficking, crisis and emergency, and veterans. It is accessible 24 hours a day, 7 days a week in all languages through phone or web.
Geographic Availability: U.S.
Cost: Free
http://www.211.org/

COMMUNITY HEALTH CORPS
Developed By: Community Health Corps
National AmeriCorps program that funds members in full-time positions at health centers to perform a variety of activities associated with health services and programs for patients and the community, often by functioning as community health workers.
Geographic Availability: In 17 states and Washington, DC
Cost: Application to begin program but members funded by Community Health Corps
http://www.communityhealthcorps.org/ToolsforProgram%20Staff.cfm

HEALTHIFY
Developed By: Healthify
Leading software solution for healthcare and community services addressing the social determinants of health. Provides extensive database that allows users to easily identify and access community resources available within certain radius and service eligibility requirements
ASSESS WHERE YOU ARE IN TERMS OF RESOURCES (PEOPLE, PROCESSES, TECHNOLOGY)

<table>
<thead>
<tr>
<th>Health Center Resources</th>
<th>Local Community Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Few resources</strong></td>
<td></td>
</tr>
<tr>
<td>Substantial resources within the health center</td>
<td>Substantial resources within the health center</td>
</tr>
<tr>
<td>Limited resources in the local community</td>
<td>Limited resources in the local community</td>
</tr>
<tr>
<td><strong>Many resources</strong></td>
<td></td>
</tr>
<tr>
<td>Substantial resources within the community health center</td>
<td>Substantial resources in the community</td>
</tr>
<tr>
<td>Limited resources in the local community</td>
<td>Limited resources within the health center</td>
</tr>
</tbody>
</table>

SDH DATA AND DATA ON INTERVENTIONS GO HAND IN HAND

**NEED**
- Standardized data on patient risk

**RESPONSE**
- Standardized data on interventions

**BOTH are necessary to demonstrate health center value**
AAPCHO DATA COLLECTION PROTOCOL:
THE ENABLING SERVICES ACCOUNTABILITY PROJECT

Enabling Services Accountability Project (ESAP)
The ONLY standardized data system to track and document non-clinical enabling services that help patients access care.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CODE</th>
<th>Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASE MANAGEMENT ASSESSMENT</td>
<td>CM001</td>
<td></td>
</tr>
<tr>
<td>CASE MANAGEMENT TREATMENT AND FACILITATION</td>
<td>CM002</td>
<td></td>
</tr>
<tr>
<td>CASE MANAGEMENT REFERRAL</td>
<td>CM003</td>
<td></td>
</tr>
<tr>
<td>FINANCIAL COUNSELING/ELIGIBILITY ASSISTANCE</td>
<td>FC001</td>
<td></td>
</tr>
<tr>
<td>HEALTH EDUCATION/SUPPORTIVE COUNSELING</td>
<td>HE001</td>
<td></td>
</tr>
<tr>
<td>INTERPRETATION</td>
<td>IN001</td>
<td></td>
</tr>
<tr>
<td>OUTREACH</td>
<td>OR001</td>
<td></td>
</tr>
<tr>
<td>TRANSPORTATION</td>
<td>TR001</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>OT001</td>
<td></td>
</tr>
</tbody>
</table>

CONCEPTUAL FRAMEWORK

Social Determinants of Health
(PRAPARE Domains: Race/ethnicity, poverty employment, English proficiency, etc.)

Appropriate Care
(For health condition in question, for example, # of doctor visits, exams/tests levels...)

Health Outcomes
(For example, ideal outcomes, reduced complications, ED visits, etc.)

Enabling Services & other non-clinical interventions
NEXT STEPS

Complete Implementation & Action Toolkit
Including:
* Free EHR Templates—by May
* Training Materials—by this summer
* Model Interventions to Address the SDH—by this summer

Spread

Phase II
Including:
* Standardized data on Interventions
  * National PRAPARE Learning Network
  * State Based Action groups
* Validation
* Translation
* Pediatric PRAPARE Tool

2016
RESOURCES AVAILABLE TO YOU

PRAPARE resources will be posted at www.nachc.com/research
- PRAPARE Tool
- Implementation steps and timeline
- Data Documentation

AAPCHO’s ESAP technical and other resources at http://enablingservices.aapcho.org.

PRAPARE info and listserv signup: Michelle Jester, mjester@nachc.org

AAPCHO ESAP technical assistance: Tuyen Tran, ttran@aapcho.org

PRAPARE NEXTGEN-SPECIFIC WEBINAR

- Stay tuned for date and time!!
- Email Michelle and mjester@nachc.org if interested

- Will cover the following:
  - Steps to implement the NextGen template in another clinic’s EHR system
  - The particulars of using the NextGen PRAPARE template
  - A health center’s experience in redesigning or modifying workflow to collect and respond to the data on social determinants
  - How the NextGen PRAPARE template can expedite the reporting and aggregation of data and be used for patient and population-level interventions
QUESTIONS AND DISCUSSION