COLLECTING SOCIAL DETERMINANTS OF HEALTH DATA TO REDUCE DISPARITIES AND IMPROVE OUTCOMES

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SESSION OBJECTIVES

- Discuss methods to collect data on the social determinants of health without undue data burden
- Identify ways to use data to create early interventions and build partnerships to address findings in real time
- Summarize ways to use data on the social determinants of health to inform population health planning
WHAT ARE THE SOCIAL DETERMINANTS OF HEALTH (SDH)?

Health Outcomes
- Length of Life (50%)
- Quality of Life (50%)

Health Factors
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
- Physical Environment (10%)
  - Air & Water Quality
  - Housing & Transit

Individual lifestyle factors
- Age, sex, and constitutional factors

Social and community networks
- Education
- Work environment
- Employment
- Income
- Family & Social Support
- Community Safety

Living and working conditions
- Unemployment
- Housing
- Health care services
- Water and sanitation
- Education
- Agriculture and food production

General socio-economic, cultural and environmental conditions
- Work environment
- Education
- Health care services
- Employment
- Income
AUDIENCE POLL

Is your organization CURRENTLY collecting data on patient’s social risk factors beyond what you already collect in the UDS?

Yes
No

WHAT ARE HEALTH CENTERS?
1960s War on Poverty and Civil Rights Movement
Based on Community Oriented Primary Care (COPC) model

Two-Fold Purpose:
1) Be *Agents of Care*
2) Be *Agents of Change*

**BRIEF HISTORY**

**MODEL OF CARE**

- Community governance
- Located in/serve federally-designated medically underserved areas
- Non-profit, must be open to all
- Broad definition of “health”
- Community needs assessments
- Quality Improvement/Assurance Plans
HEALTH CENTERS TODAY

- 24+ million patients
  - 1 in 14 US residents
  - 1 in 7 Medicaid beneficiaries
  - 1 in 5 low income, uninsured
  - 1 in 3 people in poverty
  - 1 in 4 minority individuals below poverty
- 1300+ organizations with 9000+ sites
- 92% with EHRs
- 65% recognized PCMH

PATIENTS BY RACE & ETHNICITY

Source: 2014 Uniform Data System, Bureau of Primary Health Care, HRSA, HHS. Based on % known.
**PATIENT BY INCOME LEVEL & INSURANCE STATUS**

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% FPL and below</td>
<td>71%</td>
</tr>
<tr>
<td>101-150% FPL</td>
<td>15%</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>8%</td>
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<tr>
<td>Over 200% FPL</td>
<td>6%</td>
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<tr>
<td>Private Insurance</td>
<td>16%</td>
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<tr>
<td>Other Public Insurance</td>
<td>1%</td>
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<tr>
<td>Medicaid / SCHIP</td>
<td>47%</td>
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<tr>
<td>Medicare</td>
<td>9%</td>
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<tr>
<td>Uninsured</td>
<td>28%</td>
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</table>

FPL = Federal Poverty Level

Source: 2014 Uniform Data System, Bureau of Primary Health Care, HRSA, HHS. Based on % known. May not total 100% due to rounding.

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**NON-CLINICAL SERVICES AT HEALTH CENTERS**

- **Enabling Services reported by health centers (17,250+ FTEs)**
  - Case management, transportation, eligibility assistance, interpretation, health education, outreach, etc

- **Examples of other services to address the social determinants**
  - Charter School
    - Mary’s Center in DC, Urban HealthPlan in NY
  - Environmental Health Dept
    - Sixteenth Street CHC in Milwaukee, WI
  - Small Business Grants
    - Beaufort Jasper Comprehensive Health Services, SC
  - Youth programs and college scholarships
    - Sea Mar Community Health Centers, Seattle, WA
  - Home improvements
    - Hudson River Healthcare, Peekskill, NY

[For more information, visit: http://www.altfutures.org/leveragingSDH]
Note: Out of a sample of 52 health centers documenting 176 programs, efforts, and activities addressing social determinants of health in the Institute for Alternatives Future's database (as of March 22, 2012), see http://www.altfutures.org/leveragingSDH/IAF-CHCsLeveragingSDH.pdf. Some activities fall into more than one category. Source:

WHY IS IT IMPORTANT TO COLLECT DATA ON THE SOCIAL DETERMINANTS OF HEALTH?
Payers are increasingly holding providers accountable

- 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

How well do we know our patients?

Are services addressing SDH incentivized and sustainable?

Are community partnerships adequate and integrated?
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).

In order to:

- Document patient/patient population complexity
- Use that data to **improve patient health**, affect change at the community/population level, and sustain resources and create community partnerships necessary to improve health.

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

**PRAPARE POSITIONS HEALTH CENTER STAFF TO IMPROVE INDIVIDUAL AND COMMUNITY HEALTH**

- **Patient and Family**
  - Improve health
  - Better manage patient needs with services

- **Care Team Members**
  - Better understand patient population

- **Health Center**
  - Inform advocacy efforts related to local policies around SDH

- **Community Policies**
  - Provide comparison data for other local clinics and to inform partnerships

- **Local Health System**
  - Demonstrate the relationship between patient SDH and cost of care for fair provider comparisons (risk adjustment)

- **Payment Negotiation**
  - Improve health center capacity for serving complex patients (payment reform)

- **State and National Policies**
UNDERSTANDING PATIENT COMPLEXITY

Care teams can respond through shared decision making, priority setting, and appropriate interventions.

Communities can respond through advocacy, policy change, and delivery system redesign.

FROM DATA TO PAYMENT: CONNECTING THE DOTS

Analyze standardized data
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 TOOL DEVELOPMENT
Literature reviews of SDH associations with cost and health outcomes

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

Collected existing protocols from the field
- Collected 50 protocols
- Interviewed 20 protocols
- Identified top 5 protocols

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

Identifying Core Domains

Used evidence to apply domain criteria

Identified 15 Core Domains

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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<td>Social Integration</td>
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<td>Stress</td>
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</table>
PRAPARE DOMAINS

- 9 align with health center federal reporting (Uniform Data System)

- Plus 6 optional domains:

<table>
<thead>
<tr>
<th>Optional Questions</th>
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</thead>
<tbody>
<tr>
<td>SDH Domains</td>
</tr>
<tr>
<td>1. Incarceration History</td>
</tr>
<tr>
<td>2. Transportation</td>
</tr>
</tbody>
</table>

IMPLEMENTING PRAPARE: PILOT TEST
PILOT TESTING PRAPARE WITH A LEARNING COMMUNITY OF IMPLEMENTATION TEAMS

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

**Team 2**
- Waimanalo 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)

Teams reach states across the country, aiding with the national dissemination of PRAPARE.

PILOT PROCESS

- Year long bi-directional Learning Community
  - Kick off planning meeting
  - “Syllabus” designed to facilitate implementation
  - Webinars for group learning and sharing
  - Regular 1 on 1s to track progress and trouble shoot
  - Track best practices and lessons learned
  - Grant teams flexibility to test implementation approaches
## CURRENT DATA COLLECTION MODELS

<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>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>2 &amp; 3</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>4</td>
<td>Non-clinical staff (patient navigators, patient advocates, and BH specialists)</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 because patient advocates and providers’ offices right next to each other</td>
<td>Wanted same person to ask question and address need</td>
</tr>
<tr>
<td>5</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>6</td>
<td>Care Coordinators</td>
<td>&quot;No wrong door&quot; approach</td>
<td>No wrong door approach, but mostly as care coordinators complete chart review and HRA</td>
<td>Allows staff to address similar issues in real time that may arise from both PRAPARE and HRA</td>
<td></td>
</tr>
</tbody>
</table>

## ACHIEVEMENTS TO DATE

- Implemented Learning Community and created implementation resources
- Demonstrated ease of use
- Community Linkages Reassessed & Interventions provided
- EHR templates developed
- Data collected
- Dissemination and spread
LESSONS LEARNED

WHAT WE'VE LEARNED

- Does not take long (most report <9 minutes)
- Staff find value in tool
- Patients appreciate being asked and comfortable answering
- Identifying new needs
  - sometimes also means new partnerships
- Emotional toll on staff
- There's more to do!
  - more granular needs
  - more interventions and coding of interventions provided
  - more support from vendors
Teams report the following plans:

- Streamline and expand case management services
- Asset mapping of community resources, build/strengthen community partnerships
- Assess enabling services
- Create risk score and risk stratification using SDH factors
- Inform ACO and payment reform discussions
- Build on SDH and “alternative touches” data

Group of advanced clinics that are participating in an APM which allows them to create a patient-centric model of care to:

- Improve clinic population outcomes
- Improve patient and staff engagement
- Support open access
- Contain costs

GOAL: Five strategies of APCM

1. Teams use actionable, real-time information/data
2. Teams expand/enhance access
3. Teams proactively reach out and provide acute care
4. Teams engage patients and provide self-management support
5. Teams enhance appropriate care and work to reduce unnecessary utilization

SEGMENTATION TOOL: to inform cost models
EXPERIMENTING WITH PRAPARE IN OR

- We invited clinics to pick a patient population and interview 10 consumers using 3 questions from PRAPARE
- Afterwards, clinics met face-to-face to share their experiences
  - How did you and the patient discuss these questions?
  - What did you observe about the process (your experience, patient’s reaction)?
  - Did asking these questions lead to conversations about other topics?

WHAT DID WE HEAR IN OR?

- Everyone did the assignment
- “Now we understand people better”
- Patients appreciated being asked
- Some clinics expressed wanting more ownership of the tool (i.e. participation in the development of the questions)
- Overall: lots of positivity around the exercise!
NEXT STEPS

2015

Complete pilot-test, refine as needed
Including:
* Data reports
* Best practices/lessons learned

Complete Implementation & Action Toolkit
Including:
* Free EHR Templates
* Training Materials
* Model Interventions to Address the SDH

2016

Spread

Phase II
Including:
* Validation
* Translation
* Standardized data on Interventions
* National PRAPARE Learning Network

Including:
* Data reports
* Best practices/lessons learned

NEXT STEPS
NEED FOR DATA ON SDH INTERVENTIONS

**NEED**
- Standardized data on patient risk

**RESPONSE**
- Standardized data on interventions

**BOTH** are necessary to demonstrate and understand VALUE, and to determine the intervention’s IMPACT.

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>
</tr>
</thead>
<tbody>
<tr>
<td>CASE MANAGEMENT ASSESSMENT</td>
<td>CM001</td>
</tr>
<tr>
<td>CASE MANAGEMENT TREATEMENT AND FACILITATION</td>
<td>CM002</td>
</tr>
<tr>
<td>CASE MANAGEMENT REFERRAL</td>
<td>CM003</td>
</tr>
<tr>
<td>FINANCIAL COUNSELING/ELIGIBILITY ASSISTANCE</td>
<td>FC001</td>
</tr>
<tr>
<td>HEALTH EDUCATION/SUPPORTIVE COUNSELING</td>
<td>HE001</td>
</tr>
<tr>
<td>INTERPRETATION</td>
<td>IN001</td>
</tr>
<tr>
<td>OUTREACH</td>
<td>OR001</td>
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<tr>
<td>TRANSPORTATION</td>
<td>TR001</td>
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<tr>
<td>OTHER</td>
<td>OT001</td>
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</tbody>
</table>
### EXAMPLES OF INTERVENTIONS

<table>
<thead>
<tr>
<th>Screen Trigger</th>
<th>Patient Level</th>
<th>Population Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td>Peer support</td>
<td>Group visits</td>
</tr>
<tr>
<td></td>
<td>In-home navigators</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Tutoring and Mentoring programs</td>
<td>Develop a Charter School for Health</td>
</tr>
<tr>
<td>Work schedule problems</td>
<td>Skype visit during employment breaks</td>
<td>Extend hours; mobile van into communities</td>
</tr>
<tr>
<td>Material security</td>
<td>Care plan include help with meal planning and budgeting.</td>
<td>Empowerment training classes on economic survival skills including budgeting, meal preparation and thrifty alternatives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Farmers’ markets on site at the clinic for patients</td>
</tr>
</tbody>
</table>

### RESOURCES AVAILABLE TO YOU

PRAPARE resources will be posted at [www.nachc.com/research](http://www.nachc.com/research)

- **PRAPARE Tool**
- **Implementation steps and timeline**
- **Data Documentation**

AAPCHO’s ESAP technical and other resources at [http://enablingservices.aapcho.org](http://enablingservices.aapcho.org).
QUESTIONS AND DISCUSSION

THANK YOU

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