Bridging the Gap: Lessons from Assessing and Addressing the Social Determinants of Health

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Waianae Coast Comprehensive Health Center

- Established 1972 as a community-driven response to the lack of health care providers available on the Waianae coast.
- The largest and oldest of Hawaii's 14 community health centers.
- In 2017, served over 37,000 patients through over 200,000 encounters from the main clinic and satellite sites.
- Largest employer on the Waianae coast with nearly 650 employees – most of them residents of the community.

Waianae Coast Primary Service Area

- Highest number of households in the state receiving financial aid and food stamps
- Highest percent of individuals on Oahu living below the Federal Poverty Level
- Highest number of obese adults, adults with diabetes, and adult smokers.

2016 State of Hawaii Primary Care Needs Assessment Data Book (Hawaii State Department of Health, May 2016)

Long History Of Addressing SDOH

- 1991 developed a Perinatal program to address poor birth outcomes from high risk pregnancies in the Waianae community.
- Homeless outreach program.
- Implemented service coordinators in primary care setting to address social complexities
- "No wrong door" approach of referring complex patients to case management.
- Over 200 enabling codes developed and tracked.

No wrong door approach

- Initial plans were to expand our 'no wrong door' approach to data collection.
- Every 'door' a patient enters contributes to the understanding of who we serve.
- This includes: receptionists, medical assistants and providers.
- However, resulted in incomplete data.
- Recognized need to develop a standardized method of data collection.

PRAPARE:

Protocol For Responding To & Assessing Patients' Assets, Risks, & Experiences

- **PRAPARE** is a national effort to help health centers and other partners to collect data needed to better understand their patients SDOH.
- **PRAPARE** assessment tool was
  - informed by research on SDH domains that predict poor outcomes and high cost.
  - consists of a set of national core measures as well as optional measures.
- **Core Measures Include:**
  - Race & Ethnicity
  - Housing Status
  - Insurance Status
  - Language Preference
  - Education
  - Employment
  - Transportation
  - Safety
  - Neighborhood
  - Stress
  - Material Security
  - Domestic Violence

Humble Beginnings

- Small set of staff to pilot the survey
- One clinic for pilot
- Face to face contacts
- Administrative support
- Present with purpose/meaning

Relationships, Connections & Trust

- Relationships are key to establishing mutual respect and positive outcomes
- Seek out common interests
- Cultural diversity
- Encourage patients to be their own change agents
- Patients perspective
- Active listening and positive body language

PRAPARE Video

https://vimeo.com/179376045/5430c68d17

WCCHC Experiences In Implementing PRAPARE

- Trained RN care coordinators to administer the survey.
- Survey administered to a cohort of 500 Medicaid non-pregnant adults with either diabetes or cardiovascular disease.
- Time it took to administer the survey varied from 15 minutes to an hour.
- Care coordinators were trained to address concerns raised during the course of administering survey.

Implementation

- Initially implemented survey into care coordinators' workflow.
- Found to be too time consuming.
- Adapted process to create a 'talk story' environment.
- This process allowed care coordinators a 'foot in the door'.
- Encouraged us to build community resource data base.

PRAPARE Survey Experiences

- Resistance noted on questions regarding household income and incarceration.
- Care coordinators needed to provide reassurance that this data was not going to be shared.
- Surveyors felt flow of survey as written did not flow smoothly, they therefore modified the order in which they asked specific questions.

PRAPARE Plus

Expand Certain Categories To Include Assessing:

- Stability Of Housing Situation
- Access To Health Care
- Work Situation
- Legal Concerns And Rights
- Social And Emotional Health To Include Screening For Depression And Domestic Violence

Example Of PRAPARE Plus

15. What are your current legal concerns (Check all that apply)

	Parole		Probation
	Supervised release		Formerly in system, completed requirements
	Drug Court		None
	I choose not to answer this question		

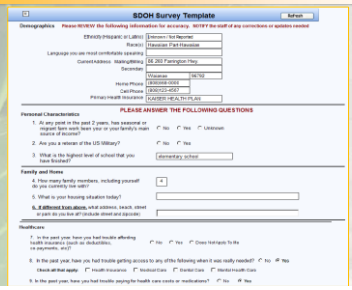
16. Do you have other concerns regarding your legal rights, the law and the courts such as the following (Check all that apply)

	Divorce/Custody/Guardianship/Visitation		Bankruptcy
	Eviction/Housing concerns with landlord		Public benefits
	Immigration		Tax issues
	Life Planning		I choose not to answer this question

Today's PRAPARE Workflow

- Developed a patient mode of PRAPARE to allow patients the ability to self administer the survey
- Created workflow conducive to clinic practices
- Collaboration with support staff
- Check in, demographics verified > called by MA, placed in exam room, vitals completed, completes PRAPARE in patient mode
- Average time to complete survey - 5-7 minutes
- PRAPARE is now implemented in all clinics, just begun initial analysis

Patient Mode



PRAPARE Positive Triggers

- Positive responses on trigger questions produces an automatic referral to Community Health Services
  - Difficulty affording health insurance
  - Transportation
  - Material resources
  - Physical & emotional safety
  - Domestic violence
- Triage patients to appropriate workforce for social support

Engaging Community Resources

- Develop a strong network of community partners
  - Reached out to partners that would impact SDOH needs
  - Scheduled two-way in-service meetings
  - Assured partners they in turn could also rely on us
- Created a resource guide for staff
  - Updated quarterly

Lessons Learned & Future Plans

- Strong leadership in disseminating the tool
- Start small, one clinic, one provider
- Accountability of staff, tie into evaluations
- Stronger network of community partners
- Use of patient portal to disseminate the tool prior to the appointment
- Ultimately develop a holistic risk score, incorporating SDOH with claims based data, to better define the complex patients we serve.

How Can PRAPARE Help You?

- **PRAPARE** propels providers who serve underserved populations towards transformed, integrated care and the demonstration of value.
- By understanding patients' SDOH, this allows providers to:
  - Define & document the complexity of patients.
  - Better target clinical care, enabling services and community partnerships.
  - Enables providers to demonstrate the value they bring to patients, communities and payers.
  - Advocate for change at the community and national levels.

PRAPARE toolkit & tool

www.nachc.org/prapare

Summary

- CHCs well positioned to address SDOH
- CHCs have long sought solutions to providing care enabling services with limited resources – used to doing "more with less"
- Start small, engage your staff, engage community partners
- With appropriate compensation, targeted intensive care enabling services can be provided