Building Patient-Centered Social Determinants of Health Workflows to Improve Population Health Management

Carly Hood Ronick, Oregon Primary Care Association
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.
Leading barriers to screening patients for SDH?

- Staffing / Workflow implementation 72%
- 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
### Areas of work

<table>
<thead>
<tr>
<th>Social Determinants of Health</th>
<th>PRACTICE/Innovation</th>
<th>DATA/Improvement</th>
<th>POLICY/Influence</th>
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<tbody>
<tr>
<td></td>
<td>Create workflows and referral pathways to utilize SDH data, and identify and share best practices to spread SDH interventions, including trauma informed practice.</td>
<td>Clinics will align around a collective SDH screening tool and utilize the data to inform care interventions.</td>
<td>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.</td>
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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
### Core

<table>
<thead>
<tr>
<th>UDS SDH Domains</th>
<th>Non-UDS SDH Domains (MU-3)</th>
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<tbody>
<tr>
<td>1. Race</td>
<td>10. Education</td>
</tr>
<tr>
<td>2. Ethnicity</td>
<td>11. Employment</td>
</tr>
<tr>
<td>6. Income</td>
<td>15. Transportation</td>
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<tr>
<td>8. Neighborhood</td>
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<td>9. Housing Status</td>
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### Optional

<table>
<thead>
<tr>
<th>1. Incarceration History</th>
<th>3. Domestic Violence</th>
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<tr>
<td>2. Safety</td>
<td>4. Refugee Status</td>
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Spanish and Chinese (Mandarin) translated versions

Find the tool at: [www.nachc.org/prapare](http://www.nachc.org/prapare)
Housing Status (Texas)

CHC 1
- Have Housing: 83.49%
- Homeless: 10.42%

CHC 2
- Have Housing: 82.76%
- Homeless: 4.93%

CHC 3
- Have Housing: 86.78%
- Homeless: 7.45%

Did Not Answer: 6.08%, 12.81%, 5.77%
APCM and SDH screening
Oregon APCM: population segmentation

10,000 PEOPLE
POPULATION

SUB-POPULATION(S)

TARGET POPULATION

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

- 834 diabetics
- 223 with HbA1c >9

- 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...

<table>
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<th>Local-level</th>
<th>State and national-level</th>
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<tbody>
<tr>
<td>Patient and Family</td>
<td>Improve health</td>
<td>Community Policies</td>
<td>Inform advocacy efforts related to local policies around SDH</td>
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<tr>
<td>Care Team Members</td>
<td>Better manage patient needs with services</td>
<td>Local Health System</td>
<td>Provide comparison data for other local clinics and to inform partnerships</td>
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<tr>
<td>Health Center</td>
<td>Better understand patient population</td>
<td>Payment Negotiation</td>
<td>Demonstrate the relationship between patient SDH and cost of care for fair provider comparisons (risk adjustment)</td>
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<tr>
<td>State and National Policies</td>
<td></td>
<td></td>
<td>Improve health center capacity for serving complex patients (payment reform)</td>
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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.
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.
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.
- Clinical staff also notify case manager or social worker for post-visit discussion or follow up.
- 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.
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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