Humanizing Your Enabling Services Data for Patient Care

Session 2 – Deep Dive
February 26, 2020

The Social Determinants of Health Academy

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In case of technical difficulties – yours or ours – relax!
This session will be recorded and available for you to share with your team.

Please alert Danielle of any technical challenges with Webex through the chat box feature.

About the 2020 SDOH Academy Learning Collaboratives

- **Target Audience:** Staff from health centers, primary care associations, and health center-controlled networks are encouraged to participate.
- **Time Commitment:** Each learning collaborative includes two 90-minute sessions that offer a 60-minute training followed by 30 minutes of office hours, where participants can get coaching and ask specific questions. You can choose to participate in one or both of a collaborative's sessions.
- **Registration:** Use the link at the end of this presentation or in the chat box to register for each session you plan to attend. And yes, you can participate in more than one collaborative!
- **Recordings:** All trainings are recorded and will be available afterward under the "SDOH Trainings" tab on the SDOH Academy website.

SDOH Academy Faculty

The Social Determinants of Health Academy

2020 Steering Committee

National Center for Medical Legal Partnership at the George Washington University

Health Outreach Partners — Healthy People. Equitable Communities.

CSH — The Source for Housing Solutions

National Health Care for the Homeless Council

National Nurse-Led Care Consortium — a PHMC affiliate

2020 Additional Faculty

AAPCHO

acu — association of clinicians for the underserved

Capital Link

Farmworker Justice

Migrant Clinicians Network — MCN

MHP Salud

National Association of Community Health Centers

NCHPH — National Center for Health in Public Housing

National Center for Equitable Care for Elders

NCFH — National Center for Farmworker Health, Inc.

National LGBT Health Education Center — A program of the Fenway Institute

SDOH Academy 2020

The Social Determinants of Health Academy

2020 Topics Addressing Social Determinants of Health:

1. **Humanizing Your Enabling Services Data for Patient Care**
   - February 12 and 26: 2 - 3:30pm Eastern Time

2. **Fostering a Health Care Workforce Able to Address Current and Emerging Needs**
   - March 11 and 25: 2 - 3:30 pm Eastern Time

3. **Reducing Health Disparities through Community Partnerships**
   - April 8 and April 22: 2 - 3:30 pm Eastern Time

4. **Equitable Preparedness for Vulnerable Populations**
   - May 20 and June 3: 2 - 3:30 pm Eastern Time

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SDOH Academy Core Competencies Learning Collaborative Series

1. **Improve Access to Quality Health Care and Services:** Health Centers; PCAs; and HCCNs will develop the capacity to improve access to SDOH services and health needs.

2. **Foster a Health Care Workforce Able to Address Current and Emerging Needs:** Health Centers; PCAs; and HCCNs will understand and build the workforce capacity needed to address SDOH.

3. **Enhance Population Health and Address Health Disparities through Community Partnerships:** Health Centers; PCAs; and HCCNs will understand and build capacity to address SDOH through partnerships and system delivery transformation.

4. **Understand Emerging Issues:** Health Centers; PCAs; and HCCNs will obtain a clearer understanding of issues in relation to SDOH.

Meet the presenters!

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Joe Lee
Training & Technical Assistance Director
Association of Asian Pacific Community Health Organizations

Darlene Jenkins
Senior Director of Programs
National Health Care for the Homeless Council

Cindy Selmi
Executive Director
Health Outreach Partners

Albert Ayson
Senior Program Manager, Training & Technical Assistance
Association of Asian Pacific Community Health Organizations

Michelle Jester
Deputy Director of Research
National Association of Community Health Centers

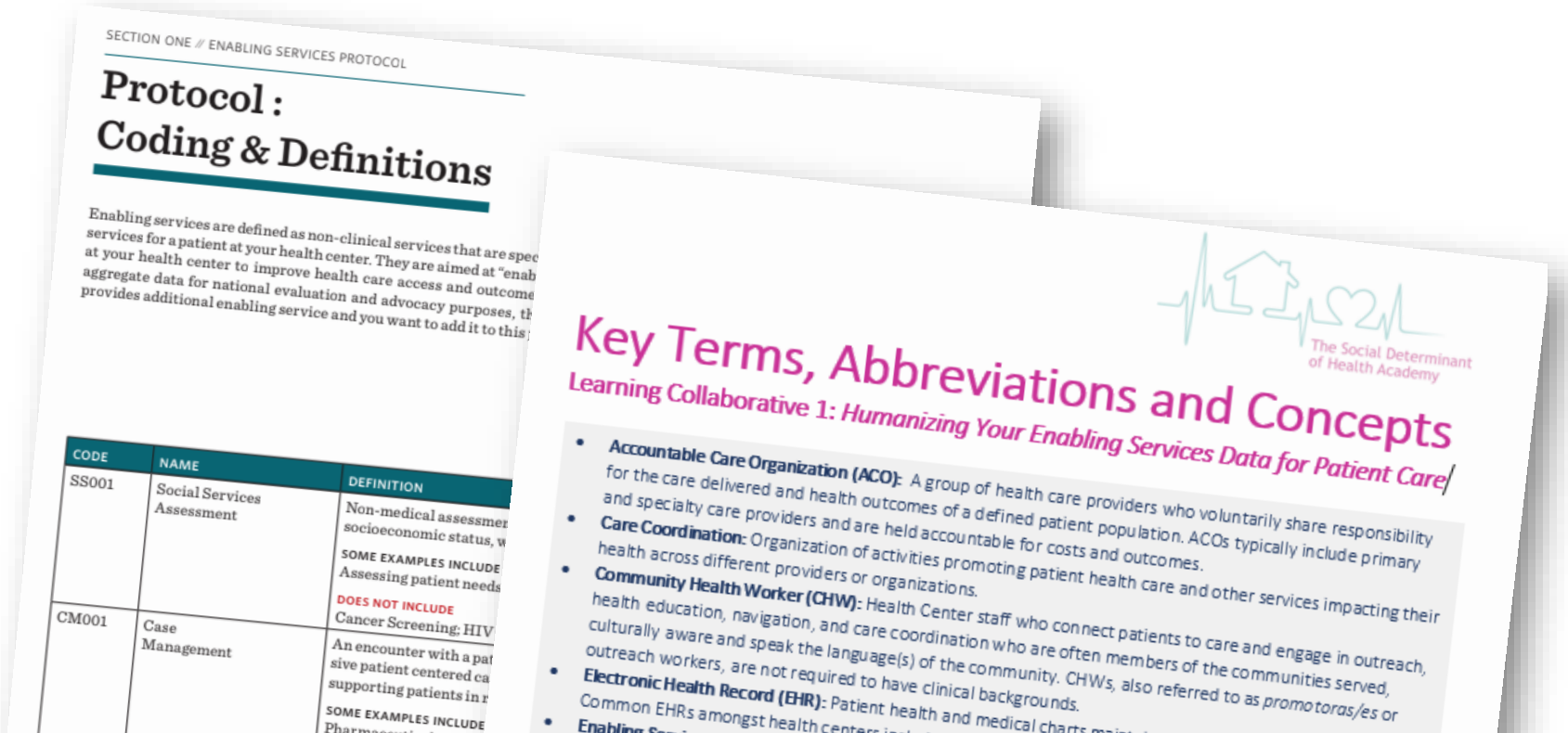
Kristina Wharton
Project Manager
Health Outreach Partners

Today's Webinar: Learning Objectives

1. Increase participant understanding of how to build capacity around **enabling services (ES) to address SDOH,** including strategies to provide, document, and track ES for underserved populations;
2. Discuss participant **health information technology** needs for SDOH and ES data collection, including basic infrastructure needs to collect and track data to assess for and address SDOH;
3. Explain the importance and **application of enabling services data for SDOH**, clinical quality improvement, patient-centered medical home initiatives, and value-based health care transformation.

Handouts in GoTo Webinar:

- Enabling Services Protocol
- Key Terms, Abbreviations and Concepts



SECTION ONE // ENABLING SERVICES PROTOCOL

Protocol : Coding & Definitions

Enabling services are defined as non-clinical services that are spec
services for a patient at your health center. They are aimed at "enab
at your health center to improve health care access and outcome
aggregate data for national evaluation and advocacy purposes, th
provides additional enabling service and you want to add it to this

CODE	NAME	DEFINITION
SS001	Social Services Assessment	Non-medical assessmer socioeconomic status, w SOME EXAMPLES INCLUDE Assessing patient needs DOES NOT INCLUDE Cancer Screening; HIV
CM001	Case Management	An encounter with a pat sive patient centered ca supporting patients in r SOME EXAMPLES INCLUDE

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Key Terms, Abbreviations and Concepts

Learning Collaborative 1: *Humanizing Your Enabling Services Data for Patient Care*

- **Accountable Care Organization (ACO):** A group of health care providers who voluntarily share responsibility for the care delivered and health outcomes of a defined patient population. ACOs typically include primary and specialty care providers and are held accountable for costs and outcomes.
- **Care Coordination:** Organization of activities promoting patient health care and other services impacting their health across different providers or organizations.
- **Community Health Worker (CHW):** Health Center staff who connect patients to care and engage in outreach, health education, navigation, and care coordination who are often members of the communities served, culturally aware and speak the language(s) of the community. CHWs, also referred to as *promotoras/es* or outreach workers, are not required to have clinical backgrounds.
- **Electronic Health Record (EHR):** Patient health and medical charts
Common EHRs amongst health centers
- **Enabling**

Strategizing Social Determinants of Health and Enabling Services Data Collection

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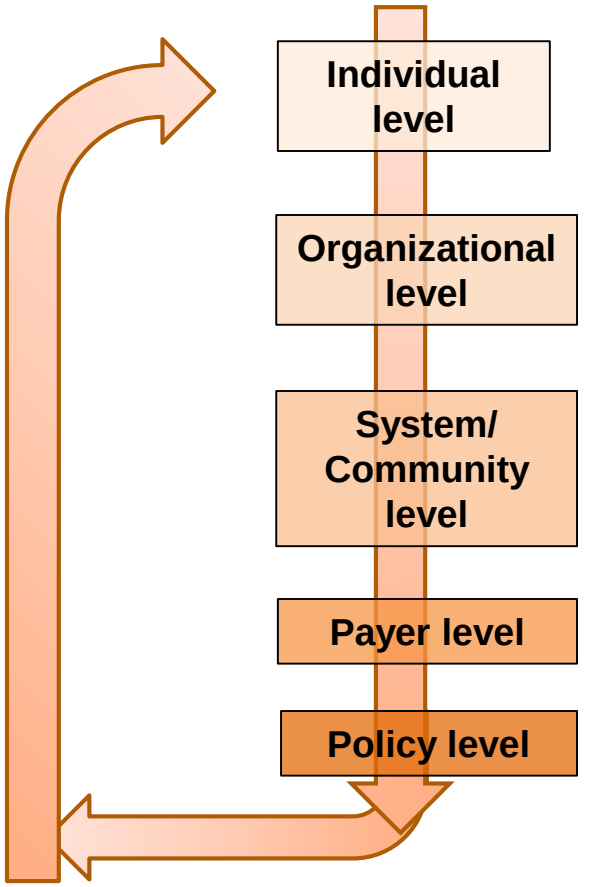
Why It's Important To Collect Standardized Data on Social Determinants of Health



Individual level	Better understand patients and provide appropriate care and treatment plans based on patient's socioeconomic circumstances
Organizational level	Design care teams and services to better manage patient and population needs
System/ Community level	Integrate care through cross-sector partnerships. Develop community-level redesign strategy for prevention
Payer level	Execute payment models that sustain value-based care by incentivizing services, interventions, and partnerships that address social risk
Policy level	Demonstrate value of health centers to health care system. Ensure capacity for serving complex patients, including uninsured patients

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Tools to Help Health Centers Collect Standardized Data on Social Determinants and Enabling Services:

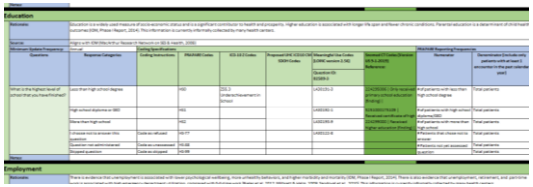
PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

- National, standardized social determinant of health assessment tool
- Developed by NACHC, AAPCHO, and Oregon PCA
- Built into EHR and meant to be patient-centered
- Most common SDH screening tool used by CHCs and Medicaid managed care organizations

Enabling Services Accountability Project

- Standardized codification system to document enabling services provided
- ESDC Toolkit developed by AAPCHO



Standardized Codes on SDH

- PRAPARE Crosswalked with ICD-10 Z codes, LOINC codes, and SNOMED codes

PRAPARE

www.nachc.org/prapare

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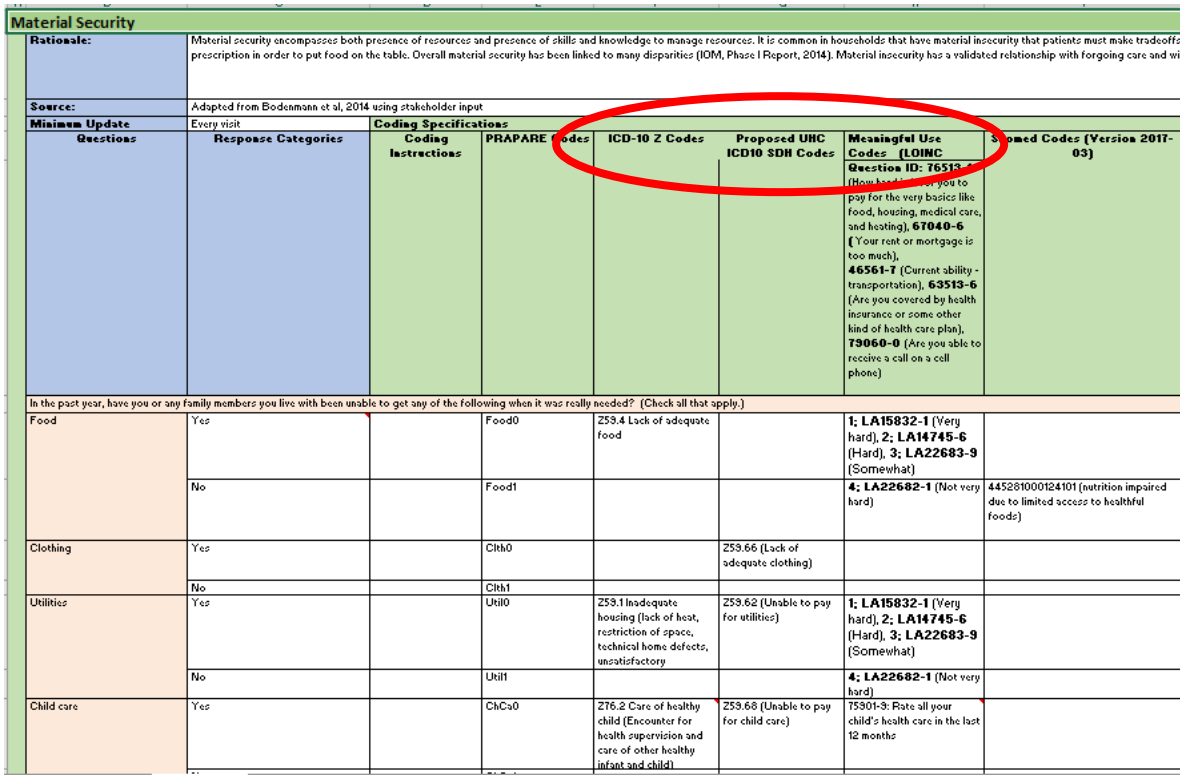
PRAPARE Data Dictionary: Mapping to Standardized Codes to Enhance Interoperability

- Crosswalks include ICD-10 Z codes, LOINC codes, and SNOMED codes
- Many PRAPARE EHR templates map PRAPARE measures to ICD-10 Z codes
- Gaps in ICD-10 Z codes
  - Proposed new codes to fill in gaps
- Created new codes in LOINC for PRAPARE
- PRAPARE Data Documentation available in Toolkit
- www.nachc.org/prapare



Material Security

Rationale:	Material security encompasses both presence of resources and presence of skills and knowledge to manage resources. It is common in households that have material insecurity that patients must make tradeoffs prescription in order to put food on the table. Overall material security has been linked to many disparities (IOM, Phase I Report, 2014). Material insecurity has a validated relationship with forgoing care and wi						
Source:	Adapted from Bodenmann et al, 2014 using stakeholder input						
Minimum Update	Every visit	**Coding Specifications**					
Questions	**Response Categories**	**Coding Instructions**	**PRAPARE Codes**	**ICD-10 Z Codes**	**Proposed UHC ICD10 SDH Codes**	**Meaningful Use Codes (LOINC** **Question ID: 76513-** (How hard is it for you to pay for the very basics like food, housing, medical care, and heating), **67040-6** (Your rent or mortgage is too much), **46561-7** (Current ability - transportation), **63513-6** (Are you covered by health insurance or some other kind of health care plan), **73060-0** (Are you able to receive a call on a cell phone)	**Snomed Codes (Version 2017-03)**
In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Check all that apply.)							
Food	Yes		Food0	Z59.4 Lack of adequate food		**1; LA15832-1** (Very hard), **2; LA14745-6** (Hard), **3; LA22683-9** (Somewhat)	
	No		Food1			**4; LA22682-1** (Not very hard)	445281000124101 (nutrition impaired due to limited access to healthful foods)
Clothing	Yes		Clth0		Z59.66 (Lack of adequate clothing)		
	No		Clth1				
Utilities	Yes		Util0	Z59.1 Inadequate housing (lack of heat, restriction of space, technical home defects, unsatisfactory	Z59.62 (Unable to pay for utilities)	**1; LA15832-1** (Very hard), **2; LA14745-6** (Hard), **3; LA22683-9** (Somewhat)	
	No		Util1			**4; LA22682-1** (Not very hard)	
Child care	Yes		ChCa0	Z76.2 Care of healthy child (Encounter for health supervision and care of other healthy infant and child)	Z59.68 (Unable to pay for child care)	75901-3: Rate all your child's health care in the last 12 months	

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5 Rights Framework to Determine PRAPARE Workflows

5 Rights	Workflow Considerations
Right Information–WHAT	What information in PRAPARE do you already routinely collect? • Part of registration • Part of other health assessments or initiatives
Right Format–HOW	How are we collecting this information and in what manner are we collecting it? • Self-Assessment • In-person with staff
Right Person–WHO	Who will collect the data? Who has access to the EHR? Who needs to see the information to inform care? Who will respond to needs identified? • Providers and other clinical staff • Non-Clinical Staff
Right Time–WHEN	When is the right time to collect this information so as to not disrupt clinic workflow? • Before visit with provider? (before arriving to clinic, while waiting in waiting room, etc.) • During visit? • After visit with provider?
Right Place–WHERE	Where are we collecting this information? Where do we need to share and display this information? • In waiting room? In private office? • Share during team huddles? Provide care team dashboards?

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Sample Workflow Models for PRAPARE Collection

Who	Where	When	How	Rationale
Non-Clinical Staff: (enrollment assistance, community health workers, patient navigators or patient advocates)	In waiting room or staff's office	Before provider visit or after clinical visit	Administered PRAPARE with patients who would be waiting 30+ mins for provider and relay information to provider	Wanted same person to ask question and address need. Often administer PRAPARE with other data collection effort (Patient Activation Measure) to assess patent's ability and motivation to respond to their situation. Has time to discuss SDH needs
Clinical Staff: (Nursing staff, MAs, BH staff, etc.)	In exam room	Before provider enters exam room	Administered it after vitals and reason for visit. Provider reviews PRAPARE data for referrals needed	Wanted trained staff to collect sensitive information. Waiting area not private enough to collect sensitive info
Care Coordinators	In office of care coordinator	When completing chart reviews and administering HRAs	Administered PRAPARE in conjunction with HRAs	Allows care coordinators to address similar issues in real time that may arise from both PRAPARE and HRA
Any staff (from Front Desk Staff to Providers)	No wrong door approach	No wrong door approach	No wrong door	Allows everyone to be part of larger process of "painting a fuller picture of the patient" and helping the patient
Self-Administration (patient fills it out themselves)	Waiting room or outside clinic	Before visit	Patient completes PRAPARE via email, phone, tablet, kiosk	Potential to collect large quantities of PRAPARE data in short amount of time but important to f/u with patient to discuss needs and provide services.

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Walking Through PRAPARE Workflows: Chapter 5 in PRAPARE Toolkit

- Walks through each workflow type, including:
  - Reasons to use that workflow model
  - Advantages
  - Tradeoffs
- Webinar walking through each workflow model and their tradeoffs
  - Available at www.nachc.org/prapare

Using Non-Clinical Staff After the Visit

Non-clinical staff includes patient navigators, patient advocates, community health workers, eligibility assistance workers, outreach and enrollment workers, among others.

Reasons to Use this Model

- Non-Clinical staff are often employed from the community so can more easily relate to patients, understand their needs, and build trusting relationships
- Non-clinical staff are also often more aware of available community resources
- Non-clinical staff often have similar responsibilities so may have more time to administer and respond to socioeconomic needs compared to other staff
- Ensures staff person administering PRAPARE also addresses needs identified by referring patient to resources

Advantages

- Doesn't delay visit with provider
- Provides immediate warm hand-off to services and resources
- Allows patient to become familiar and comfortable with the clinical setting

Tradeoffs

- Provider doesn't have PRAPARE socioeconomic data available during clinic visit to inform care
- Could lengthen overall visit time

CLINICAL VISIT WITH PROVIDER

- Provider conducts clinical visit
- Provider refers patient to non-clinical staff on an annual basis or if need certain services

REFERRAL TO NON-CLINICAL STAFF

- Non-clinical staff explains why they are administering PRAPARE and how it can help inform the patient's care plan

ADMINISTER PRAPARE

- Non-clinical staff asks the patient to answer PRAPARE questions, either on their own or through conversation
- If patient has already answered PRAPARE questions in the past, staff asks if patient would answer these differently

DOCUMENT PRAPARE RESPONSES

- Non-clinical staff records and dates the patient's answers and/or updates in the PRAPARE EHR template, using ICD-10 Z codes when possible

RESPOND TO NEEDS

- Non-clinical staff connects patient to available resources, either those in-house or those available in the community
- If no needs are identified, non-clinical staff will flag next appointment for annual PRAPARE screening

CLOSE THE LOOP

Population of Focus May Affect Your Workflow Model

- What will the population of focus be? How does that affect the workflow model?
  - All patients: multiple types of staffing possibilities
  - Patients with chronic disease: care management team
  - Patients with behavioral health conditions: behavioral health integration specialists
  - Patients who receive home health visits: community health workers
  - Patients attending diabetes education class: health educator

- How does PRAPARE align with existing staff and workflows? Are there staff with similar responsibilities where PRAPARE could add value?
  - Don't necessarily need new staff
  - Cross-train staff

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Case Study: Using PRAPARE for Population Segmentation with Diabetic Patients

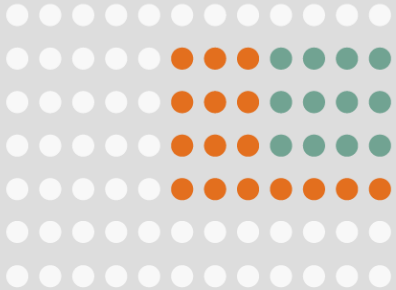
10,000 PEOPLE

POPULATION

Use analytics to piece together target population characteristics.

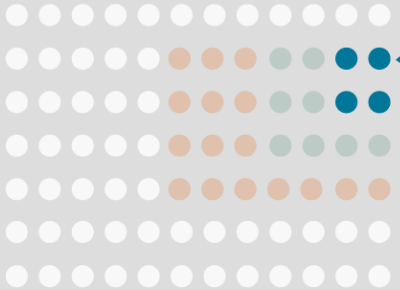
May require multiple data sources and analytic processes.

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

PRAPARE

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PRAPARE Resources: www.nachc.org/prapare

- ✓ Free PRAPARE Implementation and Action Toolkit
- ✓ Free EHR templates for Cerner, eCW, Epic, GE Centricity, Greenway, NextGen
  - ✓ More EHR templates in progress
- ✓ Recorded Webinars on:
  - PRAPARE Development
  - Workflows
  - EHR Templates
  - Responding to Interventions
  - Risk Stratification
  - Research on SDH Data
- ✓ Case Studies and User Stories
- ✓ 10 translations of PRAPARE including Spanish, Somali, Arabic, Chinese, and more!
  - ✓ 16 more on the way!

Chapter 1: Understand the PRAPARE Project

Chapter 2: Engage Key Stakeholders

Chapter 3: Strategize the Implementation Process

- **Chapter 4: Technical Implementation with EHR Templates**
- **Chapter 5: Develop Workflow Models**
- **Chapter 6: Develop a Data Strategy**
- **Chapter 7: Understand and Evaluate Your Data**

- **Chapter 8: Build Capacity to Respond to SDH Data**
- **Chapter 9: Respond to SDH Data with Interventions**
- **Chapter 10: Track Enabling Services**

PRAPARE

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5 Rights Framework to Determine Response Workflows

5 Rights	Responses/Interventions
Right Information	What information and resources do you have to respond to social determinants data? Is it up to date? . Update your community resource guide and referral list with accurate information . Track referrals, interventions, and time spent
Right Format	How will information be stored for use & presented to patients? . Searchable database of resources (in-house or via partner); . Printed resource for patients to take with them . Warm hand-off for referrals
Right Person	Who will respond to social determinants data? . By a dedicated staff person? By any staff person who administers PRAPARE with patient? By the provider?
Right Time	When will referrals take place? . Immediately after need is identified? . After patient sees provider? At end of visit?
Right Place	Where will referral take place? . In private office or exam room?

Enabling Services Deep Dive

Definitions & Data Documentation

Definitions

- **Enabling Services:** Non-clinical services that are specifically linked to a medical encounter or the provision of medical services for a patient at your health center. *"Enabling" patients to improve access and outcomes.*
- Standardized collection allows for better tracking of these unique services across health centers for national evaluation and advocacy

15 categories of services

- *Social Services*
- *Case Management*
- *Referral – Health*
- *Referral - Social*
- *Financial Counseling*
- *Health Education, 1-1*
- *Health Ed, 2-12*
- *Health Ed, 13+*
- *Supportive Counseling*
- *Interpretive Services*
- *Outreach*
- *Inreach*
- *Transportation – Health*
- *Transportation – Social*
- *Other*

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Old ES Categories	Revised Categories	Code
Case Management Assessment (CM001)	Social Services Assessment	SS001
Case Management Treatment and Facilitation (CM002)	Case Management	CM001
CM Referral (CM003)	Referral- Health	RF001
	Referral- Social Services	RF002
Financial Counseling/ Eligibility Assistance	Financial Counseling/Eligibility Assistance	FC001
Health Education/Supportive Counseling *Individual *Group	Health Education- Individual (one-on-one)	HE001
	Health Education- Small Group (2-12)	HE002
	Health Education- Large Group (13 or more)	HE003
	Supportive Counseling	SC001

AAPCHO ES Data Collection: https://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/

Old ES Categories	Revised Categories	Code
Interpretation	Interpretation	IN001
Outreach	Outreach	OR001
	Inreach	IR001
Transportation	Transportation- Health	TR001
	Transportation- Social Services	TR002
Other	Other	OT001

AAPCHO ES Data Collection: https://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/

Select Examples

- **Social Services Assessment:** Non-medical assessment that includes the use of an acceptable instrument measuring socioeconomic status, wellness, or other non-medical health status.

- Includes:
  - Assessing patient needs, such as housing, food, transportation, legal needs, education, etc.

- Does NOT include:
  - Cancer Screening; HIV testing.

Select Examples

- **Interpretation:** Provision of interpreter services by a third party (other than the service provider) intended to reduce barriers to a limited English-proficient (LEP) patient or a patient with documented limitations in writing or speaking skills sufficient to affect the outcome of a medical visit or procedure.

- Includes:
  - Interpreting between a patient and a healthcare or social service provider, providing sign language during a health education workshop, interpreting over the phone for a physician at a hospital and a health center patient, translating medication instructions and also include sign language.

- Does NOT include:
  - Interpreting GED materials (this belongs in the Other category), providing health education in the patient's own language (this should be marked as Health Education provided in another language), or translating an electric bill for a health center patient (this should be marked as Other).

Select Examples

- **Transportation – Social Services:** Providing transportation assistance, either directly or through referral, to a patient requiring transport to receive appropriate social services.

- Includes:
  - Van service to and from social service appointments at the health center or o -site, enrolling patients in a transportation voucher or assistance program, transportation service to a soup kitchen or shelter.
- Does NOT include :
  - Providing reimbursement for a patient's taxi fares, handing out transportation tokens.**
  - ***Participants are encouraged to log distribution of transportation resources such as vouchers, bus tokens, taxi fares, etc., in order to track utilization and make the case for need. A sample template is shown.*

- FULL LIST AND DESCRIPTIONS OF SERVICES AVAILABLE IN TOOLKIT!

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Documentation

What to track?: Demographics, services, and time (templates on next slides)

How to Track: Paper and EHR/EMR

Workflow: Discuss w/ service providers, current documentation, timing, ES champion, reporting back to all-staff

Template: Demographics, header

Service Date (M/D/Y)	Provider ID	Patient ID	Pt. DOB (M/D/Y)	Pt. Gender
Encounter Type (check one): ☐ face to face ☐ telephone ☐ off-site				
☐ Services provided in language other than English -- specify language:				

Documentation Criteria

A valid entry needs to meet the following criteria:

- Service must be provided by a staff member or volunteer of the health center/ contractor*
- Service must be linked to a medical patient of the health center
- Services must be provided directly to the patient or to their primary caregiver (e.g. parent)** (or on behalf of the patient- referral)

Service must last 10 minutes or greater:

- For services less than 10 minutes, do not document
- Document services longer than 10 minutes in 10-minute increments. Time includes only direct patient time and does not include documentation time
- To calculate time increments that fall between 10-minute increments, any amount ending in less than or equal to 4, round down, all amounts ending in 5 and more, round up to the nearest 10 minutes.

Enabling Service	Code	Minutes												Other
Social Services Needs Assessment	SS001	10	20	30	40	50	60	70	80	90	100	110	120	
Case Management	CM001	10	20	30	40	50	60	70	80	90	100	110	120	
Referral - Medical	RF001	10	20	30	40	50	60	70	80	90	100	110	120	
Referral - Social Services	RF002	10	20	30	40	50	60	70	80	90	100	110	120	
Eligibility Assistance/ Financial Counseling	FC001	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education - Individual	HE001	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education - Small Group (2-12)	HE002	10	20	30	40	50	60	70	80	90	100	110	120	
Health Education - Large Group (12+)	HE003	10	20	30	40	50	60	70	80	90	100	110	120	
Supportive Counseling	SC001	10	20	30	40	50	60	70	80	90	100	110	120	
Interpretation	IN001	10	20	30	40	50	60	70	80	90	100	110	120	
Outreach	OR001	10	20	30	40	50	60	70	80	90	100	110	120	
In-reach	IR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation – Medical	TR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation – Social Services	TR002	10	20	30	40	50	60	70	80	90	100	110	120	
Other	OT001	10	20	30	40	50	60	70	80	90	100	110	120	

Enabling Services Data Collection:

Interactive Activity

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Document ES Encounters – Scenarios!

ACTIVITY 1

Scenarios: Documenting ES Encounters

Scenario 1

A 42-year-old male patient whose primary language is Vietnamese, walked in your health center without an appointment. First, the enabling service (ES) provider spends 23 minutes translating between the physician and patient during the exam. He is diagnosed with hypertension and is prescribed medications. After the appointment, the ES provider spends another 18 minutes explaining in Vietnamese a brochure on hypertension that is written in English, discussing the condition and treatment in more detail.

WHICH TYPE OF SERVICES WERE PROVIDED AND FOR HOW LONG?

SERVICE DATE (MM+DD+YR) _____ PATIENT DOB (MM+DD+YR) _____

PROVIDER ID _____ PATIENT GENDER _____

PATIENT ID _____ PATIENT ZIP CODE _____

ENCOUNTER TYPE *(CHECK ONLY ONE)* ☐ FACE TO FACE ☐ TELECOMMUNICATION ☐ OFF-SITE ☐ OTHER

APPOINTMENT TYPE *(CHECK ONLY ONE)* ☐ SCHEDULED ☐ WALK-IN

GROUP OR INDIVIDUAL *(CHECK ONLY ONE)* ☐ GROUP ☐ INDIVIDUAL

SERVICE PROVIDED IN LANGUAGE OTHER THAN ENGLISH (SPECIFY LANGUAGE) _____

		MINUTES												OTHER
	S001	10	20	30	40	50	60	70	80	90	100	110	120	
	M001	10	20	30	40	50	60	70	80	90	100	110	120	
	F001	10	20	30	40	50	60	70	80	90	100	110	120	
	F002	10	20	30	40	50	60	70	80	90	100	110	120	
	C001	10	20	30	40	50	60	70	80	90	100	110	120	
	E001	10	20	30	40	50	60	70	80	90	100	110	120	
	E002	10	20	30	40	50	60	70	80	90	100	110	120	
	E003	10	20	30	40	50	60	70	80	90	100	110	120	
	C001	10	20	30	40	50	60	70	80	90	100	110	120	
Interpretation	IN001	10	20	30	40	50	60	70	80	90	100	110	120	
Outreach	OR001	10	20	30	40	50	60	70	80	90	100	110	120	
Inreach	IR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation - Health	TR001	10	20	30	40	50	60	70	80	90	100	110	120	
Transportation - Social Services	TR002	10	20	30	40	50	60	70	80	90	100	110	120	
Other	OT001	10	20	30	40	50	60	70	80	90	100	110	120	

Directions

Individually (or in a group if you're viewing this webinar with others in the same room)

1. Read each scenario out loud and complete the encounter form (1 min). Only complete the following:
   - **Encounter type:**
   - **Service provided in language other than English-specify language:**
   - **Enabling Service & Time:**
2. Come to an agreement on your final answers (2 min)
3. Submit your response via Chat Box (and/or verbally by unmuting your line)

Scenario 1

A 42-year-old male patient whose primary language is Vietnamese, walked in your health center without an appointment. First, the enabling service (ES) provider spends 23 minutes translating between the physician and patient during the exam. He is diagnosed with hypertension and is prescribed medications. After the appointment, the ES provider spends another 18 minutes explaining in Vietnamese a brochure on hypertension that is written in English, discussing the condition and treatment in more detail.

Scenario 1: ANSWER KEY

Encounter type: face to face

Service provided in language other than English-specify language: Vietnamese

Enabling Service & Time:

- Interpretation- 20 minutes (translating between the physician and patient)
- Health Education- 20 minutes, since you are providing an education on top of the brochure.
- If you were to just translate the materials on the brochure, then you would code for Interpretation for 20 minutes. But the primary service that you are providing in this case is health education in the patient's language.

Scenario 2

A 55-year-old Mexican male who is experiencing homelessness came to the health center's mobile medical unit during its weekly rounds at a local church. The ES provider performed a psychosocial assessment, which took 24 minutes. The ES provider also spent 18 minutes talking with him about his challenges related to alcohol dependency and 12 minutes talking to him about a supportive housing program.

Scenario 2: ANSWER KEY

Encounter type: face to face

Service provided in language other than English-specify language: N/A

Enabling Service & Time:

- CM-Assessment for 20 minutes (for the psychosocial assessment
- Health Education/Supportive counseling- 20 minutes (talking with him about his alcohol dependency)
- Other- 10 minutes (talking to him about supportive housing program because you're giving him information but it's not specifically "health topic" information.
- If you decide to add "Social Case Management Treatment and Facilitation and Social Case Management Referral", you can select 10 minutes for "Social Case Management Referral"

Scenario 3

A health education specialist records a radio program on various health topics every week. The recording is 10 minutes long and she spends about 90 minutes in preparation for each recording.

Scenario 3: ANSWER KEY

Encounter type: N/A

Service provided in language other than English-specify language: N/A

Enabling Service & Time:

None since you have no way of knowing if you have provided your services to specific patients.

Enabling Services Data in Practice:

Case Studies

The Social Determinants of Health Academy

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Enabling Services Data in Practice

Case Study 1:

SOCIAL SERVICES ASSESSMENT

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Case Study 1: Social Services Assessment

One of the four health centers who collaborated with AAPCHO and the New York Academy of Medicine to conduct the enabling service pilot project in 2004

CHARLES B. WANG COMMUNITY HEALTH CENTER
王 嘉 廉 社 區 醫 療 中 心

ES Data in Practice: Case Study 1

The Social Determinants of Health Academy

Why it is important to track health center interventions in addressing patients' social determinants of health risk?

- Understand the nature of social determinants the Health Center patients are experiencing and the impacts on their health outcome
- Measure the level of the complexity of the patients' bio-psychosocial issues
- Help develop services and resources that better meet the patient service needs
- Tool to document the components of a service and pattern of service delivered e.g. case management vs. interpretation, in-person vs. phone
- Better budgets planning, staffing and resources allocation

Source and credit to: Manna Chan, LCW from Charles B. Wang Community Health Center

ES Data in Practice: Case Study 1

The Social Determinants of Health Academy

ES Implementation Protocol

Social Work Department:

- Social Workers conduct a biopsychosocial assessment to assess the social determinants for every patient who was referred to Social Work Department for service.
- The enabling service taxonomy is used to capture the services delivered at the end of every encounter.
- In 2017, SW delivered 22,911 unit of enabling services for approximately 11,000 patients.
- Top three enabling services:
  1. Treatment and Facilitation: 11,647 units; avg. time spent: 17minutes
  2. Assessment: 9,416 units; avg. time spent: 14 minutes
  3. Referral: 626 units; avg. time spent: 12 minutes

Source and credit to: Manna Chan, LCW from Charles B. Wang Community Health Center

ES Implementation Protocol (cont.)

Nursing and Health Education Department:

- Nursing department and Health Education department utilized the enabling service taxonomy to capture the non-clinical services such as specialist referral follow up, providing disease management health education counseling.

Mental Health Department:

- The care managers use the enabling service taxonomy to capture the non-clinical services delivered such us appointment follow up.

PRAPARE:

- Starting from March 2018, the Health Center utilizes the PRAPARE form to collect social determinant data for the patients at their annual physical visit. Social Work/Mental Health referral for services will be made if needed.

Source and credit to: Manna Chan, LCW from Charles B. Wang Community Health Center

Resources available to implement the protocol within the Health Center:

- Support from senior leadership
- Electronic medical record system
- IT/CI support
- Staffing—data collection and analysis
- Time--- data collection, education and training

Source and credit to: Manna Chan, LCW from Charles B. Wang Community Health Center

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Enabling Services Data in Practice

Case Study 2:

TRANSPORTATION

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Case Study 2: Transportation

- Rural upstate NY health center
- Large agricultural economy (grapes, apples, cabbage)
- MHC funding to serve migrant and seasonal agricultural workers (MSAWs)
- MSAWs live in largely isolated areas with few transportation options

SOURCE: Health Outreach Partners, *Transportation Models that Work* (2014).
https://outreach-partners.org/2014/06/04/overcoming-obstacles-to-health-care-transportation-models-that-work/

ES Data in Practice: Case Study 2

The Social Determinants of Health Academy

Case Study 2: Transportation

- HC uses PRAPARE paper forms to collect ES data
- The HC QI team analyzed the PRAPARE data, finding many patients lacked needed transportation
- Public transportation is nonexistent or very time consuming
- Personal vehicles are limited, and when available, require a driver's license
- All options expensive

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

✓ Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
✓ Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

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

✓	Yes, it has kept me from medical appointments or from getting my medications
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

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

Optional Additional Questions

18. 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

19. Are you a refugee?

	Yes		✓ No		I choose not to answer this question

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

	Yes		No		✓ Unsure
	I choose not to answer this question				

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

	Yes		✓ No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

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Transportation Solutions: **Direct Service Provision**

- The health center provides transportation Patients pay a transportation co-pay of $5.00 round-trip, regardless of the distance traveled
- Number of rides and case managers varies seasonally
- Bilingual, bicultural staff members that serve as case managers to transport migrant and seasonal farmworkers to primary care visits, specialty care visits, and local pharmacies
- Or partner with transportation service providers

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Transportation Solutions: In-Camp Mobile Services

- Health Center provides mobile in-camp services
- Includes screening services, health education and referrals
- Schedule clinic appointments
- Address transport needs
- The teams generally try to see 20 pts/day
- Case managers coordinate these visits with both patients and farm owners and assist the providers on-site, including serving as interpreters

The Social Determinants of Health Academy

Transportation Solutions: School-based Health & Dental

- Health Center provides comprehensive health and dental services to farmworkers at Migrant Head Start sites
- Migrant Education summer school sites and at community Head Start sites
- This program allows children to receive comprehensive dental care with permission from their parents.
- School-based services eliminate the need for parents to miss work to transport their children to appointments

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Transportation Solutions: **Telehealth**

- Telehealth program increases access to care for patients located in rural communities by connecting them to primary care providers, specialty providers,
- bilingual, bicultural staff members that serve as case managers to transport migrant and seasonal farmworkers to primary care visits, specialty care visits, and local pharmacies.

References and Resources

The Social Determinants of Health Academy

Resources

- PRAPARE (NACHC)
  - www.nachc.org/prapare
- Enabling Services Implementation Toolkit (AAPCHO)
  - www.enablingservices.aapcho.org
- Transportation & Health Access QI Toolkit:
  - https://outreach-partners.org/2016/10/19/transportation-quality-improvement-toolkit/
- Outreach Starter Kit (HOP)
  - https://outreach-partners.org/resources/outreach-starter-kit/

Questions?

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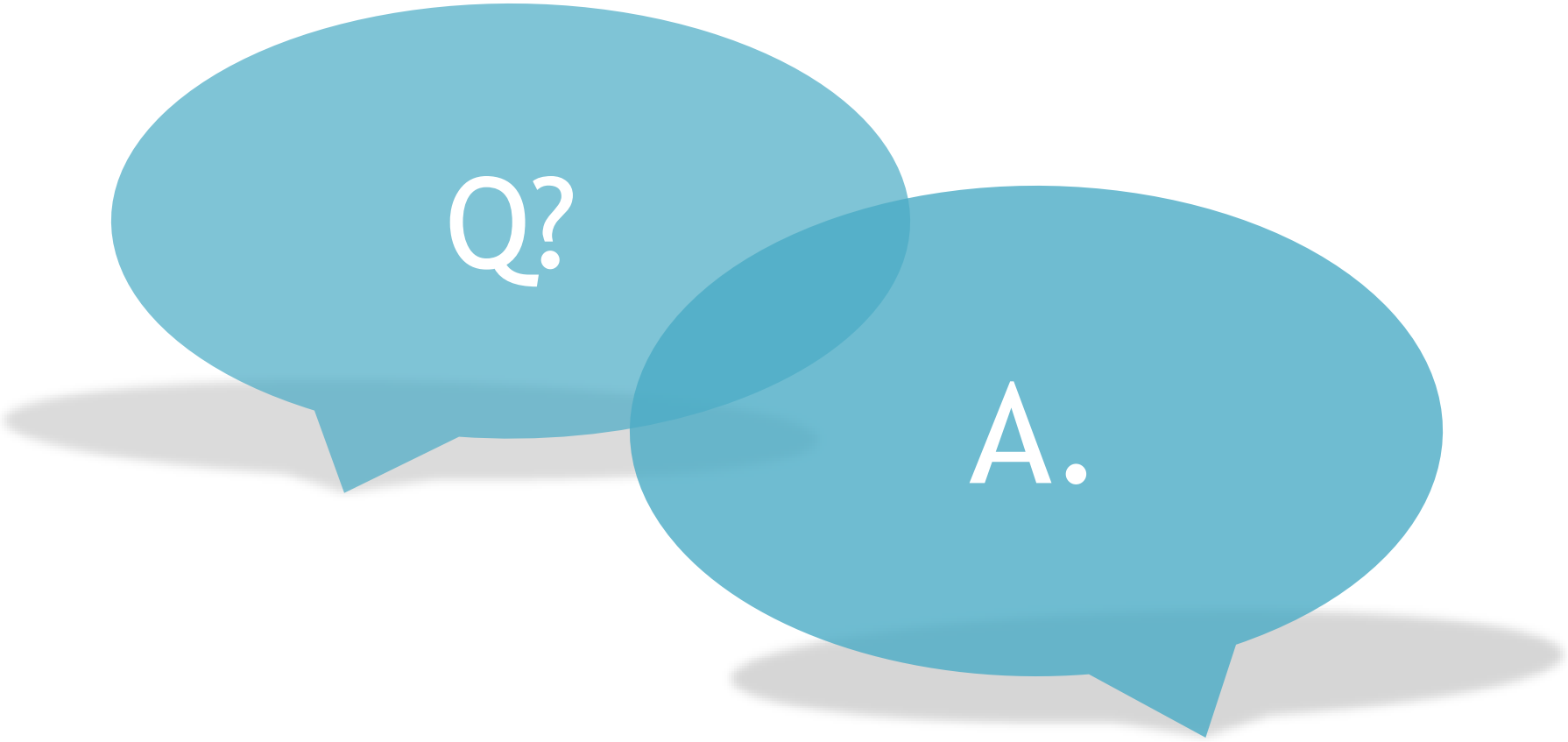

Upcoming Events!

The Social Determinants of Health Academy

SDOH Academy: Learning Collaborative 2

Fostering a Health Care Workforce Able to Address Current and Emerging Needs

- March 11 and 25 from 2 - 3:30 pm Eastern Time
- Register here: https://sdohacademy.com/collaboratives

This learning collaborative is designed to help health center, PCA, and HCCN staff build workforce capacity through community health workers (CHWs) and LGBTQIA+ cultural competence to improve the health of vulnerable populations.

Faculty

- Cei Lambert, National LGBT Health Education Center
- Suzanne Speer, Association of Clinicians for the Underserved
- Colleen Velez, Corporation for Supportive Housing

Upcoming Events!

The Social Determinants of Health Academy

- Hosted by: Health Center Association of Nebraska
- NCA Presenters: AAPCHO, HOP, MHP Salud, NACHC, NCMLP
- Register: https://events.r20.constantcontact.com/register/eventReg?oeidk=a07egswe4i0ceaf0923&oseq=&c=&ch=

Brief Webinar Evaluation

- Please complete the brief follow up survey that will be launched immediately following this session and also will be emailed to participants through Webex.

Contact Us

Albert Ayson, Jr.
AAPCHO
aayson@aapcho.org

Joe Lee
AAPCHO
joelee@aapcho.org

Cindy Selmi
HOP
cynthia@outreach-partners.org

Kristina Wharton
HOP
kristina@outreach-partners.org

Darlene Jenkins
NHCHC
djenkins@nhchc.org

Michelle Jester
NACHC
mjester@nachc.org

Thank you!

https://sdohacademy.com/collaboratives

The Social Determinants of Health Academy

Office Hours

30 minutes

The Social Determinants of Health Academy

Questions for Participants: Enabling Services Data Collection

- *Are you collecting enabling services data?*
- *What tools are you using for ESDC?*
- *What staff are involved in ESDC?*
- *What specific challenges do you experience when collecting ESDC?*

Questions for Participants: Using Enabling Services Data

- *Do you use aggregated ES data for population health or QI efforts?*
- *What tools are you using to analyze ES data?*
- *What specific challenges or successes do you have analyzing ES data?*

Questions for Participants: Providing Enabling Services

- *Do you use aggregated ES data to inform care planning or coordination for patients?*
- *What enabling services is your health center providing?*
- *What is working well with the enabling services your health center provides? What could be improved?*

THANK YOU!!