Humanizing Your Enabling Services Data for Patient Care

Session 1 - Overview and Issues

February 12, 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.

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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 links below 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 our website.

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 16: 2pm - 3:30 p.m. Eastern Time

2. **Fostering a Health Care Workforce Able to Address Current and Emerging Needs**
   - February 12 and 16: 2pm - 3:30 p.m. Eastern Time

3. **Reducing Health Disparities through Community Partnerships**
   - February 12 and 16: 2pm - 3:30 p.m. Eastern Time

4. **Equitable Preparedness for Vulnerable Populations**
   - February 12 and 16: 2pm - 3:30 p.m. 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.

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

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

Today's Learning Collaborative Faculty

Presented by:

- **Association of Asian Pacific Community Health Organizations**
  - Albert Ayson, Jr., *Senior Program Manager, Training & Technical Assistance*
  - Joe Lee, *Training & Technical Assistance Director*
- **Health Outreach Partners**
  - Cindy Selmi, *Executive Director*
  - Kristina Wharton, *Project Manager*
- **National Association of Community Health Centers**
  - Michelle Jester, *Deputy Director of Research*
- **National Health Care for the Homeless Council**
  - Darlene Jenkins, *Senior Director of Programs*

Meet the presenters!

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Joe Lee
AAPCHO

Darlene Jenkins
NHCHC

Cindy Selmi
HOP

Albert Ayson
AAPCHO

Michelle Jester
NACHC

Kristina Wharton
HOP

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.

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SDOH Academy Core Competencies

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.**
   a) Participants will understand and build capacity around **Enabling Services for SDOH** including how to provide (AAPCHO, HOP, NHCHC, NACHC); how to document (AAPCHO, HOP, NHCHC); and how to track for underserved populations (AAPCHO, HOP, NHCHC).
   b) Participants understand **Technology** needs for SDOH including what is the infrastructure needed to address SDOH; to assess for SDOH; to collect data and track SDOH- the necessary infrastructure to improve health access, quality services, and patient engagement.

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Format
Learning Collaborative Series

LC Session # 1 February 12 - Big Picture – 60 minutes

Office Hours – 30 minutes

LC Session # 2 February 26 - Deep Dive – 60 minutes

Office Hours – 30 minutes

Today's Session

- Addressing SDOH Core Competencies: Humanizing Your Enabling Services Data for Patient Care
  - Session 1 of 2: Overview and Issues

- Speakers:
  - Michelle Jester, National Association of Community Health Centers
  - Joe Lee, Association of Asian Pacific Community Health Organizations
  - Kristina Wharton, Health Outreach Partners
- Moderator:
  - Darlene Jenkins, National Health Care for the Homeless Council

Brief Session Evaluation

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

I. Enabling Services to Address Social Determinants of Health

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Where would you say your health center currently is in training your workforce for Enabling Services (ES) data collection?

To Address Social Risks, You First Need to Document Needs…

- Likely already are focusing on social determinants in some way given mission but without standardized data, it is harder to systematize and streamline this work into workflow
- Standardized data on social determinants of health is needed to inform care planning and population health management activities
- Standardized data on social determinants of health is also needed to demonstrate value of health centers and your focus on addressing non-clinical needs

I. Enabling Services to Address SDOH

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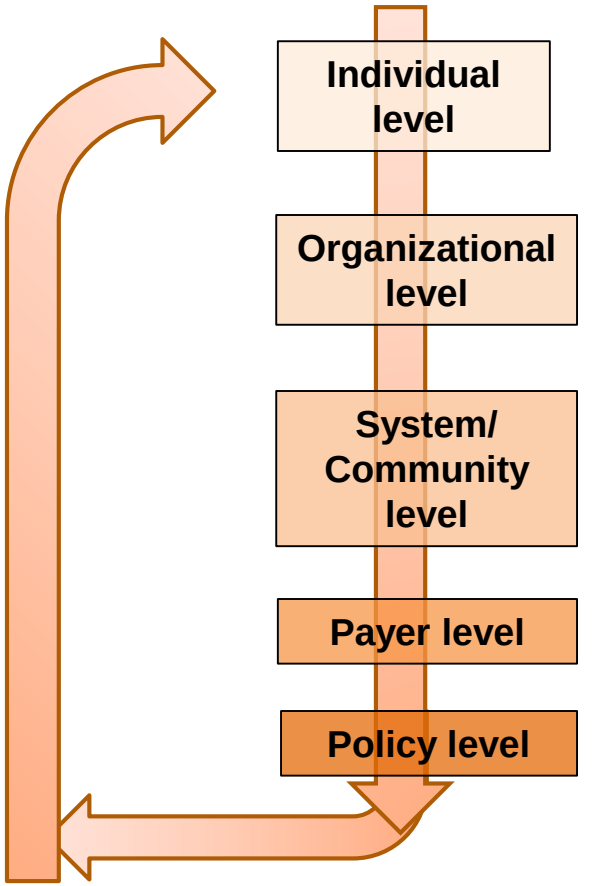
Why It's Important To Collect Standardized Data on Social Determinants of Health



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

PRAPARE: A Tool to Help You Collect Social Determinants of Health Data

PRAPARE

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

A national **standardized** patient risk assessment **protocol built into the EHR** designed to **engage patients** in assessing and addressing social determinants of health

Customizable Implementation and Action Approach At the Patient and Population Level

Assess Needs → Responding to Needs

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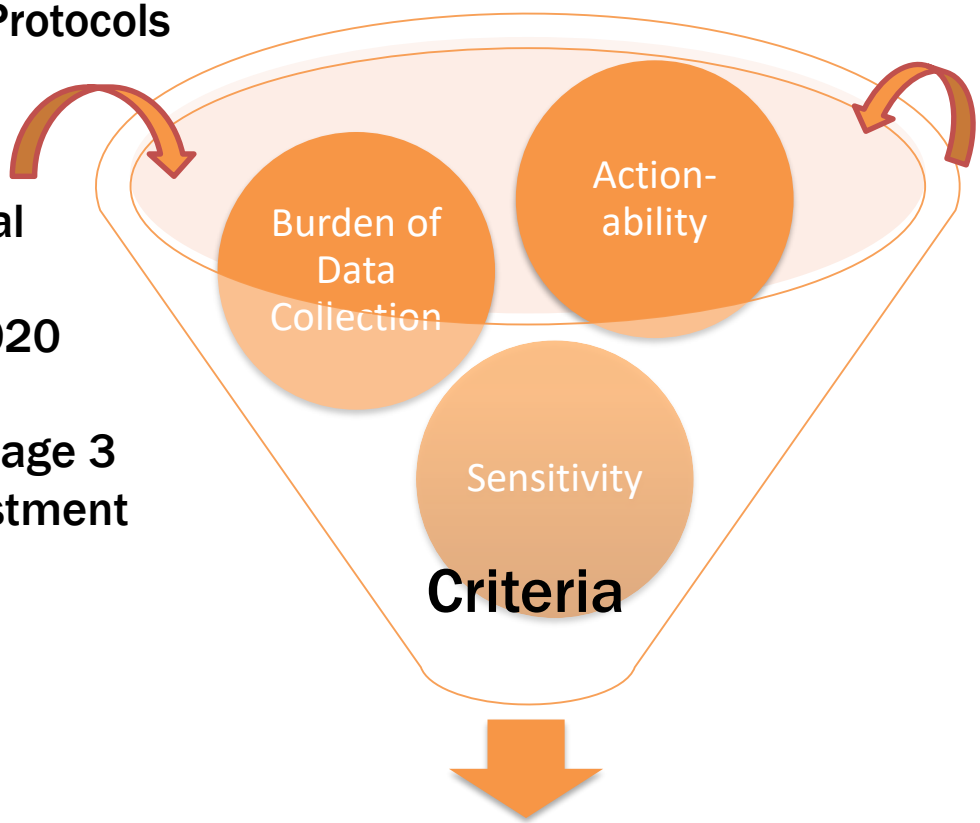
How Did We Develop PRAPARE?

Experience of Existing Protocols

Stakeholder Feedback

Literature Review

Aligned with National Initiatives:
* Healthy People 2020
* ICD-10
* Meaningful Use Stage 3
* NQF on Risk Adjustment



Identified 16 Core Social Determinants of Health

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What Data Is Collected with PRAPARE?

Core	
UDS SDH Domains	**Non-UDS SDH Domains**
1. Race	10. Education
2. Ethnicity	11. Employment
3. Veteran Status	12. Material Security
4. Farmworker Status	13. Social Isolation
5. English Proficiency	14. Stress
6. Income	15. Transportation
7. Insurance	16. Housing Stability
8. Neighborhood	
9. Housing Status	

Optional	
1. Incarceration History	3. Domestic Violence
2. Safety	4. Refugee Status

Find the tool at:
www.nachc.org/prapare

I. Enabling Services to Address SDOH

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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!
- ✓ PRAPARE Readiness Assessments
- ✓ Recorded Webinars on PRAPARE, Workflows, EHR Templates, Responding to Interventions, Risk Stratification, Research on SDH Data, etc.
- ✓ Case Studies and User Stories
- ✓ 10 translations of PRAPARE including Spanish, Somali, Arabic, Chinese, Tagalog, Korean, Vietnamese, and more!
  - ✓ 16 more translations on the way!

You Should Also Document What You Are Doing to Address Social Risks

- Better track which services and interventions are most effective in addressing needs
- Develop evidence base to demonstrate to payers what it takes to care for complex patients
- Use evidence to inform care transformation and payment models to sustain non-clinical work

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PRAPARE SDH and Enabling Services Data Go Hand-in-Hand

PRAPARE

- Collects standardized data on social risks (NEED)
- Measures patient complexity in terms of non-clinical risk

ESAP

- Collects standardized data on enabling services provided to address SDH (RESPONSE)
- Measures what types and intensity (time) of enabling services provided

BOTH Are Necessary To:

- Demonstrate health center value to payers
- Seek adequate financing
- Better target and/or improve services
- Achieve integrated, value-driven delivery system reform and reduce total cost of care

WHAT ARE ENABLING SERVICES?

Non-clinical services that are provided to health center patients that **promote, support and assist in the delivery of health care** and facilitate access to quality patient care.

I. Enabling Services to Address SDOH

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Enabling Services Categories

- CASE MANAGEMENT ASSESSMENT
- CASE MANAGEMENT TREATMENT AND FACILITATION
- REFERRALS
- FINANCIAL COUNSELING/ ELIGIBILITY ASSISTANCE
- HEALTH EDUCATION
- SUPPORTIVE COUNSELING
- INTERPRETATION
- OUTREACH
- TRANSPORTATION

I. Enabling Services to Address SDOH

Enabling services in the UDS

- Table 5: Staffing & Utilization (Lines 24-29)
  - Case managers, patient and community education specialists, outreach workers, transportation workers, eligibility assistance workers, interpretation staff, community health workers, personnel performing other enabling service activities
- New! Table 6a: Quality Improvement
  - Enabling, Other Program-Related Services, and Quality Improvement (Lines 11a–13)
- Table 8A: Financial Costs

I. Enabling Services to Address SDOH

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Enabling services in the UDS

22c.	Other Vision Care Staff	0.00	
22d.	**Total Vision Services** (Sum Lines 22a-c)	**0.16**	
23.	**Pharmacy Personnel**	209.97	
24.	Case Managers	152.89	
25.	Patient/Community Education Specialists	60.48	
26.	Outreach Workers		
27.	Transportation Staff		
27a.	Eligibility Assistance Workers		
27b.	Interpretation Staff		
27c.	Community Health Workers		
28.	Other Enabling Services		
29.	**Total Enabling Services** (Sum Lines 24-28)		
29a.	**Other Programs/Services**		
29b.	**Quality Improvement Staff**		

Financial Costs of Enabling and Other Services		
11a.	Case Management	7,591,003
11b.	Transportation	803,301
11c.	Outreach	2,535,902
11d.	Patient and Community Education	3,443,802
11e.	Eligibility Assistance	3,213,413
11f.	Interpretation Services	2,335,220
11g.	Other Enabling Services	417,047
11h.	Community Health Workers	602,105
11.	**Total Enabling Services Cost** (Sum Lines 11a-11h)	**20,941,793**
12.	Other Related Services	26,035,322
12a.	Quality Improvement	4,492,143
13.	**Total Enabling and Other Services**	**51,469,258**

Enabling Services, QI & Value-Based Care:

- Stage 3 Meaningful Use (MU)
- PCMH and other value-based delivery models
- Z codes
- Medicaid MCOs
- Accountable Care Organizations

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Enabling Services & PCMH

NCQA, 2020. Accessed at: https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

II. Humanizing enabling services through data

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II. Humanizing enabling services through data

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AAPCHO 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

CATEGORY	CODE	Minutes
CASE MANAGEMENT ASSESSMENT	CM001	
CASE MANAGEMENT TREATMENT AND FACILITATION	CM002	
CASE MANAGEMENT REFERRAL	CM003	
FINANCIAL COUNSELING/ELIGIBILITY ASSISTANCE	FC001	
HEALTH EDUCATION/SUPPORTIVE COUNSELING	HE001	
INTERPRETATION	IN001	
OUTREACH	OR001	
TRANSPORTATION	TR001	
OTHER	OT001	

AAPCHO Enabling Services Accountability Project: https://www.aapcho.org/projects/enabling-services-accountability-project/

II. Humanizing enabling services through data

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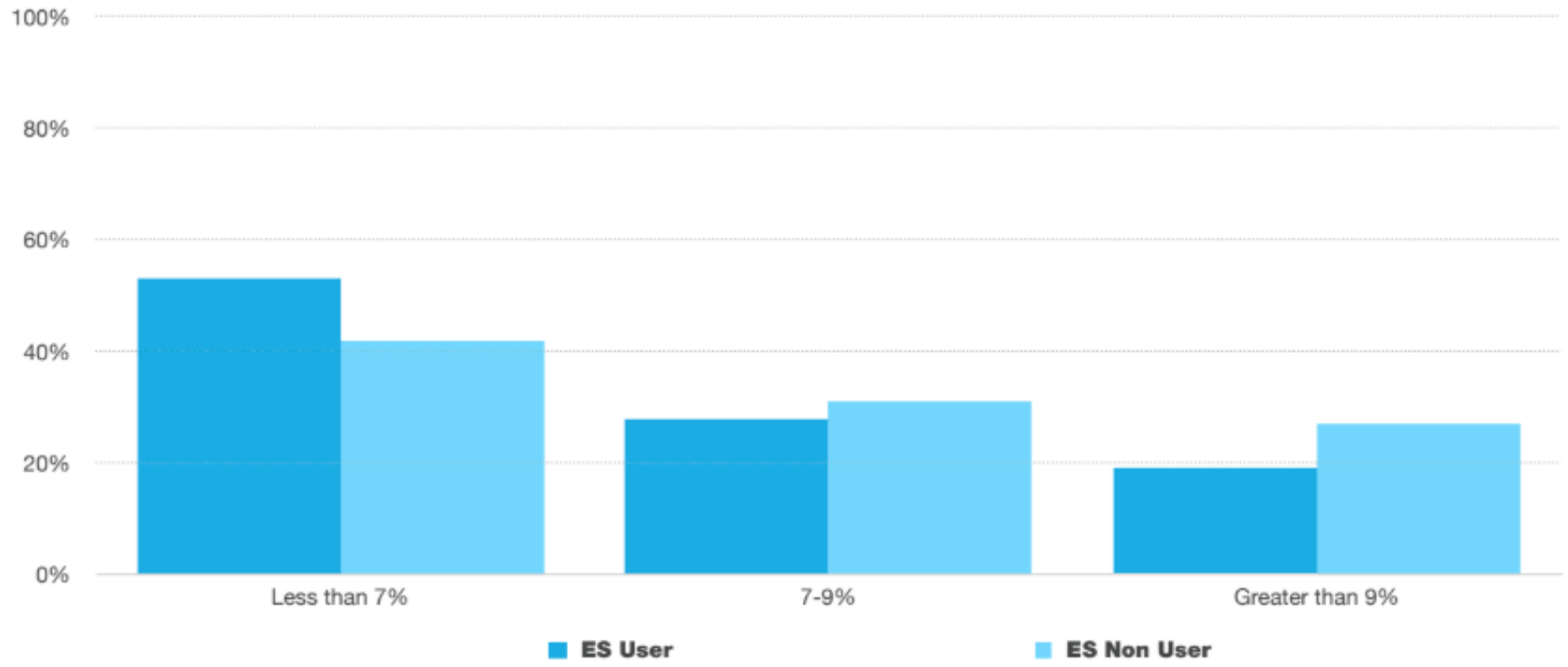
ES Users: Association w/ reducing health disparities and improving health services quality

HBA1C LEVELS

+ **More ES users had their HbA1c under control compared to ES nonusers.**



AAPCHO Enabling Services Accountability Project: https://www.aapcho.org/projects/enabling-services-accountability-project/

II. Humanizing enabling services through data

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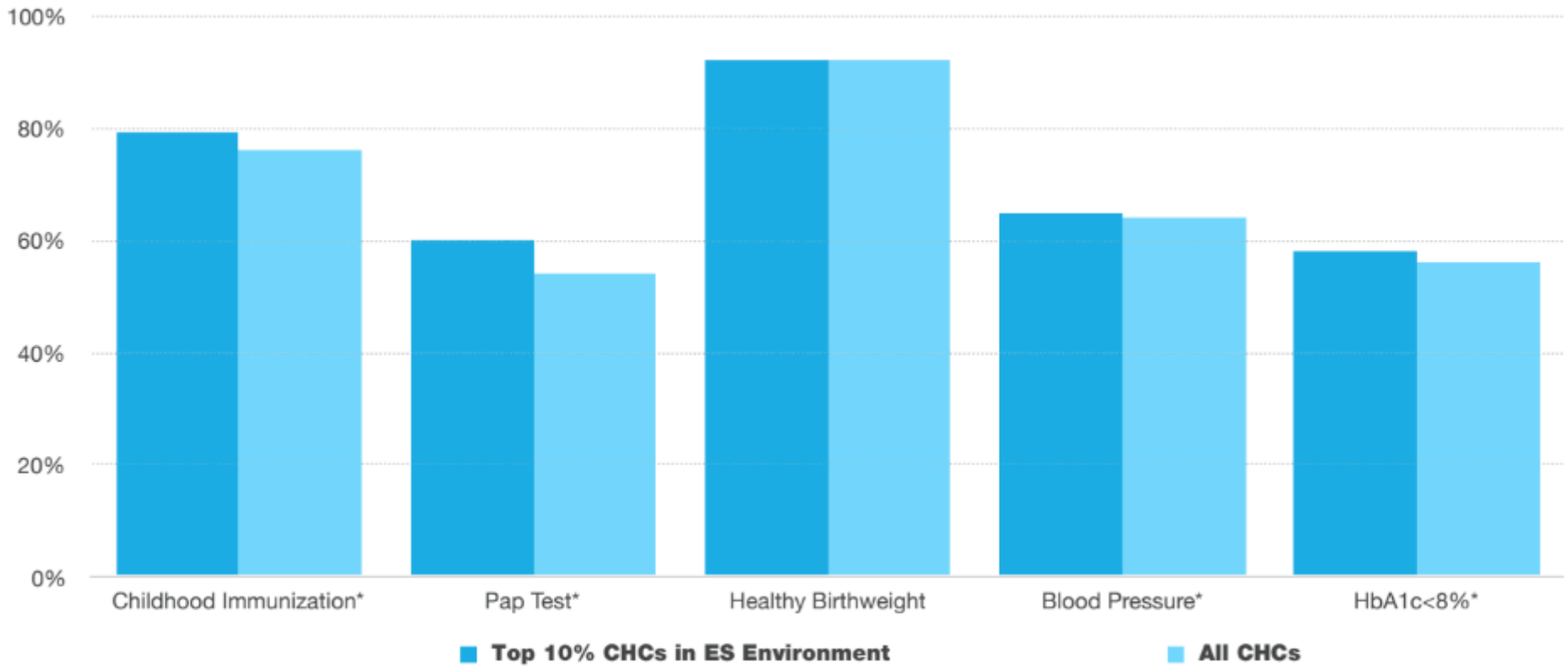
Investment in ES is associated with better health outcomes



AAPCHO Enabling Services Accountability Project: https://www.aapcho.org/projects/enabling-services-accountability-project/

II. Humanizing enabling services through data

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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/

II. Humanizing enabling services through data

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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/

II. Humanizing enabling services through data

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Waianae Coast Comprehensive Health Services (Hawaii) – used ES data to support reduction in ER utilization. Received better funding from local health plan by submitting ES data.

LifeLong Medical Care (California) – tracked ES for community/non-patients to sustain or expand health education programs (e.g. walking groups, zumba, cooking classes)

Valley Wide Health Systems (Colorado) – worked with Colorado Medicaid office for per member per month (PMPM) for care coordination staff

Charles B. Wang CHC (New York) – reallocation of resources to hire more care coordinator or case managers. Also, led to more Medicaid eligibility assistant for enrollment and eligibility.

Acknowledgement to Waianae Coast Comprehensive Health Services, LifeLong Medical Care, Valley Wide Health Systems, and Charles B. Wang CHC for their contributions. Image Source: Wikipedia.

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.

III. Health information technology infrastructure for data collection

III. HIT infrastructure for data collection

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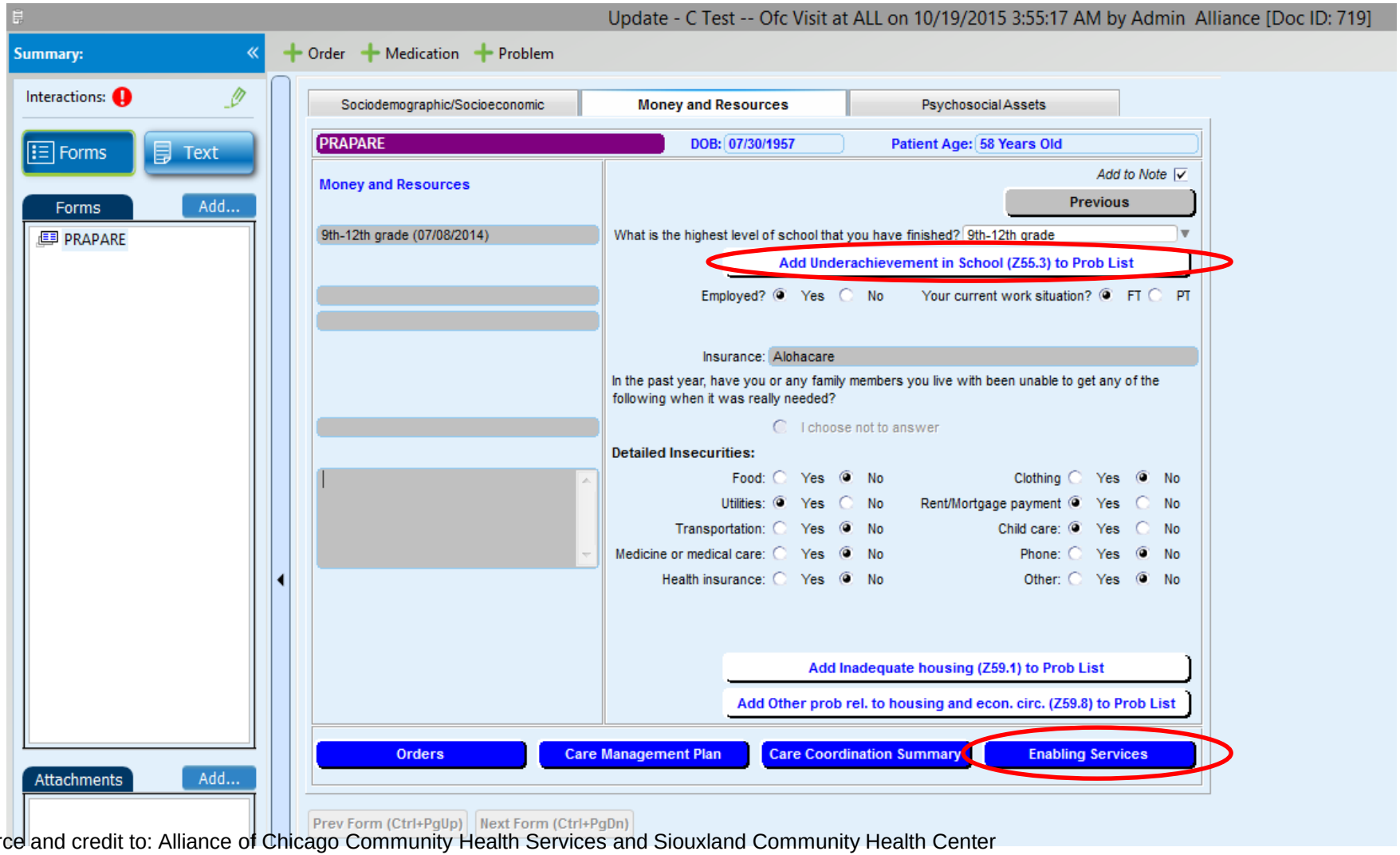
PRAPARE EHR Template Example



Source and credit to: Alliance of Chicago Community Health Services and Siouxland Community Health Center

III. HIT infrastructure for data collection

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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

III. HIT infrastructure for data collection

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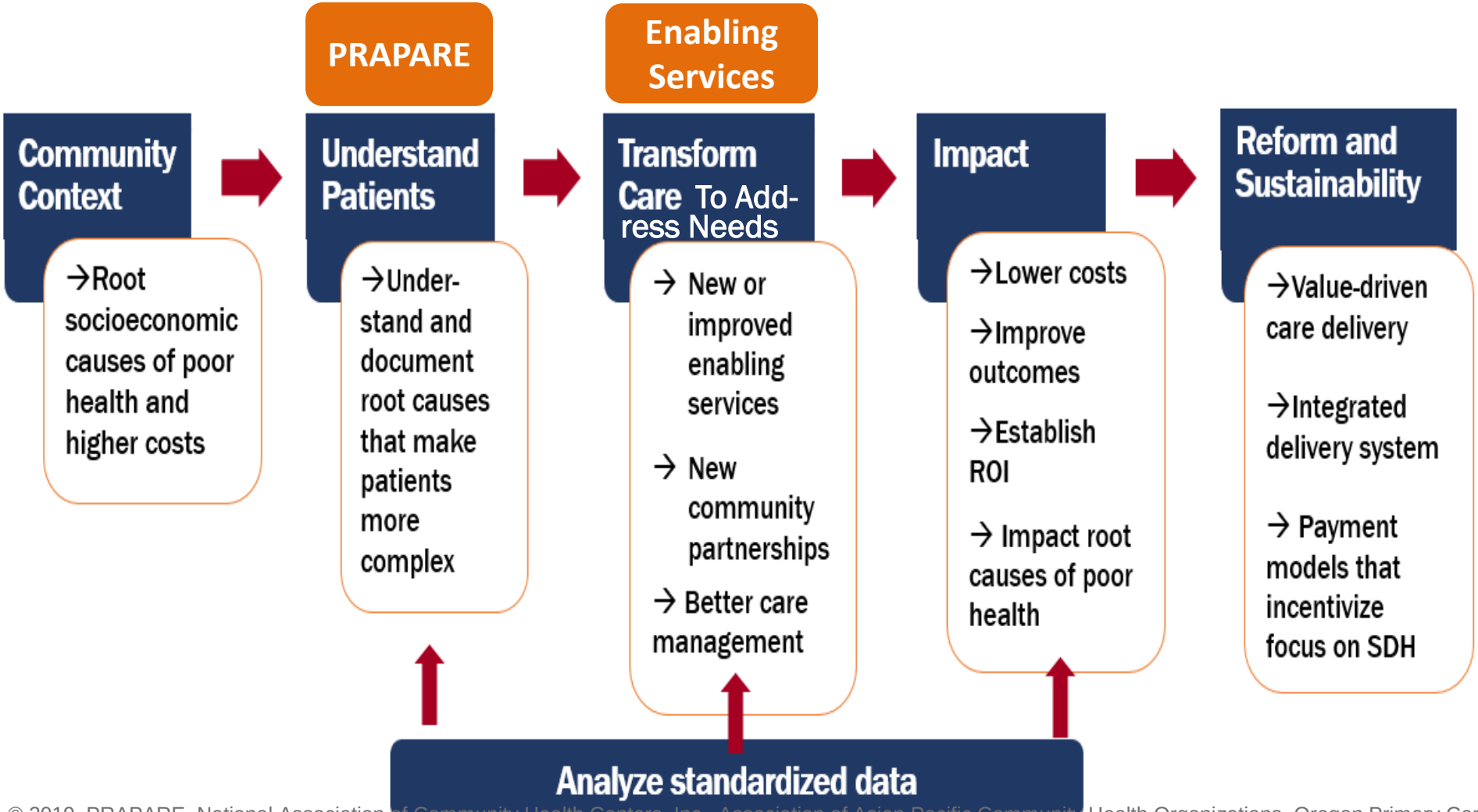
SDH and ES Data Work Together to Transform Care



Resources

- PRAPARE
  www.nachc.org/prapare

- Enabling Services Implementation Toolkit
  www.enablingservices.aapcho.org

Questions?

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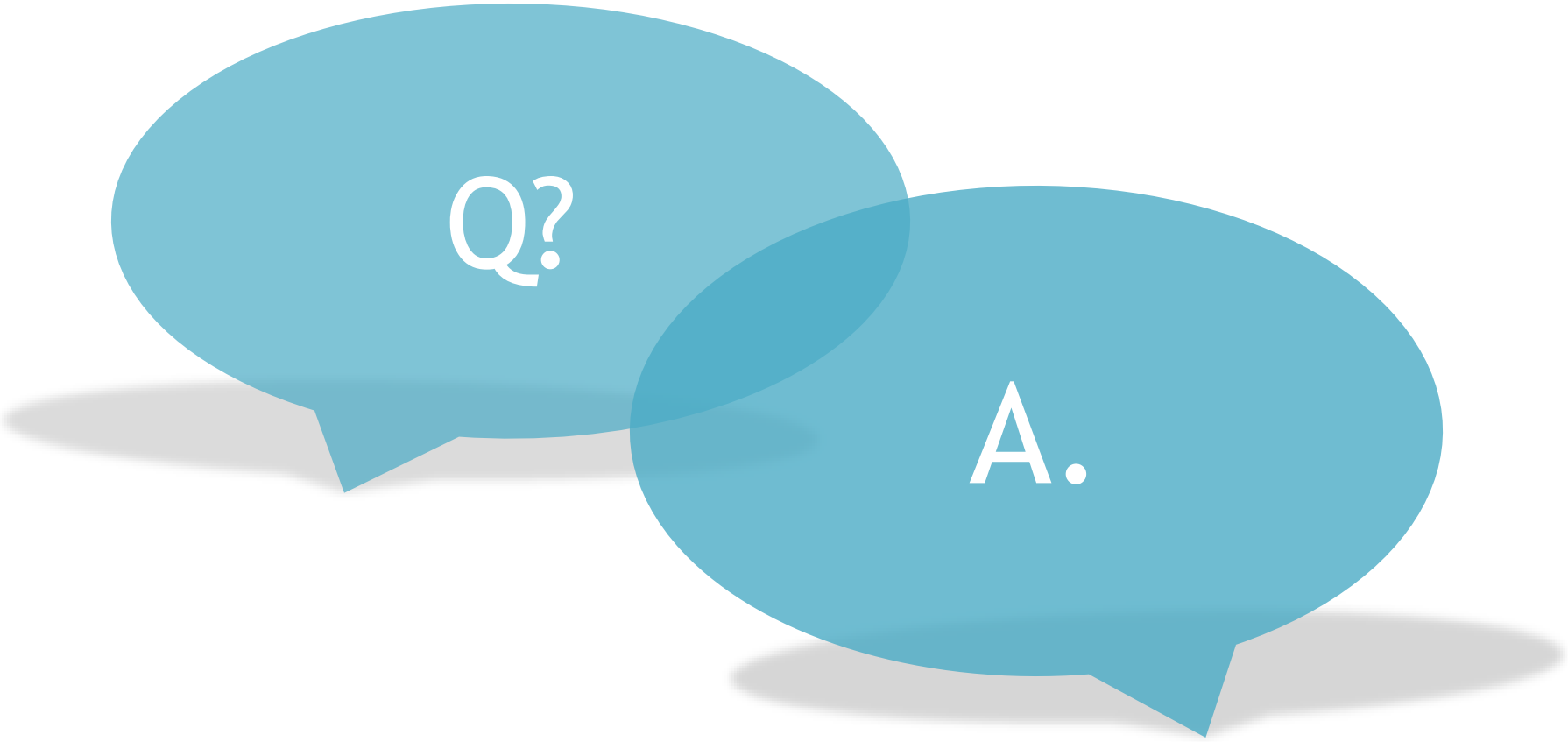

Teaser!

Join us next week for in-depth applications

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Examples of PRAPARE Workflows

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.

Teaser!

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Using PRAPARE for Population Segmentation with Diabetic Patients

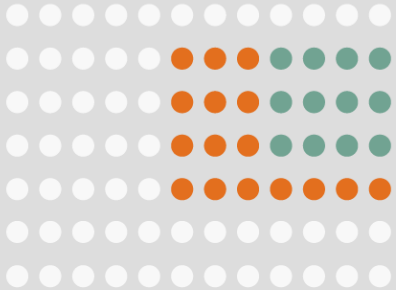
10,000 PEOPLE

POPULATION

Use analytics to piece together target population characteristics.

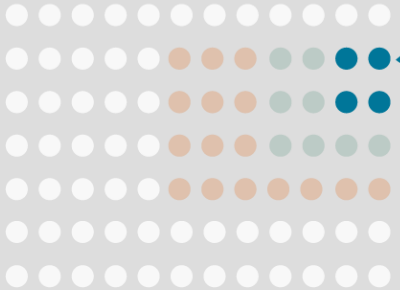
May require multiple data sources and analytic processes.

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

Teaser!

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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	

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.

Join us for the *"Deep Dive" on ESDC implementation strategies!*

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Next Session – February 26th

- **Addressing SDOH Core Competencies: Humanizing Your Enabling Services Data for Patient Care**
  - Session 2 – Implementation Strategies
  - Wednesday, February 26, 2020 @ 2:00 – 3:30 PM EST
  - Register here: https://register.gotowebinar.com/register/1488961249876648460

Contact Us

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mjester@nachc.org

Office Hours

30 minutes

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Thank you!

https://sdohacademy.com/collaboratives

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Enabling Services data in practice

Health Center example helpful for Office Hours)

ES Data in Practice: HC Example

- As part of Patient Centered Health Care Home*, care coordination services were provided to high risk targeted patients diagnosed with diabetes (250.xx) and with a HbA1c >8.
- Assessed if care coordination improves HbA1c levels for those with HbA1c>8.

Defining Care Coordination

	Average # of encounter per patient	Top 3 Enabling Services	Average time per encounter
1/1/2012-12/31/2012	26.8	CM003 (83.45%) HE001 (13.71%) FC001 (1.61%)	12.38 minutes
1/1/2013-12/31/2013	26.08	CM002 (28.68%) CM001 (24.89%) HE001 (20.35%)	28.13 minutes

HbA1c results

	Patients' Average HbA1C	Patients' HbA1C <=7%	Patients' HbA1C>9%
Baseline (March 2011-May 2013)	10.5	3 (4%)	54 (72%)
Post-Intervention (Jan 2012- May 2014)	9.3	13 (17.33%)	39 (52%)

Total # patients receiving intervention: 103
Denominator: 75

THANK YOU!!