ORAL HEALTH INFORMATION TECHNOLOGY VIRTUAL CONVENING

Social Determinants of Health and Oral Health Information Technology
November 19, 2020

DentaQuest

Session Participation

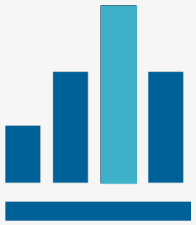
Zoom Features

LISTEN ONLY

CHAT

Q&A

POLLING



SOCIAL DETERMINANTS OF HEALTH AND ORAL HEALTH INFORMATION TECHNOLOGY

November 19, 2020

DentaQuest®
Partnership
for Oral Health Advancement

Learning Objectives

1. Define social determinants of health as they pertain to oral health
2. Highlight examples of practical implementation of the collection of SDOH data
3. Identify opportunities to engage in the collection, reporting and use of SDOH data in dental settings

Housekeeping

- Participants are in audio only mode. If you have questions for the panel please use the Q/A feature.
- A copy of the slides and a link to the recording will be shared after the webinar concludes. They will also be available on the dentaquestpartnership.org website under the **Learn** tab. Select **Webinars**.
- In order to receive CE credit you must fill out the webinar evaluation, which will be shared at the end of the presentation. The evaluation must be completed by **EOD Wednesday, November 25** to receive CE credit. CE certificates will be distributed a few days after the webinar takes place.
- Your feedback is also greatly appreciated.

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*Full disclosures available upon request

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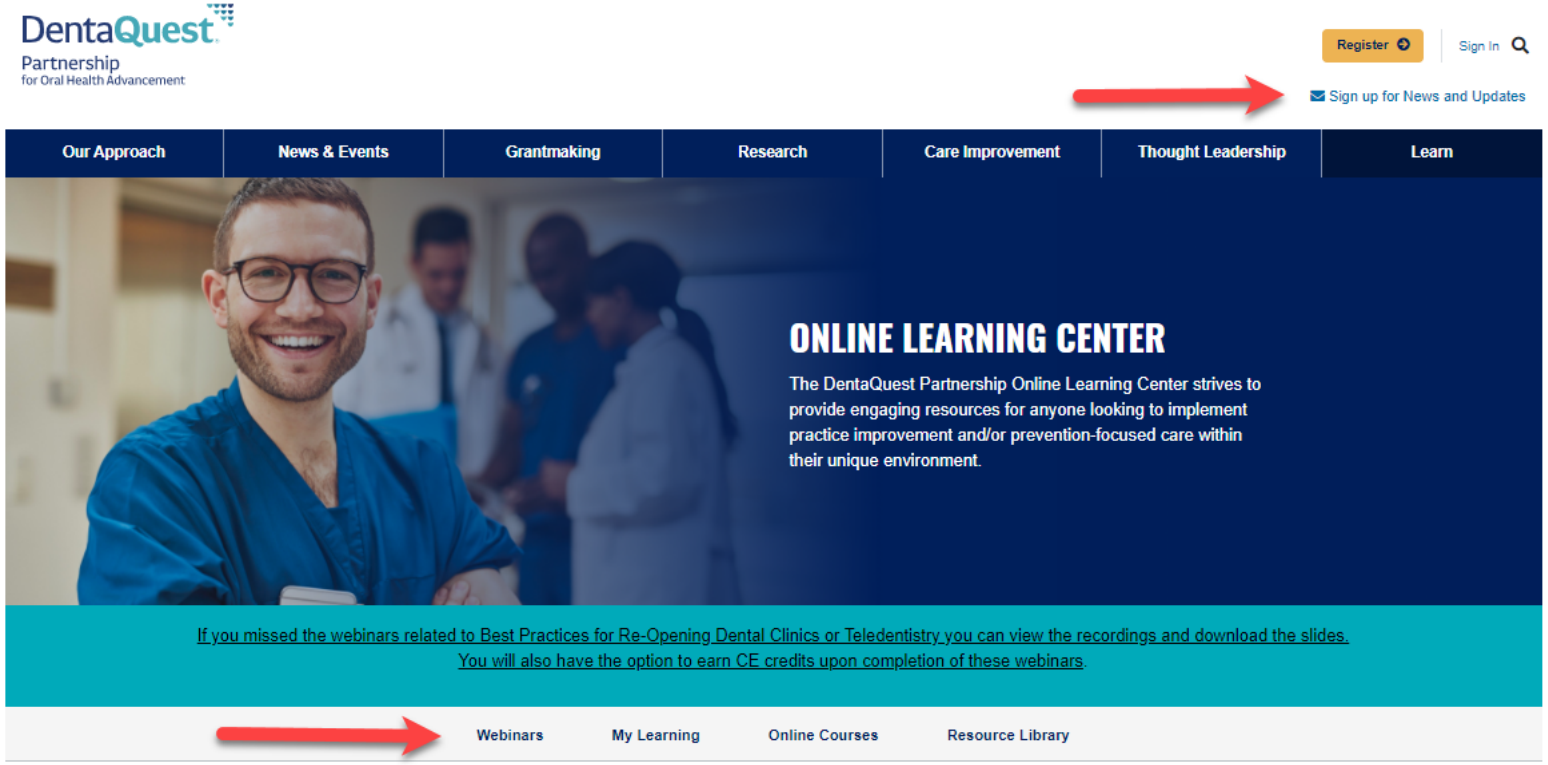
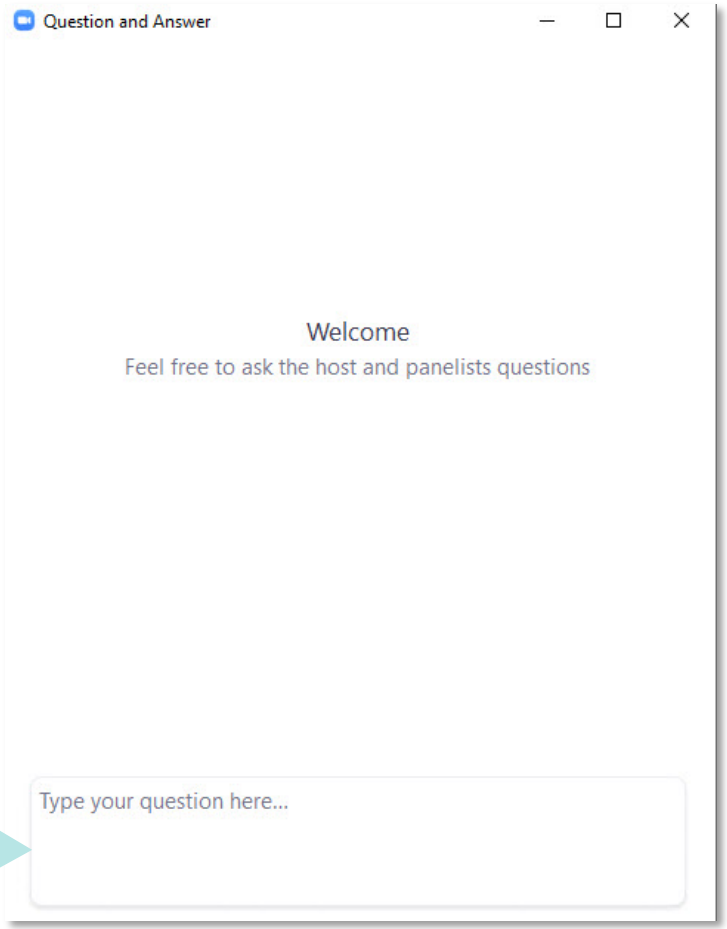
- Sign up for our newsletter to get more information on upcoming webinars.
- https://www.dentaquestpartnership.org/learn



Question and Answer Logistics

- After the presentations we have time allocated for audience Q&A.
- We are not going to take any questions in between presentations. We will be monitoring the Zoom Q&A box through the entire presentation and we will do our best to answer all of your questions at the end.



Type your question in the **Question and Answer** box.

POLLING

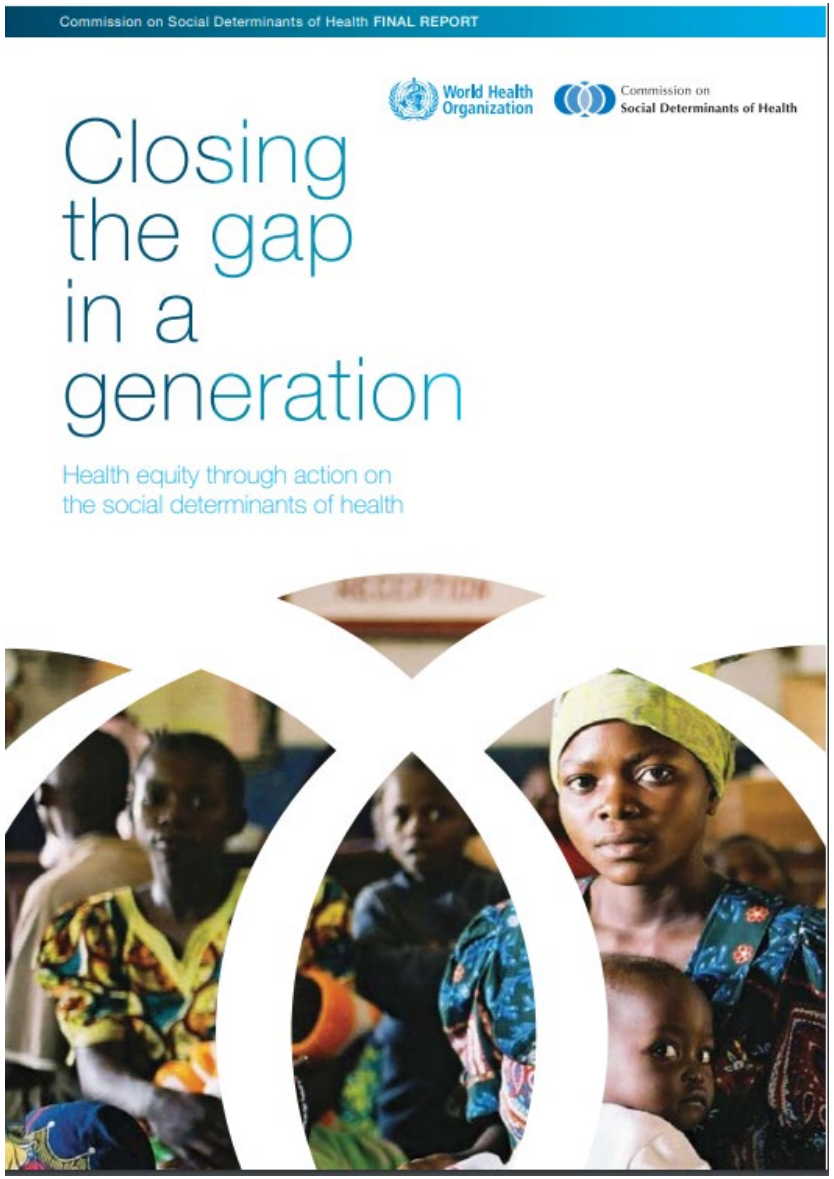
Audience Polling

Make your selection

Don’t forget to hit **Submit**

SOCIAL DETERMINANTS OF HEALTH

Rural Health Day

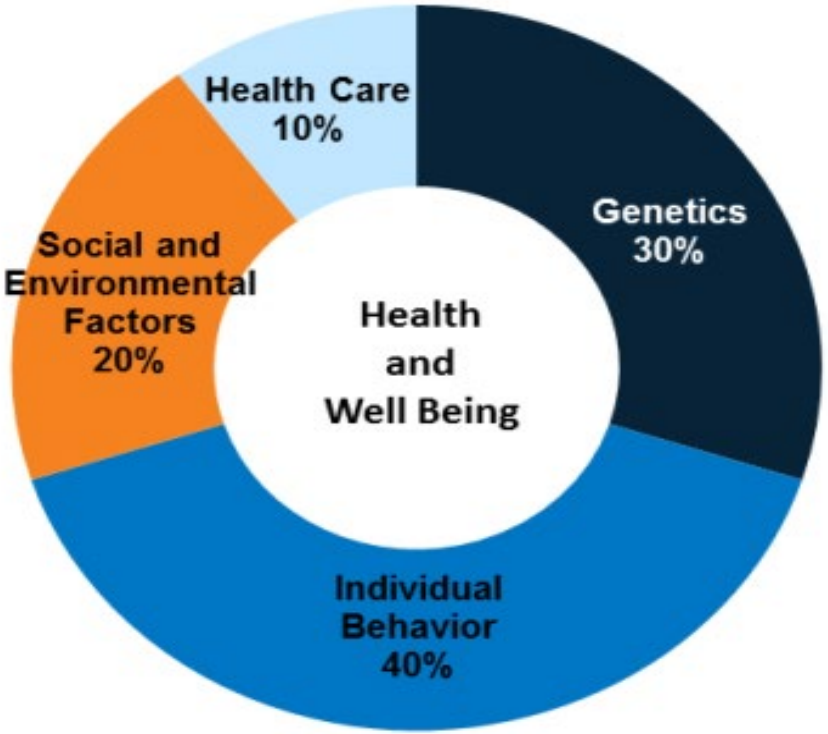


"This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place.“

- Director-General Dr Margaret Chan, at the launch of the final report of the CSDH in **2008**

Figure 2

Impact of Different Factors on Risk of Premature Death



SOURCE: Schroeder, SA. (2007). We Can Do Better — Improving the Health of the American People. *NEJM*. 357:1221-8.

KFF
HENRY J. KAISER FAMILY FOUNDATION

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Definition

The social determinants of health are the conditions in which people are born, grow, live, work and age that shape health.

- Kaiser Family Foundation

Definition (cont.)

"…it is the understanding that when available, access to resources and technical assistance is often socially determined.[1]"

Social Determinants of the Health of Urban Populations: Methodologic Considerations (NCBI)

1 Kim JY, Millen JV, Gershman J, Irwin A. Dying for Growth: Global Inequality and the Health of the Poor. Monroe, ME: Common Courage Press; 2000.

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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Healthcare IT News

How SDOH will influence the next wave of health tech startups

The industry already has seen some startups working with social determinants of health. Their number will only increase as healthcare moves to value-based care and needs more data.

By **Bill Siwicki** | September 30, 2019 | 01:13 PM

Value-based care driving SDOH

With a goal of providing the best outcomes at an optimal price, stakeholders must now expand their scope to address the social determinants of health, too, Lin said. Ultimately, this paradigm shift supports payers and providers in aligning social needs and clinical care, she added.

"If we can collect standardized SDOH data at the individual level, it must also be incorporated into population health management platforms to inform care coordination efforts."

— Joanne Lin, Newark Venture Partners

Where do you start?

Source: Ravi Narayan, SOCHARA, India

MEET PAUL

a 30-year-old male who has mild hypertension, Type 1 Diabetes, and has an insulin pump. He lives in a rural area, his home has no potable water, and he does his primary grocery shopping at the town convenience store. He receives health care at a Federally Qualified Health Center which is more than 30 miles away.

Paul’s Story

POLLING

- Housing Suitability
- Food Insecurity
- Rural
- Transportation

SOCIAL DETERMINANTS OF HEALTH AND ORAL HEALTH TECHNOLOGY

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National Association of Community Health Centers

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Clinical Quality Risk Manager, Family Health Services of Darke County, Inc.

Parrish Ravelli
Grants and Program Associate,
DentaQuest Partnership for Oral Health Advancement

Practice Setting

POLLING

The Gravity Project: Consensus-driven Standards on Social Determinants of Health

Oral Health Information Technology Virtual Convening

November 19, 2020

Presented By: Evelyn Gallego, EMI Advisors LLC,
Gravity Program Manager

Agenda

- Gravity Project Team
- Background (WHY)
- Project Scope (WHAT)
- Accomplishments & Success Factors
- How to Engage

Gravity Project Team

Gravity Project Management Office (PMO)

- **Caroline Fichtenberg**, Managing Director, UCSF/ SIREN
- **Evelyn Gallego,** Program Manager, EMI Advisors
- **Carrie Lousberg**, Project Manager, EMI Advisors
- **Mark Savage,** SDOH Policy Lead**,** USCF/SIREN
- **Sarah DeSilvey,** Clinical Informatics Director, University of Vermont
- **Bob Dieterle,** Technical Director, EnableCare

siren
Social Interventions Research & Evaluation Network

EMI ADVISORS

cdhi Center for Digital Health Innovation at UCSF

The University of Vermont
LARNER COLLEGE OF MEDICINE

EnableCare

Gravity Project Sponsorship (Financial & In-Kind)

HL7 International

https://confluence.hl7.org/display/GRAV/Gravity+Project+Sponsors

gravity PROJECT

Overview

Business Drivers

There is broad consensus that SDOH information improves whole person care and lowers cost. Unmet social needs negatively impact health outcomes.

- **Food insecurity** correlates to higher levels of diabetes, hypertension, and heart failure.
- **Housing instability** factors into lower treatment adherence.
- **Transportation barriers** result in missed appointments, delayed care, and lower medication compliance

One of the biggest barriers to addressing social risk and social needs in clinical settings is the limited standards available to represent the data.

Key Learning: Despite increased interest around identifying and addressing SDOH in context of US health care settings, existing medical coding vocabularies and health information exchange standards are poorly equipped to capture related activities.

Enter the Gravity Project…

Goal

Develop consensus-driven data standards to support use and exchange of social determinants of health (SDOH) data within the health care sectors and between the health care sector and other sectors.

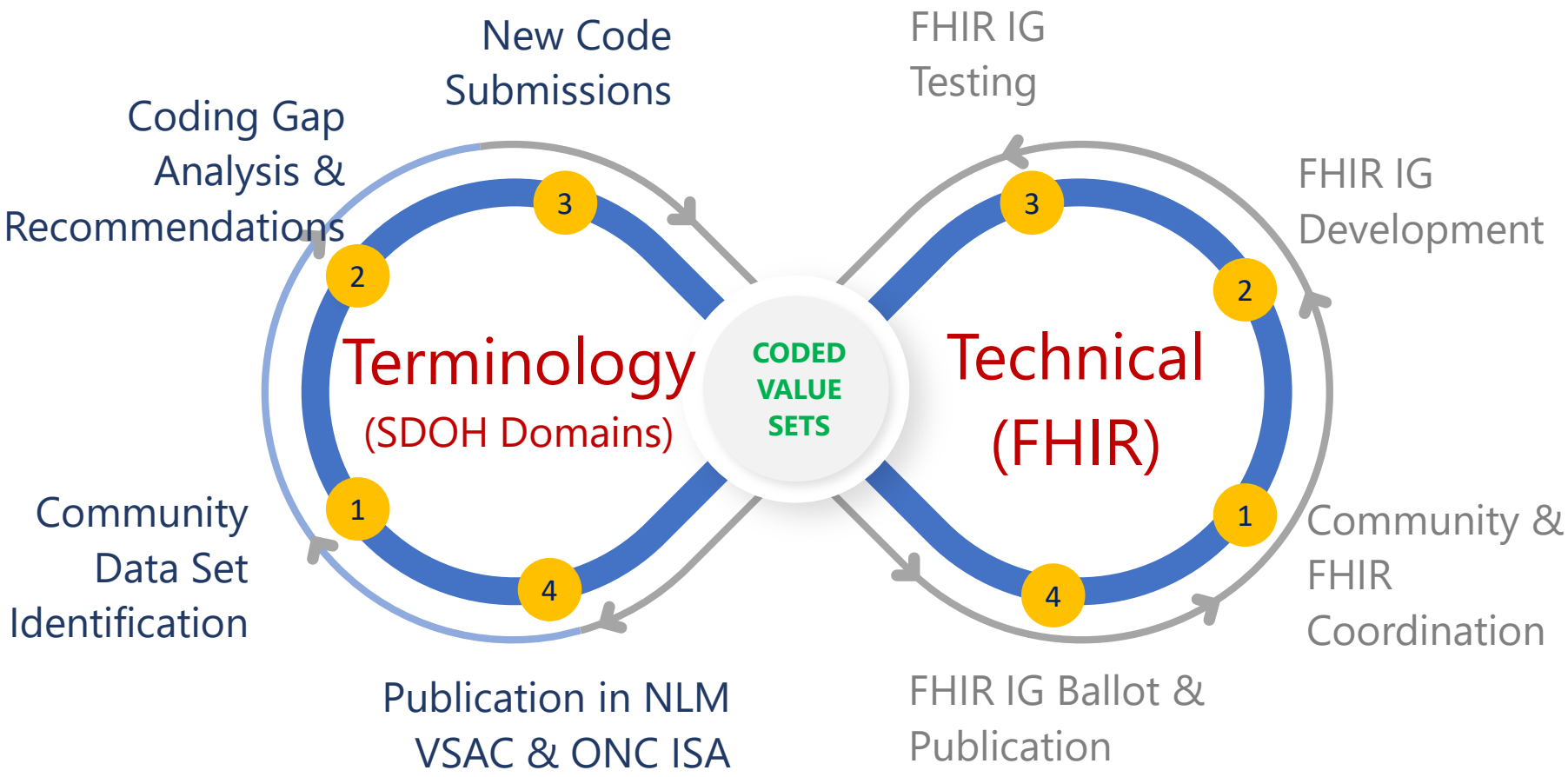
Project Scope

In May 2019, the Gravity Project was launched as a multi-stakeholder public collaborative with the goal to develop, test, and validate standardized SDOH data for use in patient care, care coordination between health and human services sectors, population health management, public health, value-based payment, and clinical research.

The Gravity Project was initiated by the Social Interventions Research and Evaluation Network (SIREN) with funding from the Robert Wood Johnson Foundation and in partnership with EMI Advisors LLC.

Gravity Project Scope: Develop data standards to represent patient level SDOH data documented across four clinical activities: screening, assessment/diagnosis, goal setting, and treatment/interventions.

Gravity Overview: Two Streams



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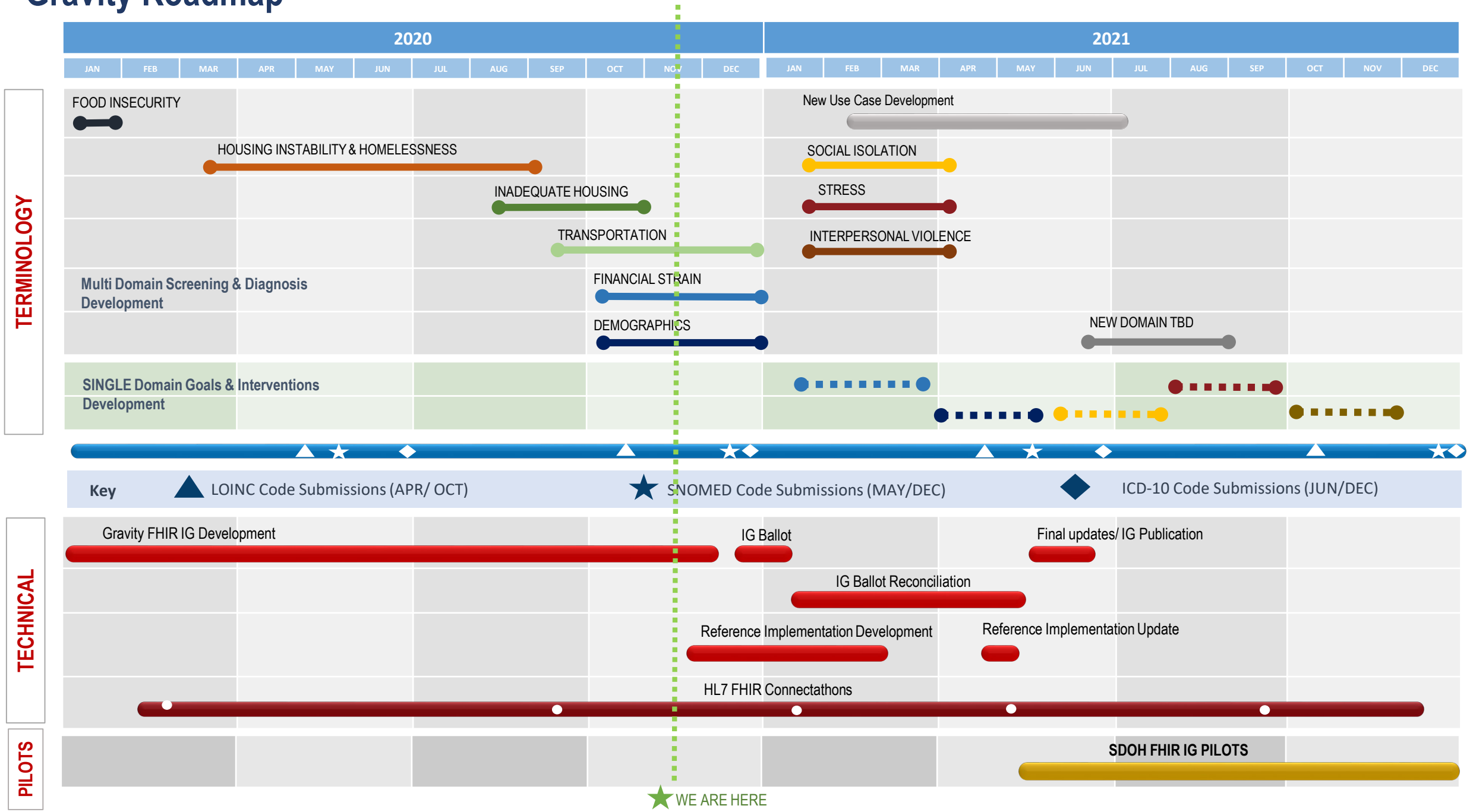
Gravity Roadmap



Public Collaboration

Gravity has convened over **1,100+** participants from across the health and human services ecosystem from clinical provider groups, community-based organizations, standards development organizations, federal and state government, payers, and technology vendors.

https://confluence.hl7.org/pages/viewpage.action?pageId=46892669#JointheGravityProject-GravityProjectMembershipList

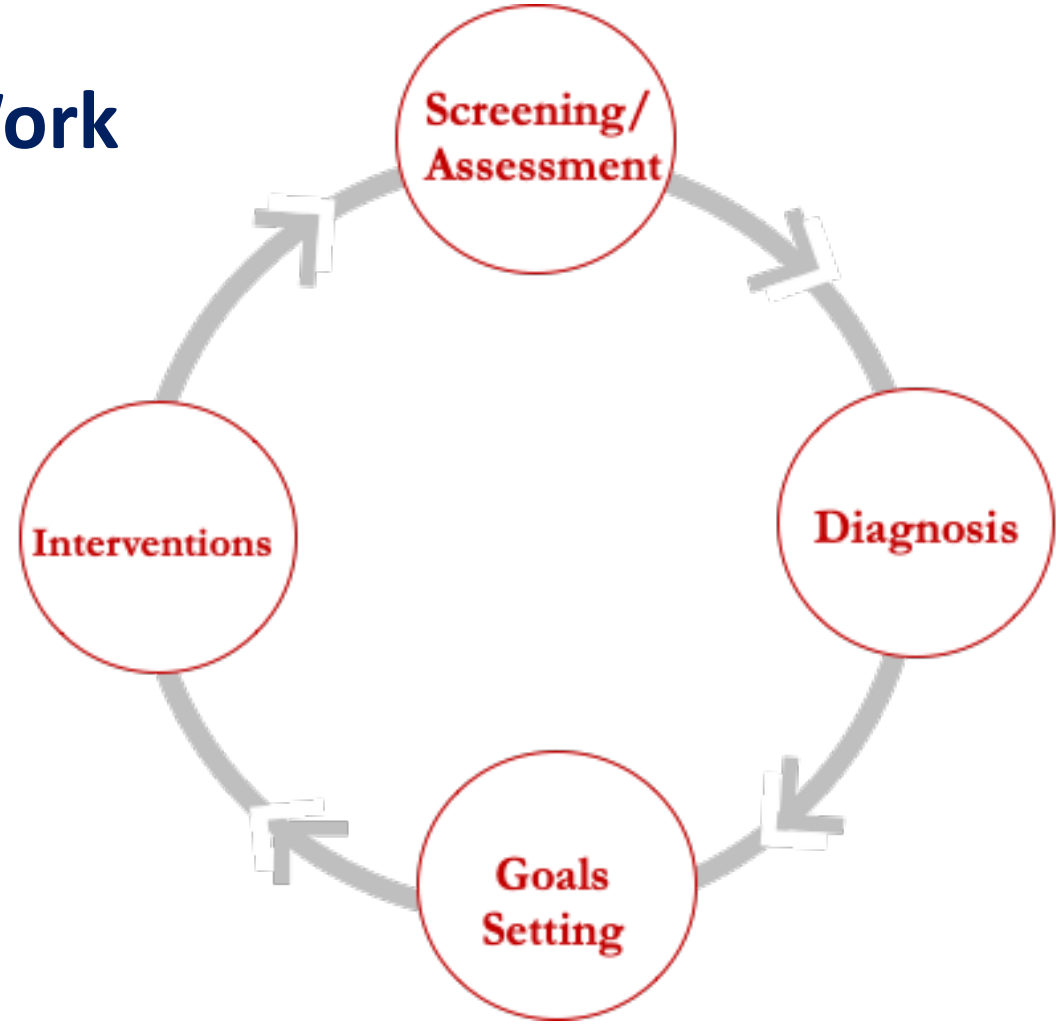
Terminology Workstream

Terminology Workstream

Data Element and Gaps Analysis Work

For each domain:

- What concepts need to be documented across the following activities?
- What codes reflecting these concepts are currently available? What codes are missing?



SDOH Terminology Domains

12/4 ICD-10 Submission

2019

- Food Insecurity

2020

- Housing Instability and Homelessness
- Inadequate Housing
- Transportation Insecurity
- Financial Strain – Screening and Diagnoses
- Education - Screening and Diagnoses
- Employment - Screening and Diagnoses
- Veteran status - Screening and Diagnoses

2021 – Established

- Financial Strain – Goals and Interventions

- Education - *Goals and Interventions?*
- Employment - *Goals and Interventions?*
- Veteran status - *Goals and Interventions?*

2021- New

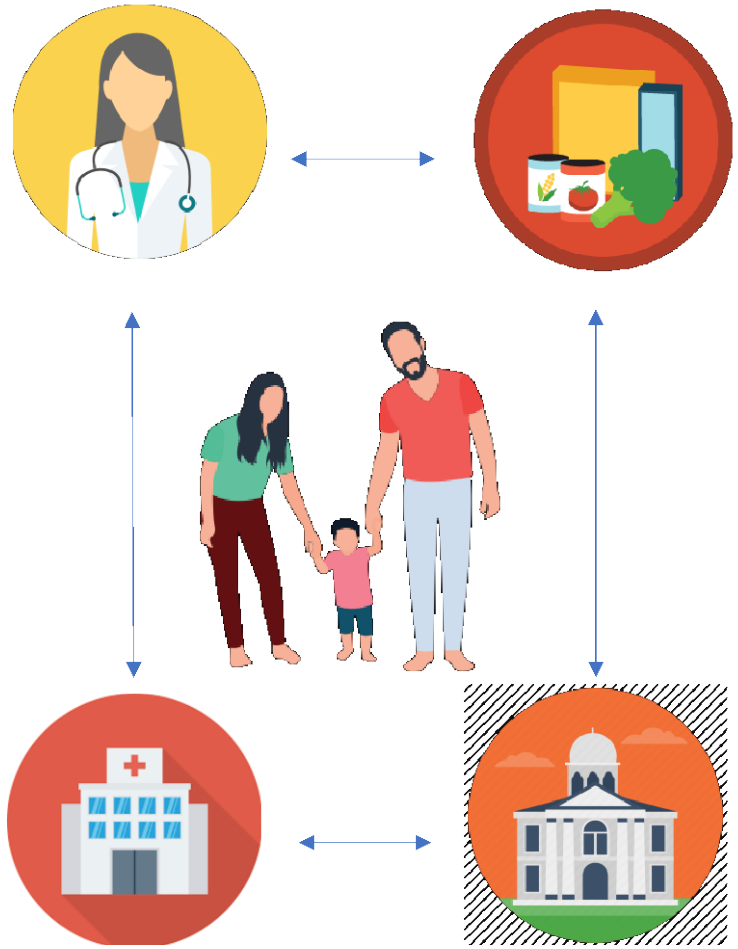
- Social Isolation- Screening and Diagnoses
- Stress - Screening and Diagnoses
- Interpersonal Violence - Screening and Diagnoses

Perspectives on Data

What **kinds of data** does the provider need to care for their patients?

- the hospital need to study the effects of provider interventions?
- the WIC office or food bank need to address the need of their clients?
- the state need to plan for population health needs?

And what are the principles we need to consider to keep patients at the center?

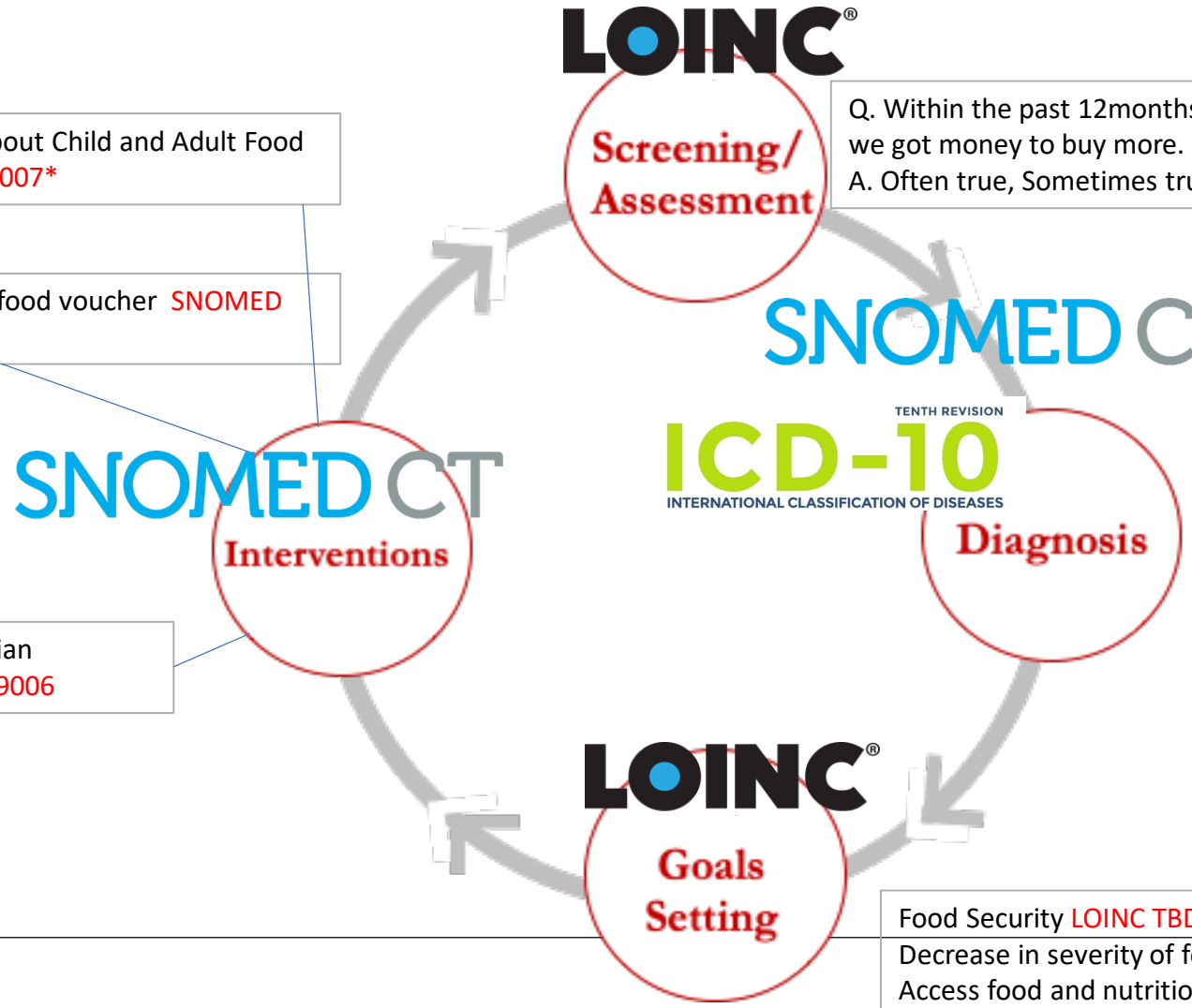


Gravity Project Data Use Principles for Equitable Health and Social Care

- Improving Personal Health Outcomes
- Improving Population Health Equity
- Ensuring Personal Control
- Designing Appropriate Solutions
- Ensuring Accountability
- Preventing, Reducing, and Remediating Harm

https://confluence.hl7.org/display/GRAV/Gravity+Data+Principles

Food Insecurity Terminology Build



PROCEDURE: Education about Child and Adult Food Program SNOMED 409073007*

PROCEDURE: Provision of food voucher SNOMED 119270007*

REFERRAL: Referral to Dietician Nutritionist SNOMED 103699006

Q. Within the past 12months we worried whether our food would run out before we got money to buy more. **LOINC 88122-7**
A. Often true, Sometimes true, Never true, don't know/refused. **LOINC LL4730-9**

Food Insecurity Observation: Mild food insecurity, moderate food insecurity, severe food insecurity **SNOMED 733423003**

Food Insecurity Diagnoses ICD-10-CM:
Food Insecurity Z59.42
Mild food insecurity Z59.421
Moderate food insecurity Z59.422
Severe food insecurity Z59.423
Food Insecurity, unspecified Z59.429

Food Security LOINC TBD
Decrease in severity of food insecurity LOINC TBD
Access food and nutrition support LOINC TBD

HL7 International

* Proposed. Not final.

gravity PROJECT

Food Insecurity: Building Concepts Into Code

- **Food Insecurity Screening Tools-** LOINC V2.68 released 6/17/20
  - The three USDA Screeners submitted by Gravity are included in this release (U.S. Household Food Security (18), U.S. Adult Food Security (10), U.S. Household Short Form (6)
  - Additional screeners from the Food Insecurity Master List are being prepared to submit for consideration in the December LOINC release.
- **Diagnoses/Problems and Interventions-** SNOMED CT
  - Submitted concepts are currently being reviewed by SNOMED
- **Diagnoses-** ICD-10
  - Food insecurity diagnoses from the master list have been submitted for review

https://confluence.hl7.org/pages/viewpage.action?pageId=55938680#FoodInsecurityDomain-CodingSubmissions

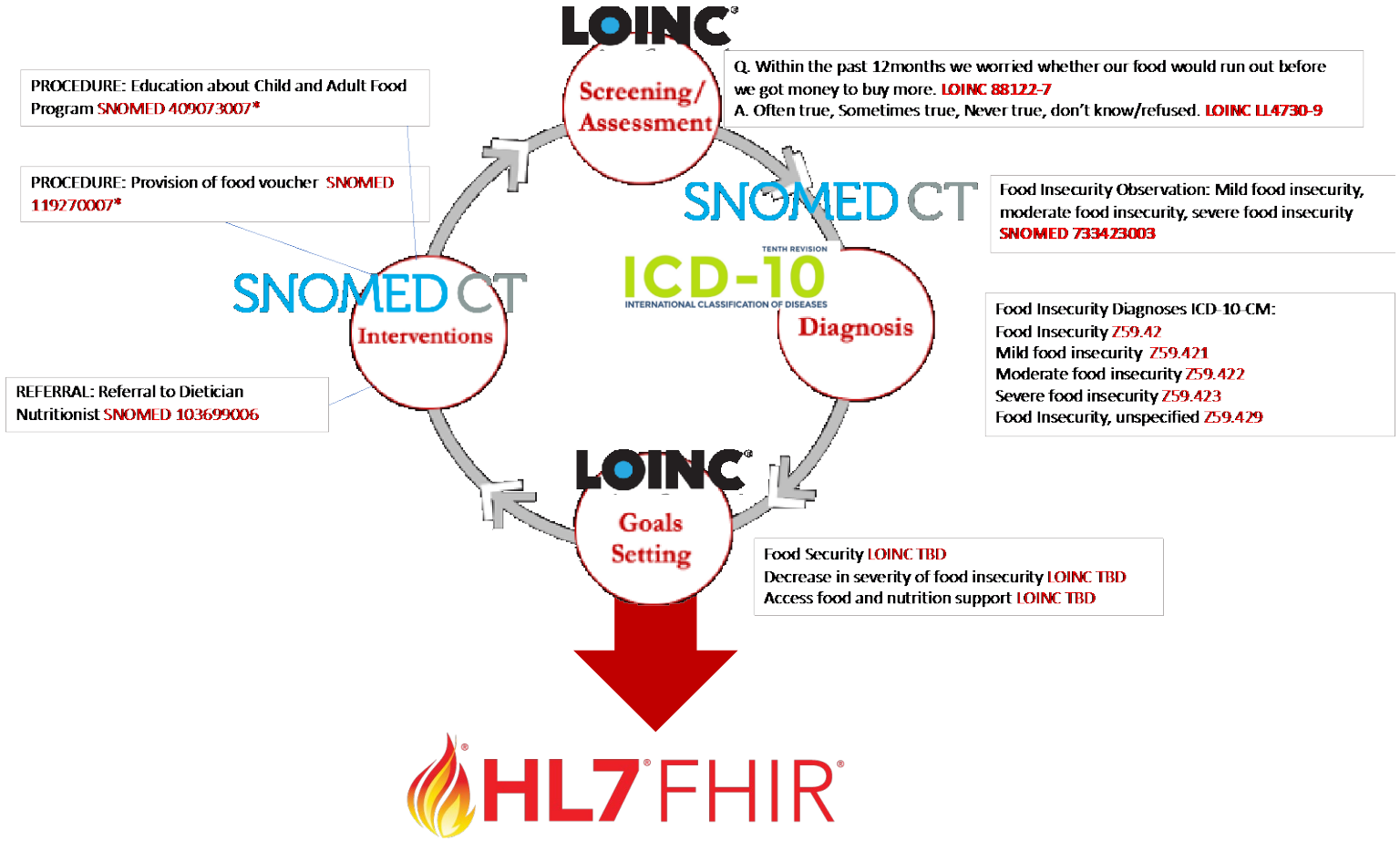
Technical Workstream

Gravity & FHIR

HL7® FHIR® Accelerator Program

- Designed to assist implementers across the health care spectrum in the creation of FHIR Implementation Guides or other informative documents
- Gravity Project became an official Accelerator in August 2019:
  http://www.hl7.org/documentcenter/public_temp_3840821C-1C23-BA17-0C64E3ACBE05D630/pressreleases/HL7_PRESS_20190820.pdf

Accelerating Adoption Using Nationally Recognized Standards



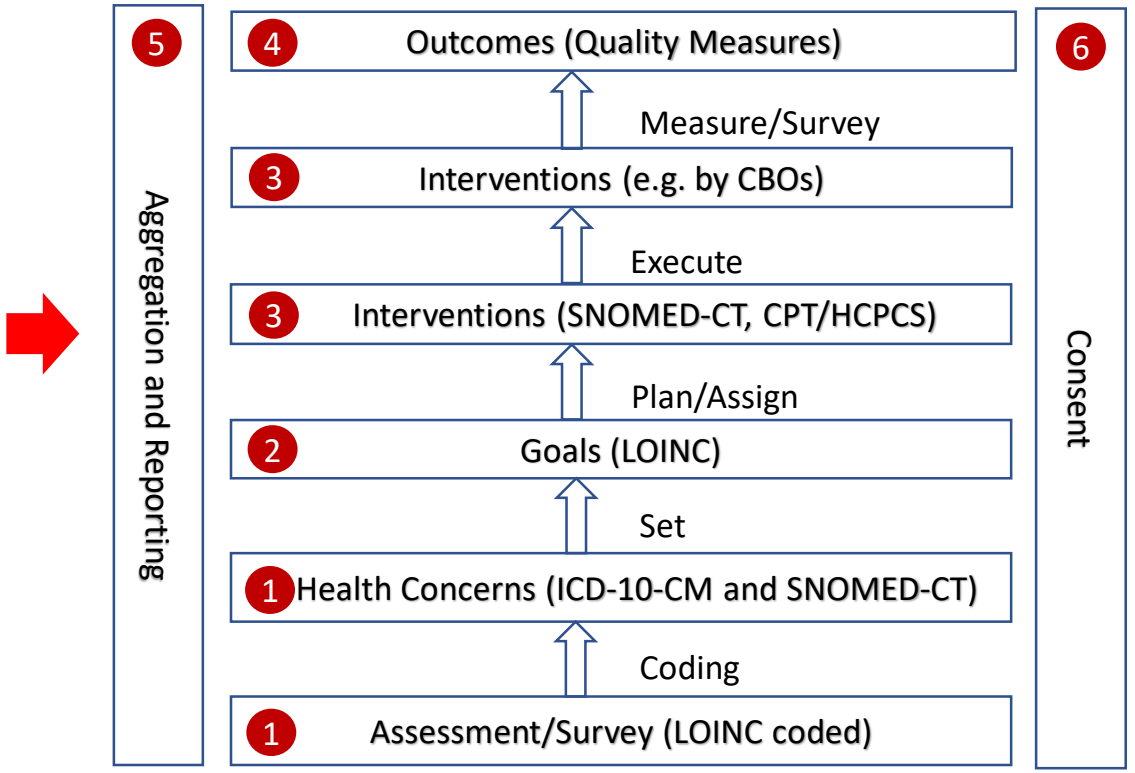
Technical Stream – FHIR IG Focus

1. Redesigning the FHIR IG to support multiple domains
   - Working on new FHIR methods to allow value sets to “flex” based on the domain requirements
2. Support for exchange of information related to SDOH primary clinical activities related to SDOH
3. Plan to ballot STU1 version of the FHIR IG in the January ballot cycle

   It is important to remember that the IG is a definition of how to represent SDOH information for exchange. (e.g. via a FHIR based API – conformant to the ONC 21st Century Cures Act final rule)
4. Planning for January HL7 Connectathon 26

Gravity FHIR SDOH Clinical Care IG Scope

1. Document SDOH data in conjunction with the patient encounter
2. Set SDOH related goals.
3. Establish interventions to completion.
4. Measure outcomes.
5. Gather and aggregate SDOH data or uses beyond the point of care (e.g. population health management, quality reporting, and risk adjustment/ risk stratification).
6. Manage patient consent



http://build.fhir.org/ig/HL7/fhir-sdoh-clinicalcare/

Accomplishments & Success Factors

Accomplishments & Success Factors

- **June 2019:** Published comprehensive use case package
- **July 2019**: Launched food insecurity domain.
- **November 2019**: Published the final food insecurity data set and received national recognition in Department of Health & Human Services (HHS) Roundtable on "Leveraging Data on the SDOH" Report
- **January 2020**: Completed food insecurity coding gap analysis recommendations.
- **March 2020**: Launched housing instability domain.
- **May - June 2020**: Submitted new code applications for food insecurity
- **May 2020:** Tested draft HL7 FHIR SDOH Implementation Guide (IG) at two FHIR Connectathons; achieved 1st place status in competition.
- **Sept 2020:** Tested HL7 FHIR SDOH IG at FHIR Connectathon; launch Transportation Domain; complete Housing Domain
- **Oct 2020**: Launch financial strain and demographics domains in parallel
- **November 2020:** Target food insecurity value set publications in NLM Value Set Authority Center (VSAC) and ONC Interoperability Standards Advisory.
- **December 2020:** ballot-ready FHIR SDOH Implementation Guide.

- **POLICY:** (e.g. ONC USCDI, CMS Promoting Interoperability, State Medicaid Director Letters)
- **PAYMENT MODELS:** (e.g. CMMI SDOH Model)
- **PROGRAMS:** (e.g. Medicare Advantage, Medicaid Managed Care, Hospital QRRP, MIPS).
- **GRANTS**: (e.g. ACL Challenge Grant, ONC Health IT LEAP, RWJF SDOH Integration in Clinical Care).
- **PRACTICE:** (e.g. repeatable process for adoption, implementation, and use of SDOH data at practice level.
- **INNOVATION:** New tools for capture, aggregation, analytics, and use.

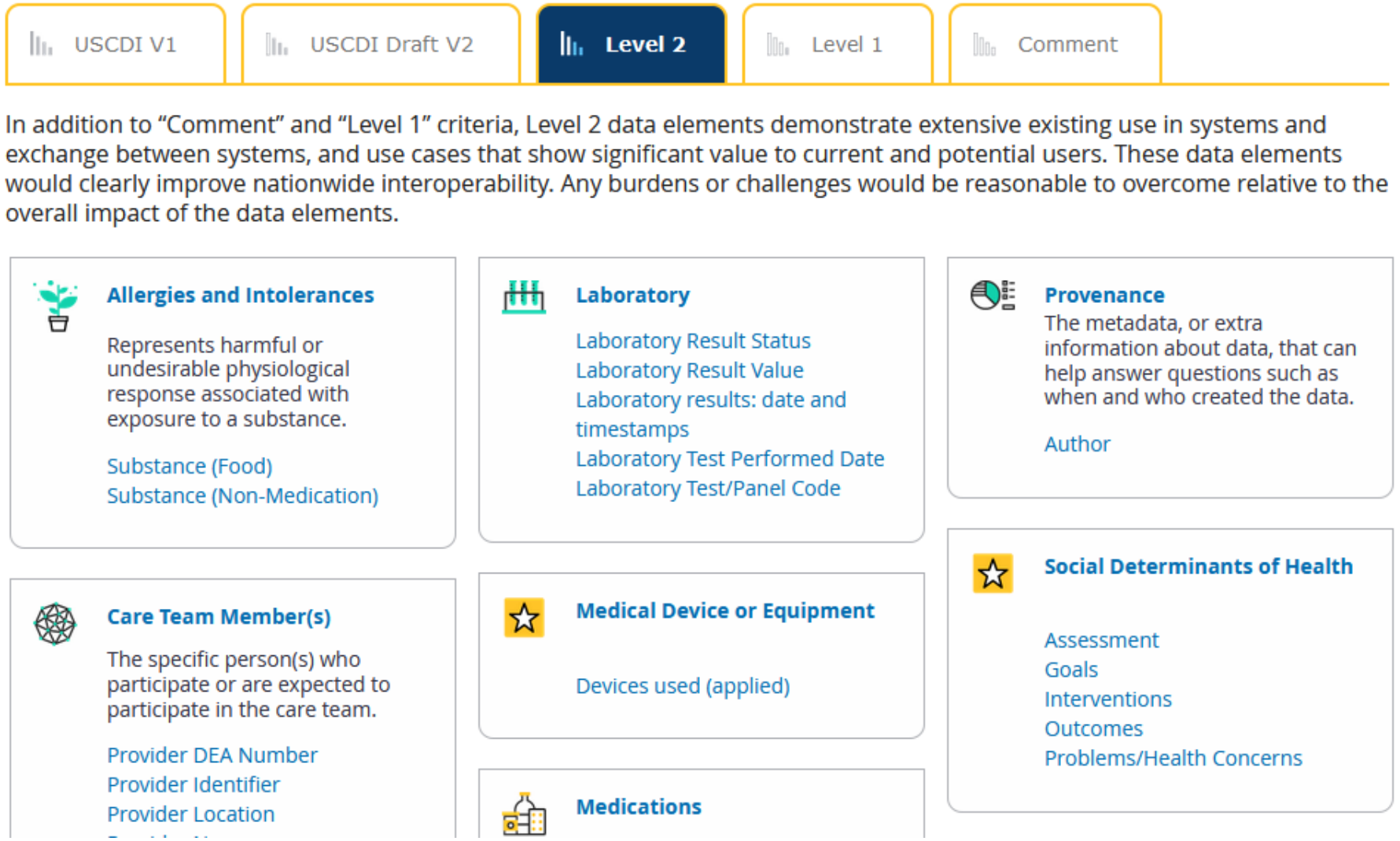
Gravity Project's Submission to USCDI: A New SDOH Data Class!

- ONC announced that the United States Core Data for Interoperability (USCDI) is open for submissions through October 23, 2020.
- The Gravity Project formally submitted our collective work as a new SDOH data class.
- Members of the Gravity Community also made submissions to ONC's USCDI v2 building on the Gravity Project's work.
- On November 4, ONC categorized our submitted SDOH data class as Level 2:
  - Level 2 data elements demonstrate extensive existing use in systems and exchange between systems, and use cases that show significant value to current and potential users. These data elements would clearly improve nationwide interoperability. Any burdens or challenges would be reasonable to overcome relative to the overall impact of the data elements.
  - Level 2 data classes/elements will be considered for USCDI V2 Draft based on ONC assessment of a number of factors, including impacts for potential users, maturity of data and technical standards/implementation specifications, burden for implementation, etc.

Gravity Project's submission for USCDI version 2

Domains / Data Elements	Activities	Code Systems / Value Sets
PHASE 1 • Food insecurity • Housing instability & Homelessness • Housing inadequacy • Transportation insecurity • Financial stress • Employment • Education • Veteran status PHASE 2 • Social isolation • Stress • Interpersonal violence	• Assessments • Problems/Health concerns • Goals • Interventions • Outcomes • Consent	• LOINC ▪ Assessments ▪ Goals ▪ Outcomes (e.g., quality measures • SNOMED-CT ▪ Problems/Health concerns (clinical) ▪ Interventions (clinical) • ICD-10-CM ▪ Problems/Health concerns (billing) • CPT/HCPCS ▪ Interventions (billing, where available)

Submission to USCDI version 2



How to Engage!

Join our Project!

- Join the Gravity Project: https://confluence.hl7.org/display/GRAV/Join+the+Gravity+Project
- Give us feedback on the Data Principles: https://confluence.hl7.org/display/GRAV/Gravity+Data+Principles
- Submit SDOH domain data elements: https://confluence.hl7.org/display/GRAV/Data+Element+Submission
- Help us with Gravity Education & Outreach
  - Use Social Media handles to share or tag us to relevant information
    - @the gravityproj
    - https://www.linkedin.com/company/gravity-project
  - Partner with us on development of blogs, manuscripts, dissemination materials

Questions?

Evelyn Gallego evelyn.gallego@emiadvisors.net
Twitter: @egallego
LinkedIn: linkedin.com/in/egallego/

Additional questions? Contact: gravityproject@emiadvisors.net

@thegravityproj
https://www.linkedin.com/company/gravity-project

Oral Health Information Technology Virtual Convening
Session: Social Determinants of Health and Oral Health IT

Using PRAPARE to Collect Data on the Social Determinants of Health and Advance Health Equity

November 19, 2020

NATIONAL ASSOCIATION OF Community Health Centers®

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

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

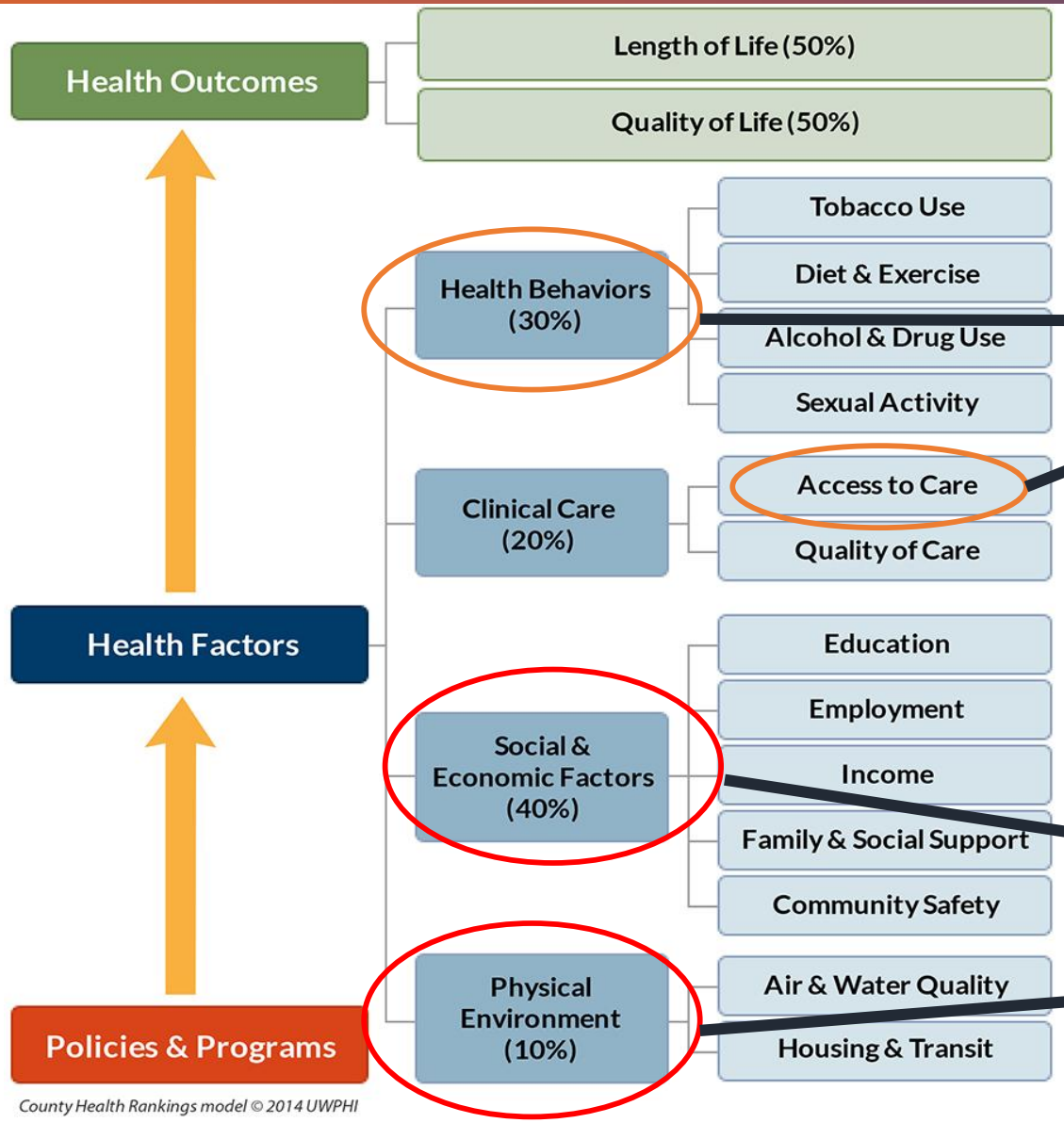
NATIONAL ASSOCIATION OF Community Health Centers®

Important Definitions

1. **Social determinants of health:** the conditions in which people are born, grow, live, work, and age. These conditions are shaped by the distribution of money, power, and resources.
2. **Social risk factors:** specific adverse social conditions that are associated with poor health.
3. **Social needs:** patient's role in identifying and prioritizing social interventions.
4. **Population health:** the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Source: AAFP https://www.aafp.org/news/practice-professional-issues/20190610sdohterms.html

Why Are the Social Determinants of Health Important?



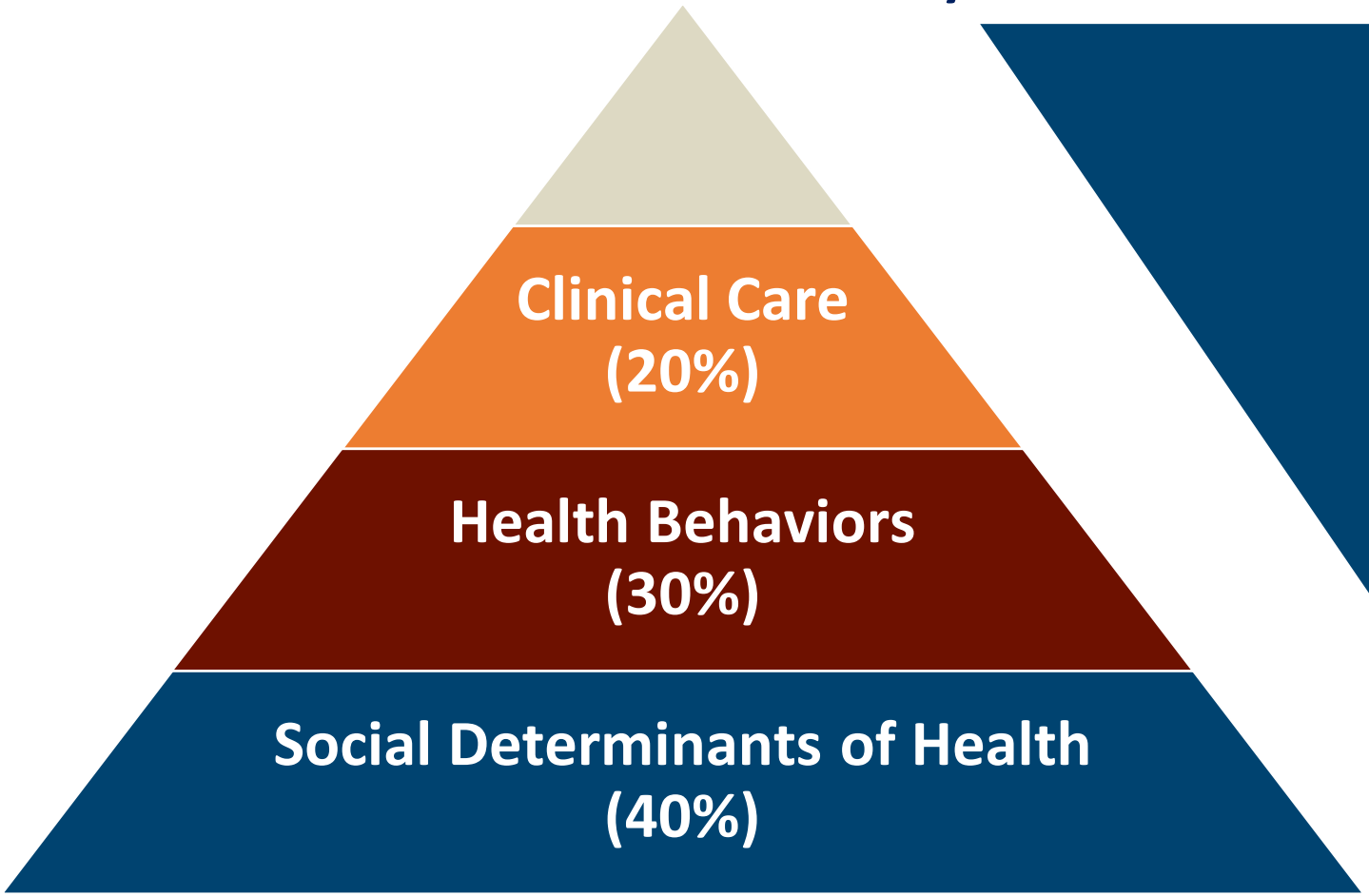
Impacted by the social determinants of health

Social determinants of health

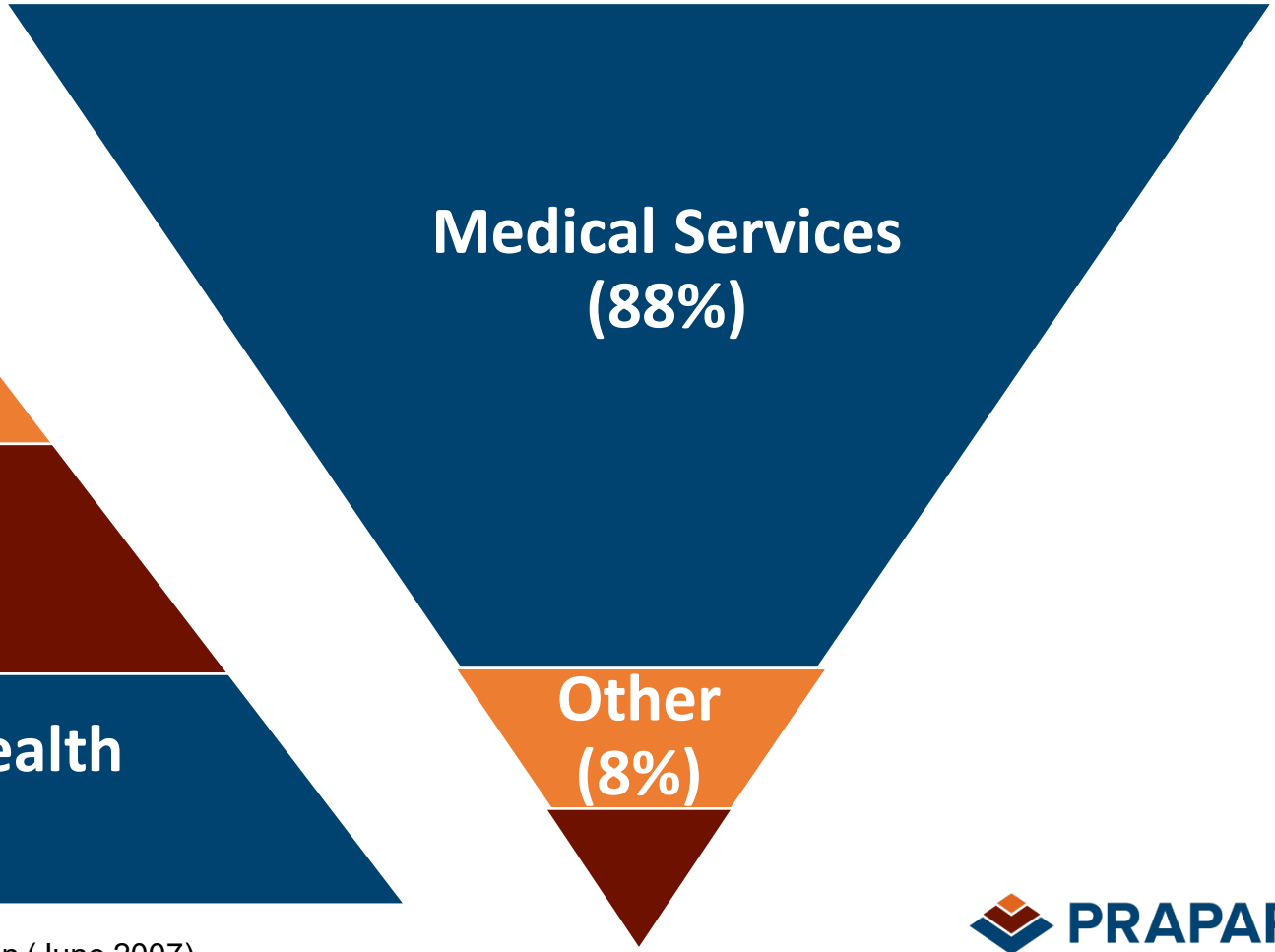
PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Why is it Important to Focus on Social Determinants?

What Makes Us Healthy



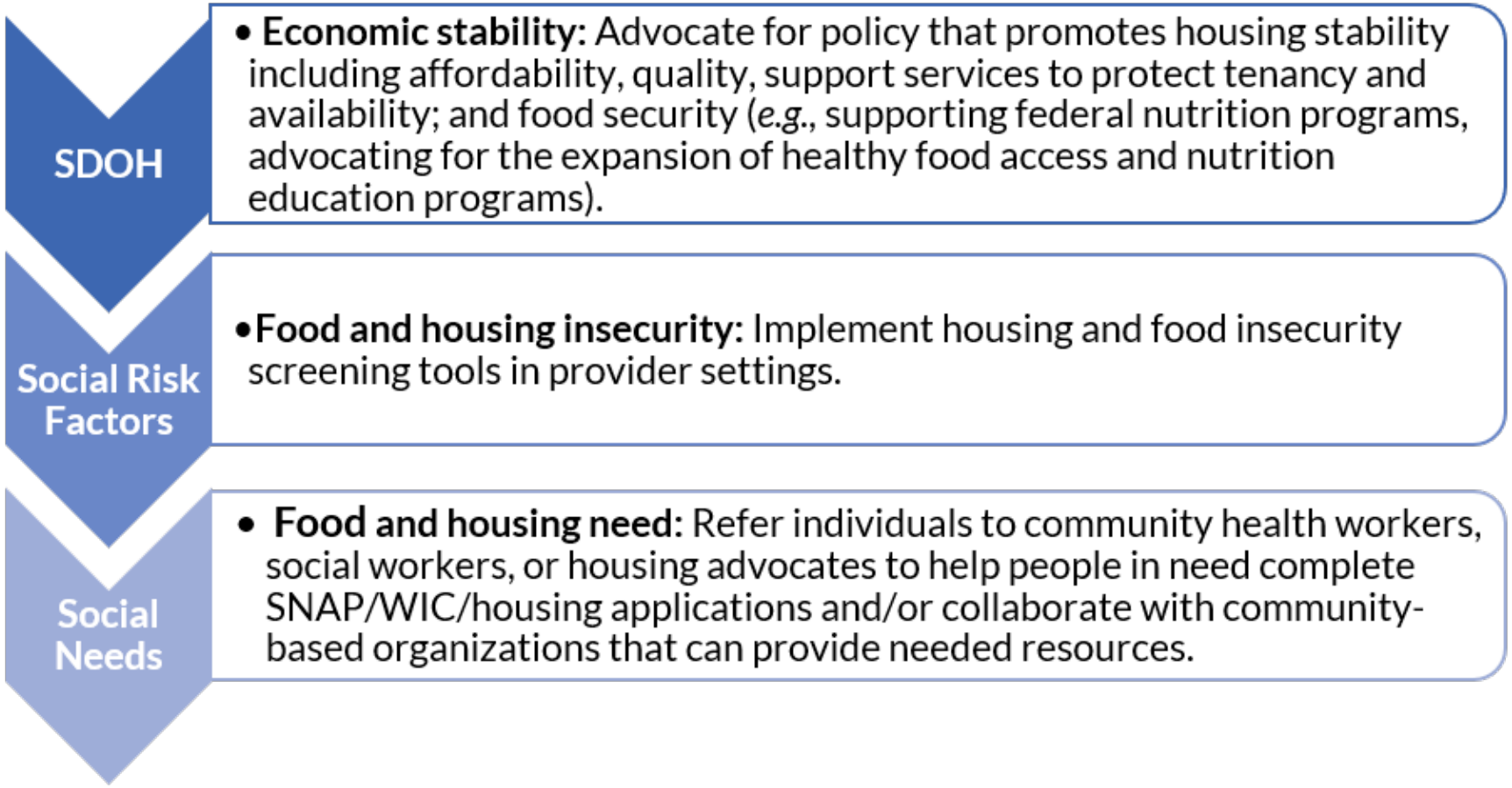
What We Spend On Being Healthy



Source: Derived from information from the Boston Foundation (June 2007).

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

Examples of interventions across the continuum



Source: Health Affairs https://www.healthaffairs.org/do/10.1377/hblog20191025.776011/full/

Why collect SDOH data?

1. Define and document the increased complexity of patients
2. Better target clinical care, enabling services, and community partnerships to drive care transformation
3. Enable providers to demonstrate the value they bring to patients, communities, and payers
4. Advocate for change at the community and national levels

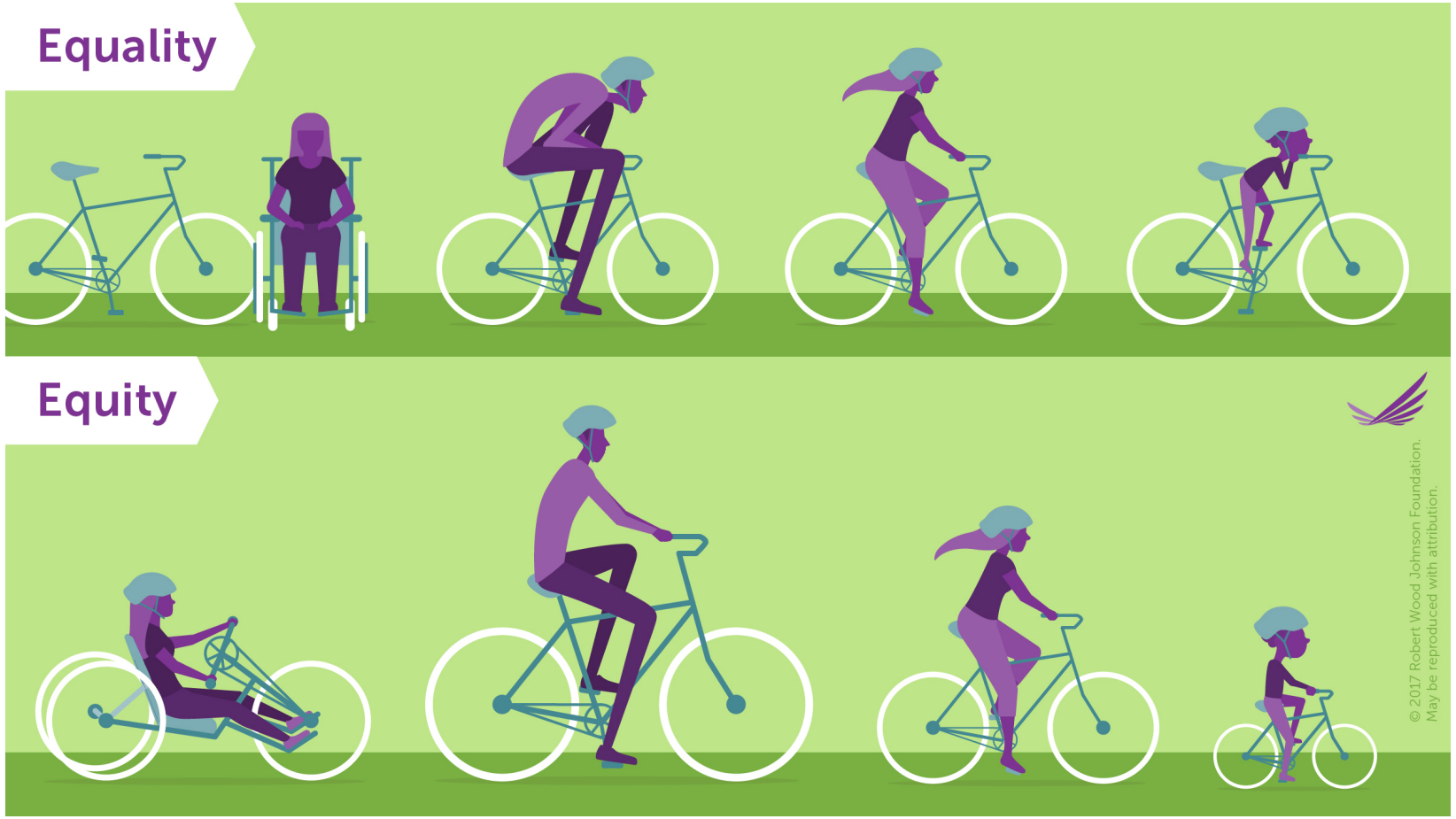
PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Advancing Health Equity

- Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.
- Health equity is achieved when every person has the opportunity to “attain full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

Source: CDC https://www.cdc.gov/chronicdisease/healthequity/index.htm

Visualizing Health Equity: One Size Does Not Fit All



Source: The Robert Wood Johnson Foundation: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html#/download

What is PRAPARE?

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

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

What is PRAPARE?

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

www.nachc.org/prapare

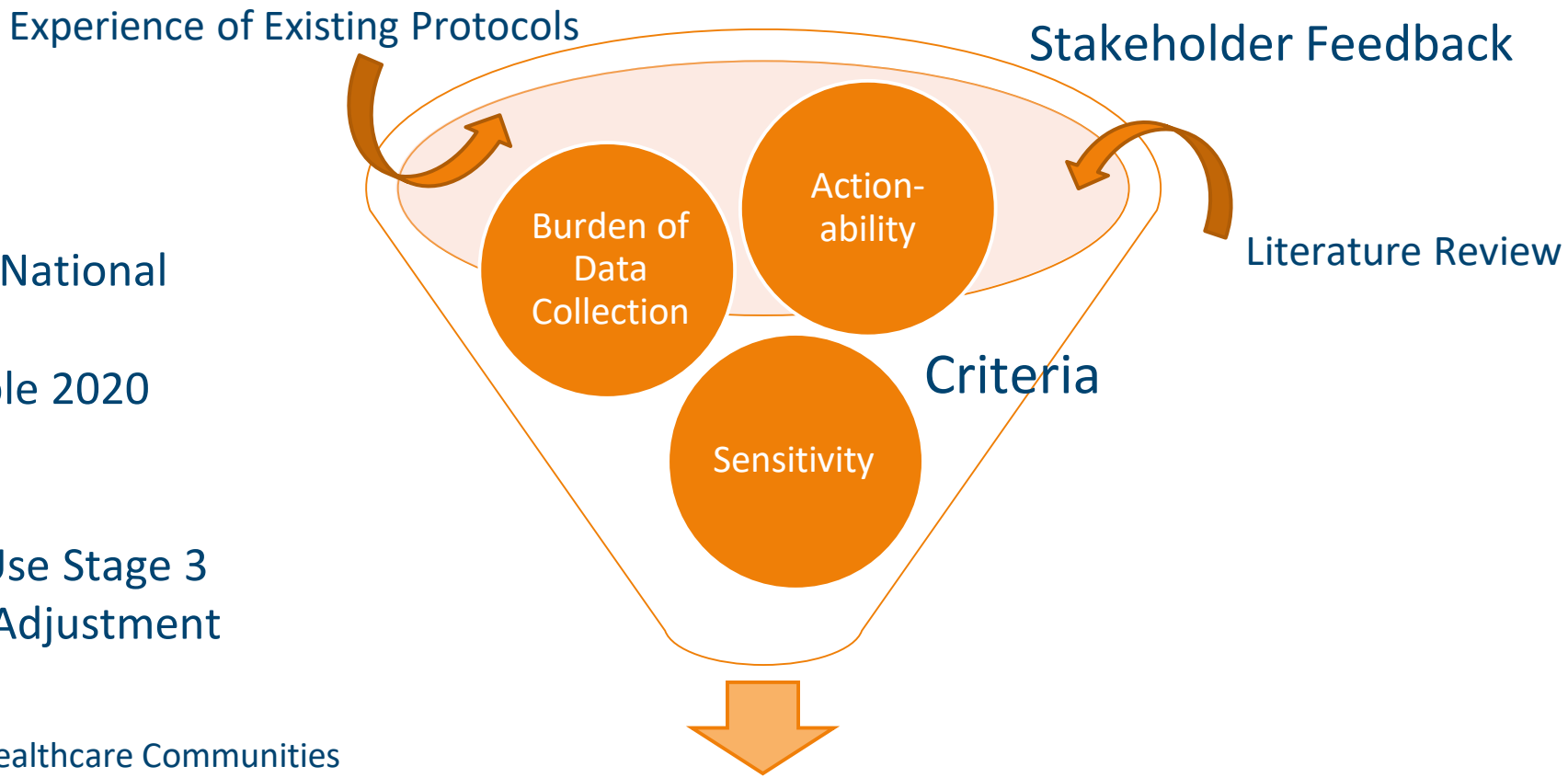
PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE's Evidence-Base and Stakeholder-Driven Development Process

Alignment with National Initiatives:

- Healthy People 2020
- ICD-10
- IOM
- Meaningful Use Stage 3
- NQF on Risk Adjustment

Note: Accountable Healthcare Communities Tool did not exist in 2014



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

What questions are in PRAPARE?

Core	
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

Optional Granular	
1. Employment: How many hours worked per week	3. Insurance: Do you get insurance through your job?
2. Employment: # of jobs worked	4. Social Support: Who is your support network?

* UDS measures are automatically populated into PRAPARE EHR templates. You do NOT need to ask those questions multiple times!

Find the tool at www.nachc.org/prapare

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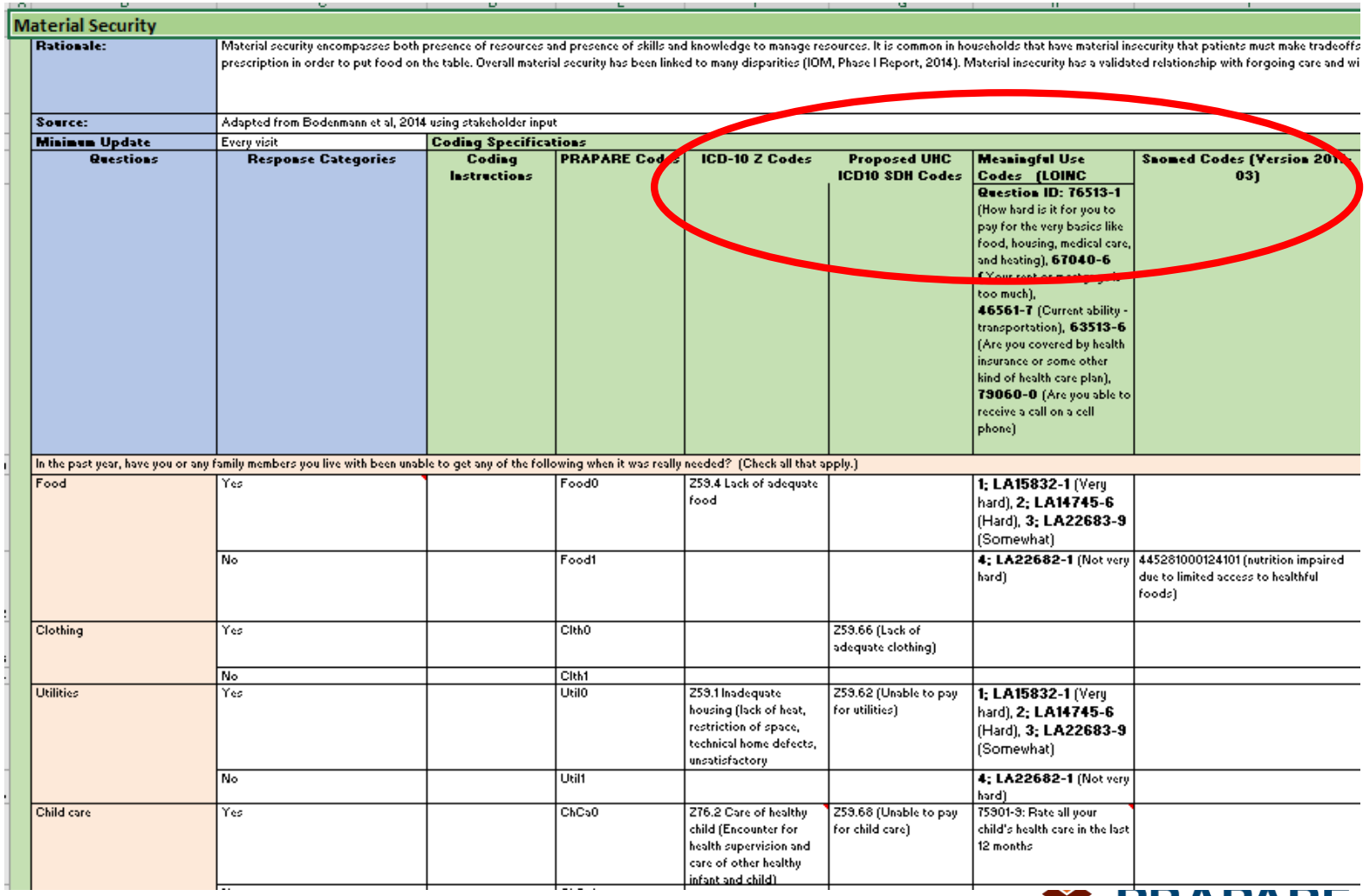
Why use PRAPARE to Collect SDOH?

- **STANDARDIZED and WIDELY USED**
  - Measures Linked with standardized codes (ICD-10, LOINC, SNOMED)
  - Dominant SDOH risk screening tool used by health centers and Medicaid managed care organizations
- **EVIDENCE-BASED and STAKEHOLDER-DRIVEN**
  - Developed and tested by health centers
- **FREE EHR Templates**
- **FREE PRAPARE Implementation and Action Toolkit**
  - Accompanying resources, best practices, & lessons learned to guide users on PRAPARE implementation
- **WORKFLOW AGNOSTIC**
  - Can fit within existing workflows and be combined with other tools/data
- **PATIENT-CENTERED and ACTIONABLE**
  - Meant to facilitate conversations and build relationships with patients
  - Standardize the need rather than the question

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

PRAPARE Coding and Data Dictionary

- Crosswalks include ICD-10, LOINC, SNOMED
- Many PRAPARE EHR templates have used crosswalks to map PRAPARE measures to ICD-10 codes
- New proposed codes for PRAPARE in LOINC and ICD-10
- PRAPARE Data Documentation available in Toolkit



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 Code**	**ICD-10 Z Codes**	**Proposed UHC ICD10 SDH Codes**	**Meaningful Use Codes (LOINC**	**Snomed Codes (Version 20 03)**
						Question ID: 76513-1 (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), **79060-0** (Are you able to receive a call on a cell phone)	
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)	75301-3: Rate all your child's health care in the last 12 months	

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EHR Templates

FREE EHR Templates Available:

- ✓ NextGen*
- ✓ eClinicalWorks
- ✓ athenaPractice (formerly GE Centricity*)
- ✓ Epic
- ✓ Cerner*
- ✓ Greenway Intergy
- ✓ Athena

Available for FREE after signing EULA at www.nachc.org/prapare

* Automatically map to ICD-10 Z codes so you can easily add relevant Z codes to problem or diagnostic list

- **In Development:**
  - ✓ Allscripts
  - ✓ Meditech

→ 70% of all health centers

→ Current 7 + New EHRs = 85-95% of all health centers

Recorded demos of each PRAPARE EHR template available at www.nachc.org/prapare

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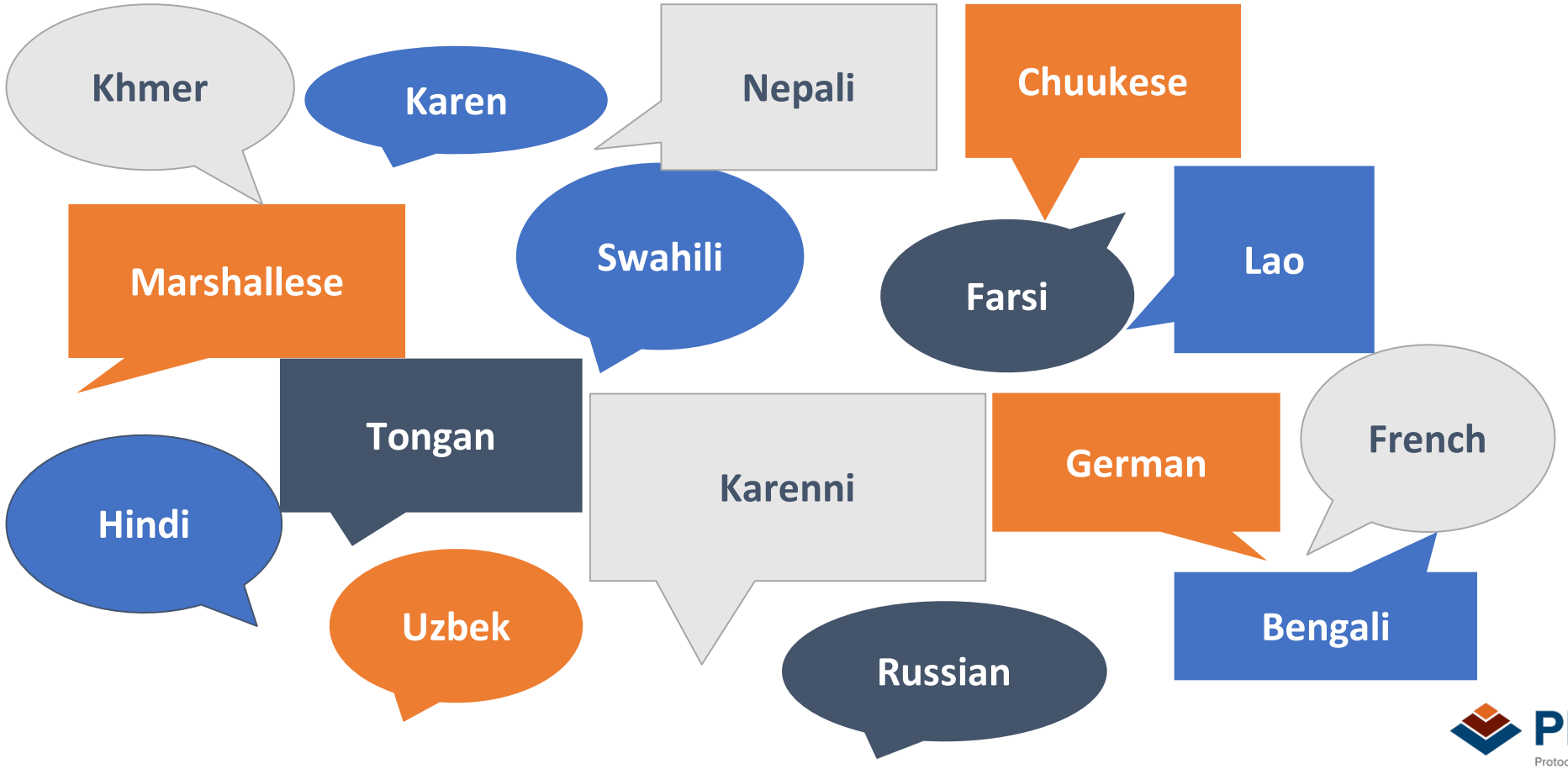
PRAPARE is Now in 26 Languages!

- Validated at community health centers for comprehension and cultural competence
- New additions include:



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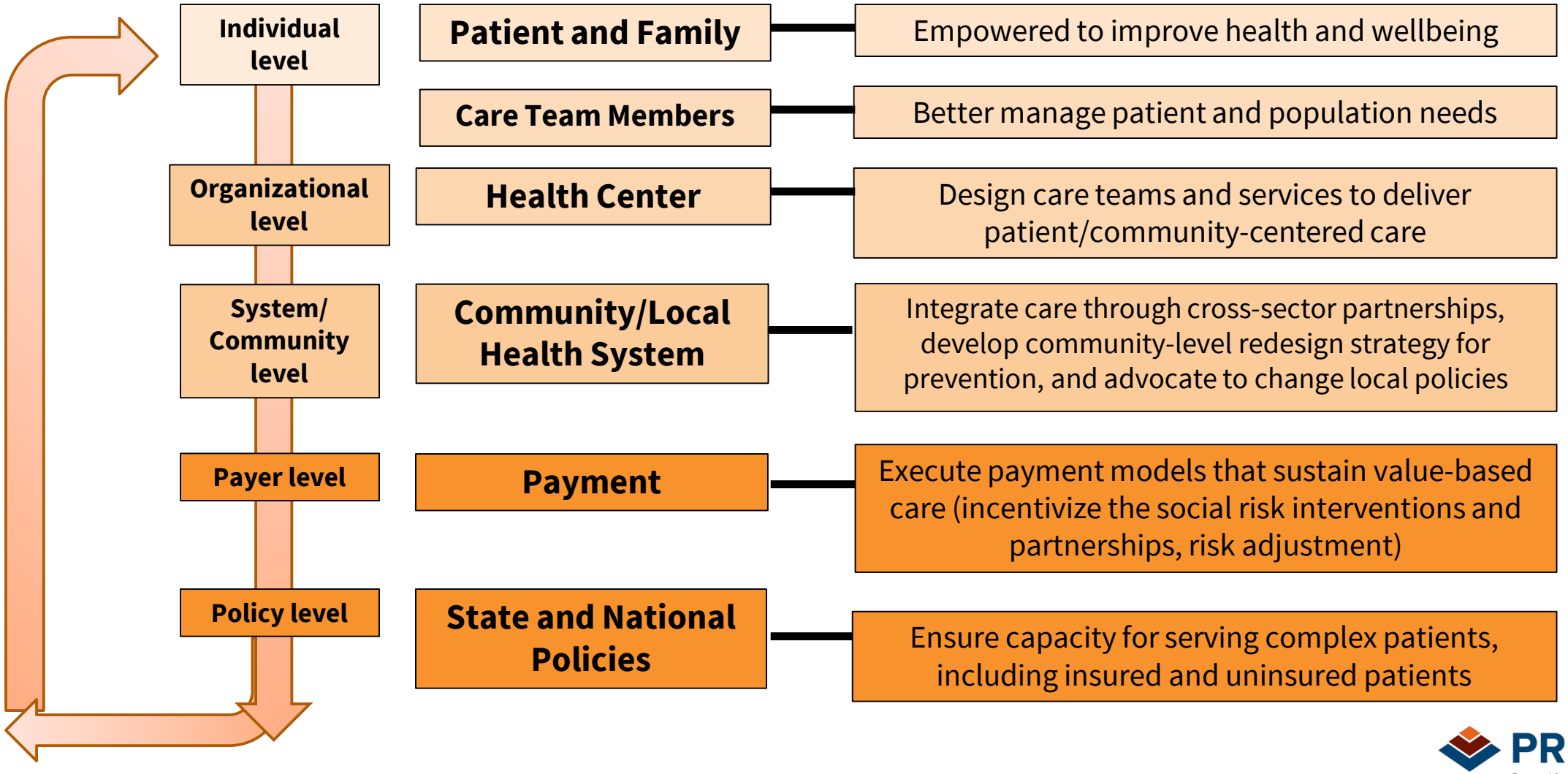
Why do Health Centers Collect Standardized Data on SDOH?



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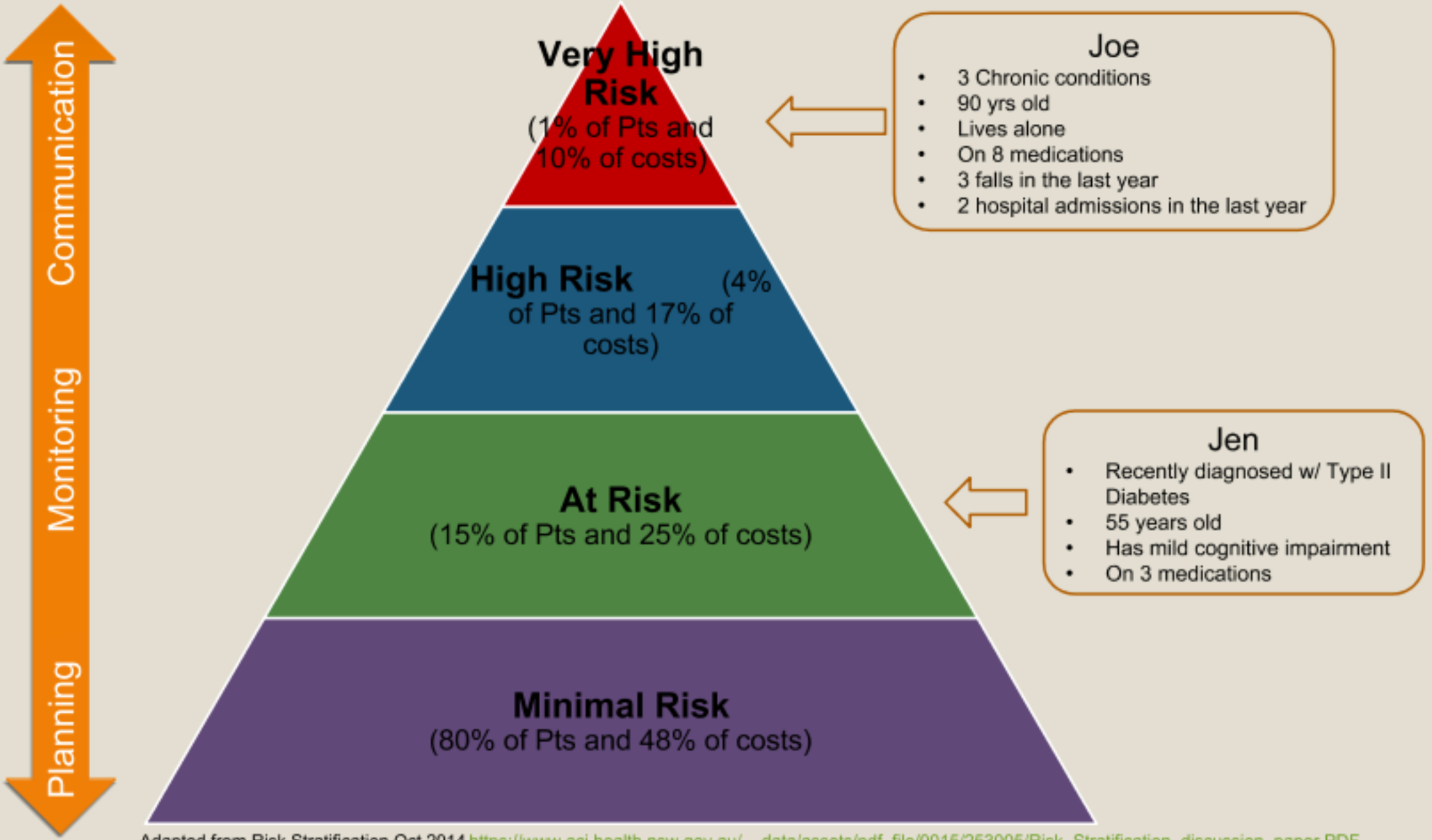
Definitions

- **Risk Stratification:** Process or tool for identifying – and predicting – which patients are at high risk (or likely to be at high risk) and prioritizing the management of their care in order to prevent worse outcomes (care team, clinic level)
- **Risk Adjustment:** is a method to offset the cost of providing health insurance for individuals who represent a relatively high risk to insurers (policy, payment level)



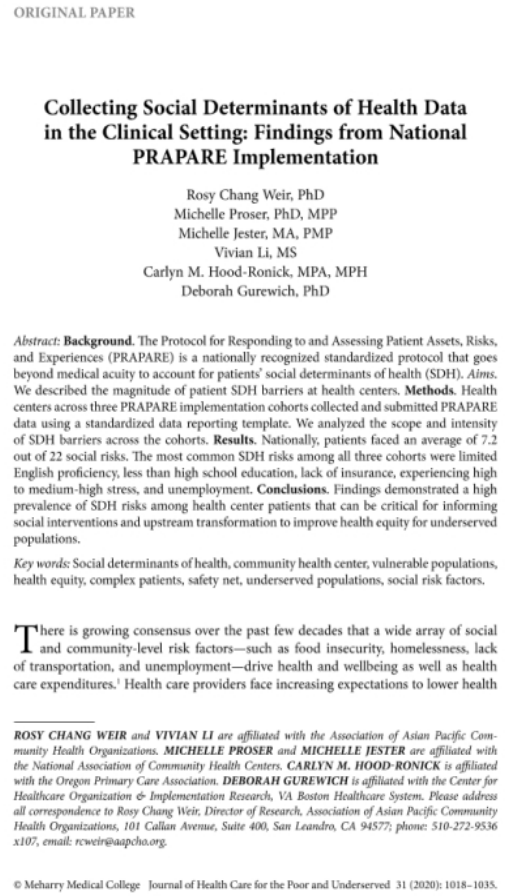
Adapted from Risk Stratification Oct 2014 https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0015/253005/Risk_Stratification_discussion_paper.PDF

NEW! Research Publication

NEW Publication in the Journal of Health Care for the Poor and Underserved: Collecting Social Determinants of Health Data in the Clinical Setting: Findings from National PRAPARE Implementation

The Protocol of Responding and Assessing Patient Assets, Risks, and Experiences (PRAPARE) team was recently published in the Journal of Health Care for the Poor and Underserved! The study revealed that nationally, health center patients face an average of 7.2 out of 22 social risks and demonstrate a high prevalence of social determinants of health (SDH) risks—key findings that can be critical for informing social interventions and upstream transformation to improve health equity for underserved populations.

Access now: available here



ORIGINAL PAPER

Collecting Social Determinants of Health Data in the Clinical Setting: Findings from National PRAPARE Implementation

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Michelle Proser, PhD, MPP
Michelle Jester, MA, PMP
Vivian Li, MS
Carlyn M. Hood-Ronick, MPA, MPH
Deborah Gurewich, PhD

Abstract: **Background.** The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) is a nationally recognized standardized protocol that goes beyond medical acuity to account for patients' social determinants of health (SDH). *Aims.* We described the magnitude of patient SDH barriers at health centers. **Methods.** Health centers across three PRAPARE implementation cohorts collected and submitted PRAPARE data using a standardized data reporting template. We analyzed the scope and intensity of SDH barriers across the cohorts. **Results.** Nationally, patients faced an average of 7.2 out of 22 social risks. The most common SDH risks among all three cohorts were limited English proficiency, less than high school education, lack of insurance, experiencing high to medium-high stress, and unemployment. **Conclusions.** Findings demonstrated a high prevalence of SDH risks among health center patients that can be critical for informing social interventions and upstream transformation to improve health equity for underserved populations.

Key words: Social determinants of health, community health center, vulnerable populations, health equity, complex patients, safety net, underserved populations, social risk factors.

There is growing consensus over the past few decades that a wide array of social and community-level risk factors—such as food insecurity, homelessness, lack of transportation, and unemployment—drive health and wellbeing as well as health care expenditures.[1] Health care providers face increasing expectations to lower health

***ROSY CHANG WEIR** and **VIVIAN LI** are affiliated with the Association of Asian Pacific Community Health Organizations. **MICHELLE PROSER** and **MICHELLE JESTER** are affiliated with the National Association of Community Health Centers. **CARLYN M. HOOD-RONICK** is affiliated with the Oregon Primary Care Association. **DEBORAH GUREWICH** is affiliated with the Center for Healthcare Organization & Implementation Research, VA Boston Healthcare System. Please address all correspondence to Rosy Chang Weir, Director of Research, Association of Asian Pacific Community Health Organizations, 101 Callan Avenue, Suite 400, San Leandro, CA 94577; phone: 510-272-9536 x107, email: rcweir@aapcho.org.*

© Meharry Medical College Journal of Health Care for the Poor and Underserved 31 (2020): 1018–1035.

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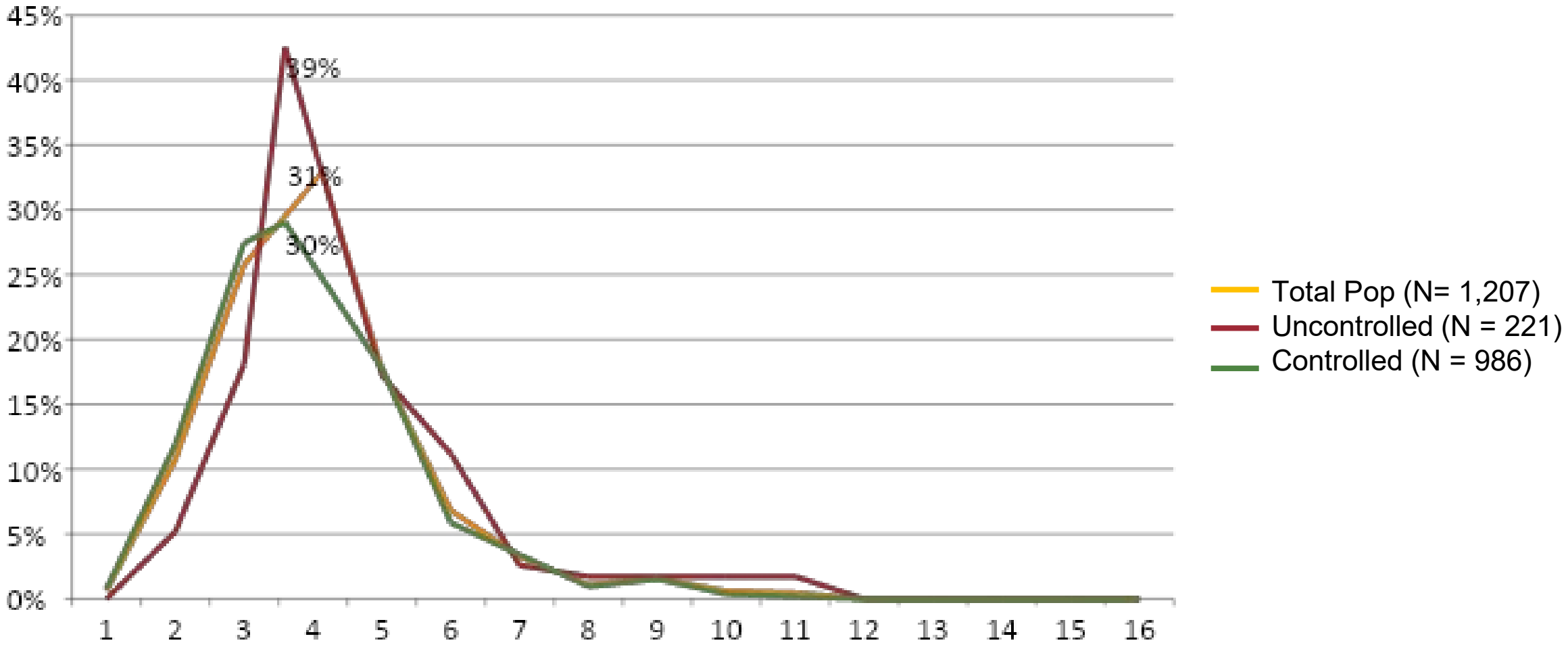
Pilot Findings: Most Common SDOH Risks and Assets

- **Most Common Social Determinant Risks**
  - Limited English Proficiency (32%)
  - Less than High School Education (32%)
  - Uninsured (25%)
  - Experiencing High to Medium High Stress (24%)
  - Unemployment (18%)

- **Most Common Social Determinant Assets**
  - Socially integrated (> 50% of patients see those they care about 5+ times a week)

PRAPARE Data Linked to Clinical Indicators: Diabetes



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Value-Add Opportunities to Leverage PRAPARE Data

- Delivery System Transformation Activities (VBP, Shared Savings, etc.)
- Payment Reform Efforts
- Payers Interested in Social Determinants Data Collection (e.g., Medicaid, private, etc.)
- PCMH and QI Initiatives
- Data Sharing and Aggregation Opportunities (e.g., HIE, CIE, etc.)
- State Foundation Interests in Social Determinants or Related Topics (Opioids, etc.)
- Community Health Worker Initiatives
- Quality Incentives that Reward for Social Determinant Data Collection

PRAPARE

PRAPARE Related Resources

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

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PRAPARE IMPLEMENATION AND ACTION TOOLKIT

www.nachc.org/prapare

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

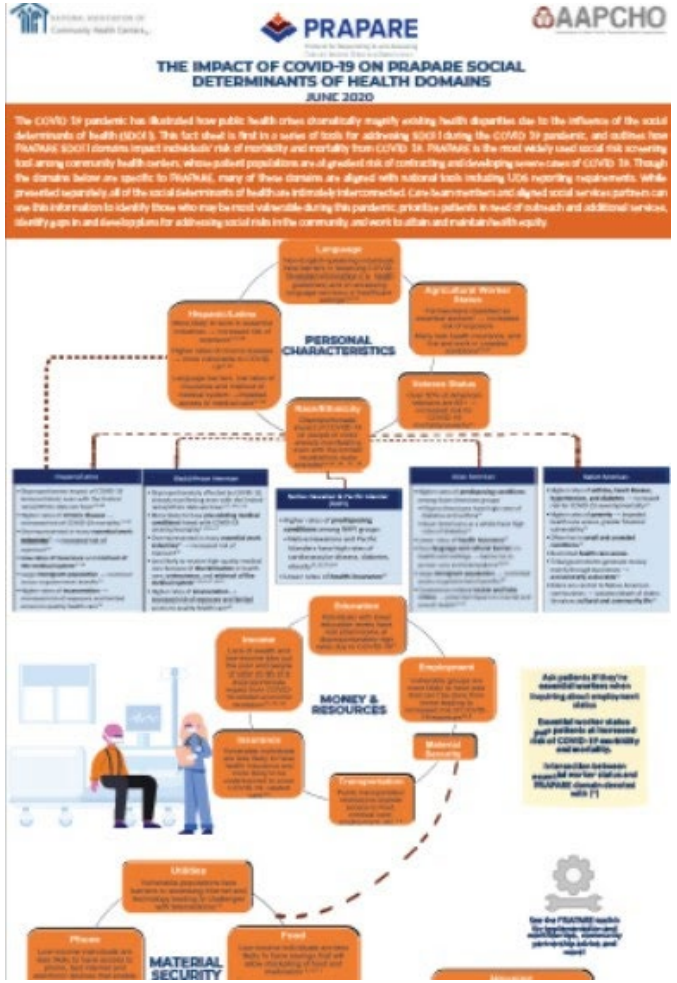
PRAPARE SDOH & COVID-19 Fact Sheet

NEW

Fact Sheet: The Impact of COVID-19 on PRAPARE Social Determinants of Health Domains

This fact sheet outlines how PRAPARE SDOH domains impact individuals' risk of morbidity and mortality from COVID-19. Care team members and aligned social service partners can use this information to identify those who may be most vulnerable during the pandemic, prioritize patients in need of outreach and additional services, and develop plans for addressing social risks in the community.

Access now: Printer-friendly version available here!



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Thank you for joining us today!

For more information, visit
www.nachc.org/prapare

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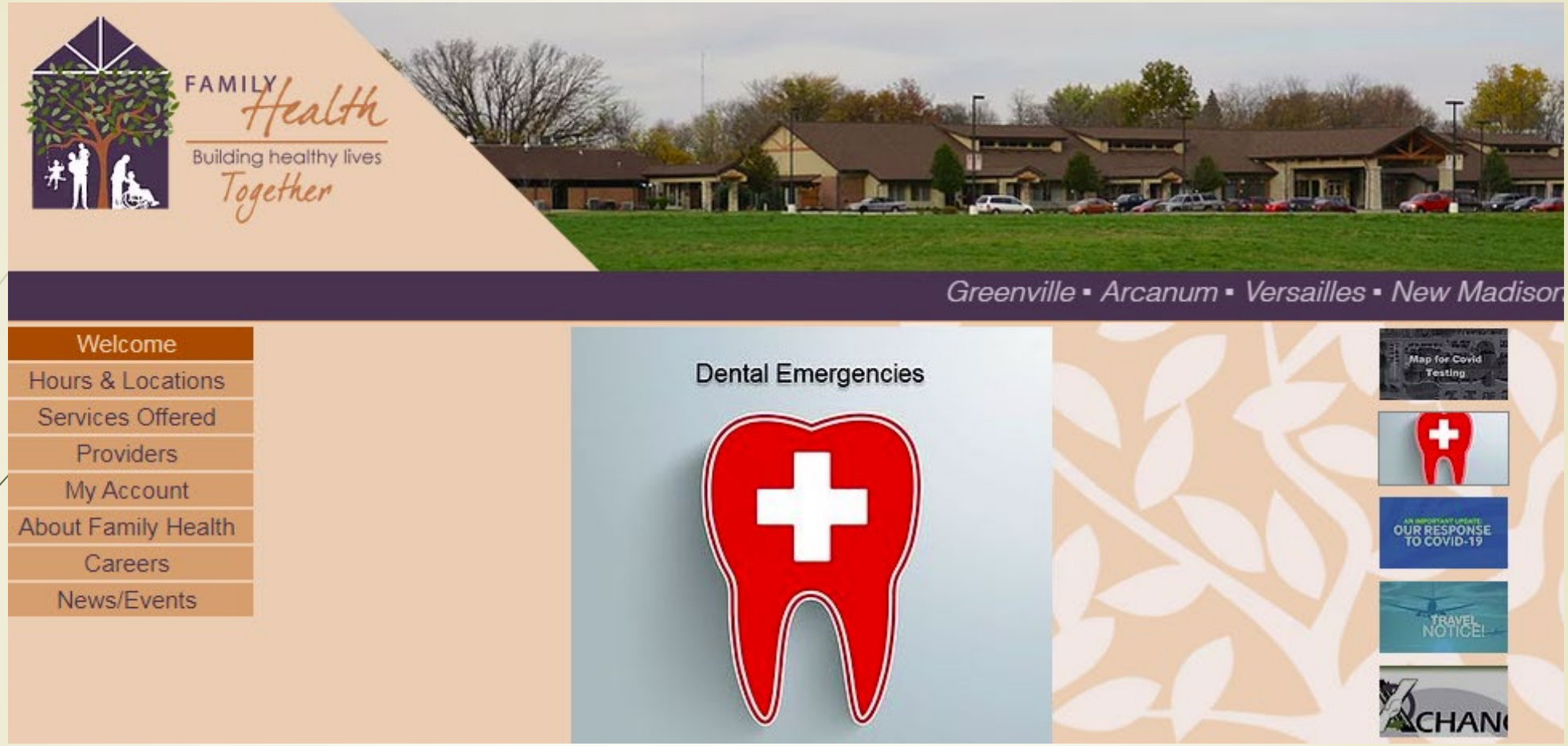


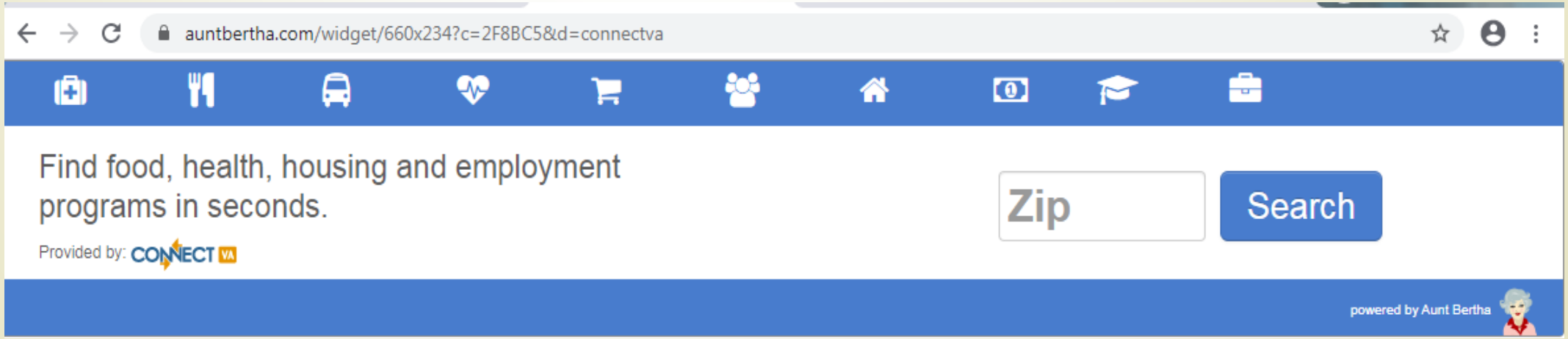
Family Health Services of Darke County, Inc.

PCMH - Integrated Care Coordination

- Patient centered care – is not silo care
- Integrated EMR
- Efficiency, Structured data, and comprehensive health summary

SDOH – Our approach…WHY?

- Screening for SDOH – Identification of needs, Address patient needs and Improve patient experiences
- 1815 Grant (OACHC/NACHC/CDC/ODH)
  - Undiagnosed/uncontrolled diabetes and hypertension patients, statin therapy for prevention and treatment of CAD; Clinical Pharmacy referrals; and Social Determinants of Health (SDOH)
- HCCN Grant (OACHC) – Focus on enhancing patient and provider experience, advancing interoperability, and use data to enhance value.

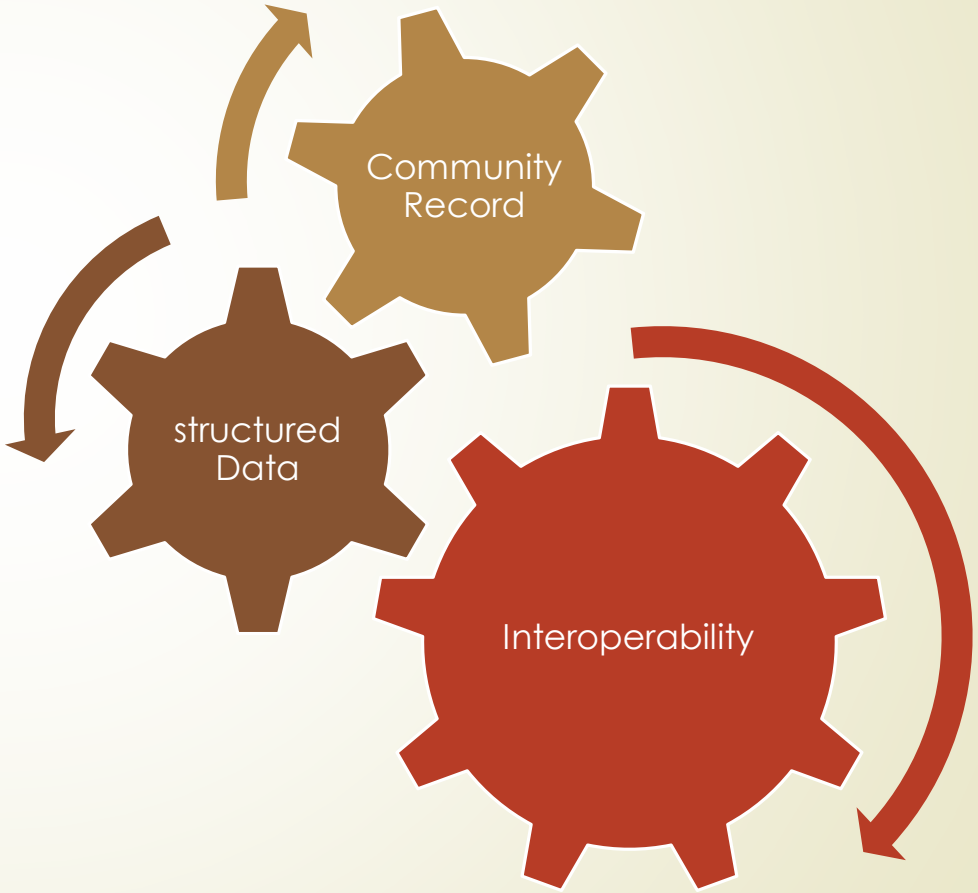


SDOH - Process

- PRAPARE Screening Form - Paper process > Electronic Form > Identification of Need > Referral to Care Team or Provide Community Resource Brochure)
- Why Structured?
  - ***Data…Data…Data***
  - Reporting- Identify highest area of needs. Prioritize.
- Goals
  - Build/strengthen relationships
  - Improve patient satisfaction
  - Increase patient engagement
  - Improve patient outcomes

HIE Integration

- Structured Data
- Ongoing Data Validation
- Interoperability – Make connections
- Community Health Record



Disease Management

- Smoking Cessation
  - Clinical Pharmacy Shared Visits
- Elevated Blood Pressure
  - HTN Clinic/Referrals
  - Warm Handoff to PCP
- Diabetes
  - Comprehensive education class
  - PCP Room Flyers on Dental Complications
  - Clinical Pharmacy Shared Visits

Questions:

Family Health Services of Darke County, Inc.

5735 Meeker Road, Greenville, Ohio 45331

Charlene Wright, BSMI, RT(R)

Clinical Quality Risk Manager

cwright@familyhealthservices.org

Panel Discussion and Audience Questions

Webinar Evaluation

https://www.dentaquestpartnership.org/content/survey-social-determinants-health-and-oral-health-information-technology

Must complete by **EOD Wednesday, November 25 in order to receive CE credit*

Upcoming Sessions:

- Oral Health System Transformation: Healthcare Data and Technology as a Driver for Health Improvement
  - Thursday, November 19, 1:00 pm ET

Sign up to receive our newsletter to get more information on future webinars!


DentaQuest®
Partnership
for Oral Health Advancement