Implementation and Evaluation of PRAPARE Including a Novel "Help Desk" Feature

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Duke Center for Personalized Health Care

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Social Determinants of Health (SDOH)

- Upstream factors such as **educational attainment**, **income**, **housing**, **food access**, **access to health care**, and **employment status**
- Can predict **risk** for **negative health outcomes**
- May account for **40% of an individual's health outcomes**[1]

https://www.cdc.gov/socialdeterminants/index.htm

[1]Booske BC, Athens JK, Kindig DA, Park H, Remington PL. Different perspectives for assigning weights to determinants of health. *University of Wisconsin: Population Health Institute.* 2010

Lincoln Community Health Center (LCHC)

- FQHC in Durham, NC serving **vulnerable and predominantly low-income populations**
- Served **33,961 unique patients** in 2018 (all ages)
- 26 FTE **Providers;** 12 FTE **Behavioral Health Staff**
- **Nine locations** in Durham County
- Main LCHC site offers:
  - Pediatrics, Adult, and Family Medicine Clinic
  - Behavioral Health Clinic
  - Dental Clinic
  - WIC Clinic
  - Pharmacy
  - Laboratory services
  - Radiology Unit

Lincoln Community Health Center: Patient Population

- **71%** of patients are at or below 100% of **federal poverty level**
- **89%** of patients are **members of racial or ethnic minorities**
- **55%** of adult patients are **uninsured**
- **49%** of patients report they are **best served in a language other than English**

State Policy Context – Medicaid Reform

Currently in NC

- DHHS identified 4 key SDOH to address[2]
  - Food insecurity
  - Housing instability
  - Lack of Transportation
  - Interpersonal violence

- Due to impact of SDOH on health outcomes, need assessment tool to assist community health centers in connecting their patients with community resources

- Also need sustainable model that can be implemented in various clinics or community centers

[2] North Carolina Department of Health and Human Services. (n. d.) Screening Questions. Retrieved from https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

National Effort Towards Standardized SDOH Assessment

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (**PRAPARE**)[3] developed by the National Community Health Center Association and partners.

- Standardized patient risk assessment tool
- Consists of a set of national core measures as well as a set of optional measures for community priorities
- Aids collection of the data needed to better assess and address social determinants of health
- Will assist health centers in identifying key areas of need that they can specifically target for their unique populations

PRAPARE Core Measures	
Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/ Neighborhood	Stress

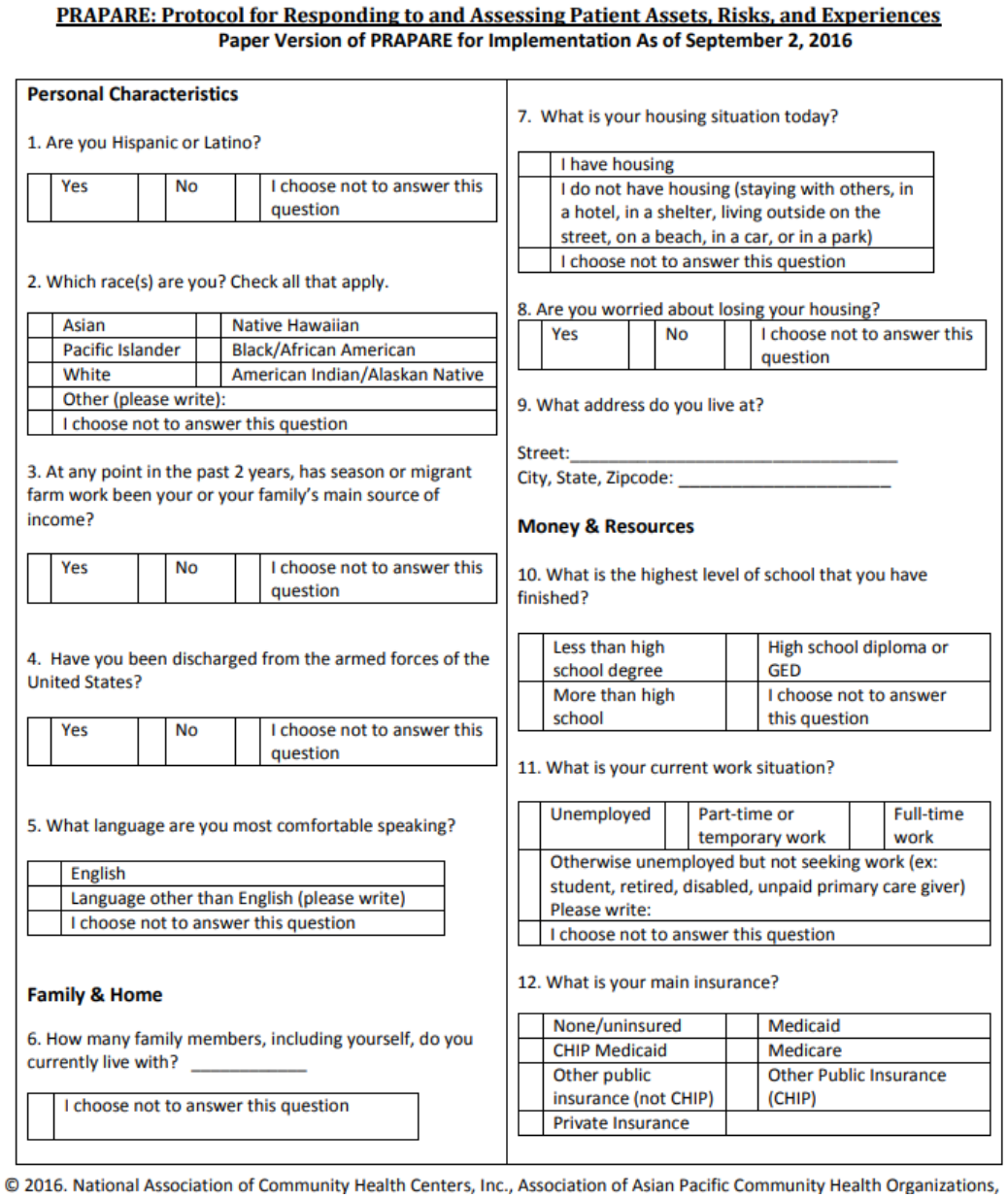
PRAPARE Optional Measures	
Incarceration History	Safety
Refugee Status	Domestic Violence

[3]National Association of Community Health Centers. (2018). Research and Data. Retrieved from PRAPARE: http://www.nachc.org/research-and-data/prapare/

PRAPARE Tool

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (**PRAPARE**)

- Created by National Association of Community Health Centers and Related Stakeholders
- Can be integrated into a patient's EMR
- No current scoring system
- Further evaluation of implementation efforts will support uptake



PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE for Implementation As of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

	English
	Language other than English (please write)
	I choose not to answer this question

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?

Street:_____
City, State, Zipcode: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

Project Objectives

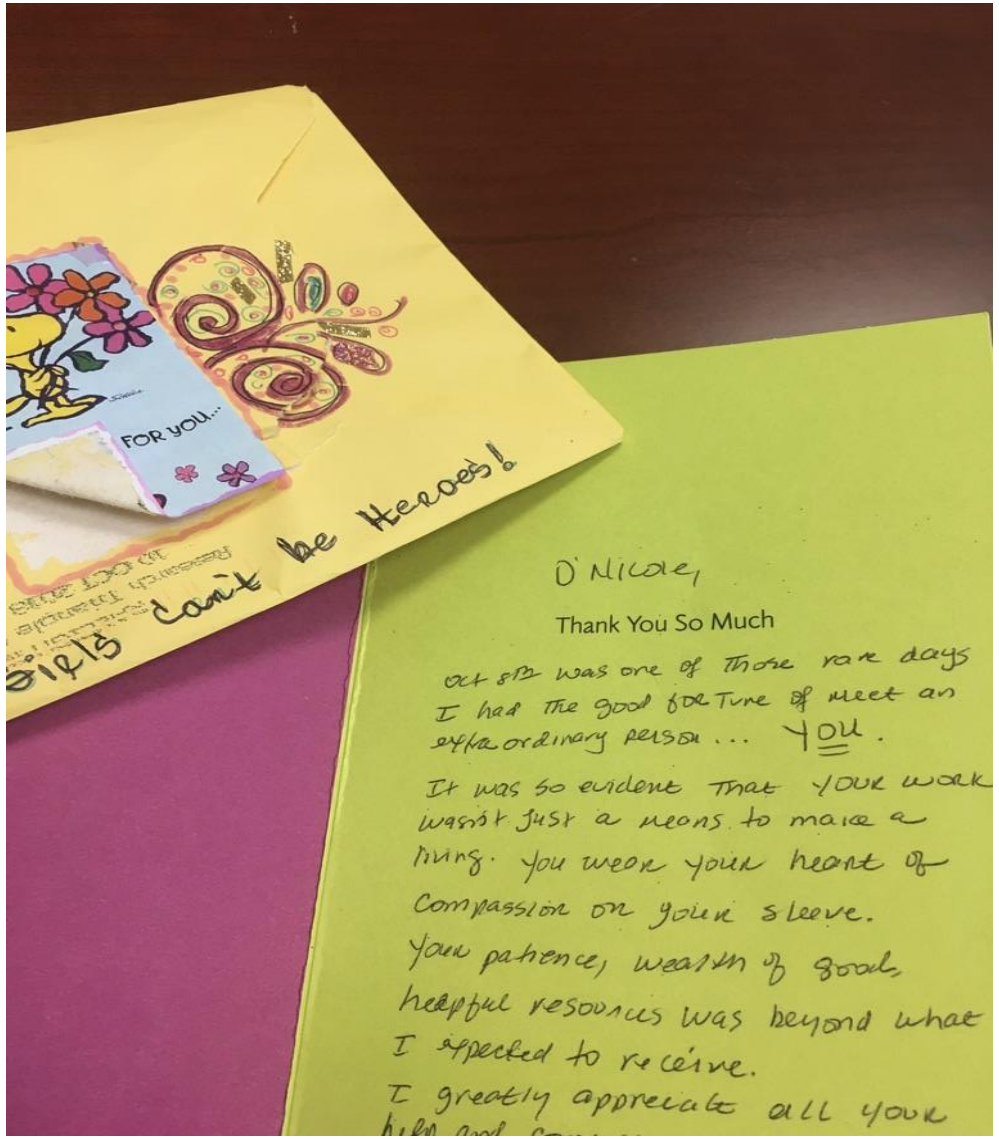
1. Identify what barriers and facilitators exist for implementing PRAPARE at LCHC and whether the corresponding referral workflow can be successfully integrated into LCHC care delivery

2. Identify the prevalence of SDOH risk factors in LCHC patients

3. Identify what resources patients are being connected to in the community

4. Identify the effectiveness of PRAPARE to link patients to tailored community resources using a novel volunteer student help desk model

5. Evaluate the relationship of PRAPARE assessment responses with measure of health and clinical risks



PRAPARE in Action

D'Nicole Tangen, MSW LCSW LCAS-A
&
Nekoba Mutima, MSW

Lessons Learned

BARRIERS:

-Time constraint

-Location

-Mental health challenges

-Patient barriers

-Patients sometimes have a hard time “accepting help”

-Explaining the process to patients

BENEFITS:

-Identify social and economic factors that are driving health problems

-Helps providers understand barriers impacting adherence to treatment plans

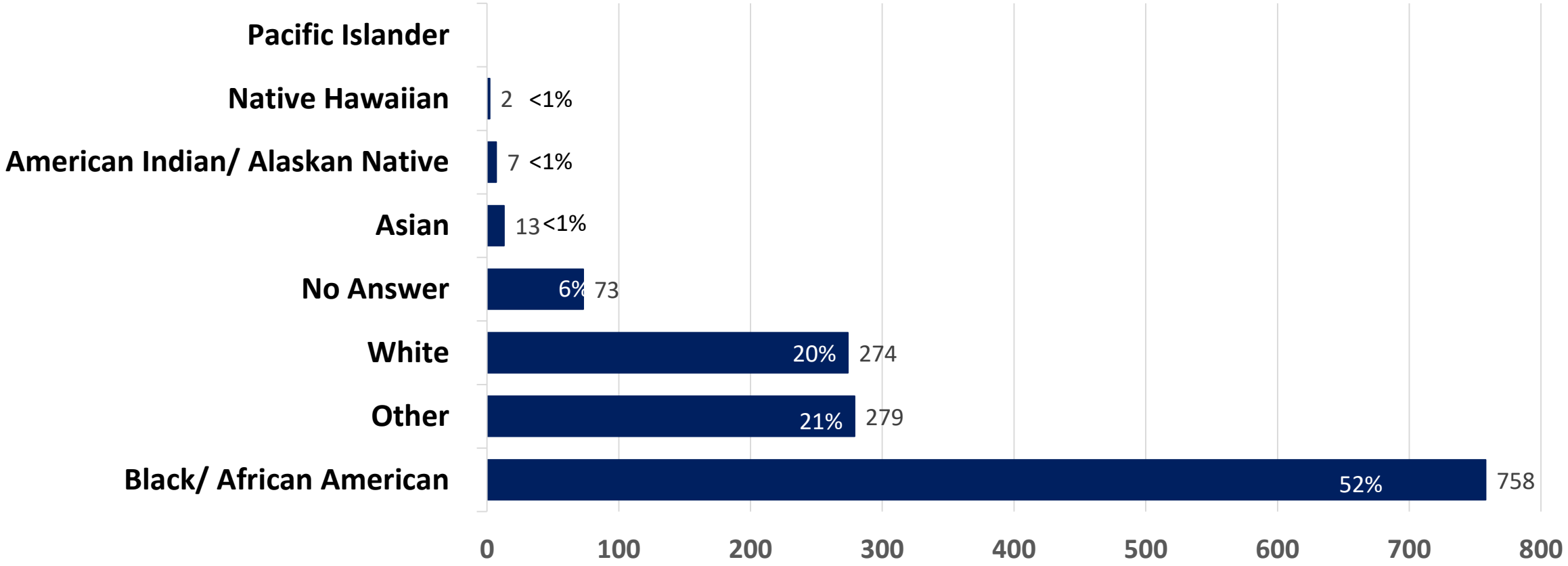
Preliminary PRAPARE

Assessment Findings

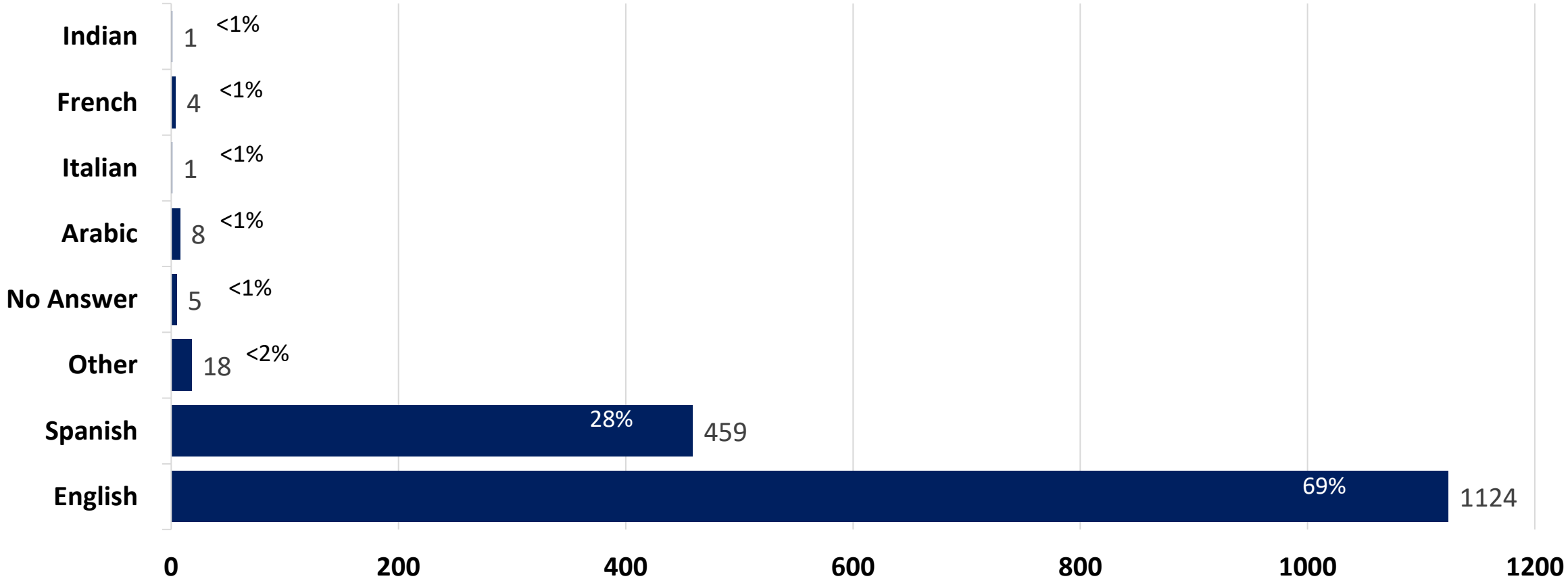
(n=1,684)

Connor Drake, MPA

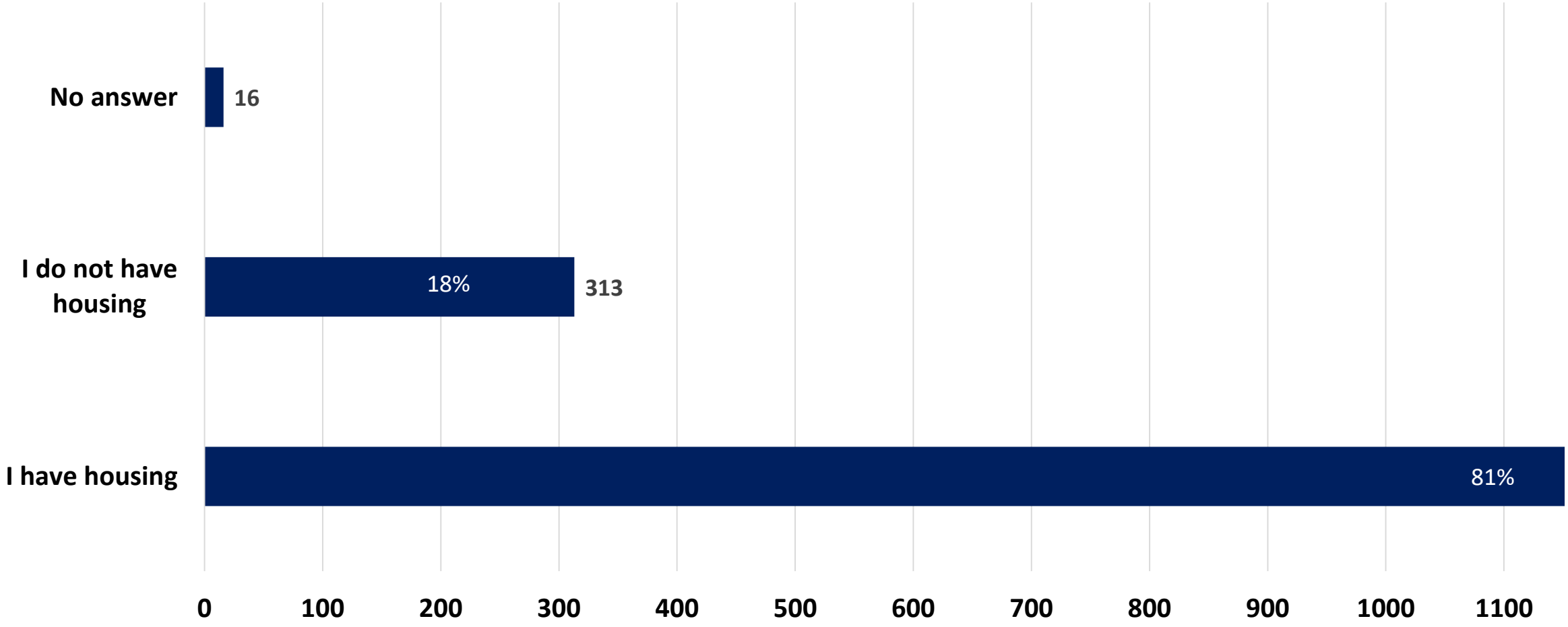
Demographics: Reported Race



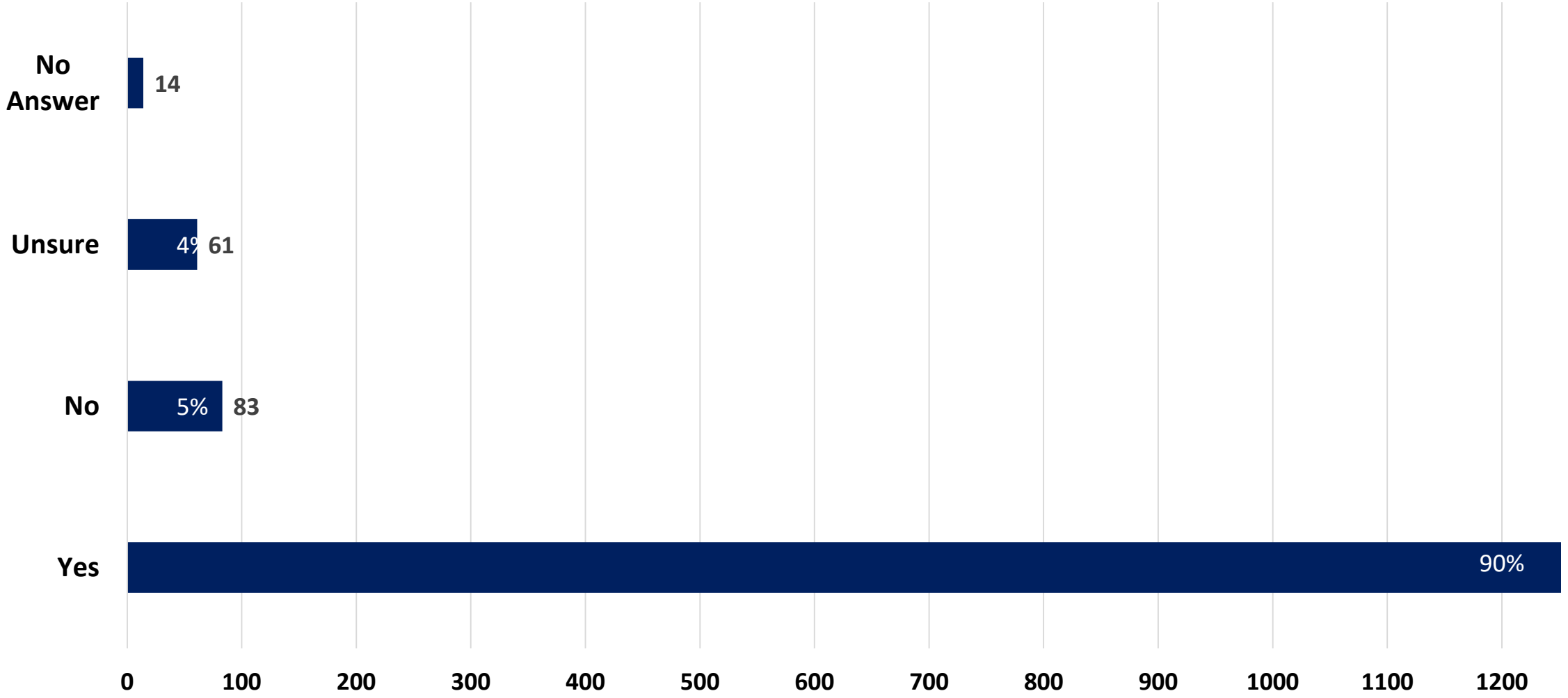
Demographics: Language Most Comfortably Speaking



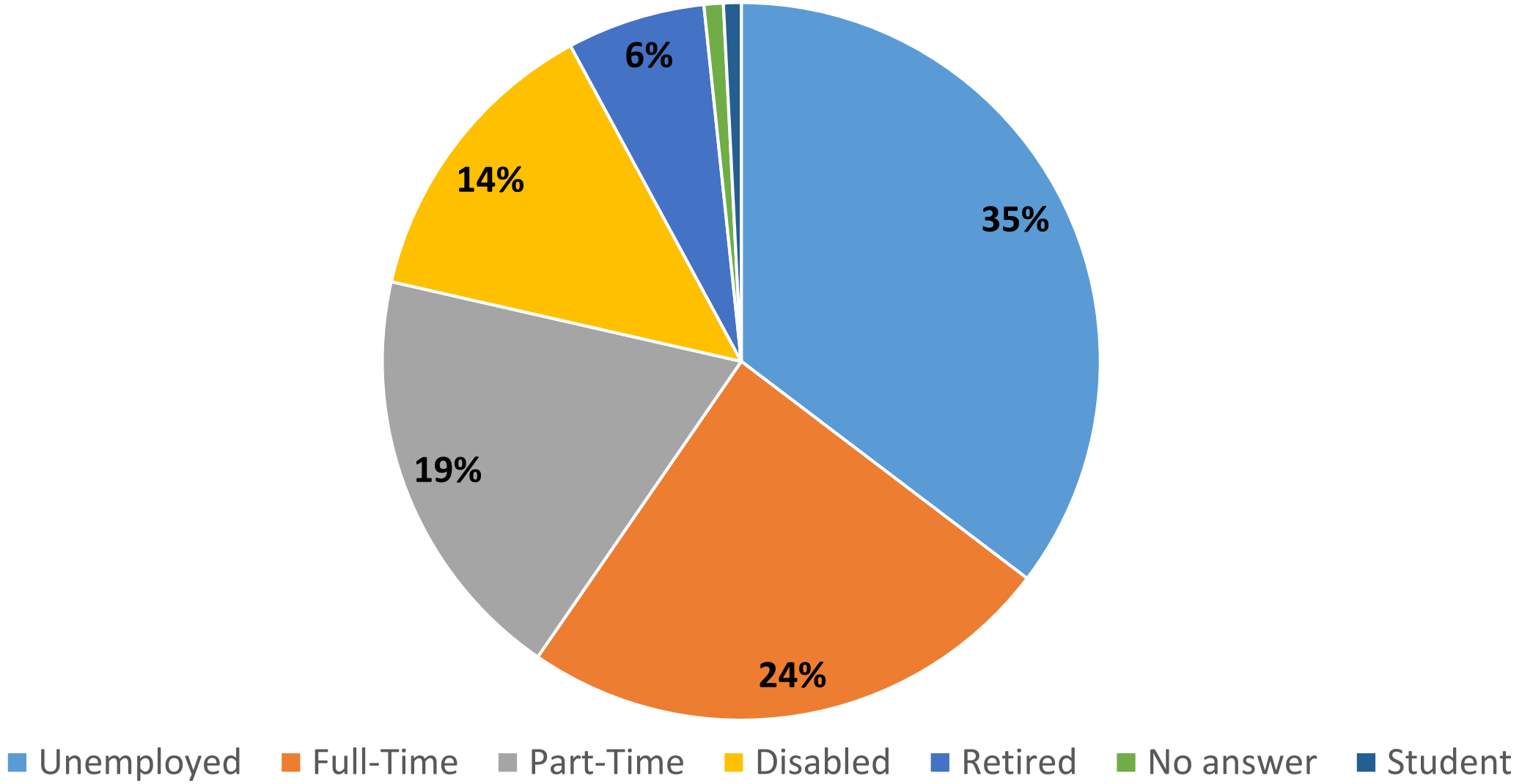
Current Housing Situation



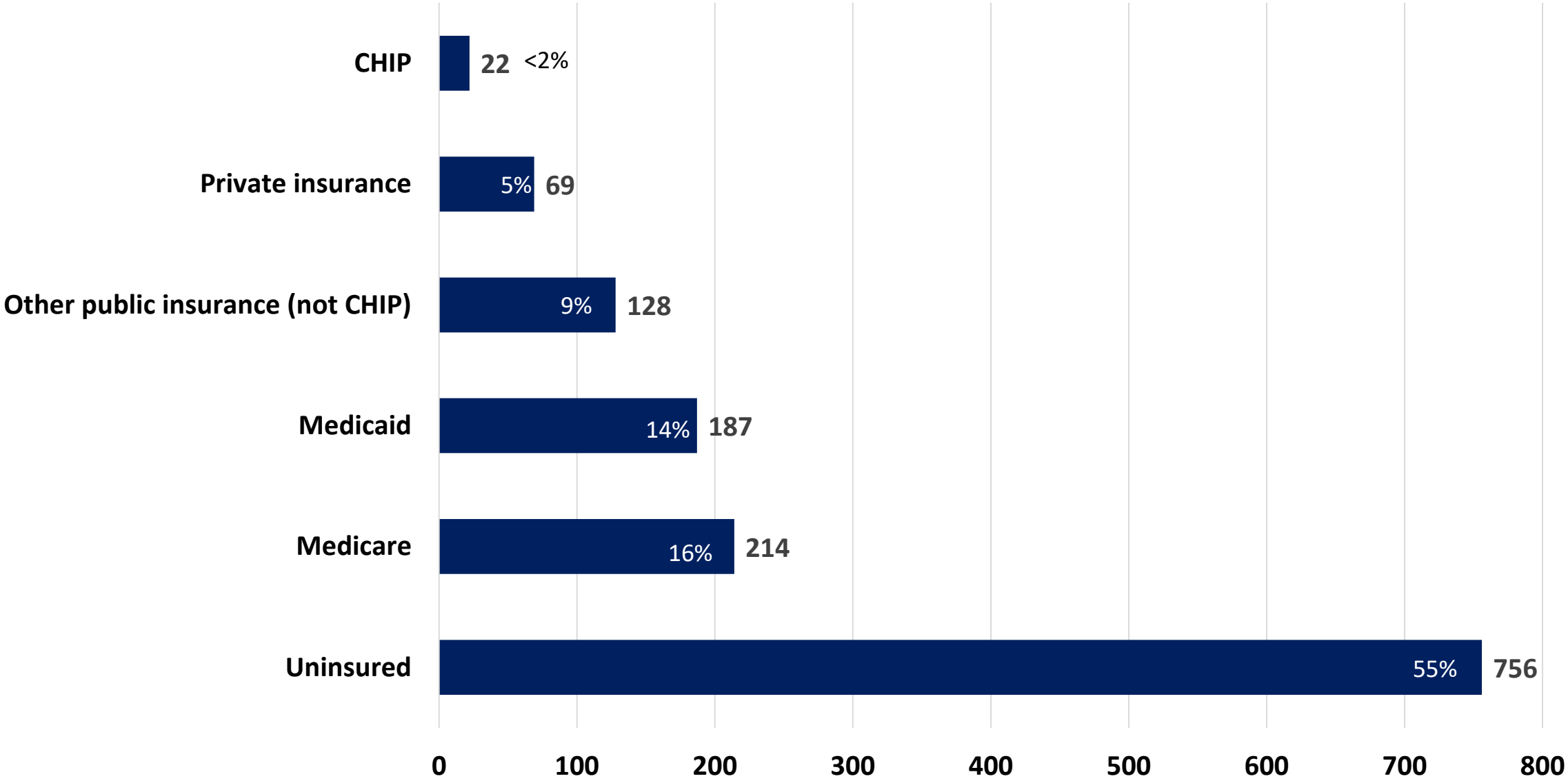
Do you feel physically and emotionally safe where you currently live?



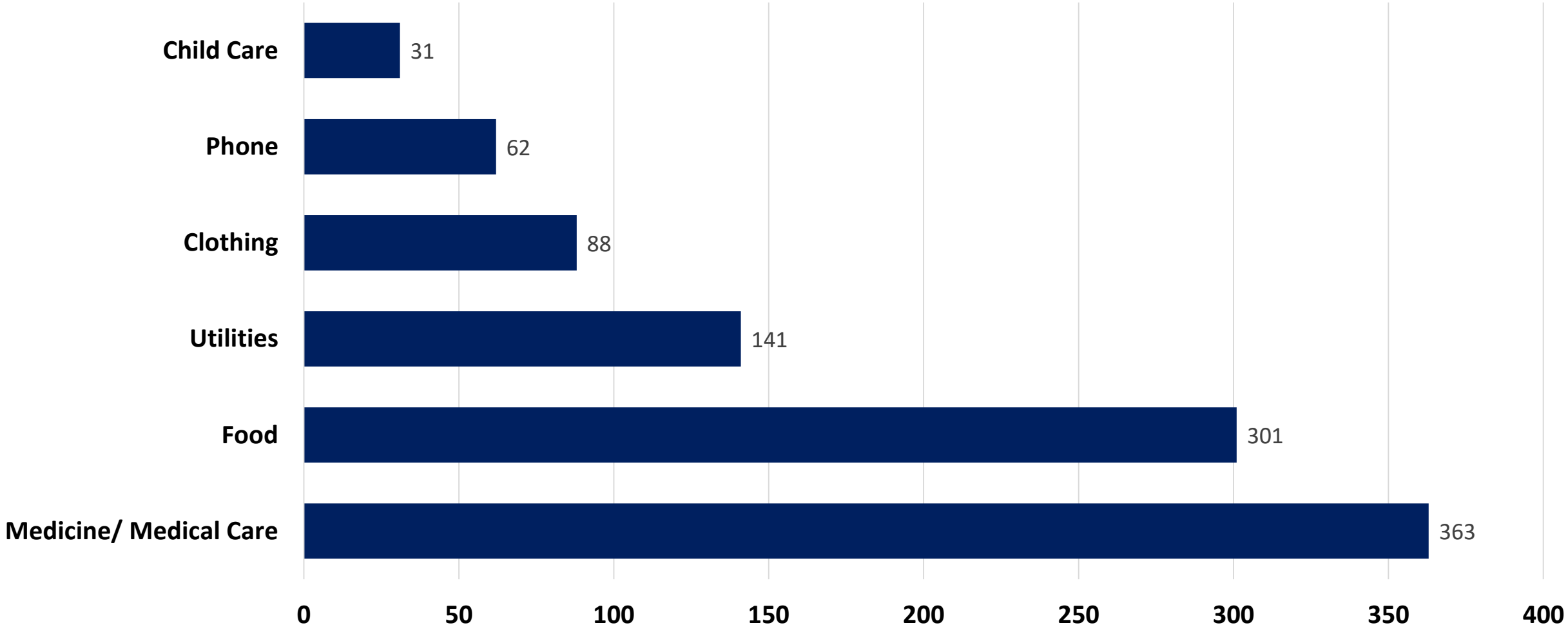
Current Work Situation



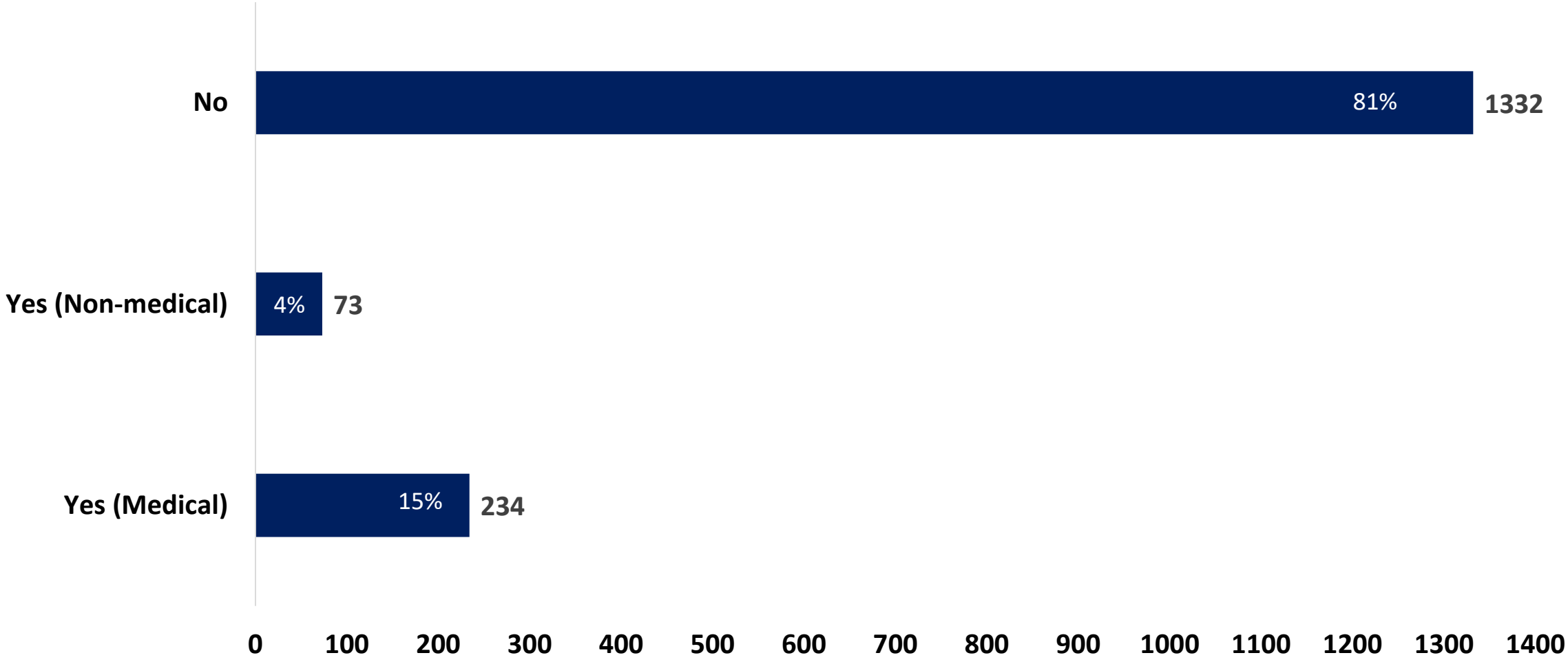
Main Insurance



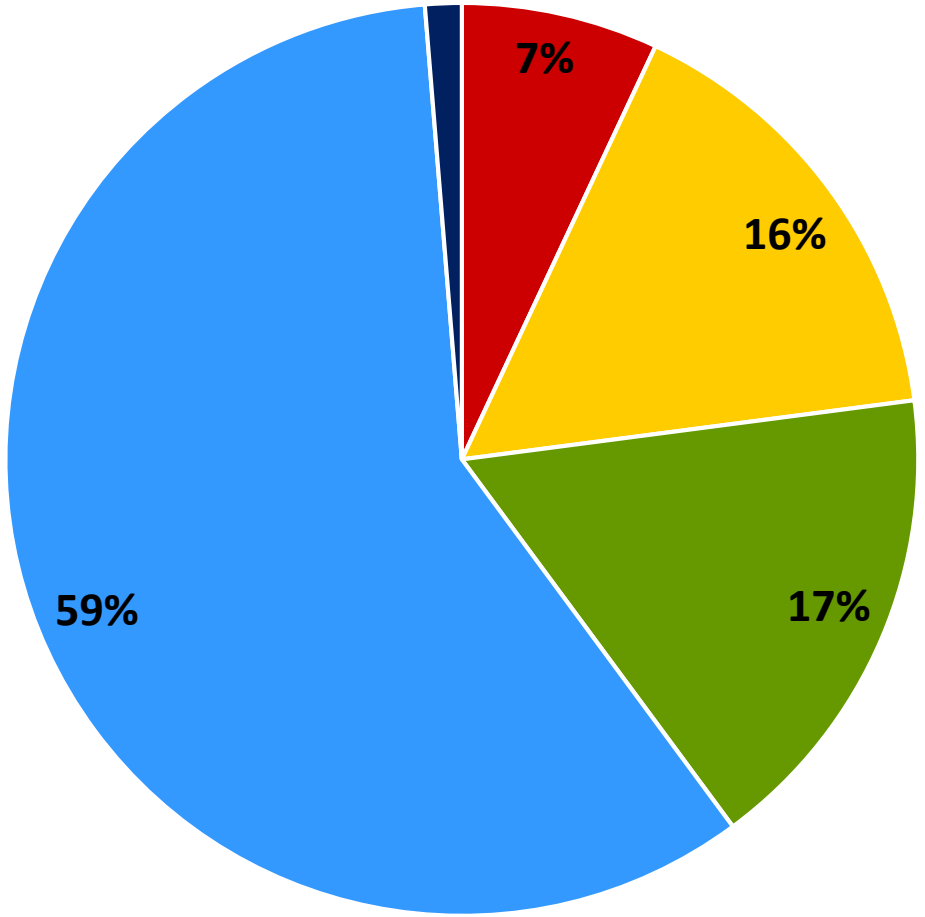
“In the past year, have you or someone in your household had to go without any of the following when it was really needed?”



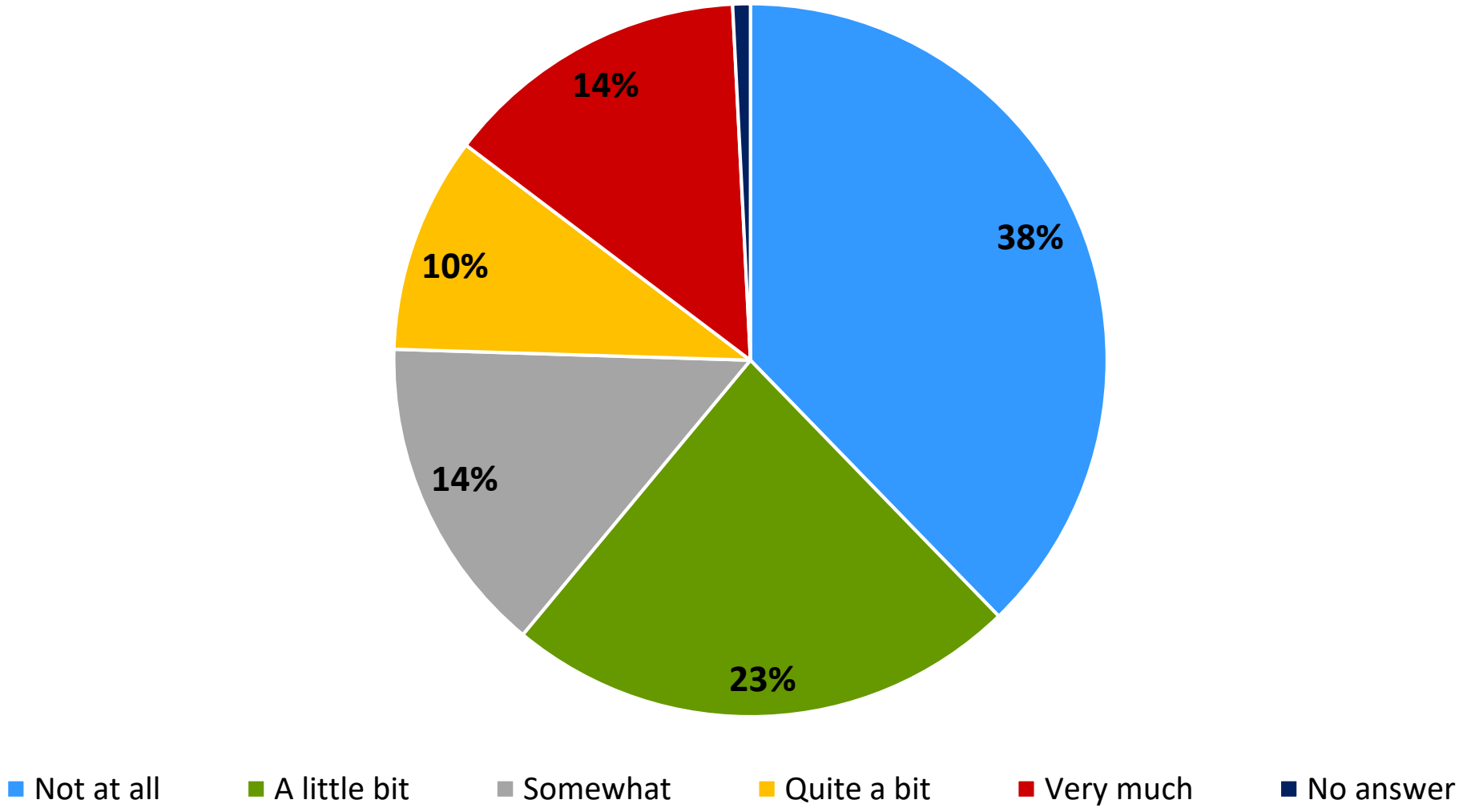
“Has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?”



Social Isolation

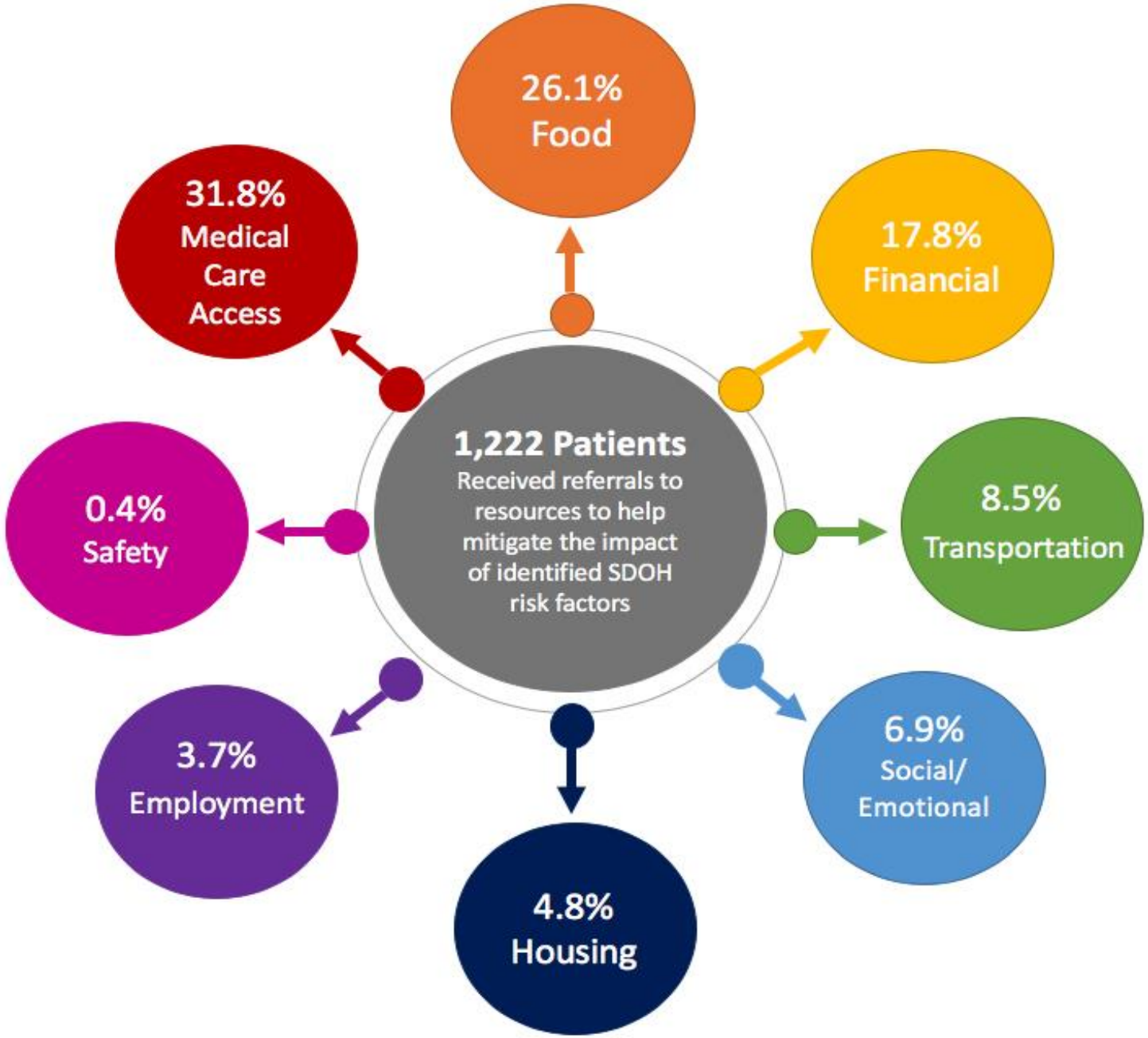


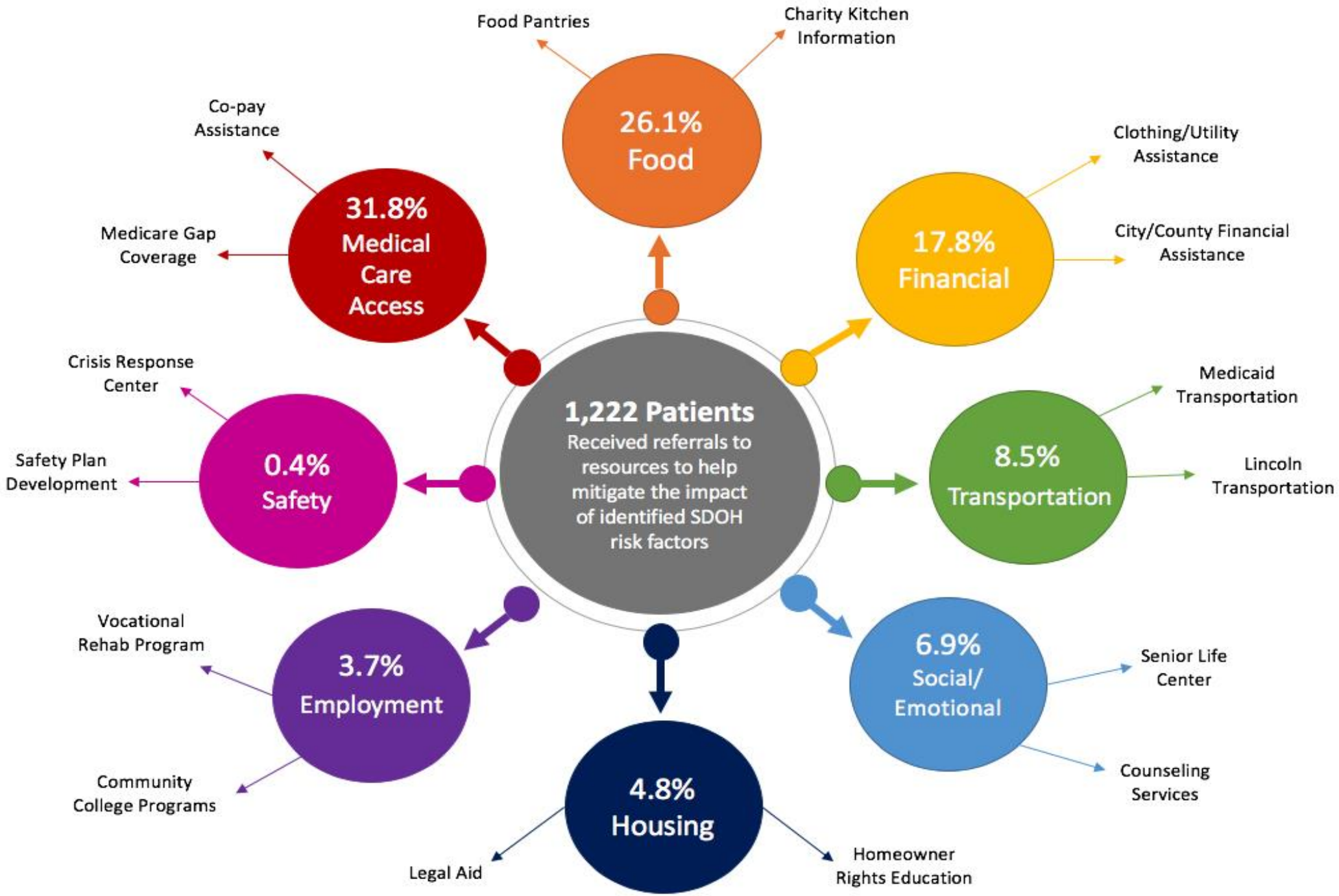
“How stressed are you?”



Moving from Assessment to Action on SDOH

https://www.cdc.gov/socialdeterminants/index.htm


26.1%
Food
17.8%
Financial
8.5%
Transportation
6.9%
Social/
Emotional
4.8%
Housing
3.7%
Employment
0.4%
Safety
31.8%
Medical
Care
Access
1,222 Patients
Received referrals to resources to help mitigate the impact of identified SDOH risk factors


1,222 Patients
Received referrals to resources to help mitigate the impact of identified SDOH risk factors
26.1% Food
Food Pantries
Charity Kitchen Information
31.8% Medical Care Access
Co-pay Assistance
Medicare Gap Coverage
17.8% Financial
Clothing/Utility Assistance
City/County Financial Assistance
0.4% Safety
Crisis Response Center
Safety Plan Development
8.5% Transportation
Medicaid Transportation
Lincoln Transportation
3.7% Employment
Vocational Rehab Program
Community College Programs
6.9% Social/ Emotional
Senior Life Center
Counseling Services
4.8% Housing
Legal Aid
Homeowner Rights Education

Following up and supporting patients through the Student Help Desk

Sahil Sandhu

Student Help Desk Model

Student Help Desk

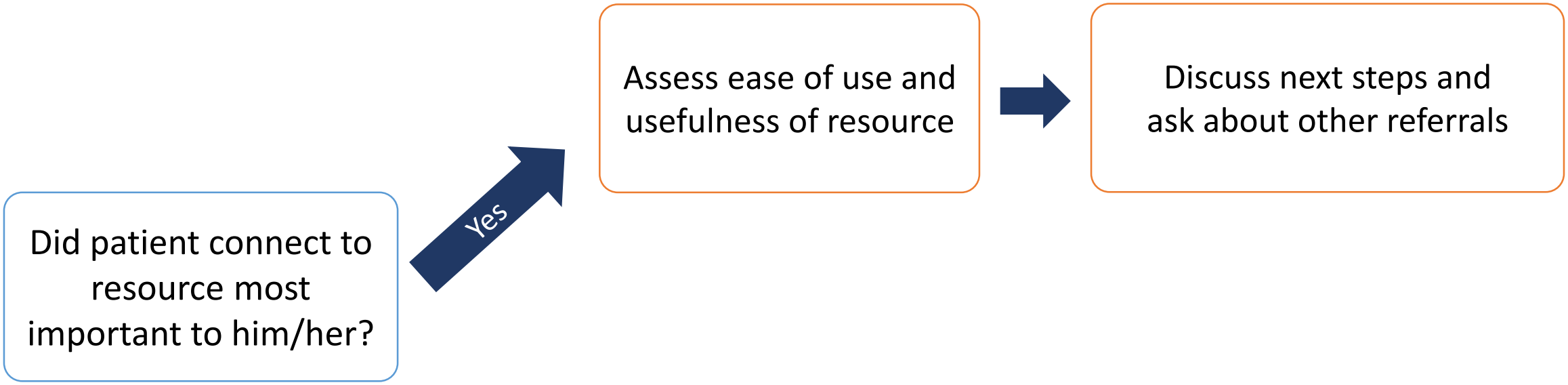
Student Initiative to Help Address Social Determinants of Health

- **Train** volunteers to become **community resource navigators**
- Conduct **follow-up calls** with patients to **assess success of connections** with community-based resources
- Provide information to patients to **troubleshoot reported barriers and problems**
- **Maintain** a community resource directory
- Identify **gaps in local community resources**
- Funded by Duke University **Bass Connections**

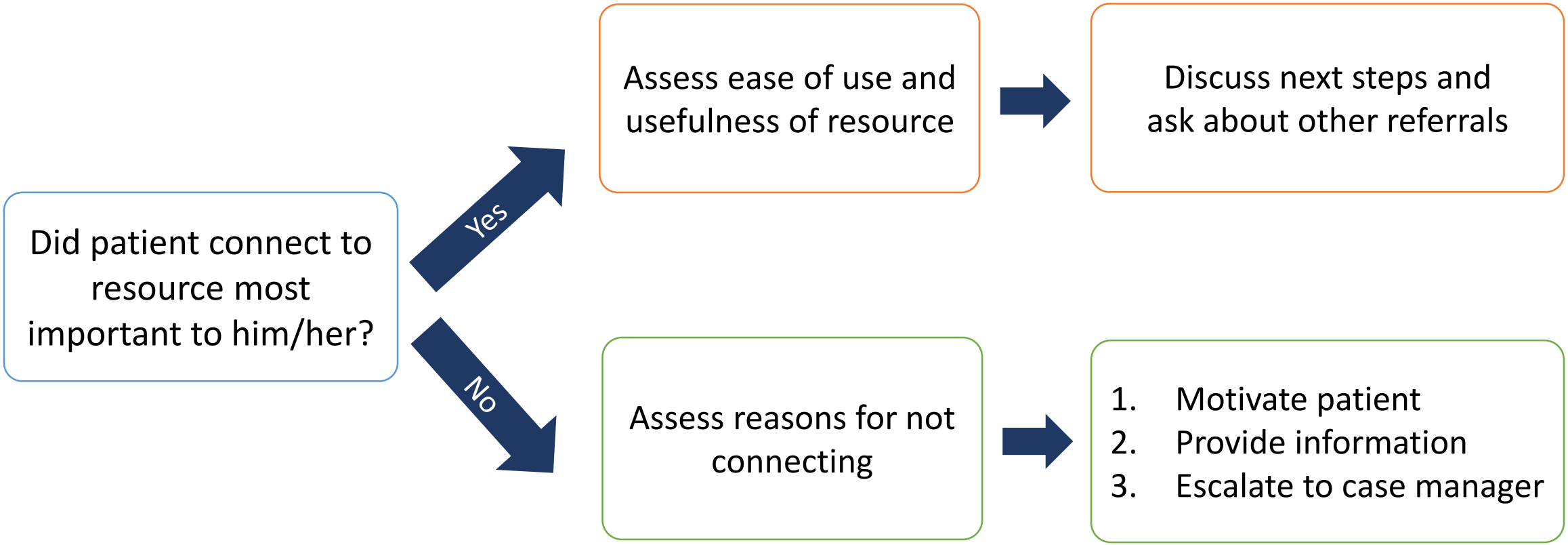
Student Help Desk Phone Call

Did patient connect to resource most important to him/her?

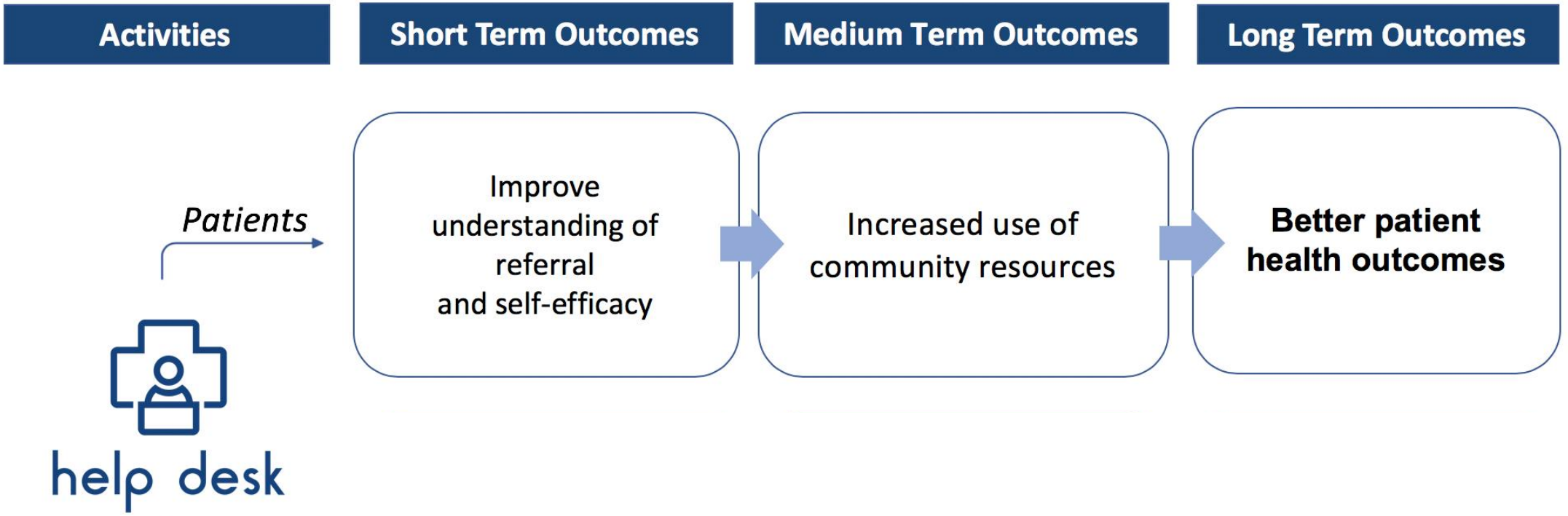
Student Help Desk Phone Call



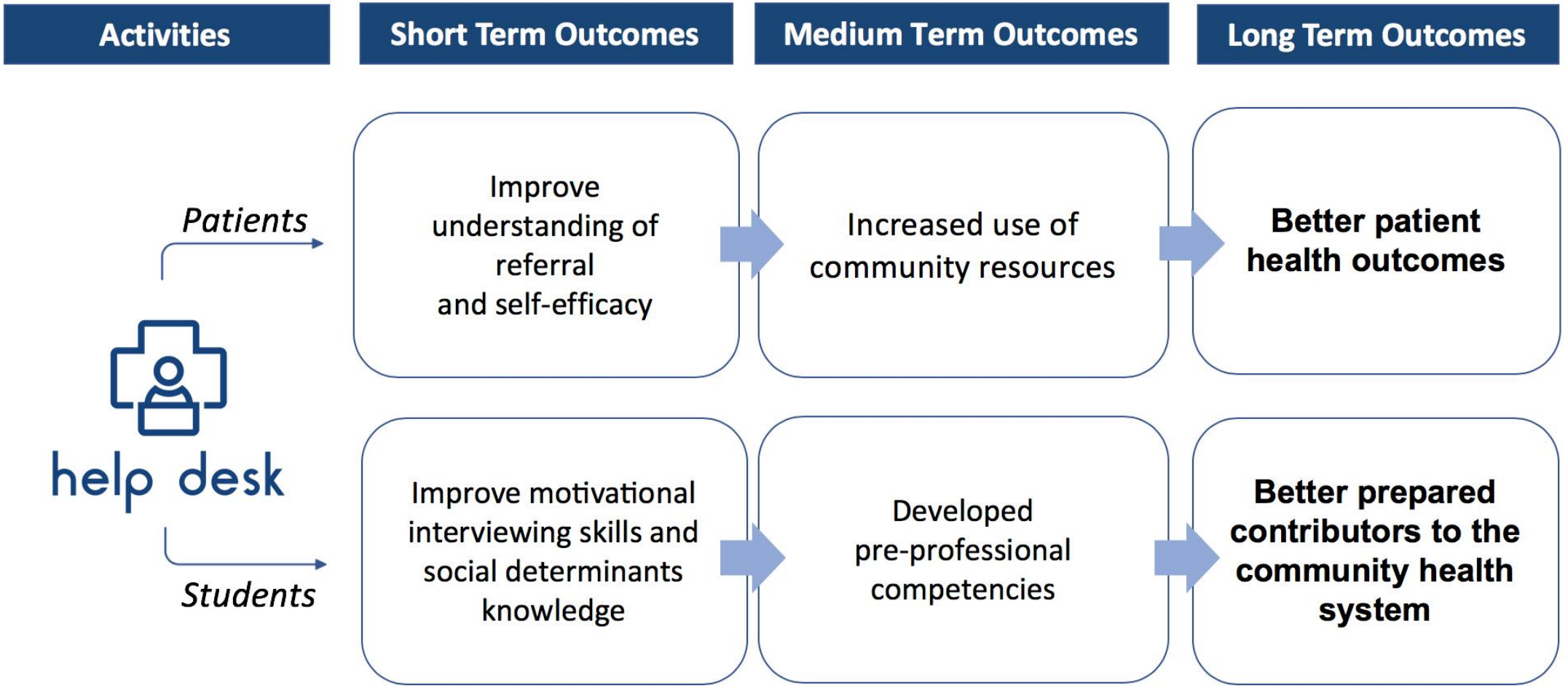
Student Help Desk Phone Call



Student Help Desk Logic Model



Student Help Desk Logic Model



Student Help Desk Data

**Still attempting to reach 26 patients*

61%*

of patients we reached were in the process of connecting to a service or connected to a service

**18 patients still in active follow-up*

Common Reasons for Not Connecting

- Too busy
- Lost contact information
- No longer interested in service (primary need resolved)
- Unsure of service application process
- Major change in physical health change status or other life event
- Contacted service but did not hear back

Future Data Analysis

- Characteristics that affect referral success
  - Number of referrals
  - Setting of referral (behavioral health appointment, warm-handoff from provider)
  - Means of referral (handout, warm hand-off, application completed with case manager)
  - Type of referral (e.g. government agency, NGO, health system)
  - Need addressed (e.g. food, housing, etc.)
  - Patient demographics (e.g. age, race, language, etc.)
- Number of new resource connections after initial Help Desk call
- Patient reported usefulness and ease of use of resources they utilized

Evaluation & Priorities Moving Forward

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Goals of the Project

1. Identify the prevalence of SDOH risk factors in LCHC patients

2. Evaluate the relationship of PRAPARE assessment responses with measure of health and clinical risks

3. Identify what resources patients are being connected to in the community

4. Identify the effectiveness of PRAPARE to link patients to tailored community resources using a novel volunteer student help desk model

Next Steps

- Chart abstraction for PRAPARE respondents
- Qualitative interviews with patients to understand patient experience with PRAPARE
- Expand Help Desk staffing, refine data collection, and explore novel engagement techniques (SMS text messaging)
- Continue to curate community based resource directory in conjunction with NCCARE 360
- Disseminate initial experiences with state and national stakeholders
- Refine protocols for referral and follow-up
- Increase volume of PRAPARE, targeting specific subgroups

How successful with healthy living advice?

Don’t smoke. If you can, stop. If you can’t, cut down

Follow a balanced diet with ample fruits and vegetables

Keep physically active

Manage stress, for example by making time to relax

Get adequate rest

If you drink alcohol, do so in moderation

Don’t take drugs

Practice safer sex

Be safe on the road

adapted from Michael Marmot, The Health Gap. 2015

Would these health tips work better?

Don’t be poor. If you can, stop. If not, try not to be poor for long

Don’t live in a deprived area. If you do, move

Don’t be disabled or have a disabled child

Don’t work in a stressful, low paid, manual job

Don’t live in low quality housing or be homeless

Be able to afford to pay for social activities and holidays

Don’t be a lone parent

Use education to improve your socio-economic position

Claim all benefits to which you are entitled

Acknowledgements

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Questions?

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Works Cited

1. Booske BC, Athens JK, Kindig DA, Park H, Remington PL. Different perspectives for assigning weights to determinants of health. *University of Wisconsin: Population Health Institute.* 2010

2. North Carolina Department of Health and Human Services. (n. d.) Screening Questions. Retrieved from https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/screening-questions

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4. National Association of Community Health Centers. (2016). *PRAPARE: Protocol for responding to and assessing patient assets, risks, and experiences* [PDF File]. Retrieved from http://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf

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