Implementation and Evaluation of PRAPARE Including a Novel “Help Desk” Feature

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Connor Drake, MPA
Sahil Sandhu
D’Nicole Tangen, MSW LCSW LCAS-A
Nekoba Mutima, MSW
Howard Eisenson, MD
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

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
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

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

<table>
<thead>
<tr>
<th>PRAPARE Core Measures</th>
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<tbody>
<tr>
<td>Race</td>
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<tr>
<td>Ethnicity</td>
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<tr>
<td>Migrant and/or Seasonal Farm Work</td>
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<tr>
<td>Veteran Status</td>
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<tr>
<td>Language</td>
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<tr>
<td>Housing Status</td>
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<tr>
<td>Housing Stability</td>
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<tr>
<td>Address/Neighborhood</td>
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<tr>
<th>PRAPARE Optional Measures</th>
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<tr>
<td>Incarceration History</td>
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<td>Refugee Status</td>
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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
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

<table>
<thead>
<tr>
<th>Race</th>
<th>Count</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Black/African American</td>
<td>758</td>
<td>52%</td>
</tr>
<tr>
<td>Other</td>
<td>279</td>
<td>21%</td>
</tr>
<tr>
<td>White</td>
<td>274</td>
<td>20%</td>
</tr>
<tr>
<td>No Answer</td>
<td>73</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>7</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Asian</td>
<td>13</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>2</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

The chart visually represents the distribution of reported races, with the percentage and count for each category. The largest category is Black/African American, followed by Other and White.
Demographics: Language Most Comfortably Speaking

- Spanish: 28% (459)
- English: 69% (1124)
- Other: <2% (18)
- No Answer: <1% (5)
- Arabic: <1% (8)
- Italian: <1% (1)
- French: <1% (4)
- Indian: <1% (1)
Current Housing Situation

- I have housing: 81% (813 respondents)
- I do not have housing: 18% (313 respondents)
- No answer: 16 (16 respondents)
Do you feel physically and emotionally safe where you currently live?

- Yes: 90%
- No: 5%
- Unsure: 4%
- Answer: 14
Current Work Situation

- Unemployed: 35%
- Full-Time: 24%
- Part-Time: 19%
- Disabled: 14%
- Retired: 6%
- No answer: 0%
- Student: 0%
Main Insurance

- **CHIP**: 22 (<2%)
- **Private insurance**: 5% (69)
- **Other public insurance (not CHIP)**: 9% (128)
- **Medicaid**: 14% (187)
- **Medicare**: 16% (214)
- **Uninsured**: 55% (756)
“In the past year, have you or someone in your household had to go without any of the following when it was really needed?”

- Child Care: 31
- Phone: 62
- Clothing: 88
- Utilities: 141
- Food: 301
- Medicine/ Medical Care: 363
“Has a lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?”

- No: 81% (1332)
- Yes (Non-medical): 4% (73)
- Yes (Medical): 15% (234)
Social Isolation

- Less than once a week: 59%
- 1 or 2 times a week: 16%
- 3 to 5 times a week: 17%
- More than 5 times a week: 7%
- No Answer: 38%
"How stressed are you?"

- Not at all: 38%
- A little bit: 10%
- Somewhat: 14%
- Quite a bit: 14%
- Very much: 23%
- No answer: 0%

The pie chart illustrates the distribution of responses to the question 'How stressed are you?'.
Moving from Assessment to Action on SDOH

https://www.cdc.gov/socialdeterminants/index.htm
1,222 Patients
Received referrals to resources to help mitigate the impact of identified SDOH risk factors

- 31.8% Medical Care Access
- 26.1% Food
- 17.8% Financial
- 8.5% Transportation
- 6.9% Social/Emotional
- 4.8% Housing
- 3.7% Employment
- 0.4% Safety

Resources:
- Food Pantries
- Charity Kitchen Information
- Clothing/Utility Assistance
- City/County Financial Assistance
- Medicaid Transportation
- Lincoln Transportation
- Vocational Rehab Program
- Community College Programs
- Legal Aid
- Homeowner Rights Education
- Senior Life Center
- Counseling Services
- Crisis Response Center
- Medicare Gap Coverage
- Co-pay Assistance
Following up and supporting patients through the Student Help Desk

Sahil Sandhu
Student Help Desk Model

Lincoln behavioral health team **screens** patients for unmet social needs

Lincoln behavioral health team **refers** patients to community resources

Student volunteers make **follow-up** calls to evaluate connection to these resources
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**
Did patient connect to resource most important to him/her?
Student Help Desk Phone Call

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

Assess ease of use and usefulness of resource

Discuss next steps and ask about other referrals

Yes
Student Help Desk Phone Call

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

Yes

Assess ease of use and usefulness of resource

Discuss next steps and ask about other referrals

No

Assess reasons for not connecting

1. Motivate patient
2. Provide information
3. Escalate to case manager
Student Help Desk Logic Model

Activities

Short Term Outcomes
- Improve understanding of referral and self-efficacy

Medium Term Outcomes
- Increased use of community resources

Long Term Outcomes
- Better patient health outcomes

Patients

help desk
Student Help Desk Logic Model

**Activities**

- **Patients**
  - Improve understanding of referral and self-efficacy

**Short Term Outcomes**

- **Students**
  - Improve motivational interviewing skills and social determinants knowledge

**Medium Term Outcomes**

- Increased use of community resources

**Long Term Outcomes**

- Better patient health outcomes
  - Developed pre-professional competencies
  - Better prepared contributors to the community health system
Student Help Desk Data

355 patients screened by case managers

157 patients referred to Help Desk follow-up

112* patients reached by Help Desk volunteers

*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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Howard Eisenson, MD
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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.
Questions?
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