OPERATIONALIZING SDOH

Salud Family Health Centers

Todd J. Lessley MPH RN BSN, VP Population Health

30TH ANNUAL BEST PRACTICE FORUM – SEPTEMBER 11, 2019

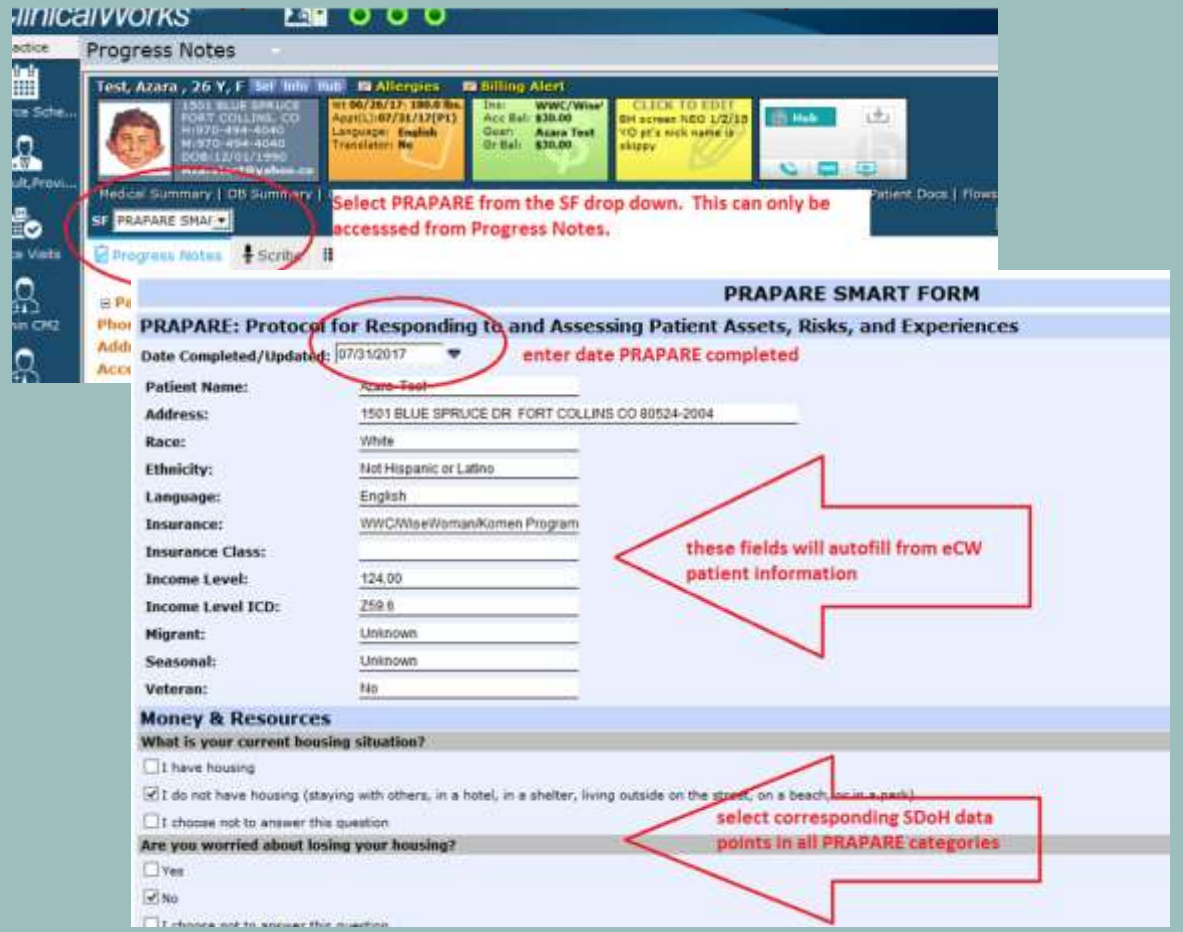
SOURCE: John Moore

SDOH ASSESSMENT CONTEXT

- Colorado ACC/RAE program: 5 of 7 RAEs, ~63K attributed lives
- Alternative Payment Model: Volume to value based care
- 2018 Colorado Community Health Network (CCHN) and 3 FQHCs participated in a PRAPARE Pilot Project as part of *NACHC's National PRAPARE Train the Trainer Academy*
- Currently 6 FQHCs exclusively using PRAPARE

PRAPARE IMPLEMENTATION

- Local Care Managers (SDOH specialists) complete during initial patient contact
- Work with patient to address social needs identified in PRAPARE through Care Plan development
- PRAPARE is entered as *Smart Form* in eCW, embedded in Social History on all future progress notes
- As part of our CCHN pilot used Azara to identify high risk DM/HTN patients to strategically align SDOH and Chronic Disease Management



PRAPARE IMPLEMENTATION

Sample PRAPARE results in eCW Social History

PRAPARE
Date Completed/Updated: *09/29/2017*
What is your current housing situation? *I have housing*
Are you worried about losing your housing? *Yes*
What is the highest level of school that you have finished? *Less than a high school degree*
What is your current work situation? *Unemployed and seeking work*
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,Clothing,Utilities,Medicine or any health care (medical, dental, mental health or vision),Phone
Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? *Yes, it has kept me from medical appointments or from getting my medications,Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living*
How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings) *More than 5 times a week*
How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled *Very much*
In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility? *No*
Are you a refugee? *I choose not to answer this question*
What country are you from? *United States*
Do you feel physically and emotionally safe where you currently live? *No*
In the past year, have you been afraid of your partner or ex-partner? *Yes*
PRAPARE Score: *18*
Enabling Services Provided? *Yes*

- Brings awareness of SDOH issues to every member of the Care Team
- Influences integrated treatment plans and Quality Improvement efforts
- Helps inform team-based approach to patient care

PRAPARE RESULTS

Since 2018: 1351 Assessments completed

CHALLENGES	%
Food Security	20.6
Access to Clothing	8.1
Access to healthcare and medicine	13.1
Access to childcare	2.7
Access to a phone	7.5
Paying for utilities	10.0
Transportation to healthcare appointments/medicine	22.4
No housing (couch surfing, hotel, shelter, living outside etc.)	12.6
Worried about losing housing	21.6
Don't feel physically or emotionally safe where I live	7.4
Afraid of partner/ex-partner (domestic violence)	6.2

STRESS LEVEL (TENSE, NERVOUS, CAN'T SLEEP)	%
Quite a Bit	14.0
Very Much	20.7

SOCIAL SUPPORT CONTACT FREQUENCY	%
1-2 times per week	15.9
Less than once a week	6.3

PRAPARE RESULTS

Since 2018: 1351 Assessments completed

CHALLENGES	%
Food Security	20.6
Access to Clothing	8.1
Access to healthcare and medicine	13.1
Access to childcare	2.7
Access to a phone	7.5
Paying for utilities	10.0
Transportation to healthcare appointments/medicine	22.4
No housing (couch surfing, hotel, shelter, living outside etc.)	12.6
Worried about losing housing	21.6
Don't feel physically or emotionally safe where I live	7.4
Afraid of partner/ex-partner (domestic violence)	6.2

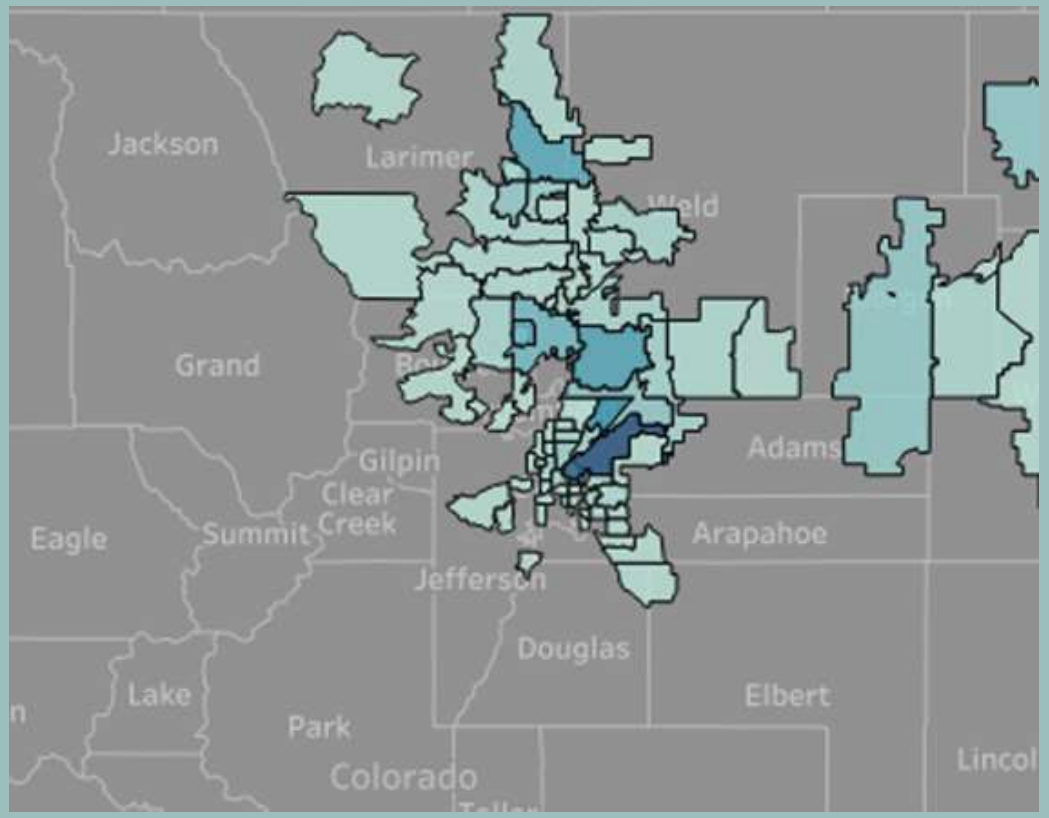
STRESS LEVEL (TENSE, NERVOUS, CAN'T SLEEP)	%
Quite a Bit	14.0
Very Much	20.7

SOCIAL SUPPORT CONTACT FREQUENCY	%
1-2 times per week	15.9
Less than once a week	6.3

PRAPARE DASHBOARD

CCMCN PRAPARE Dashboard: As we systematically collect individual level data we will begin to see population level data that will help focus resources on issues that most impact our patient population.

Geographic Distribution by Zip code (Hover over to see age/gender distribution. Click on zip code to filter demographics



PRAPARE PREPARES US TO..