Strategies for Using PRAPARE and other Tools to Address Homelessness: *Quick Guide and Recommendations*

Background & Goals

Over the last few years, the social determinants of health (SDOH), including housing stability, have been gaining recognition as an important piece of the health care continuum. To best address patients' needs, providers must first identify the social determinants individuals are experiencing. Screening tools, like the PRAPARE tool,[1] have been developed to assess the needs of individuals seeking care. CSH and National Healthcare for the Homeless Council (NHCHC) organized a learning collaborative to understand 1) how social determinants data are being collected, 2) how the data collected inform individual care planning, 3) and how health center staff use data to build partnerships and programs, and 4) the learning collaborative also surveyed how health center staff use the information collected to support fundraising and efforts at the local, state, and federal levels to support services and resources specifically focused on housing status. Through a series of listening sessions conducted with six Primary Care Associations (PCAs) and one focus group session, key challenges and strategies were identified that provide state and local health center perspectives.

PRAPARE and Date Collection Tools Experience

Health providers are trained to find cures. We get frustrated when we know about SDOH and can't make a referral that solves the problem.

Key Challenges	Key Strategies & Innovations
Staff not comfortable or lack training asking about housing status and other 'sensitive questions.'	Collecting SDOH data requires training on details of the data collection tool, and ensuring staff have a general comfort with asking personal, non-medical questions. • Many provide staff training on the data collection tool, as well as motivational interviewing, sensitivity and cultural awareness which also helps staff feel more comfortable asking questions related to housing status and other social and economic factors. Some health centers have coached staff on why the information is relevant to health and to be prepared for negative responses. • Some participants reported assigning a care coordinator, case manager, community health worker (CHW) or other para-professionals to ask housing status or SDOH related questions prior to the appointment either in person or by phone. Some reported that primary care or behavioral health providers may also ask about SDOH during an appointment. • PCAs are encouraging health centers to adopt a health promotion approach and build the questions into standard workflow.
Data collection can be challenging or burdensome.	Interviewers find it helpful for tools to be conversational and distinct from the medical history or other health forms. • Health centers reported that time is an issue with a longer tool and identifying the appropriate placement in the workflow is important. • Health centers are being encouraged to make screening for SDOH as a part of the system of care, rather than giving incentives to patients to participate.

[1] PRAPARE is a data collection tool available through National Association of Community Health Centers to track SDOH data. http://www.nachc.org/research-and-data/prapare/toolkit/ National Association of Community Health Center

Various data collection tools are being used.	More health centers are implementing SDOH data collection, and PRAPARE specifically. PCAs are working with national organizations to deliver training and developing tools to encourage and support SDOH data collection and data validation. • Tools reported: PRAPARE, Accountable Health Communities Screening Tool, Medical Vulnerability Index, and other health center designed systems. • PCAs favor uniformity of SDOH data collection for health centers across their state so that state and regional data can be collected and analyzed together. One PCA is 'crosswalking' the tools to understand the range of questions and data available. • Information was shared that some health centers are pilot testing the data collection process with targeted populations before scaling up to all patients, i.e. pregnant women, seniors, chronic disease patients, participants in a care coordination program. • One PCA reported they have heard MCOs and other funders may require SDOH data collection.
How data is being stored varies by health center.	Ideally the data is being collected in the EHR to be used by providers and other staff members. However, it was reported that aligning the systems takes significant effort. • Some health centers have begun to connect the SDOH to ICM 10-Z Code, which helps with funding, health outcomes and patient satisfaction. • Larger health centers have IT capacity to support implementation and linkages to other reporting. For smaller health centers, support from EHR vendors can lessen burden of integrating the PRAPARE template and collecting SDOH data.

Using Housing Status Data for Referrals and Care Coordination

Some parents are not wanting to disclose information on social determinants for fear of children being removed from the family by the authorities.

Key Challenges	Key Strategies & Innovations
Knowing where to make referrals, and how to follow-up.	Generally, a health center's care coordinator, navigator or other 'enabling services staff' creates a resource guide to be adapted by health center staff for the community. • Some health centers recommend adding set protocols for referrals to lessen reliance on a single staffer's personal relationships. Others are developing resource data bases in their intranet systems for easy access for staff. • Health centers are looking to create a follow-up 'loop' or protocol including where referrals are made, what are the results, what are the gaps. They are also exploring ways to receive data from partner agencies to close the 'loop' after a referral. • Some current referrals are made to fair housing, foodbanks, and legal assistance.
Understanding how SDOH can impact care plans.	Data may inform a person-centered approach to include health, and quality of life. • Despite the challenges, PCAs and HCs recognize collecting data on SDOH presents an opportunity to report on activities that may improve health outcomes. • For example, when an individual identifies housing instability and corresponding and challenges associated with medicine storage, providers can adapt type of medicine or the prescription frequency to accommodate storage issues where feasible.

- Health centers can ensure that behavioral health and social work connections when available onsite are accessed if trauma or other issue identified.
- In some communities, information is used by the case management team to identify health resources for populations in supportive housing.

Using Data for Building Partnerships and Program Design

Many of our health centers are just getting to this point. We're encouraging health centers to build partnerships and identify programs that are needed and leverage existing resources.

Key Challenges	Key Strategies & Innovations
Many health centers do not have the capacity to provide needed services and there are limited resources in the community.	Health centers have been able to identify potential partnerships based on high prevalence of a certain population with housing instability. • One health center created a partnership for parolees from prison to connect to housing. The program included hiring a 'health coach' with lived experience to connect with target population. • Health centers are beginning to use the data to confirm gaps in systems, connect with resources, and support policy changes. • PCAs reported that health centers are seeking guidance on their role in building (and funding) partnerships. • PCAs and HCs are developing protocol and training on building relationships and 'warm handoff' to community partners. • Health centers are using data to increase understanding of how housing conditions can inform chronic health conditions. • PCAs and health centers are working to coordinate with the data that partners (housing, hospitals, criminal justice) want to see. • Health centers are starting to work towards sharing data with Continuum of Care (CoC).

Using Data to Access Funding

Staff response to concerns (financial and organizational capacity) about delving into non-medical areas is that 'We are doing it already. We might as well gather the data and develop the tools to address the issues.'

Key Challenges	Key Strategies & Innovations
Many health centers do not yet have robust SDOH data or a team dedicated to using the data for funding and impacting policy.	Health centers and partners have used preliminary data to explore small funding opportunities. • One PCA used SDOH data to identify community need for Substance Use Disorder funding awards. • One community accessed seed funding from other state departments based on data shared, i.e. Dept. of Correction. • More than one PCA reported interest in connecting SDOH data from health centers with Medicaid Health Home initiatives. • PCAs reported that managed care organizations (MCO) and hospitals are interested, however direct connections to funding may not be readily available. • Some health centers are hoping to use the data to support negotiations on payment structures, risk adjustments and rates.

Recommendations and Lessons Learned

- Provide training and support for staff conducting the SDOH data collection interviews: script, engagement strategies, motivational interviewing, trauma informed care strategies, and role playing can help to guide responses to traumatized or fearful patients.
- Encourage both clinical and non-clinical staff to ask about SDOH. The key focus is on creating an environment of trust, health and culture of help.
- Expand, strengthen and train on technology supports to aid in diagnosis coding, transfer and storage of SDOH data in other health records.
- Incorporate SDOH data in ICD diagnosis coding to demonstrate impact of SDOH on health for risk assessment and payment rate negotiations with MCOs and other funders.
- Develop strategies to analyze and utilize SDOH data to build partnerships and attract funding from government, philanthropy and private entities with an interest in common outcomes.
- Support health centers in current SDOH data collection efforts with focus and flexibility on data results rather than mandates for a specific tool or questionnaire.
- Create a community resources directory (electronically preferred) that includes housing templates and referral protocols, with follow-up and updates built into workflow.
- Health Centers can become assessment points as part of the communities Coordinated Entry System (CES) for Homeless Services to ensure smoother access to partner services.

Resources

- National Association of Community Health Centers. PRAPARE. Available at: http://www.nachc.org/research-and-data/prapare/
- National Health Care for the Homeless Council. (August 2016.) Ask & Code: Documenting Homelessness Throughout the Health Care System. (Authors: Barbara DiPietro, Senior Director of Policy, and Sabrina Edgington, Director of Special Projects.) Available at: https://www.nhchc.org/policy-advocacy/reform/nhchc-health-reform-materials/
- National Association of Community Health Centers. (August 2016.) PRAPARE Implementation and Action Toolkit. Available at: http://www.nachc.org/research-and-data/prapare/toolkit/
- Health Outcomes & Data Measures: *A Quick Guide for Health Center & Housing Partnerships* http://www.csh.org/wp-content/uploads/2017/04/CSH-Data-Elements-Outcomes-Final.pdf
- Health Centers and Coordinated Entry: How and Why to Engage with Local Homeless Systems http://www.csh.org/wp-content/uploads/2017/05/Coordinated-Entry-and-Health-Centers-1.pdf
- Trauma Informed Care Resources and webinar series https://www.nhchc.org/training-technical-assistance/online-courses/trauma-informed-care-webinar-series/

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