

## **Practice/Community Health Team Interview**

### **Current State: Collecting Social Determinant of Health Data**

There are a number of different “drivers” that primary care practices/CHT are responding to around capturing and using patient facing social needs information including some of the following requirements:

NCQA: Patient Centered Medical Homes are asked to collect information on social determinants of health (conditions in the patient’s environment that affect a wide range of health, functioning and quality of life outcomes and risks). Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; food and housing insecurities, exposure to crime, violence and social disorder.

CPC+ Track 2 Year 2 Service Delivery Requirements include:

Using a two-step risk stratification process for all empaneled patients, addressing medical need, behavioral diagnoses, and health-related social needs: and addressing common psychosocial needs for at least for practice high-risk patients:

- Routinely assessing patients’ psychosocial needs.
- Prioritizing common needs in practice population, and maintaining an inventory of resources and supports available to address those needs.
- Establishing relationships with at least two resources and supports that meet patients’ most significant psychosocial needs.

Accountable Entity Certification Requirements have identified three priority domains including housing insecurity, food insecurity and safety and domestic violence. A/E entities can demonstrate social determinant capacity through defined relationships with social support agencies or in having social support capacity within the A/E.

Pediatric Practices: The American Academy of Pediatrics issued a statement urging pediatricians to screen all patients for food insecurity “whether they are worried that food would run out before they could buy more and whether the groceries they buy last until they had money to buy more”) and to refer patients to food assistance programs if appropriate.

The purpose of today's interview is to understand your current experience with collecting and using information patients provide on their social needs. Based on practice/CHT interviews, CTC will be providing RIQI with an Assessment Report. This Assessment Report will be used to help inform RIQI and the State on "next steps" for providing health status, social determinants of health information for inclusion in options such as CurrentCare/HIE/practice electronic health record.

**Interview questions:**

**Social Needs Information:**

1. In your practice what efforts are already underway to collect social needs information?
2. What patient-reported information are you asking patients about related to their social needs (e.g. employment, housing, food, education, utilities, transportation, ability to pay for medications, etc.)? Who collects this information? How often do you collect information on social needs?
3. Is this a standardized set of SDH data or did you create your own data set? Is your practice using a particular tool to ask patients for information about their social/medical needs? (Include sample tool being used if applicable)
4. How did your practice choose what social needs information to ask patients?
5. Are reporting requirements a factor in selecting social needs information? If yes, which reporting factors?

Are there reporting factors you need to meet but are not covered by your present data set?

6. What are the entities, either internal or external, to which you submit or report the social needs information you collect?
7. What is your practice experience with reviewing / accessing /interest in using social needs information at a neighborhood/zip code level?

**Creating a universal Social Needs tool**

The Institute of Medicine has created a standard set of Social Determinants of Health domains and questions.

8. These are social needs domains and questions recommended by the Institute of Medicine. (INSERT LINK) How do these domains and questions match with what you are already collecting? About the same? More or less?
  - a. Which domains do you think should be included or prioritized?
  - b. Let's take a look at the domains individually and by question. Are there questions missing? Wording changes you would make?
9. Patients often move between regions, states or providers. This can make it difficult for practices and payers to track patients and their social needs. What might be the benefits of having a core set of measures that are used across the state? Across the nation?

**Process for Obtaining Social Needs Information:**

10. Is your practice universally screening all patients or a sub-group of patients regarding social needs?

Do you collect one set of social needs data for patients who are low risk/low cost and a different more comprehensive data set for people that are high risk/high cost?

11. What is your practice work flow for obtaining the social needs information?

How do patients provide the social needs information?

(Paper form completed by patient/ Patient completes using cloud based link/Patient enters information into tablet/staff person reads the questions to patient)

How to make sure patients fill out social needs information as scheduled? Should an alert system be part of the data collection system?

How does the social needs information get captured into the patient record?

What would be your preferred method for patients to provide social needs information?

How are practice team members able to view patient social needs information (Problem list/demographics, other)?

12. Please describe any changes your practice needed to make in the electronic health record to capture social needs information:

13. How often does the patient provide the information? Does the frequency depend on the patients' health status, type of visit, social need?

14. How have patients responded to being asked social needs information within your setting (i.e. primary care or in home by CHT member)?

15. What are the barriers to obtaining the patient social needs information (time, language, literacy, patient response, and staff training)? What solutions have you found?

**Outcomes: Using Social Needs Information**

16. How does your practice respond when patients indicate they have a social need?

17. Please describe your process for generating aggregated social needs information:

18. Please describe how your practice uses aggregated social needs information to guide your decisions to form relationships/compacts with social service agencies to better meet patient

needs:

19. Please describe the process your practice uses to support patients who need social service referrals. (Paper referrals, United Way 211, referral to care management, etc.)
20. Please describe how resource information is made available for patients and if/how you track follow up:
21. What are the barriers to using the social needs information (time, generating reports/lack of resources, other)?
22. What are opportunities to improve use of social needs information?
23. Do you have suggestions/recommends /concerns for opportunities such as state-wide collection of social needs information?

SIM, as a separate scope of work would like to create a more centralized social needs resource directory

24. Do you have suggestions for opportunities for state-wide resource referral directory?
25. Any examples of how obtaining and using social needs information has benefited your patients?
26. Any examples of how obtaining and using social needs information has improved clinical outcomes?
27. Anything other thoughts or comments you would like to add?

**Advance Directives:**

28. What is your practice process for knowing if a patient has advance directives?
29. Please describe process your practice uses  
  
To obtain and retain advance directive documents from the patients:  
  
To obtain from other parties, such as hospital or long term care facility:
30. How often are patients asked to review or update their advance directive? How do you make sure the advance directive is current and valid?
31. Please describe proves you use to share advance directive information with other parties:

Do you share advance directive information with other caregivers?  
Do you share advance directive information with other facilities?

32. RIQI is looking to provide patients with an opportunity to update their advance directive documents into the HIE. What would your practice see as the benefits to having advance directive documents uploaded to the HIE?
33. What support would your practice need to provide patients with this uploading option?
34. Other thoughts or recommendations you would like to share on having this advance directive uploading opportunity?

### **Testing the Consumer Platform Solution**

RIQI will be using the information obtained from practice CHT interviews and using information from the State Innovation Model Work plan to develop a pilot test version of a solution that will enable consumers to provide health status and social needs information.

35. What benefits would you see if patients were able to provide social needs information on the HIE platform?
36. What recommendations/suggestions would you have for making this option available?

### **Obtaining Patient Feedback**

CTC has developed a patient focus group guide (see pages 8-10) for practices to use to solicit patient feedback on the role of primary care in obtaining/using patient social needs information and advance directives.

37. Do you anticipate your practice will host a patient focus group?
38. From your perspective, does this focus group guide meet your needs? Are there any focus questions you would recommend including in the guide? You can let us know now, or send us comments and edits by January 31, 2018.

### **Opportunity to participate in a Learning Network Collaborative**

CTC will host a Learning Network Collaborative with the primary care practice/CHT partners with quarterly meeting session over a 12 month time frame.

39. From your perspective, do you have suggestions for what you would like to see included/addressed in the social needs/advance directive Learning Network Collaborative?

**Primary Care Practice/Community Health Team Opportunity to obtain patient feedback on patients providing social need and advance directives information**

**Draft Patient Focus Group Interview Guide** (Guide will be updated based on Interview Feedback)

**Introduction**

Thank you for meeting with us today for this focus group. As you may know, a focus group is a discussion led by a moderator. As your moderator, I will ask you questions. I would like to hear your reactions and thoughts not only to the questions, but also to what others have to say. Please know, there are no right or wrong answers to these questions. It is important that we understand your views.

To protect your privacy, when we write up the results of this focus group, we will not include your names. Further, if you want to discuss with others what we talked about today, please feel free to discuss what you said, but do not give the names of the people who took part today.

**Purpose of today's focus group**

The purpose of today's focus group is to discuss one way we think Rhode Island can improve the health care we provide patients. As you may know, the cost of health care in the US is among the highest in the world. However, many countries spend less and get better outcomes. Health experts around the world strongly believe one reason that happens is that other countries actively work with patients to identify their patients' social, emotional, financial, and living needs and help patients address their problems. We refer to those needs as social determinants of health. Additionally, other countries use their SDH data to address needs at a town or country level. We will refer to SDH as "social needs" during today's session.

In Rhode Island, we would like to develop a system in which we ask primary care patients a set of standard questions about their social needs. Right now, some providers ask questions about your social needs, and some don't. Providers may ask similar, but different questions, or ask only a certain set of questions. When we don't collect the same information from patients, and when we ask questions differently, it makes it hard to help patients or to do good planning.

In this new system, Rhode Island clinicians would use your information, when appropriate and with your permission, to address your social and medical needs—for example, through referrals or care management, referrals for food or utility assistance. The state of Rhode Island would use the compiled, de-identified data to address resource gaps. This information would help Rhode Island better use our tax dollars.

We want to understand your perspective on collecting and using the social needs information. We want to gather information about your social needs and we want to use information about social needs in a way that you would find helpful.

We also will ask you about advance directives—if you want that information entered into your health record and made available to others through the Health Information Exchange (Currentcare ).

Let's start:

### Questions

1. ICE BREAKER—When was the last time you went to the doctor? And when you went, were you asked questions about your medications? About your mental health? If you had used drugs, tobacco or had a drink? About whether you felt safe at home? Were you asked if you had a health care proxy, that is, someone who could make health decisions for you? Could you tell us why or why not you expect to answer these types of questions when you go to the doctor?
2. What other types of questions about your social needs have you been asked when you have gone to see your medical provider?
3. What other types of questionnaires do you fill out at the doctor's office? How about for the census? Health surveys, either by phone or mail?
4. These are pretty personal questions. Tell us about your comfort level in answering these questions. Why do you think you answer these questions? (Prompt—it's the doctor, it's confidential, need answers to help me, etc.)
5. Summarize results, Q1-4. (Expect these answers: you fill out paperwork at the doctor, people feel okay answering those questions because they know the health provider or other organization will use the questions to help you, use information for service planning, answers will be kept confidential, etc. And, when you go to the doctor, you expect to fill out forms.
6. Distribute sample domains, questions. Let's take a look at some of the questions we are thinking about asking. How do you think these questions compare with other questions you already answer at the doctor's office, or by other health surveys? (Prompt: like other questionnaires, helpful, too personal, not the right questions or domains)
7. What benefits do you see in answering these questions? (Prompt: Do you think these questions can be used to help patients get services? For planning?)
8. How do you think patients would best answer these questions? Answer the questions by themselves on paper or on a computer or a phone? Have a nurse or someone else read the questions to them?
9. How often do you think patients should be asked these questions? Once a year at the annual physical? Every time you are at the doctors? Only as a follow up if you are getting care management services?
10. These questions and your answers could be entered into or uploaded into CurrentCare, so that you could see how you answered the questions. Is that of interest to you? Why or why not?

11. What do you see as any problems that might arise from collecting your social needs information? How might those problems be addressed?
12. Overall, do you think the benefits of asking these questions outweigh the risks?
13. Summarize responses regarding administration frequency, who administers and how, other key findings.
14. To summarize, benefits include: (examples: referrals, care management, planning, etc.)
15. To summarize, risks include: (examples: privacy, lack of resources, etc.)
16. Is there anything else you think we should know about asking patients about their social needs?

I'd like to ask a few questions about advance directives—that is, the paperwork you fill out that describes the care you want at the end of your life. Often, end of life can be a confusing time. Family members may not know what their family member would want. Doctors may need to treat a patient without knowing what the patient's wishes are regarding end of life care.

This is a form Rhode Islanders can use to let their family and health providers know their wishes about end of life care. Distribute the form:

[https://www.everplans.com/sites/default/files/Rhode\\_Island\\_Health\\_Care\\_Proxy\\_Form.pdf](https://www.everplans.com/sites/default/files/Rhode_Island_Health_Care_Proxy_Form.pdf)

1. What might be the pros and cons of having patients, regardless of their age or health conditions, fill out this form?
2. People's end of life decisions can change as they get older, or as they get sicker. How often do you think this form should be updated?
3. How helpful might it be for you to be able to go in and update the form? For example, to be able to go into CurrentCare and change your preferences?
4. Right now, this form is not included in the patient's electronic health record. What might be the pros and cons of placing this form in the electronic health record, where a doctor could read the form, or the form could be printed out for family members to read?
5. Is there anything else you would like to tell us about advance directives?

Thank you for your time and more importantly, sharing your thoughts and knowledge.