

The Role of Addressing Social Determinants of Health in Value-based Payment Models: A Rural Perspective

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The Walsh Center  for Rural Health Analysis

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NORC at the University of Chicago is an objective and non-partisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions.

NORC's Walsh Center for Rural Health Analysis, established in 1996, conducts timely policy analysis, research, and evaluation that address the needs of policy makers, the health care workforce, and the public on issues that affect health care and public health in rural America. The Walsh Center is based in Bethesda, MD.



Social Determinants of Health





Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- **Healthy People 2030**



Good health begins in the places where we live, learn, work and play. Although medical care is critically important, things like the quality of our schools, affordability and stability of our housing, access to good jobs with fair pay, and the safety of our neighborhoods can keep us healthy in the first place.

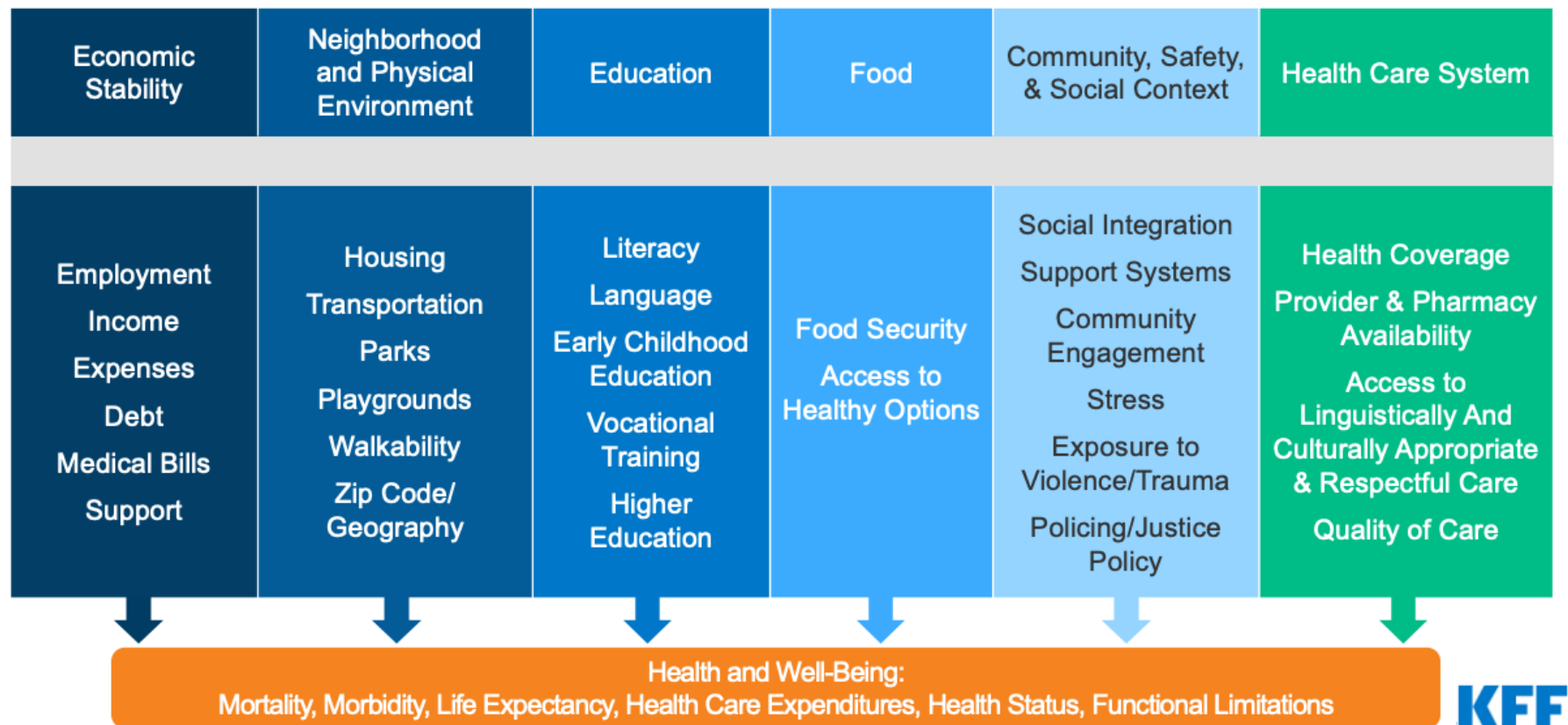
- **Robert Wood Johnson Foundation**

Social Determinants of Health

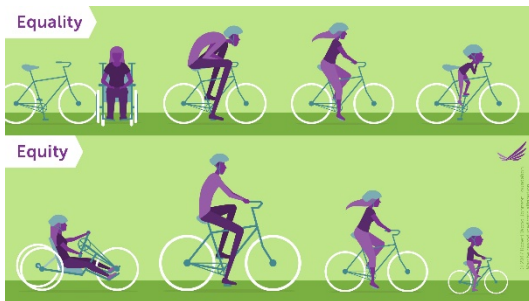


Figure 1

Social Determinants of Health



Health equity, SDOH, and health disparities



Health Equity

The goal: every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.



SDOH

The strategies: addressing SDOH is critical to achieving health equity

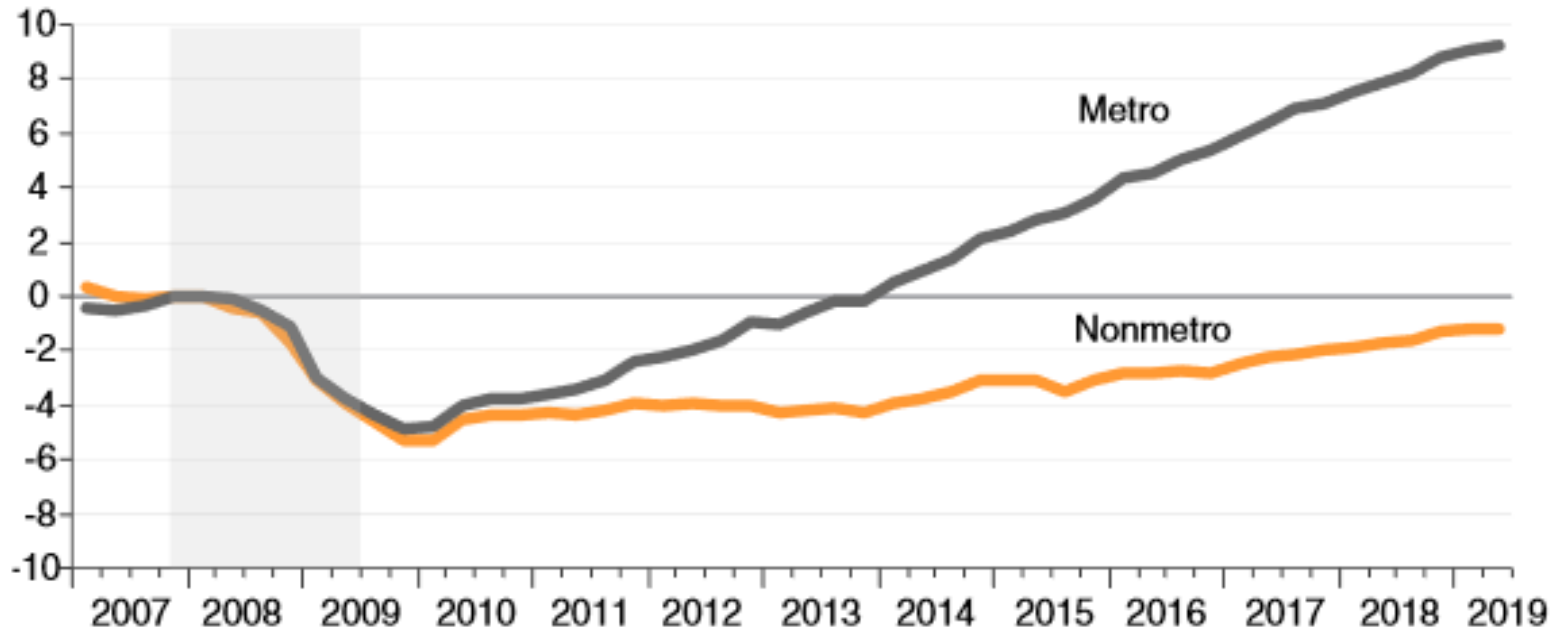


Health Disparities

The metrics: tracking health disparities helps us measure progress toward achieving health equity

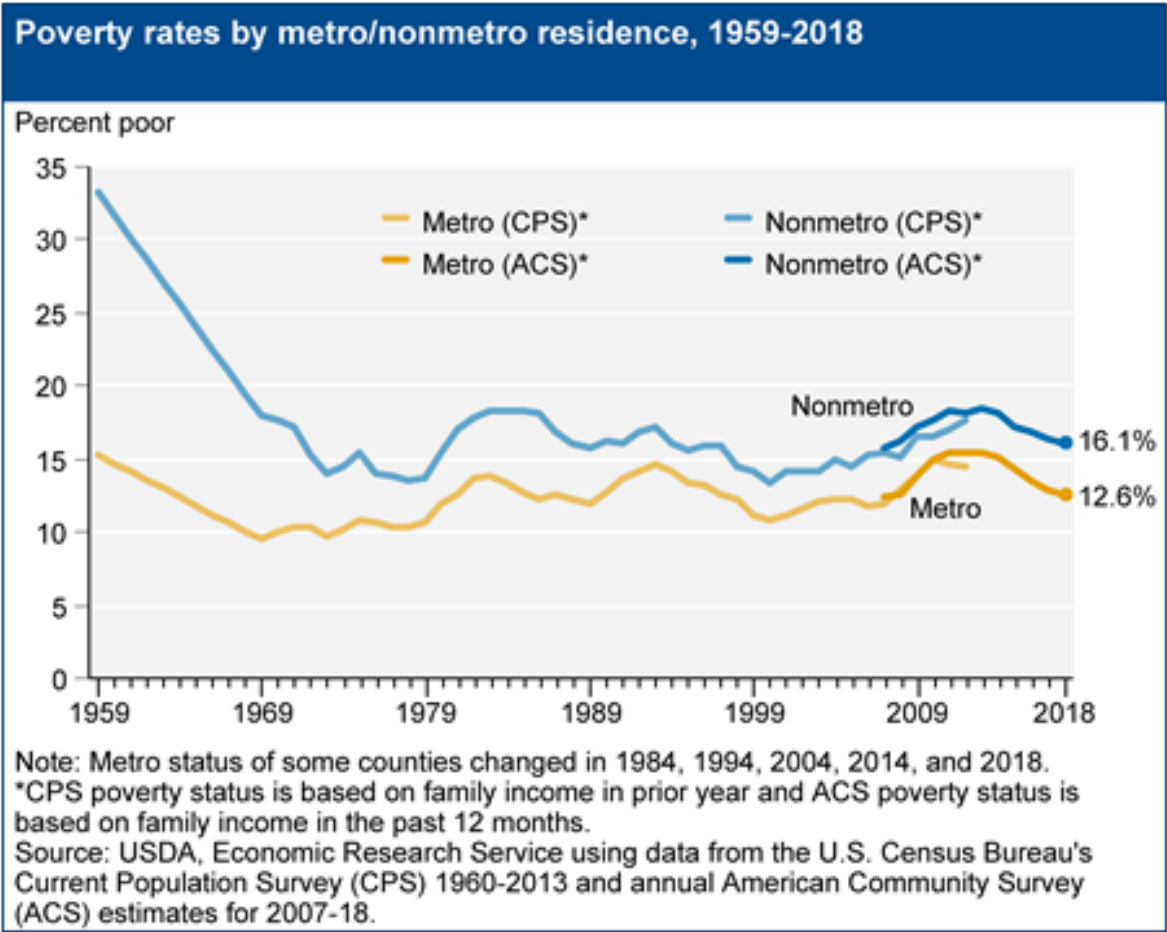
Employment has grown more rapidly in metro than nonmetro areas since the Great Recession

Percent difference from 2007 Q4

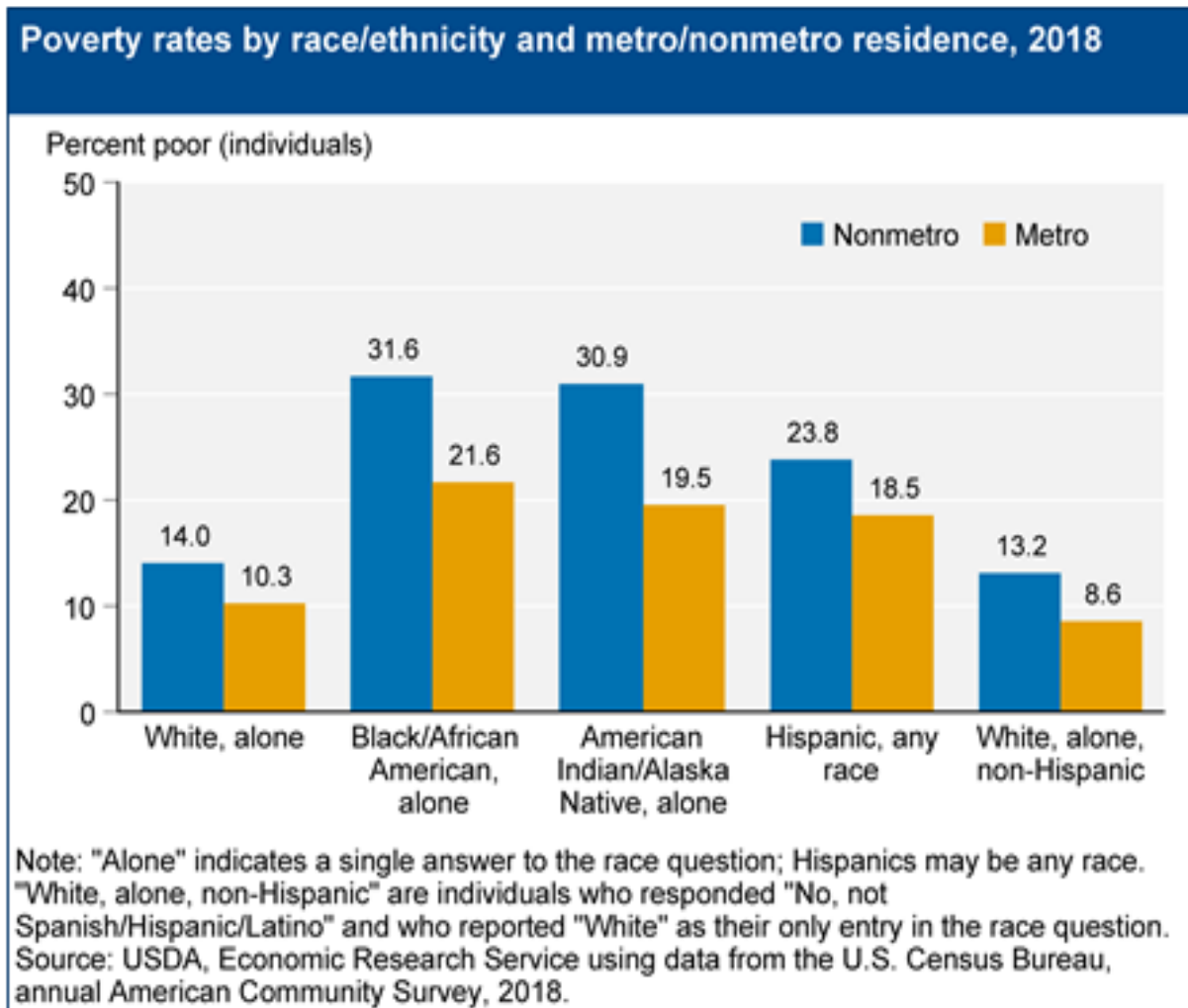


Note: Shaded area indicates Great Recession. Data are seasonally adjusted.

Source: USDA, Economic Research Service using data from the U.S. Bureau of Labor Statistics (BLS), Local Area Unemployment Statistics (LAUS).



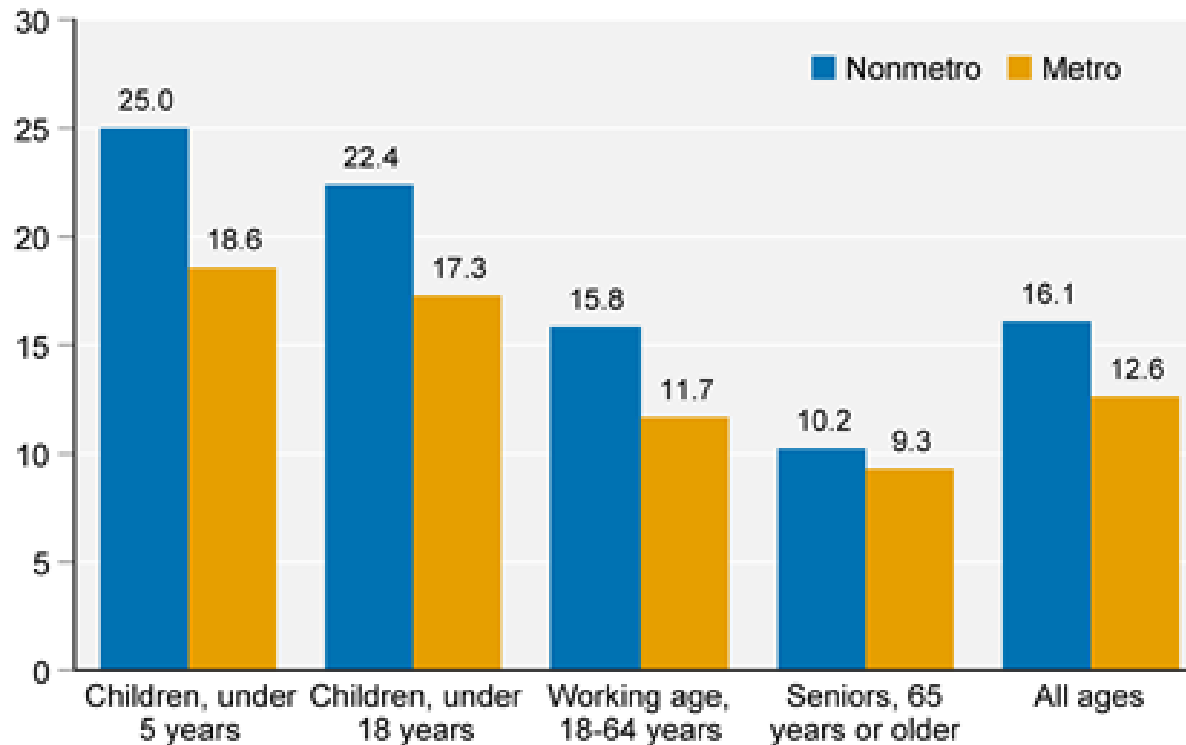
USDA Economic Research Service. (2019). Poverty Overview. Retrieved from: <https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/#historic>



USDA Economic Research Service. (2019). Poverty Overview. Retrieved from <https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/#historic>

Poverty rates by age group and metro/nonmetro residence, 2018

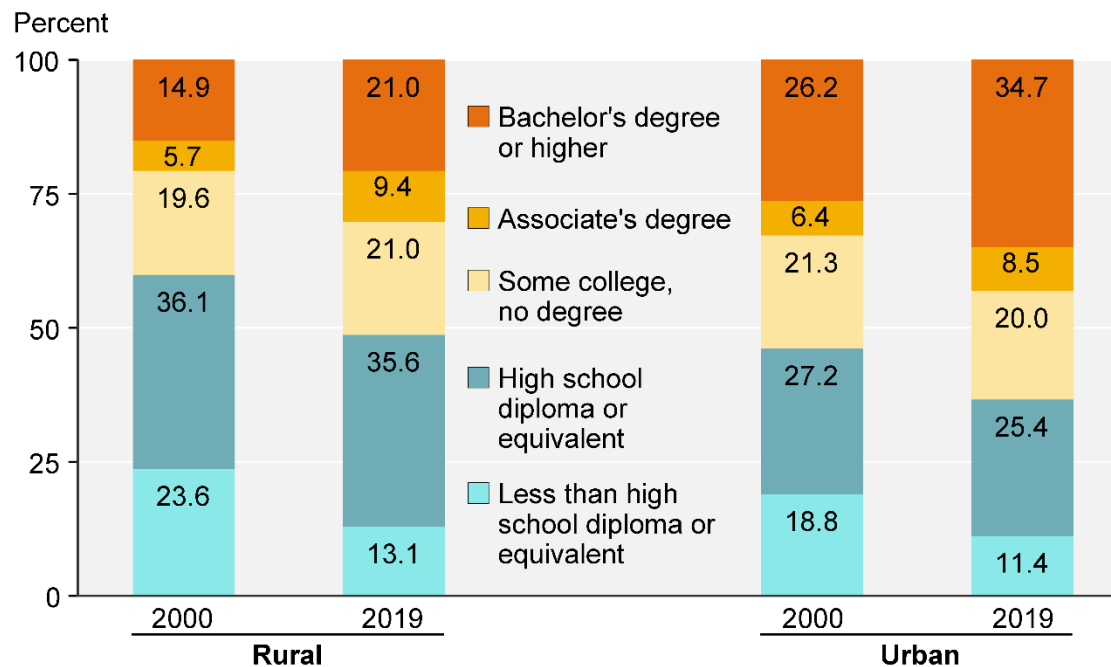
Percent poor (individuals)



Source: USDA, Economic Research Service using data from the U.S. Census Bureau, annual American Community Survey, 2018.

USDA Economic Research Service. (2019). Poverty Overview. Retrieved from <https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/#historic>

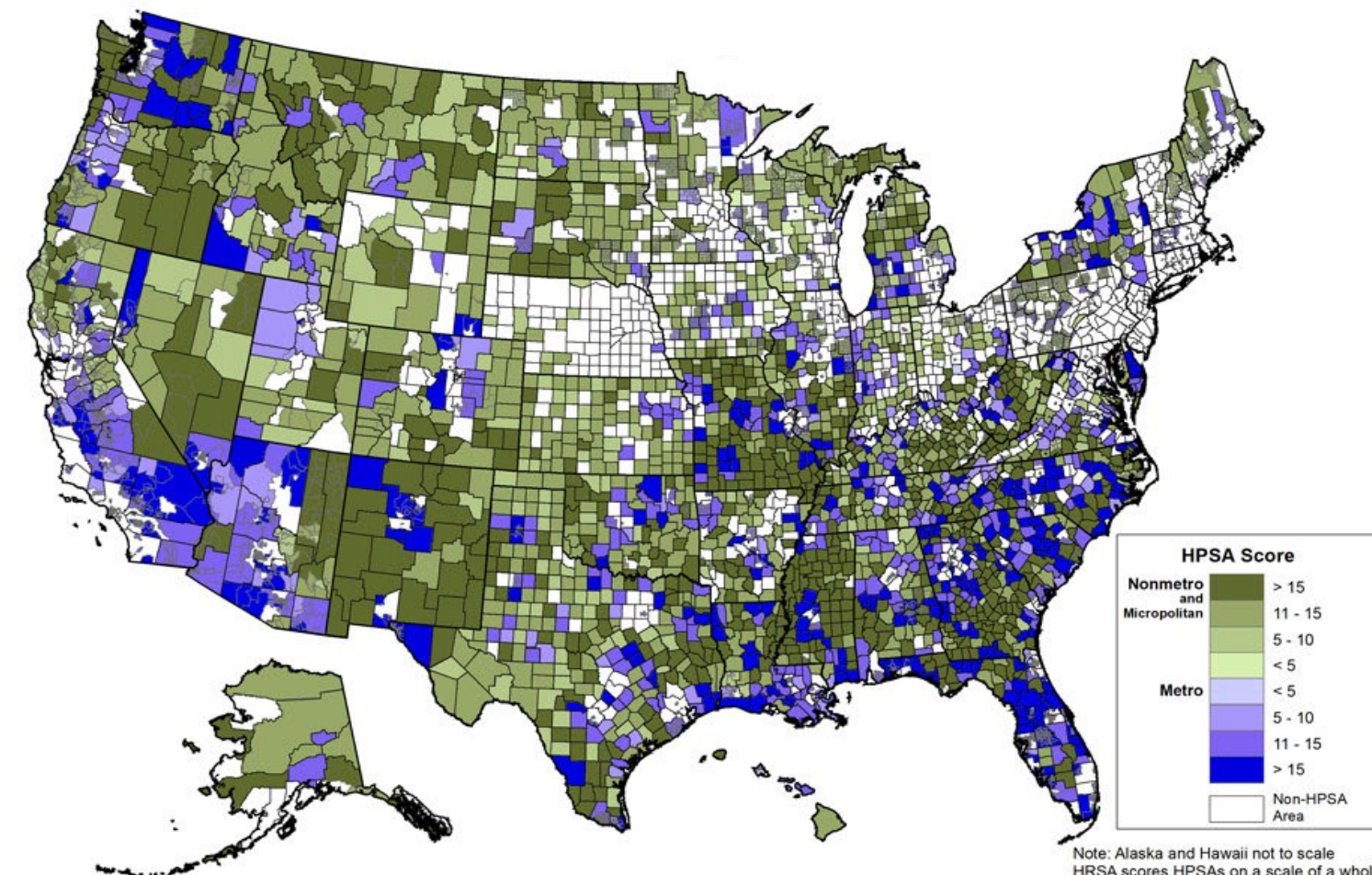
U.S. educational attainment in rural and urban areas, 2000 and 2019



Note: Educational attainment for adults 25 and older. Urban and rural status is determined by Office of Management and Budget's 2018 metropolitan area definitions.

Source: USDA, Economic Research Service using data from U.S. Department of Commerce, Bureau of the Census, Census 2000 and 2019 American Community Survey.

Primary Care Health Professional Shortage Areas



Note: Alaska and Hawaii not to scale
HRSA scores HPSAs on a scale of a whole number (0-25 for primary care), with higher scores indicating greater need

Tools & Resources

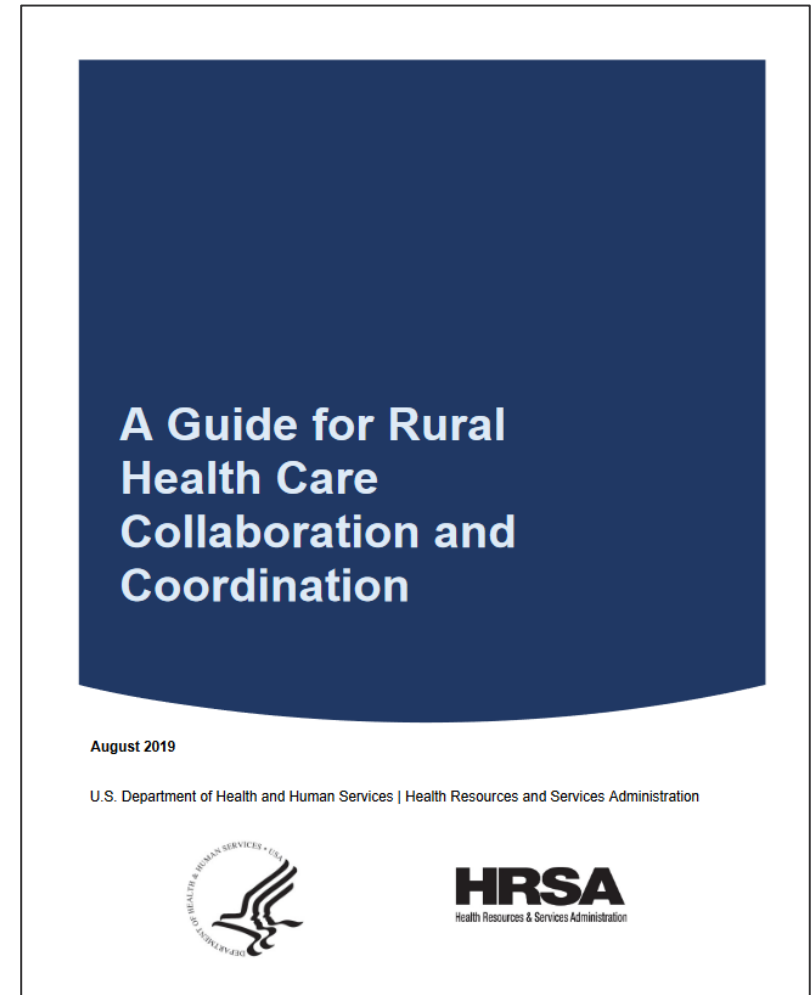


Target Audience:

Leadership and rural health
provider organizations

Development of the Guide:

Informed by local and national
level rural health provider
organizations



HRSA's Guide to Rural Health Care Collaboration and Coordination: Why is this an important issue?

- Rural providers face unique challenges (e.g., limited economies of scale, heavy dependence on public payers, low patient volume)
- Lack of collaboration can put key services at risk given the often-fragile economic status of rural providers
- Volume → Value \$\$\$
- Growing interest in *patient-centered* approaches to care to address social determinants of health





PRAPARE

Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

What is PRAPARE?

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a standardized patient social risk assessment protocol.

Assess Patients For

	Personal Characteristics	<ul style="list-style-type: none"> • Race • Ethnicity • Language Preference 	<ul style="list-style-type: none"> • Veteran Status • Farmworker Status
	Money & Resources	<ul style="list-style-type: none"> • Education • Employment • Income 	<ul style="list-style-type: none"> • Material Status • Insurance Status • Transportation Needs
	Family & Home	<ul style="list-style-type: none"> • Housing Status and Stability • Neighborhood 	
	Social & Emotional Health	<ul style="list-style-type: none"> • Social Integration and Support • Stress 	
	Other Measures	<ul style="list-style-type: none"> • Incarceration History • Refugee Status 	<ul style="list-style-type: none"> • Safety • Domestic Violence

Benefits



Actionable & HIT Enabled



Standardized & Widely Used



Patient-Centered



Evidence Based & Stakeholder Driven





Protocol for Responding to and Assessing
Patients' Assets, Risks, and Experiences

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?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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2. Which race(s) are you? Check all that apply

<input type="checkbox"/>	Asian	<input type="checkbox"/>	Native Hawaiian
<input type="checkbox"/>	Pacific Islander	<input type="checkbox"/>	Black/African American
<input type="checkbox"/>	White	<input type="checkbox"/>	American Indian/Alaskan Native
<input type="checkbox"/>	Other (please write):		
<input type="checkbox"/>	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?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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4. Have you been discharged from the armed forces of the United States?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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5. What language are you most comfortable speaking?

8. Are you worried about losing your housing?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	I choose not to answer this question
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9. What address do you live at?

Street: _____

City, State, Zip code: _____

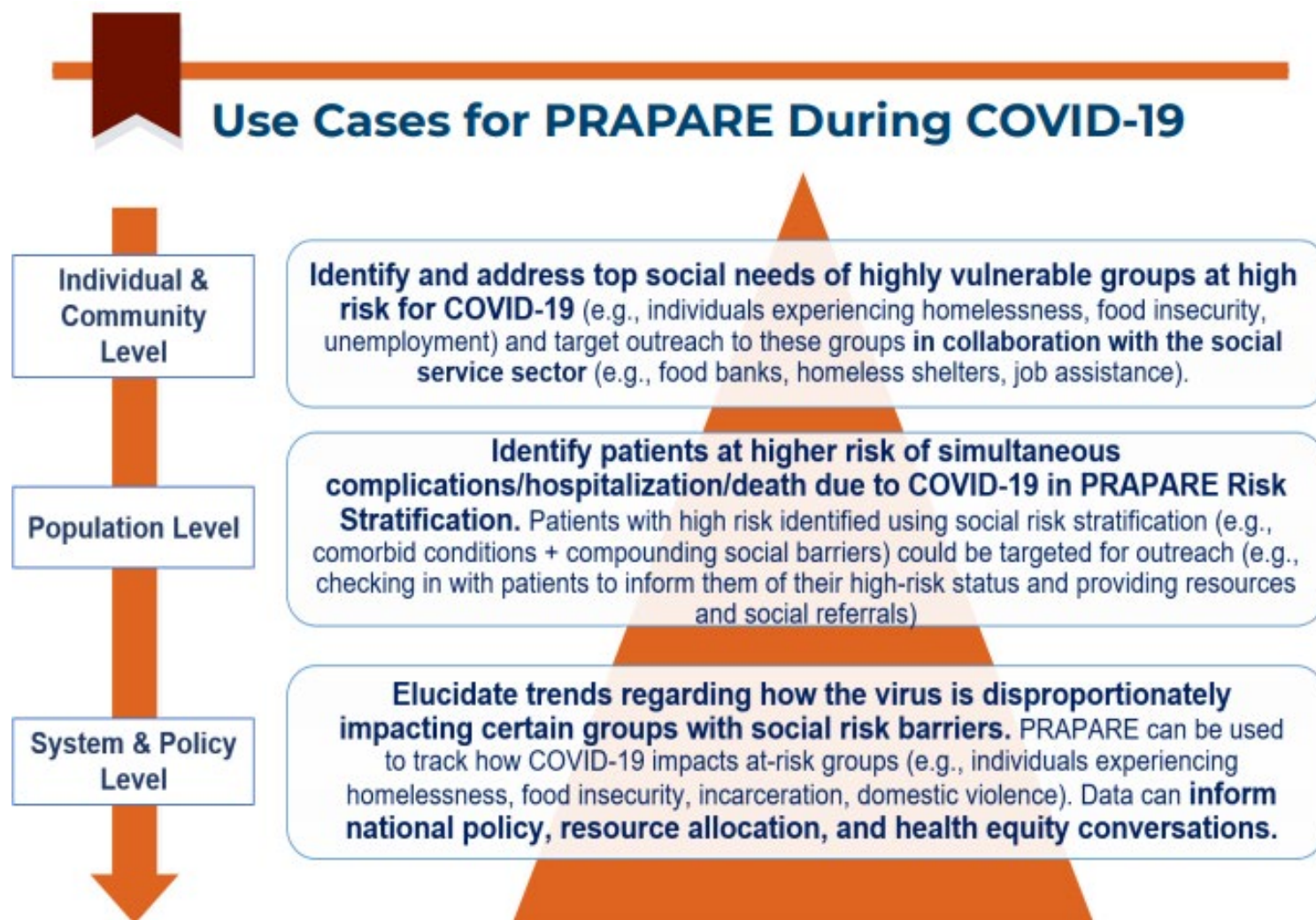
Money & Resources

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

<input type="checkbox"/>	Less than high school degree	<input type="checkbox"/>	High school diploma or GED
<input type="checkbox"/>	More than high school	<input type="checkbox"/>	I choose not to answer this question

11. What is your current work situation?

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



Demonstrate value of SDOH

ROI (e.g., transportation to health care reduces missed appointments)

Address “upstream” issues

Promote community participation

Assessment

Program design and implementation

Outreach

Evaluation

Consider special populations

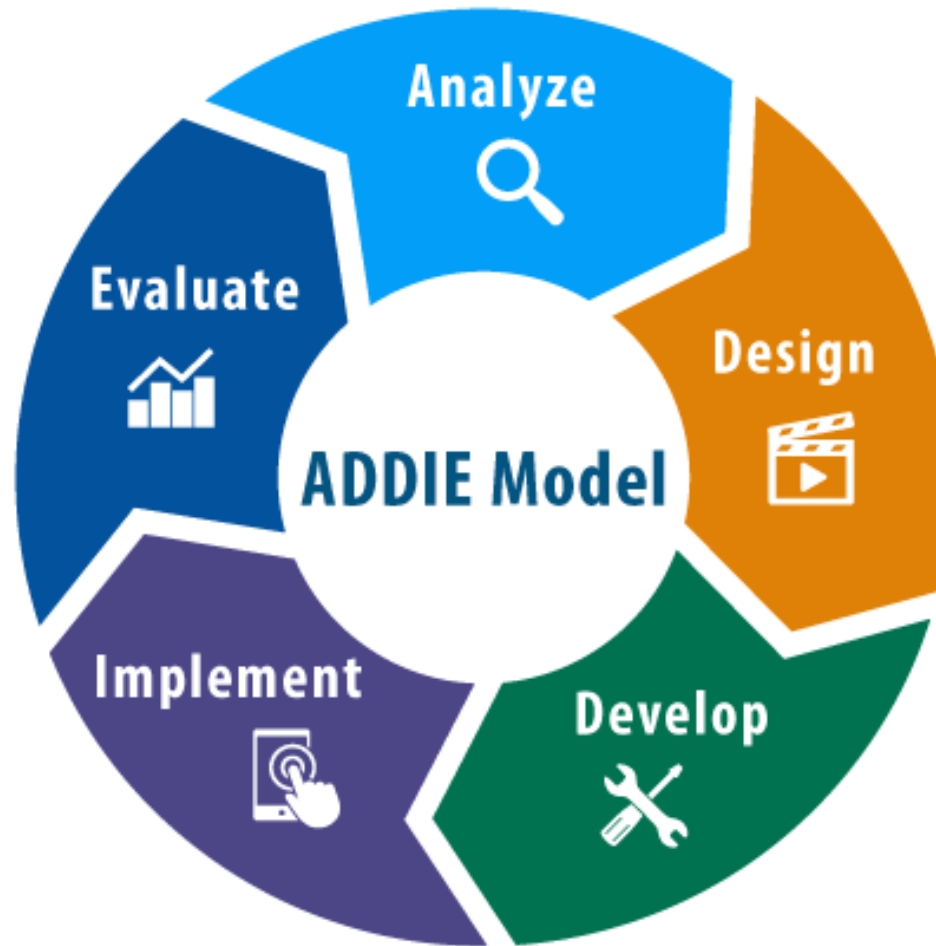
Explore training

Motivational interviewing

Leverage reimbursement opportunities

CCM and TCM





Source: CDC, www.cdc.gov/trainingdevelopment/develop_training.html

1. Identify
evidence-based
and promising
community health
programs in rural
communities



2. Study
experiences of
these programs
including
facilitators of their
success



3. Disseminate
lessons learned
through Evidence-
Based Toolkits



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IN THIS TOOLKIT

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- [2: Program Models](#)
- [3: Program Clearinghouse](#)
- [4: Implementation](#)
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Social Determinants of Health in Rural Communities Toolkit



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About This Toolkit



- Improving Economic Stability
- Improving Education
- Improving the Social and Community Context
- Improving Health and Healthcare
- Improving Neighborhoods and the Built Environment

This toolkit will supplement and expand on previous work in this area including the RHIhub [Social Determinants of Health for Rural People](#) topic guide, and several RHIhub evidence-based toolkits for rural community health:

- [Care Coordination Toolkit](#)
- [Community Health Workers Toolkit](#)
- [Food Access Toolkit](#)
- [Health Networks and Coalitions Toolkit](#)
- [Health Promotion and Disease Prevention Toolkit](#)
- [Services Integration Toolkit](#)
- [Telehealth Toolkit](#)
- [Rural Transportation Toolkit](#)



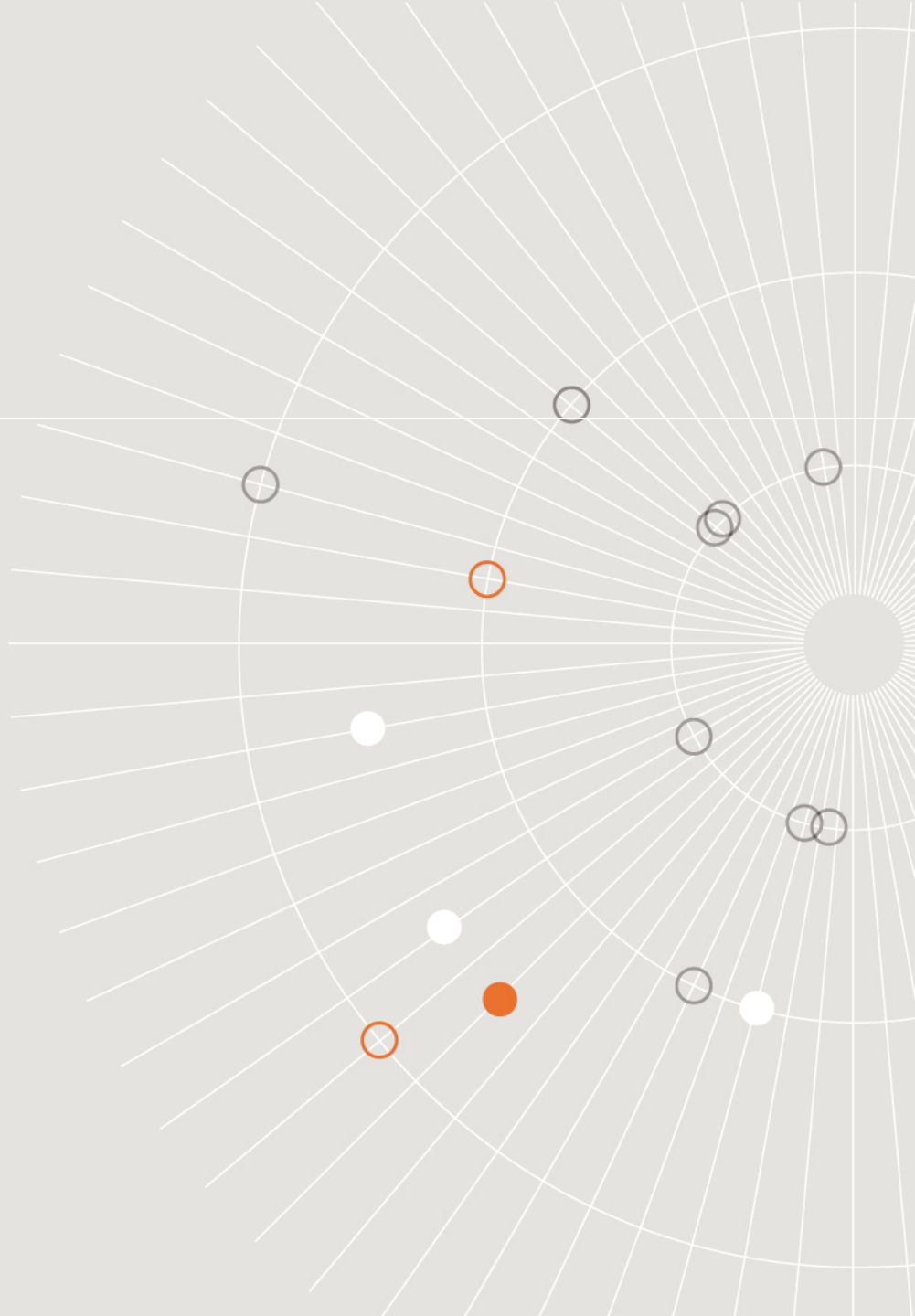
Your *First STOP* for *Rural Health* **INFORMATION**

- **Visit the website**
 - Online library
 - Funding opportunities
 - 50+ topic guides on key rural health issues
 - State guides
 - Toolkits and model programs
 - Chart gallery and data explorer with county-level data
 - Am I Rural tool
 - More...
- **Sign up for email updates and custom alerts**
- **Contact our Resource and Referral Service**
800.270.1898 or info@ruralhealthinfo.org

All services are free!

ruralhealthinfo.org

Questions?



Thank you!

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 Research You Can Trust™

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