Presentation Goals

- Share the experience of two health centers that participated in the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) pilot project
- Build upon the plenary session about how to raise awareness about patient needs in your community

PRAPARE Aim

- Create, implement, and promote a standardized health risk assessment protocol that goes beyond medical acuity to account for the SDH that matter most for health centers, patients, communities, and payers
Overview of Pilot

- Funding from Kresge Foundation, the Blue Shield of California Foundation, and the Kaiser Permanente National Community Benefit Fund at the East Bay Community Foundation
- Alliance of Chicago, INCC, Iowa PCA, Peoples, Siouxland, Waikiki
  - Content developed within GE Centricity
- We are one of four teams serving as pilot sites. Other teams are in and using three other EMR platforms (eClinicalWorks, Epic, NextGen):
  - Oregon
  - New York
  - Hawaii
- See handout

Early Experiences of Pilot

Chris Kemp, Peoples
Dave Faldmo, Siouxland

Peoples’ and Siouxland’s Approach to the Pilot

- Who was on your project steering committee?
- Why did your health center elect to participate in the pilot?
  - Provide better care to patients
  - Provide evidence to payors about the needs of patients and adequate reimbursement for an array of services
- What health center resources did it take to pilot the project?
Steps Needed to Develop Readiness

1. Educate staff and leadership of the value of PRAPARE
   - Educate everyone in the organization at a high level.
   - Educate key players at a detailed level
   - Get the right people on the bus!

Steps Needed to Develop Readiness

2. Be prepared to address concerns and questions from staff and administration
   - We have too much going on right now to add another project
   - We already screen for and address social determinants of health
   - Once we identify a social determinant of health, are we accountable to provide help to overcome the determinant?
   - Who is going to be responsible for addressing the need?

Steps Needed to Develop Readiness

2. Be prepared to address concerns and questions from staff and administration (continued)
   - Is this really worth the effort?
   - Who will administer the survey?
   - How often will a patient need the survey done?
   - Do we need to survey every patient?
   - What about pediatric patients?
   - How long does it take to administer the survey?
   - Will billing or reporting be impacted by the survey in the EHR?
Steps Needed to Develop Readiness

3. Be prepared to address questions and concerns of patients.
   • Why are you asking me these questions?
   • Who will have access to this information?
   • Will providing this information impact my ability to receive care?

Steps Needed to Develop Readiness

4. Catalog current countermeasure/resources available, both in-house and in the community, for each social determinants of health surveyed on the tool
   • Identify resources that need to be developed or improved.
   • Identify community partnerships that need to be initiated or strengthened.

Steps Needed to Develop Readiness

5. Use “5 Rights” and PDSA cycle to develop workflow for administering and responding to PRAPARE tool.

The “5 Rights” include:
   • the right information,
   • to the right person,
   • in the right intervention format,
   • through the right channel,
   • at the right time in workflow.
Steps Needed to Develop Readiness

5. Use “5 Rights” and PDSA cycle to develop workflow for administering and responding to PRAPARE tool.

- How will tool be administered to the patient to ensure that it accurately identifies the SDH the patient may have? (obtain right information)
- Who will address social determinants identified? (right person)
- How will resource information be organized so that it is readily available and standardized for all? (right intervention format)
- How is the appropriate care team member notified to address the SDH identified? (right channel)
- When in the patient visit does it make sense to administer the tool and when is the best time to address identified SDH? (right workflow)

Siouxland’s PDSA

- Aim: Administer the PRAPARE tool for SDH to a random sampling of 150 patients by the end of September 2015.
- Describe your first test of change: Have one enrollment counselor stationed at one patient care hallway (2 providers) and administer the test to patients that are expected to wait for the provider >15 minutes.
- Person responsible: Adam, supervisor, and Diane, lead enrollment counselor
- Where to be done: Starting on 8-18-15
- Where to be done: Diane will first test in DF and DP hallway, then schedule other hallways.
- Plan
  - List the tasks needed to set up this test of change:
    1. Further educate and train all enrollment counselors, provider teams, and case managers regarding the PRAPARE SDH project and workflow of administering the test.
    2. Develop schedule for each day for enrollment counselor and which team hallway.
    3. Develop a report to monitor how many PRAPARE surveys have been administered.
- Person responsible: 1. Dave (and case managers). 2. Deb and Diane. 3. Gayle or Erin
- When to be done: Staff working in each hallway will be educated during pre-session huddles prior to the enrollment counselor being stationed in hallway. Start with own hallway on 8-18-15.
- Where to be done: At provider team workstations
- Predict what will happen when the test is carried out:
  - Enrollment counselor should have plenty of time to do the required 150 PRAPARE surveys before the end of September 2015.
- Measures: To determine if prediction succeeds:
  - Will need to track how many surveys are done each day, whether teams are fully staffed, etc.
  - Will review progress on a weekly basis with PRAPARE committee.
- Act
  - Describe what modifications to the plan will be made for the next cycle from what you learned.
  - Enrollment counselor will come a hallway to administer test twice weekly.

Siouxland’s PDSA

- Aim: Administer the PRAPARE tool for SDH to a random sampling of 150 patients by the end of September 2015.
- Describe your first test of change: Have one enrollment counselor stationed at one patient care hallway (2 providers) and administer the test to patients that are expected to wait for the provider >15 minutes.
- Person responsible: Adam, supervisor, and Diane, lead enrollment counselor. Dave, project lead.
- When to be done: Starting on 8-18-15
- Where to be done: Diane will first test in DF and DP hallway, then schedule other hallways.
Siouxland’s PDSA - PLAN

**Plan**
- List the tasks needed to set up this test of change:
  1. Further educate and train all enrollment counselors, provider teams, and case managers regarding the PREPARE SDH project and workflow of administering the test.
  2. Develop schedule for each day for enrollment counselors and which hallway.
  3. Develop a report to document how many PREPARE surveys have been administered.
- Person responsible:
  1. Dave (and case managers).
  2. Deb and Diane.
  3. Gayle or Erin
- When to be done:
  Staff working in each hallway will be educated during pre-sees and huddles prior to the encounter counselor being stationed in their hallway. Start with the own hallway and then.
- Where to be done:
  At provider team workstations
- Predict what will happen when the test is carried out:
  Enrollment counselor should have plenty of time to do the required 150 PREPARE surveys before the end of September 2015.
- Measures to determine if prediction succeeds:
  Will need to track how many surveys are done each day. We will need to average 5 a day, but will try to do 8-10 a day to give ourselves some cushion. Will review progress on a weekly basis with PREPARE committee.

Siouxland’s PDSA - DO

**Do**
Describe what actually happened when you ran the test:
- Enrollment counselor had time to administer 7 PREPARE surveys in the 4 hour session.
- Each survey took about 3-5 minutes.
- None of the surveys disrupted the flow of the provider teams, but some staff didn’t know what the enrollment counselor was doing.
- 3 of the surveys had needs identified that were past on to the providers teams to address.

Siouxland’s PDSA - STUDY

**Study**
Describe the measured results and how they compared to the predictions:
- Enrollment counselor had more time than predicted and could have done more.
- Need a way to track if and how SDH identified are addressed and determine who addresses the needs.
- Despite some training and education, some staff members are still confused regarding PREPARE and role of enrollment counselor.
Siouxland’s PDSA - ACT

**Act**

Describe what modifications to the plan will be made for the next cycle from what you learned:

- Enrollment counselor will cover 2 hallways (4 provider teams) each session.
- Only need enrollment counselors to do one 4 hour session a day instead of 2 to get the 5-10 surveys.
- Need to do separate PDSA on how to respond to SDH identified on survey.
- More education and training with the provider teams.
- Next week, enrollment counselor will work with the same 2 hallways for the one session a day until workflow refined. Then roll out to entire clinic.
Share Initial Data

- See handouts for Peoples’ and Siouxland’s initial data
- Alliance working on data validation overall as well as addressing some numerator/denominator issues identified during the first run of the data
- Some changes to the template and report will be made
Questions from Pilot Data Collection Effort

- What have you changed from your original workflow for collecting the data?
- Have you thought about which staff are best equipped/available to administer the survey?
- How often do you plan to administer the survey to patients?
- What questions were most difficult for patients to answer? What questions were most sensitive?
- What was the patient response to the survey?
- What was the staff response to the survey?
- What interventions do you intend to pursue first?
  - Siouxland’s transportation example
  - Peoples’ changing their approach based on response to education question
  - What surprised you most about the data?

Matthew’s Response to Pilot Experience

Where to Go Next

- Implement the survey more broadly within the pilot FQHCs - similar to PHQ and SBIRT initiatives
- Cross tab survey results with clinical indicators such as chronic diseases
- Think about staffing needs at the health center and further community partnerships needed to connect patients to necessary interventions
- Build these necessary interventions into the overall care coordination approach at health centers
- Consider linking survey results to enabling services codes
- Using the data as part of PCMH re-recognition process
Where to Go Next

- Spread the use of the tool to other FQHCs
- Use data for clinical decision supports with HIT
- Use data with payors once the results are better linked to quality and cost data
- Use data for advocacy purposes
- PRAPARE survey for youth
- HRSA’s interest in the project and better linking the cooperative agreements they have to support interventions based on this data
- MU Stage 3 - final draft includes 10 SDH measures many of which align with the PRAPARE questions

Questions?