Assessing and Addressing Social Risk:

Piloting PRAPARE in Texas

Final Report to the Episcopal Health Foundation

January 2018

INTRODUCTION TO THIS REPORT

In 2017, the National Association of Community Health Centers (NACHC) worked with the Association of Asian Pacific Community Health Organizations (AAPCHO) and the Oregon Primary Care Association (OPCA) to construct and lead a year-long pilot to test the implementation of the standardized social determinants of health screening protocol known as PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences www.nachc.org/prapare) with three Texas health centers. This effort was made possible with generous support from both the Episcopal Health Foundation, Houston, and St. David's Foundation, Austin.

This report documents our successes and our lessons learned over the past year. We also developed a formal Evaluation Report of the pilot, Workflow Model Diagrams, and PRAPARE Best Practices and Recommendations for both Primary Care Associations and Health Centers to provide more in-depth information on these topics.

Project Goals

The overarching vision for this year-long pilot is to build capacity of Texas health centers to collect data on the social determinants of health using PRAPARE and use that data to transform clinical practice, integrate care with community resources, and redesign the larger delivery system to move towards Community Centered Health Homes. Specific project goals include:

(1) Launch a semi-structured implementation pilot with Texas health centers that would build their capacity to employ PRAPARE to collect data on the social determinants of health and respond to needs identified through a customized day-long in-person training, regularly scheduled office hours, and virtual networking and shared learning opportunities.

(2) Document best practices and disseminate them across health centers in Texas and nationally.

(3) Leverage national PRAPARE efforts to build health center readiness to use PRAPARE and PCA/health center network capacity to support these health centers.

Overview of Approach in Texas PRAPARE Pilot and Feedback on Approach

We structured the year-long pilot with a day-long in-person kickoff training, virtual trainings every 1-2 months, office hours, monthly homework assignments aligned with a monthly curriculum to apply lessons learned on the ground, and concluded with virtual harvest and evaluation meetings.

Trainings and homework assignments aligned with our PRAPARE Implementation and Action Toolkit (www.nachc.org/prapare) so that health centers could review our Toolkit chapters and apply lessons learned on the ground in their implementation processes. Trainings covered the following topics:

TRAININGS TOPICS:

- Strategizing the Implementation Plan and Workflow Models
- Engaging and Training Staff
- Collecting PRAPARE Data in the Electronic Health Record
- Reporting and Analyzing PRAPARE Data
- Responding to Social Determinant Needs Identified by PRAPARE

We worked with foundation partners to select our three health centers through an open application process available to health centers in Episcopal Health Foundation's and St. David's Foundation's service areas. Selection criteria included: using one of the four Electronic Health Records for which there is a PRAPARE template, willingness to commit to participation of key staff and completion of deliverables, commitment to screening a minimum number of patients and sharing aggregate PRAPARE data, and willingness to share customized or newly developed resources that support implementation and/or use of data. The application asked health centers to describe their organizational readiness and capacity to implement PRAPARE, how PRAPARE fit within their strategic goals, and their proposed approaches to pilot PRAPARE in their clinics. Through this process, we selected the following health centers:

1) Hope Clinic (Asian American Health Coalition) in Houston, Texas
2) Lone Star Circle of Care in Georgetown, Texas
3) People's Community Clinic in Austin, Texas

Our pilot health centers each received a modest financial incentive of $10,666. The pilot health centers found the in-person kickoff training helpful to establish relationships with other participating health centers, share and learn from each other's implementation plans and ideas, troubleshoot common challenges together, and collaborate as a team to strategize their implementation plans. This in-person, in-depth training was key to facilitating their uptake of PRAPARE implementation and to anticipate challenges.

At the pilot teams' request, we held virtual webinars every two months leading up to data collection to ensure that they had sufficient time to work on homework assignments and put their PRAPARE implementation plans into action. PRAPARE staff were available in-between webinars to answer questions and provide technical assistance. The health centers reported that the PRAPARE Implementation and Action Toolkit was a helpful resource to guide them in their implementation plans and response strategies.

Workflow Models to Implement PRAPARE Used by Texas Health Centers

Each of the health centers involved in this pilot chose different workflow models to implement PRAPARE. Each of these paths for documenting patient social risk using PRAPARE to support action planning was innovative in that they had not been tested in previous PRAPARE pilots. We documented the rationale behind each workflow model, how it worked, and the tradeoffs of using that particular workflow model.

1) Administering PRAPARE via Email and Notifying Patient of Available Community Services through Partnership with Aunt Bertha Developed and Tested by Lone Star Circle of Care	
Reasons to Use This Model	○ If organization has large patient population and/or lacks adequate staff who have time and skills to implement PRAPARE in person during workflow ○ If organization wants to obtain general understanding of population's social determinant needs quickly for care transformation and population health planning ○ If an organization wants to align PRAPARE data collection with other direct patient communication methods in use ○ If organization wants to provide patient with referrals to community services immediately upon completing PRAPARE
How Lone Star Circle of Care Implemented This Model	○ Convert PRAPARE into an email survey (both English and Spanish) that is also mobile compatible ○ Be sure to include introductory message explaining why this information is being collected, how it will be stored and protected, and how it will be used to inform care and services. ○ Work with staff who have strong relationships with the community (e.g., community health workers, medical assistants, etc.), patients, as well as data analysts to craft messaging that resonates with the community. ○ Email messages can include normalizing messaging so that patients do not feel that they were the only ones facing these challenges (e.g., "did you know that 1 out of 6 Texans do not always have enough food?"). ○ Include visuals if possible to eliminate issues associated with literacy ○ Enact partnership with a social referral organization to provide available social services in community based on patient's responses. Partnership required HIPAA data use agreement with external organization. Lone Star contracted with Aunt Bertha (which is based in Austin) to list community social services referral resources and create a portal to these resources. This cost Lone Star $6,000, which was covered by their pilot grant. ○ Connect email system with EHR and/or registration system so that data can be used to inform care and services. Lone Star did not initially do this but understands the importance of connecting the emailed survey data with the EHR for better clinical use and population health planning.

	○ Train staff on where data will live in the EHR and how to follow-up with patients before or during their next clinic visit. ○ Send email to patients with valid email address who had visit within last two years. ○ Send at least two reminder emails to non-responders. ○ Conduct follow-up survey via telephone to see if responders would like to talk about their results with anyone now or at their next clinic visit.
Lessons Learned: Findings	○ The most common response method for Lone Star was via smartphone at 62% so it is important to make the email version of the PRAPARE survey mobile compatible as well. ○ It only took patients 35 seconds to complete PRAPARE via email. ○ Lone Star found no difference in response rate if the email message containing the PRAPARE survey included normalizing messaging or not so this can be optional. ○ Patients who were seen more recently at the clinic for a visit and patients who were more active with the patient portal were more likely to complete the PRAPARE survey via email.
Lessons Learned: Advantages	○ Allows health center to reach wide swath of population easily and quickly. Lone Star collected PRAPARE data on over 1,000 patients (out of 26,000 patients) in just 2 months. ○ Low cost and burden on staff to build email message containing PRAPARE ○ Quick for patients to fill out survey (~35 seconds) and patients felt comfortable disclosing social determinant information
Lessons Learned: Tradeoffs	○ Email communication does not directly facilitate patient and care team relationship building. However, this can be achieved by calling the patient to discuss results and/or when the patient comes in for a visit to discuss results and prioritize assistance. ○ Email method only reaches patients who are email-literate and can read the language used for administering the survey as opposed to in-clinic where on-site interpretation assistance may be available. ○ Email system does not automatically connect with EHR so will require IT-savvy staff to connect it to the EHR. ○ Email administration system does not allow for any real-time feedback on the patients' experience taking the survey or navigating the Aunt Bertha services platform.

2) Using Student & Interpreters to Implement PRAPARE in Culturally Diverse Population Developed and Tested by Hope Clinic	
Reasons to Use This Model	○ If an organization serves patients speaking a variety of languages and from different cultural backgrounds
How Hope Clinic Implemented This Model:	○ A student (or staff person) administers PRAPARE in-person with the patient and with an interpreter using a paper translated-version of PRAPARE. Patient has language-specific form of PRAPARE to view with interpreter while student/staff enters data translated by interpreter on English paper version of PRAPARE. Student/staff hands English versions of PRAPARE to front desk staff who enter the data into the EHR. ○ PRAPARE is administered once patient is through triage and waiting for the provider or at the end of the provider visit so as not to disrupt clinic flow.
Lessons Learned: Advantages	○ Using single person (graduate student, staff person) provides for consistency since one person is collecting data rather than multiple and different staff being involved. ○ Interpreters recruited from community help build trust and relationships with patients.
Lessons Learned: Tradeoffs	○ PRAPARE assessments could be abruptly ended if provider was ready to see patient. ○ PRAPARE assessments were not always administered if a staff interpreter was not available to communicate with the patient in his/her preferred language. ○ Sometimes, assessment staff's schedules did not always correspond to high patient volume times which meant that patients were quickly roomed. During these times, staff would interview in the room before the provider visit.

3) Using Chronic Care Disease Management Team to Implement PRAPARE Developed and Tested by People's Community Clinic	
Reasons for Using This Model	○ If an organization wants to focus on a subset of the population that is arguably more complex because they are seeing a chronic care disease management team ○ If an organization wants to use staff with specific training and skills (crisis intervention, motivational interviewing techniques, knowledge of community resources)
How People's Community Clinic Implemented This Model	○ Screenings occurred during exam visits and were conducted by a nurse, health educator and/or social worker. Staff had conversations with patients and entered responses directly into the NextGen PRAPARE EHR form. ○ Team consisted of 3 nurses, 1 medical assistant, 1 social worker, and 1 dietician who all see patients with chronic disease
Lessons Learned: Advantages	○ Chronic Disease Management Team is a comprehensive team who can both assess and address patients' social determinant of health needs and also use that data to inform care planning ○ Helps build relationships with patients by having one on one conversations ○ Prevents other staff who conduct other screenings (e.g., medical assistants) from becoming overburdened
Lessons Learned: Tradeoffs	○ Potentially lengthens visit with chronic disease management team, many of whom are billable staff who are performing non-billable duties.

Implementation Lessons Learned

As the three health centers moved through their PRAPARE journeys, we harvested various lessons learned along the way through regular progress reports and shared report-outs during training webinars. The following sections below highlight important lessons learned on the different implementation process steps.

GATHERING BUY-IN

- Educate staff and providers during staff meetings on why it is important to collect data on the social determinants of health, where the data will live in the Electronic Health Record and how it can be used to inform at point of care, and how PRAPARE data can add value to other initiatives they are already doing (e.g., Community Centered Health Home).
- Share PRAPARE data early-on so that staff can see the value of data being collected and to spark a discussion on what they would do with this kind of data to inform care.
- Because many staff are uncomfortable screening for needs where services may be lacking, assure staff that some supports already exist to help with social determinant needs identified and that collecting PRAPARE data on social determinants will be used to develop new services and partnerships where they may currently be lacking.

SELECTING POPULATIONS OF FOCUS

- Choosing a general population of focus allows the organization to get a better understanding of common needs across their population.
- Choosing a narrow population of focus (e.g., adults with uncontrolled hypertension or diabetes, those who see behavioral health provider or chronic care manager, etc.) might make it more manageable to administer PRAPARE to a smaller, more focused group of people as well as respond to needs with existing staff and services. However, the needs of a specific population may not represent the needs of the community at large. Previous experience from our national PRAPARE pilot demonstrates that patients with a greater burden of chronic illness may have more social risks and that addressing social risks identified among a sub-population can still have broader community-wide impact.

GETTING STARTED

- Assess which information is collected already and how that data collection is streamlined with PRAPARE data collection. This may inform the workflow model used.
- Engage staff and patients at the beginning using the 3X10 model developed by the Oregon Primary Care Association. In this model, staff choose 3 questions from PRAPARE to ask with 10 different patients. After completing this, staff come together to discuss what they learned and how that data is valuable to inform their care and services. Staff can learn from patients' experiences as to how they prefer to discuss this information.
- Do a pre-pilot to determine the most efficient workflow model for the organization. Use the PDSA model to test the PRAPARE tool in different workflows to see which one works best.
- Ensure that staff who will be administering PRAPARE with the patient has access to the Electronic Health Record (EHR) so that they can input the data directly into the EHR.

STAFF ENGAGEMENT AND TRAINING

- Staff implementing PRAPARE with patients should be trained in either empathic inquiry or motivational interviewing skills as much of the relationship building and root cause analysis is done in the conversation. See training resources in Chapter 5 of the PRAPARE Implementation and Action Toolkit at www.nachc.org/prapare.
- Build in regular face to face time for staff involved in implementing PRAPARE to check-in on progress, celebrate successes, and troubleshoot challenges.
- Survey staff on experience to gather feedback as to what is working well and what is not working well.
- It is helpful to have staff who can pull PRAPARE data and provide regular population-based reports that can be used for organizational decision-making. This may be a data analyst, IT staff, population health manager, etc.

INCENTIVIZING DATA COLLECTION

- Incentive contests may be helpful to encourage staff to gather data (e.g., the first person to collect data on 10 or 20 patients gets a massage or a lunch, etc.)
- It is important to celebrate accomplishments together. For example, PRAPARE staff celebrate over a meal together once team reaches a goal of number of patients screened.
- Share data and validate with data collection staff as well as senior leadership staff so they understand the value of the data and how it can be used.
- Paper versions of PRAPARE might work well for patients who are more sensitive to answering questions.

TRANSLATION AND CULTURAL CONSIDERATIONS

- Translating all resources for PRAPARE and community resources into Spanish is key for populations in Texas. A Spanish version of PRAPARE is available at www.nachc.org/prapare.
- Staff may need to ask additional questions to gather information that is more culturally relevant or relevant to the patient's upbringing in a different country (e.g., not just question on US Veteran status but also if patient served in the military in another country).
- While translated EHR templates are not necessary, it is beneficial to have translated paper versions of PRAPARE translated into languages needed so that patients can view the questions while speaking with the interpreter.

TECHNOLOGICAL LESSONS LEARNED

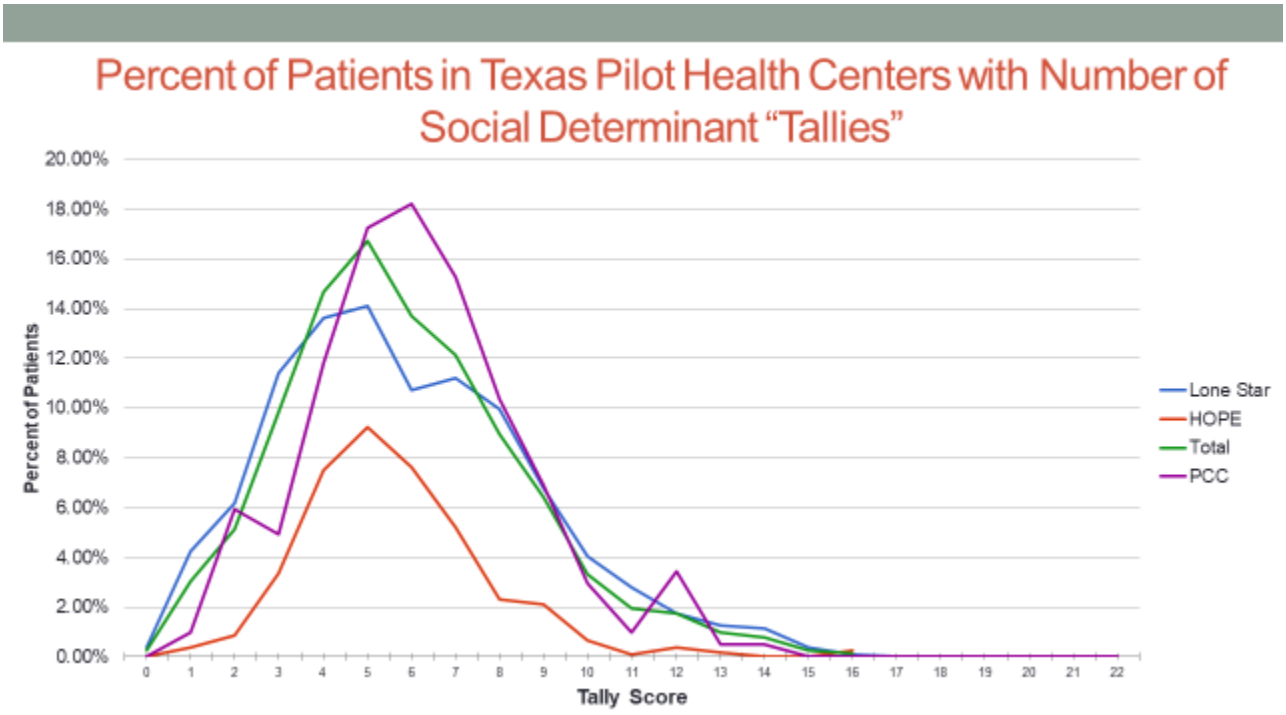
- eClinicalWorks: if the health center wants more flexibility to add additional questions, it is best that they use the free configuration guide (available at www.nachc.org/prapare) to build their own PRAPARE form into eCW. If the health center wants all of the PRAPARE data in one place for ease of use, it is best that they use the eCW PRAPARE Smart Form (note: eCW charges $1,000 per PRAPARE Smart Form configuration).

- Email Administration with EHR: Separate the UDS questions from the email version of PRAPARE. UDS questions will be collected at the front desk during a visit so this will help prevent double documentation and shorten the email version of PRAPARE.

What We Learned

PRAPARE Data Findings

Teams collectively gathered PRAPARE data on 1,655 patients. On this population of focus, around 20% of patients had between 4 to 8 social determinant risks, with an average of 6 social determinant risks. This mirrors results from our initial national pilot from 2015.



MOST COMMON SOCIAL DETERMINANT RISKS ACROSS TEXAS PILOT HEALTH CENTERS

- High stress
- Uninsured or Underinsured
- Education
- Risk of losing housing
- Unemployment
- Trouble Accessing Medicine

Health centers were surprised to learn that their patients were experiencing challenges accessing medications. As a result, they are all training staff and developing resources for patients to educate them on their 340B pharmacy programs. One of the health centers discovered that they had more patients with higher income than originally thought. They attributed this result to their work in outreach and enrollment under the Affordable Care Act.

Cost Estimates to Implement PRAPARE:

- Lone Star: Email Administration and Partnership with Aunt Bertha = below $10,000 in total
  - Partnership with Aunt Bertha = $6,000
  - Staff time for IT development and PRAPARE follow-up = $3,000 - $4,000
- Hope Clinic: Student and Translators to Input into eClinicalWorks Template = $12,000 in total
  - Staff time for eCW discussions and modifications $2,500
  - Staff time for translations = $2,000
  - Staff time to administer PRAPARE = $3,500
  - Staff time to report and analyze data = $4,000
- People's Clinic: Training Chronic Care Management Team to Implement PRAPARE = $15,000
  - Includes staff time to participate in weekly meetings, evaluations, developing materials, analyzing data, attending trainings and webinars, and providing IT support.
  - Also includes costs for incentives and rewards for collecting PRAPARE data

Implementation Process Survey Results

As part of the PRAPARE evaluation, we administered a survey to understand the data collection process from the perspective of the staff collecting the data. Overall results from five health center staff indicated that:

- PRAPARE was easy to administer (n=4, 80% respondents),
- Patients were comfortable in answering the questions (n=5, 100% respondents), and
- PRAPARE took no more than 15 minutes to administer (n=5, 100% respondents).

Overall, these results are consistent with past findings of our national PRAPARE pilot.

For more in-depth evaluation findings, please read our Evaluation Report for the Texas PRAPARE Pilot.

Growth in Capacity to Collect PRAPARE Social Determinants of Health Data

After our year-long pilot, all teams increased their capacity to collect PRAPARE social determinants of health data as demonstrated by their pre- and post- PRAPARE Readiness Assessment results. Two of the three health centers increased their capacity significantly by moving up a tier from "not yet prepared" to "moderately prepared" or from "moderately prepared" to "highly prepared," with an average increase of 15 points.

For more in-depth evaluation findings, please read our Evaluation Report for the Texas PRAPARE Pilot.

Quick Facts

1,655

Number of patients the three pilot health centers engaged to collect PRAPARE data.

20%

Percent of Texas patients who participated in the PRAPARE pilot had between 4 – 8 social determinant of health risks.

100%

Percent of Texas health centers grew their capacity to implement PRAPARE after completing the PRAPARE pilot.

62%

Percent of respondents who received PRAPARE via email completed it using their smartphone.

Impact of PRAPARE

All health centers indicated that PRAPARE implementation has been valuable ("priceless") and impactful for their clinics. Data from our evaluation demonstrated that PRAPARE implementation led to positive changes at the patient, health center, and community levels including:

(1) Improved care delivery through an improved understanding of patient needs that resulted in enhanced patient-provider relationships and investment in needed internal services (e.g., behavioral health departments, pregnancy centers, food banks, patient navigation, etc.);
(2) Increased staff and patient knowledge about existing and needed resources to address social barriers resulting in increased patient referrals/enabling services to address identified needs;
(3) Improvement in patient satisfaction at the clinic who were assessed using PRAPARE;
(4) Improved collaboration with community partners including SNAP, ride-share companies, churches, and local utility agencies.

All health centers plan to use the PRAPARE data to inform their work under the Community Centered Health Home initiative. Specifically, they seek to help identify community areas of focus, contribute to or lead community-level planning, and advocate for upstream improvement through policy and community investment as part of community coalitions. Health centers are excited to be the clinical voice to the community and to funders about how these non-clinical factors affect the community's health and well-being.

For more in-depth information and health center quotes on PRAPARE's impact across the three PRAPARE Texas Pilot health centers, please read our Evaluation Report for the Texas PRAPARE Pilot.

Challenges and Solutions to Challenges

Challenges	Solutions to Challenges
Staff turnover with staff involved in administering PRAPARE which requires training new staff	Educate all staff on PRAPARE using similar techniques to educating and training staff on collecting other sensitive information (e.g., sexual orientation and gender identity) and how that data is discussed in care teams. This way, multiple workflows can be tested using different staff

	such that if turnover is experienced, it will not disrupt PRAPARE data collection.
Confusion from patients over how to answer question on household income. This question was the lowest answered question across the health centers.	Engage front desk staff, financial counselors, and/or eligibility assistance workers to employ tested strategies for asking this question for sliding fee scale purposes.
Implementing PRAPARE with patients speaking multiple languages and different cultural backgrounds	Have language-specific forms of PRAPARE on paper for patients. Recruit interpreters from community to build trust and help converse with patients on PRAPARE questions and where they would like assistance. Where available, employ PRAPARE translated versions, currently available in Spanish and Mandarin.
Increasing response rate for email administration of PRAPARE	Improve messaging based on timing of clinic visit and target population, focus on sub-populations, and explore other settings for electronic survey delivery (e.g., tablet, with annual health assessment, before visit, etc.)

Sustaining and Spreading PRAPARE in Texas

All health centers indicated that they will continue to implement PRAPARE with additional providers and clinic sites after the pilot. Health centers also plan to link PRAPARE to their CCHH initiatives under the Episcopal Health Foundation so that they can better understand the special social determinant risks among their CCHH target populations and use that data to build a better case for needs in specific geographic areas and reinforce the need for community health improvement.

Pilot Centers' Ideas for Sustaining PRAPARE Efforts and Spreading to More Patients

- Simulate PRAPARE data collection to Uniform Data System (UDS) data collection such that PRAPARE data is collected regularly (at least annually) and reported regularly as part of standard data and paperwork process. This could be achieved by adding PRAPARE questions to annual health history questionnaire (may be administered electronically) and/or at new patient orientation to collect PRAPARE on all patients without interfering with clinic visit.
- Make PRAPARE and social determinants of health assessment and response part of the organizational culture such that staff and patients understand that PRAPARE data on the social determinants of health is part of patient care.

- Involve more staff in the PRAPARE process so that everyone is aware and feels part of a unique opportunity to help their patients. Involving more staff also facilitates discussion across care teams of data findings and sharing lessons learned. Continuously have staff ask themselves "What are we going to do with this data?" so that staff understand the bigger picture and larger purpose to collecting this data.
- Consider other unique ways to administer PRAPARE, such as via a paper survey at cooking classes and/or group diabetes education classes and later input the data into the EHR.
    - If administering PRAPARE via paper survey, add a question at the end that asks the patient if he/she would like to speak to someone about their answers so that someone can follow-up with them.
- Make PRAPARE an empowering process for patients such that the conversation does not just revolve around the patient's needs and social history but also on what he/she would like to prioritize and act on.

For more in-depth information and health center quotes on PRAPARE's impact across the three PRAPARE Texas Pilot health centers, please read our Evaluation Report for the Texas PRAPARE Pilot.

Additional Resources

As part of this work, the PRAPARE team also developed the following resources to provide more in-depth information as well as best practices and recommendations to help support the spread of PRAPARE in Texas and nationally.

- Evaluation Report for the PRAPARE in Texas Pilot: This report describes the methodology behind our PRAPARE evaluation and reports findings regarding health centers' growth in organizational capacity to implement PRAPARE, health centers' experiences implementing PRAPARE, PRAPARE data results, the impact of PRAPARE at the patient-, health center-, and community levels, and the sustainability of social determinant data collection.

- Workflows to Implement PRAPARE Used by Texas Health Centers: These infographics highlight the steps and tradeoffs for using the different workflow models tested by the three Texas pilot health centers to implement PRAPARE. These workflow diagrams will be incorporated into our PRAPARE Implementation and Action Toolkit at www.nachc.org/prapare.
- Best Practices in Implementing PRAPARE Guide: This guide provides more in-depth information beyond what is included in this final report on best practices and lessons learned from the Texas pilot health centers to help guide others in PRAPARE implementation.
- Recommendations for Primary Care Associations on PRAPARE Implementation: This document provides key takeaways for PCAs to consider when strategizing how best to support their health centers with PRAPARE implementation.

Acknowledgments

This document contains highlights and themes heard during a one-year pilot project taken on by Hope Clinic (Asian American Health Coalition) in Houston, Texas; Lone Star Circle of Care in Georgetown, Texas; and People's Community Clinic in Austin, Texas. We would like to thank the funders Episcopal Health Foundation, Houston, and St. David's Foundation, Austin, in addition to all of the clinic participants, and the Texas Association of Community Health Centers (TACHC) for their dedication to learning with and from one another, and to improving the lives of the patients seen at health centers across the state.