6/25/2021

PRAPARE Workflow

Redwood Community Health Coalition
Promising Practice

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PROMISING PRACTICE OVERVIEW

Alexander Valley Healthcare (AVH) is committed to conducting annual assessments of the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool for adult patients annually and connecting patients to needed services to address social needs. AVH's trend line for PRAPARE demonstrates their journey over the past couple of years and during the ongoing COVID-19 pandemic. In September 2017, AVH piloted PRAPARE with one provider's panel and started spreading to other provider teams in April 2019 with a goal of assessing a patient's social needs annually. There was a dramatic increase in screenings when spread across all care teams, peaking in March 2020 at 57%. Due to the pandemic, visits immediately shifted from fulltime in-person to half of all visits being conducted via telehealth visits. The PRARARE tool was not completed during telehealth visits. As in-person visits increase, more patients are screened and connected to assistance to address identified needs.

AIM

To screen all adult patients annually for social needs using PRAPARE and link patients to needed services.

MEASURES

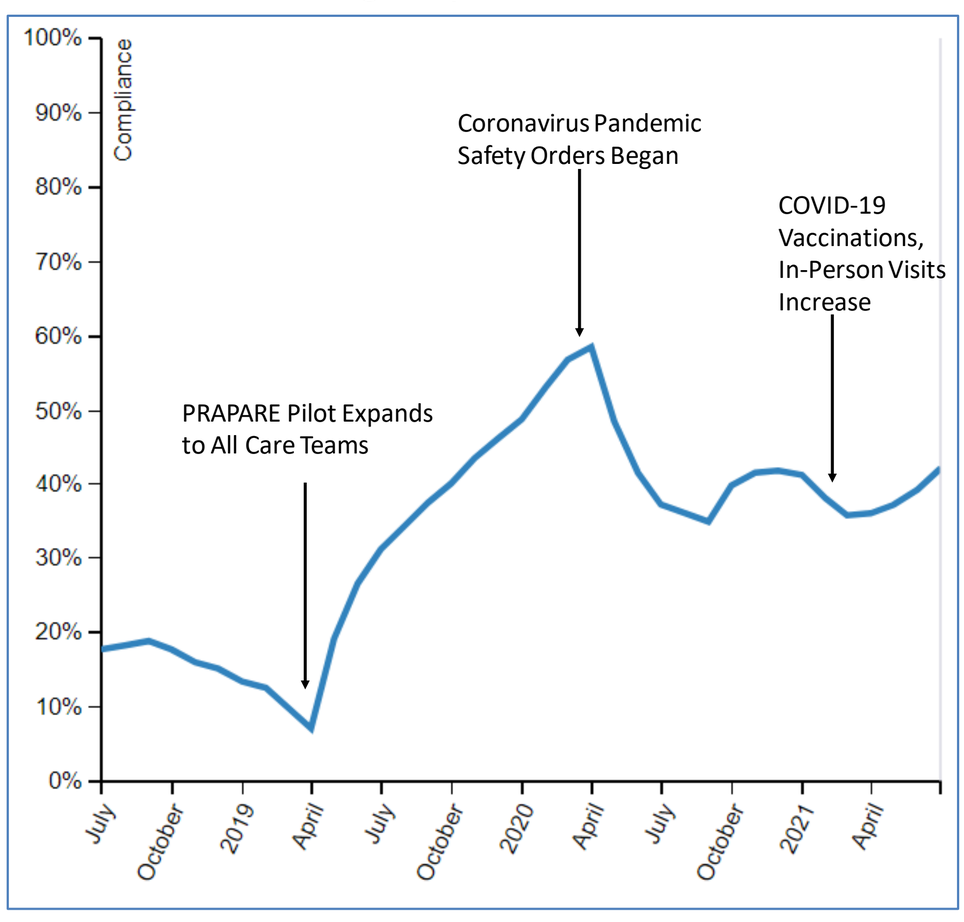
All adult patients who have had an annual social determinants of health screening using PRAPARE.

PRAPARE is a standard tool used to collect information about social determinants of health. We know that the social determinants greatly impact a patient's health outcomes. Asking patients about their social determinants of health allows us to connect them to services for assistance.

Denominator: All active adult patients who have been screened for social determinants of health using the PRAPARE smart-form within the same time period as visit.

Numerator: All active adult patients who have had at least one visit in the previous twelve months.

AVH PRAPARE Screenings July 2019- June 2021



ACTIONS TAKEN

- AVH piloted the PRAPARE tool starting with one provider panel with the goal of annual screenings for all adult patients. Link: https://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/
- From March through October 2020 when in-person visits decreased, PRAPARE screenings also decreased because workflow requires in-person visits.
- As in-person visits increased, more PRAPARE tools are being completed across all care teams.
- Patient is connected to case management via warm handoff or referred via TE and contacted within 72 hours by phone.
- Next focus is on increasing connection to resources.

WORKFLOW

Chart Prep
- In advance of visit, MA identifies what is due and enters in the appointment notes field if the PRAPARE is due

Patient arrives for visit
- Front office staff see notes field and, if due, PRAPARE paper copy is given to patient at check-in by front office staff to complete in waiting room

Data Entry
- The MA takes the paper copy and they data enter into Smart Form in eCW, which the provider reviews during the visit

Connect patient to resources
- Warm hand off to internal nurse or BH case management OR contact patient via phone within 3 business days

RESULTS TO DATE

As of June 25, 2021, AVH's PRAPARE screening rate was 42% (1383/3293). AVH is one of the only health centers in RCHC's network that was able to continue PRAPARE screenings during 2020.

LESSONS LEARNED

- Housing, food, and transportation are the top needs identified.
- Clinical champion on board helps build buy-in from providers on importance of PRAPARE. Even if you don't currently have the resources to address all the needs identified during the screening, you can identify gaps and the information can help in the future as we work together to build out services or advocate for more services in the community. It could be helpful to think of PRAPARE as a community needs assessment to learn more about what services are or are not available to patients.
- Resources can be limited due to rural location. NorCalResources.com had services too far away and required travel. Future plans to connect with Unite Us and build out internal support services.
- Involve your data teams! Get percentages and share them out.
- Use the Relevant report to access aggregate answers to the questions.
- Data informing action: Would like to focus more on connecting to the resources, either building out internal services or linking to services in the community.