CommuniCare+OLE

Caring for Napa, Solano & Yolo Counties

October 29, 2023

PRAPARE Care Coordination Workflow

Aliados Health

Promising Practice

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PROMISING PRACTICE OVERVIEW

PRAPARE is a standard tool used to collect information about social drivers of health. We know that the social drivers greatly impact a patient's health outcomes. Asking patients about their social drivers of health allows us to connect them to services for assistance. Their Care Coordination Department leads CommuniCare+OLE's PRAPARE screening workflow. The PRAPARE tool is framed as foundational to the Care Coordinator (CC) role, which supports the identification of patient needs such as transportation and trends of population needs. Screenings are conducted with all adult patients at least annually utilizing all 17 core PRAPARE screening questions. The success of their high rate of PRAPARE screenings can, in part, be attributed to the joint workflows between CCs and other health center staff that creates accountability and continuity and ensures follow-up. Utilizing the population health tool, Relevant, and eCW tools like Actions ensures that the appropriate preparation is done one day prior and creates checks and balances for a successful workflow. The Care Coordination team has direct lines that facilitate direct patient communication and inform patients about the purpose of the screening and how responses will be utilized. CCs also receive guidance from the Behavioral Health director to ensure they approach sensitive questions appropriately. This combination of strategies supports Care Coordinators in building rapport with their patients.

AIM

All active adult patients are screened annually for social drivers of health using the PRAPARE screening tool.

RESULTS TO DATE

As of October 31, 2023, CommuniCare+OLE has completed approximately **7,129** PRAPARE screenings.

TIPS FOR SUCCESS

- ✓ For sensitive questions, debrief with director of behavioral health on tips for approaching sensitive questions tactfully.
- ✓ Set clear goals for the CC role and create accountability by reviewing progress during individual weekly check-ins.
- ✓ Create tracking systems that allow CCs to follow up on actions and ensure accountability with the completion of tasks.
- ✓ Inform patients of the importance of asking these questions: *"This information will help me find resources for you so that we can take care of those barriers and that when you see your doctor, you can focus on your doctor's visit."*

ACTIONS TAKEN

- Care coordinators (CC) have direct lines and provide business cards at each encounter. This minimizes call center wait times and supports continuity in communication.
- CCs support 3-4 provider schedules depending on the care team pod they are assigned and utilize the CC resource schedule to block time with patients with an established goal of 4 patients in the A.M. and 4 in the P.M.
- Tracking systems:
  - Relevant visit planning tool is used to prepare for the following days' schedule.
  - Care Gaps are utilized to identify patients due for PRAPARE screenings.
  - Actions are created in eCW for patients a CC could not meet with and ensure they are captured at their next visit.
  - CC manager utilizes One Note to track the monthly completed screenings per CC.
  - CC manager and CC review the number of completed screenings for that week during the weekly check-in and identify possible barriers to completion. The first check-in of the month focuses on data review and goal setting.
  - Bi-weekly meetings occur with the smaller group of CCs by the health center site.
- Created joint workflow with the front office.
  - Front office staff send a message via Microsoft Team Group " New Patient [HC Site Name]" to notify CC of the new patient's arrival so that CC can meet with the patient to complete screening. If the CC cannot meet with the patent, a handoff to another available CC occurs.
- CCs are the point of contact for warm handoffs to internal resources that a patient might be interested in based on PRAPARE screening responses.

WORKFLOW