
NACHC/AAPCHO/OPCA/ALLIANCE OF CHICAGO

MICHELLE JESTER
# Table of Contents

Overview of the PRAPARE Project 2  
Standard Data Collection Workflow 5  
PRAPARE Tool Form – Screenshot 7  
PRAPARE Form FAQ 9  
Change Management 11  
Social Determinants of Health – Sensitivity Training 13  
Best Practices & Lessons Learned 14
Overview of the PRAPARE Project: Implementing a National Standardized Patient Risk Assessment in Electronic Health Record Systems

[Taken from NACHC’s Implementing a National Standardized Patient Risk Assessment in Electronic Health Record Systems Project Charter Document]

Health Centers and the Social Determinants of Health: Implementing a National Standardized Patient Risk Assessment Protocol in Electronic Health Record Systems (EHRs)

Background:
In September 2013, the National Association of Community Health Centers (NACHC), the Association of Asian Pacific Community Health Organizations (AAPCHO), the Oregon Primary Care Association (OPCA), and the Institute for Alternative Futures (IAF) launched a project funded by the Kresge Foundation, Kaiser Community Benefit, and Blue Shield of California Foundation to create, implement, and promote a national standardized patient risk assessment protocol that goes beyond medical acuity to identify risk related to the “social determinants of health” (SDH). The goal of this project is to develop and pilot a consensus-driven national standardized patient risk assessment protocol in partnership with health centers and their networks to 1) help health centers better understand and manage their patient populations, 2) support development of payment methodologies that sustains SDH-related interventions.

Millions of people in the U.S. live in circumstances or with a history that significantly their health. These include social, environmental, and economic factors that influence an individual’s health. SDH act as barriers to good health outcomes and increase health care costs through preventable health care utilization. The national network of Community, Migrant, Homeless, and Public Housing Health Centers endeavors to overcome the SDH challenges experienced by their 23 million patients in their clinical practice and community activities. Fully addressing SDH, however, requires capturing data to document and better understand the specific SDH-related risks of their patients. Standardized data on non-clinical patient risk (e.g. education, employment, homeless status) will help health centers fully assess patient and community needs, identify high priorities, develop sustainable, coordinated, and culturally and linguistically appropriate interventions, and ultimately impact SDH risks, outcomes, costs, and patient experiences. It will also help inform new payment systems as current systems do not adequately incentivize the prevention or management of SDH nor do they cultivate community partnerships necessary for approaching health holistically.

This tool was designed specifically to aid health centers in gathering data that informs and addresses individual patient care and population health management, while capturing what makes health center populations unique.
**PRAPARE will be used to meet these goals by:**

1. **Patient and Family:** Empowering patients
   - Asking patient-centered questions about risk and allowing patients to prioritize needs
   - Opening up the conversation between patients and their care team about non-clinical risks and unmet needs

2. **Care Team Members:** Improving point of service care management
   - Giving the care team information on patient risk/needs prior to the visit to inform counseling and referrals during visit
   - Giving the care team a more complete context of the patient’s medical conditions, risks, and utilization patterns

3. **Health Center:** Improving the health of the patient population
   - Gathering data that can be aggregated to inform the allocation of resources and services and to identify disparities between patient population segments

4. **Community Policies:** Informing policies
   - Gathering data that can be aggregated to inform/promote legislation and policies (e.g., continued federal 330 funding, direct state grants, policies around specific social determinants, like housing)

5. **Local Health System:** Encouraging and strengthening partnerships across organizations
   - Encouraging local partnerships for bi-directional referral services
   - Creating an opportunity for meaningful data sharing (e.g. ACO model of sharing utilization data, sharing aggregate data for comparison across healthcare organizations)
6. State and National Policies: Gathering evidence for advocacy and payment reform
   - Gathering robust quality data to validate a risk adjustment algorithm for payment negotiation

**WHY Should Your Organization Help Pilot PRAPARE?**

This tool was developed to help further the mission of your organization and we need your help! It is based on research and stakeholder input, but needs to be tested by staff in the field to make it as strong as possible. This is your chance to test and provide feedback on a tool that will ultimately be nationally disseminated.

Piloting PRAPARE is an opportunity for innovation and problem solving in multiple areas of clinic workflow.

Data collection process:

- Currently, most patient data is gathered in the waiting room or during the exam.
- There are other interaction times which are an underutilized resource for assessment administration.
  - Prior to patient arrival at clinic (reminder phone calls, online patient portals)
  - Prior to patient exam (during measurement of vital signs, during wait in exam room)
  - After the patient leaves the exam room (in-house referrals for further assessment, during check-out)
Standard Data Collection Workflow

Depending on your health center’s internal workflows and operations, the data collection workflow will be tailored towards your health center and what works best in your organization’s operational workflow. Below is a standard data collection workflow where the PRAPARE questions are embedded within a normal office visit. The Alliance of Chicago is recommending that the data collection is done within two workflows:

1. Standard Office Visit
2. Care Coordination Visit
Sample Workflows

Sample #1

1. Nursing team will identify patients needing annual administration of SDH survey when prepping charts and by viewing protocol tab.
2. When patient due for SDH survey is being roomed by the nurse, tool will be administered either on paper and later inputted into EMR, or inputted directly into EMR by nurse.
3. If SDH is indentified, nurse will either use SDH spreadsheet to provide patient with resource information or notify case manager or social worker to assist patient.
4. Provider should also be notified of SDH indentified might impact care given that visit (i.e. unable to afford medications)

Sample #2

1) Present to the patient explaining how we are involved with PRAPARE:
   a. Introduce yourself, and ask the patient if they would mind answering some questions to help the clinic better understand the needs of our patients.
   b. “PRAPARE is a nationwide pilot program People’s Clinic has been chosen to participate in to help ensure the diverse population we manage get the best possible care provided to them. This program helps PCHC determine what resources are needed to help our patients.”
   c. After rooming the patient, hold the office visit to the provider.
   d. Open a separate document- choose PRAPARE as the encounter type.
   e. Leave your name in the provider box- click OK. (Do not associate it with the office visit)
   f. Click Add PRAPARE to Note (If something is needed to be left out of the charting, can unclick the specific ‘Add to note’ box for that section)
   g. Ask the questions and answer accordingly for each tab: Sociodemographic/Socioeconomic, Money and Resources, and Psychosocial Assets. If the patient refuses to answer questions, choose the appropriate answer reflecting this.
   h. Before asking questions under the Psychosocial Assets tab- Additional Optional Domains section, remind the patient “these questions are just for our data. They will not be used for anyone else’s viewing.”
   i. After the questions are done, thank the patient and hold the document to your supervisor’s desktop.
   j. Resources are available onsite to address immediate issues.
   k. There is a referral protocol in place for other non-emergent issues needing referrals.
PRAPARE Tool Form – Sample Screenshot

The Alliance of Chicago Community Health Services created the PRAPARE tool within a Centricity Form for Health Centers to administer within the Electronic Health Record. Below is an example screenshot of the tool and the format the tool is in for health centers to utilize.

Sample Form Screenshots – First Version of the form

Sociodemographic/Socioeconomic Tab

Money & Resources Tab
PRAPARE Form FAQ

SETUP

The PRAPARE form defaults to having display fields for information captured in the CHC Add-On module. However, if you want to enable these fields for data entry in the EHR, a simple change must be made.

1. Go to Administration>Chart>Chart Documents>Text Components.
2. Navigate to the Alliance folder>Custom>Alliance PRAPARE
3. Click customize
4. Change the “yes” to “no” 
   
   {gCHC_VISUALUTIONS="yes" ""}  
   {gCHC_VISUALUTIONS="no" ""}

FORM USE

1. Sociodemographic Characteristics
   a. Ethnicity, Race and Preferred Language: Pulls from standard registration fields.
   b. Veteran Status and Migrant Status: The goal is that this information will eventually pull over from the CHC tab. (NOTE: These fields can be enabled using setup instructions.)
      i. Health centers can partner with Visualutions to have these fields in the CHC add on to pull over from as obs terms into the PRAPARE form. A Statement of Work and cost is needed.
2. Family and Home
   a. Patient Address: Pulls from standard registration field.
   b. Family Size and Monthly Family Income: The goal is that this information will eventually pull over from the CHC tab. (NOTE: These fields can be enabled using setup instructions.)
   c. Housing Situation: Should be captured on the form.
3. Money and Resources
   a. Complete question as needed.
FORM USE – Continue

4. Social and Emotional Health
   a. Complete question as needed.

5. Additional Optional Domains
   a. Complete the optional domains as specified by your Health Center.

‘How Stressed Are You?’: A response other than ‘Not at all’ will show button to jump to ‘Pt Stress Questionnaire’

‘Afraid of partner?’: A response of ‘Yes’ will show button to jump to ‘HITS’
Change Management

Change is a **Process**. We acknowledge that it will take time for staff to adjust and incorporate the tool within the current workflows set at the health center.

The Cycle of Change

3 Strategies for Managing Resistance:

- Expect it; don't be surprised when it occurs.
- Recognize it for what it is – people are expressing their discomfort; it is not people being “bad”.
- Talk about it, describe it objectively without judgment or blame, at Team meetings.
- Develop strategies to deal with it:
  - Get more information about why people are uncomfortable.
  - Solicit their suggestions for what can be done to make them more comfortable.
Roles in the Change Process:

- **Sponsor** - Individual or group who has the organizational power to legitimize the Change.
- **Change Agent** - individual or group responsible for implementing the change
- **Target** - individual or group being impacted by the change
- **Advocate** - individual or group who wants the change to occur and does not have the organizational power to legitimize it.

Roles in the Implementation / Change Management Process for PRAPARE:

- For this implementation to successfully roll out, it is important to determine the roles in the change process and who will be in the front line at the participating health centers.
  - **Sponsors:** The Health Centers’ executive and senior leadership will be essential in legitimizing the change, understanding the resources required to accomplish the change, and committing to provide the resources needed to successfully roll out the PRAPARE tool. The sponsors of the health centers will have the ability and willingness to sustain support throughout the duration of the implementation.
  - **Change Agents:** The change agents would include the Health Centers/PRAPARE implementation team that the organization designates to lead the project. This team or group of core individuals will have the knowledge to empower other staff during the change process, the willingness to solicit and provide ongoing feedback, skills at assessing the level of commitment from the key players and bolstering faltering support, and skills of recognizing and managing resistance.
  - **Target:** Understanding the Health Centers’ patients/population of focus is important to the change process. The health centers will discern from the cognitive testing and from personal experience how to best administer the tool to the patients so that they are not resistant and they understand the questions being asked.
  - **Advocate:** Network level staff, other health center staff who are interested in SDH, etc will help advocate for this change to occur. Advocated should do what they can to support health centers to successfully implement the PRAPARE tool (providing resources, training material, data, clinical content, monthly touch base meetings, etc.)

Summary:

- PRAPARE Implementation is a CHANGE Process
- This Process of Change will need to be “Managed”
- Roles in the change process should be clearly defined
- Resistance is to be expected and can be managed

[Please reference the Change Management PowerPoint Presentation for additional information on Change Management within your organization]
Social Determinants of Health - Sensitivity Training

Sensitivity training will be conducted at the health center level with internal training materials and resources. The health centers will utilize their standard process of training staff on sensitivity and cultural competency.
Best Practices & Lessons Learned

- The need to have demographic information entered in from registration: This will allow the information to pull over into the PRAPARE form in the EHR side and can refrain from duplicate administration within the office visit
- Ensure staff are only capturing the data once when needed (i.e. Every single encounter vs. annually)
- Ensure staff capture data in the appropriate part of the visit: Please be sure to follow your practice specific workflow to ensure there is a smooth flow in the data collection process
- When there are changes to the form, obs terms will need to be submitted to GE in advance to meet necessary deadlines

- Key Findings:
  - UDS discrepancy with tracking Native Hawaiian and Pacific Islander status in CPS
    - Interim Workflow: The only way for the health centers to capture this information separately is to add the two as separate sub-races (Native Hawaiian and Pacific Islander) and then train health center staff as the old category cannot be removed and there are patients already assigned to these categories. For reporting purposes, we can run a query to see if the sub-races are being pulled in.
      - This report will have to be built, generated, and run for each health center
  - Issues identified in the GE content
    - Some fields that are captured on the Practice Management side of the application do not populate on the PRAPARE form. In order for the information to populate, health centers and HCCNs will need to work with the third party vendor, Visualutions to install the scripts into the database for the fields in registration to populate as obs terms on the EMR side. The Alliance is not comfortable taking this on for each health center as it involves getting into the centers’ databases/codes.
    - Statement of Work (SOW) for the current health center test and production database is $1,000 (per site) for fields in the practice management such as Migrant, Veteran, Income, and Family Size Status.
      - Vis costs on production databases SOW for each center around obs terms mapping from PM to EMR – current SOW is just for Waikiki, other centers waiting for this as the mapping would be ideal
      - Does not include employment status (Alliance opted not to tinker with this on the registration field for a variety of reasons)

- Lessons Learned/Best Practices To Develop Readiness:
  - 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!
  - 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?
  o 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.
  o Use “5 Rights” and PDSA cycle to develop workflow for administering and responding to PRAPARE tool.