PROMISING PRACTICES

Washington Association for Community Health
Community Health Centers Advancing Quality Care for All

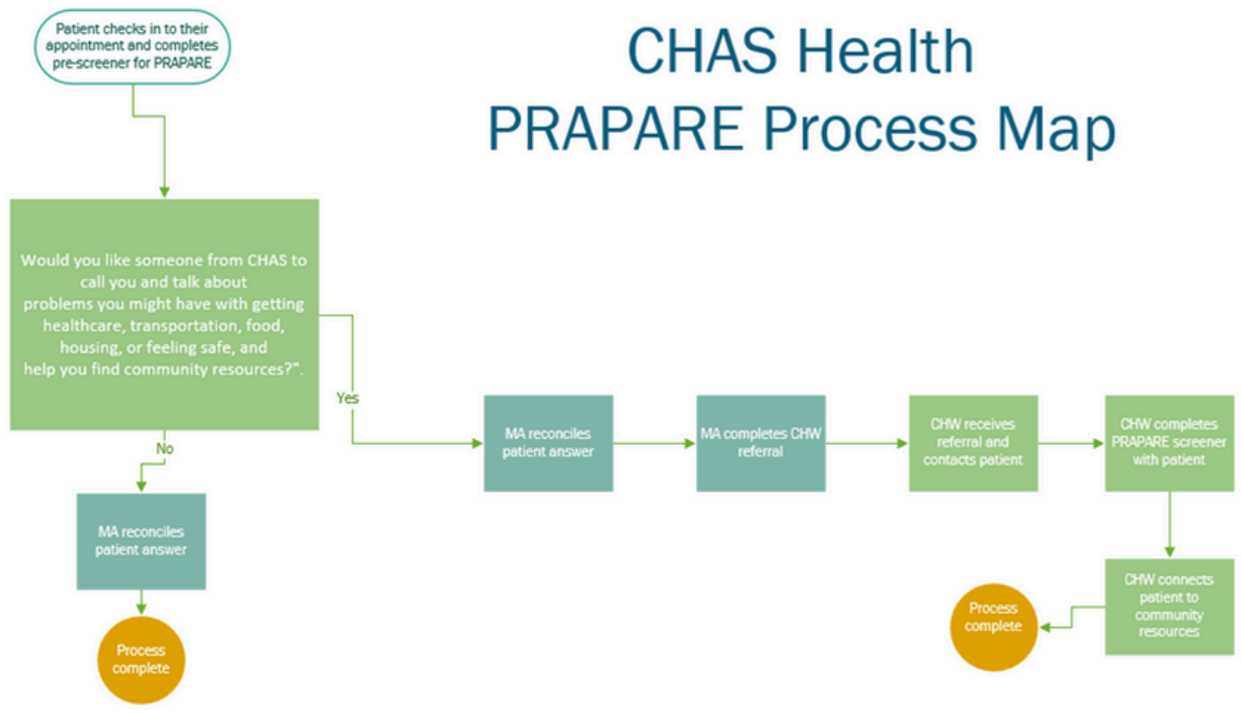
CHAS health

USING PRAPARE COMMUNITY HEALTH WORKER TEAM TO ADDRESS PATIENTS' SOCIAL NEEDS

Understanding the social needs of patients and the community has always been embedded into the mission of CHAS Health. This work has evolved over the years, in line with state and national best practices, leading to the development of a formal social needs screening program. They understood that to successfully launch an SDOH screener they needed cross-department collaboration with staff from clinic operations, leadership, Community Health Worker (CHW) teams, IT and applications departments, and the data team. This led to the creation of a workgroup which focused on the implementation of the screener. The workgroup identified team members, developed objectives with trackable goals and timelines, and executed a rollout and communication plan.

CHAS Health's board and leadership made health equity a strategic priority and a large component of this was to understand patients' SDOH needs. The development of the program stemmed from their initiative to task the health equity team in implementing a process to screen, identify and follow-up on patients' SDOH needs. They did not receive any specific funding to create the social needs screening program.

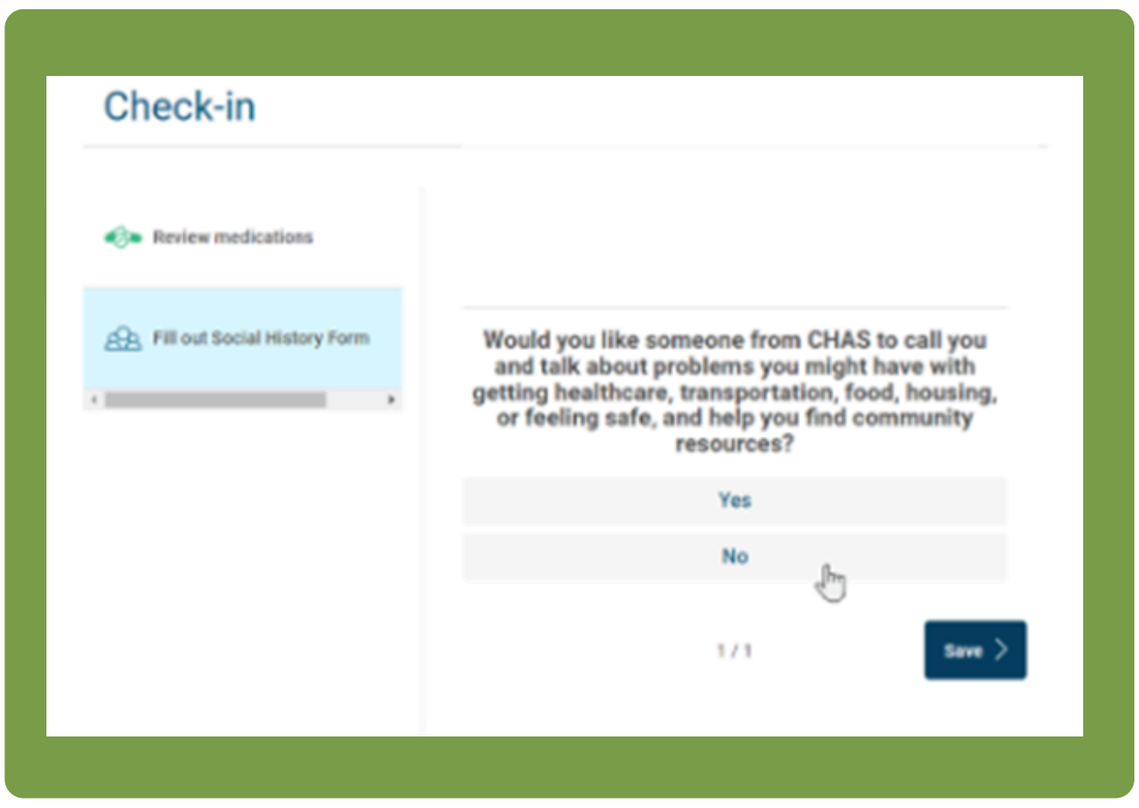
A full interdepartmental program at CHAS Health is now focused on SDOH. Their original roll out of the screening program using the PRAPARE screener was in 2019. In 2022, the team developed a new workflow in response to changes caused by the COVID pandemic, new screener functionality in their EHR (Athena), and an increase in their CHW workforce.



PROGRAM OVERVIEW

Today, all primary care provider patients at eleven CHAS Health clinics are screened for social needs annually. When they check in for an appointment, they are given an iPad and a social needs pre-screener pops up on the screen. They continue to finetune their workflows and processes for the screening program and hope to soon expand from primary care to dental and behavioral health settings.

At first patients were asked in the pre-screener, "Do you have any SDOH needs? Would you like to talk with someone about SDOH needs and connect to resources?" It became apparent that the questions were not clear to patients with some responding "No" to the first question and "Yes" to the second question.



CHAS Health decided to change the pre-screener to a single question that could be understood by clients with a wide variety of reading abilities: "Would you like someone from CHAS to call you and talk about problems you might have with getting healthcare, transportation, food, housing, or feeling safe, and help you find community resources?". If the patient responds "No", that ends the route. If the patient responds "Yes", then a Medical Assistant reconciles data from the iPad to Athena (their Electronic Health Record), verifies the answer with the patient, and submits a Community Health Worker (CHW) referral.

When a patient screens positive on their pre-screener at a clinic with a CHW on-site, patients are given a warm handoff to these CHWs to complete the PRAPARE screener and connect to resources. If the CHW is unavailable during the time the patient is in the clinic, the process outlined below will be followed.

Once the CHW Team receives the referral for patients who screen positive at a clinic without a CHW on-site, the CHWs will attempt two phone calls to reach the patient. If there is no response from the patient, a letter is sent with the website address for CHAS Health's resources page powered by findhelp (https://chasfindresources.findhelp.com) with community resources and CHAS Health contact information. CHAS Health partnered with findhelp to create the platform. So even if CHWs sometimes are unable to get in touch with patients, patients can still access community resources.

CHAS PRAPARE Letter No Contact.pdf
CHAS PRAPARE Letter Contact & Resources.pdf

When CHWs are able to connect with a patient by phone, CHWs go through the full PRAPARE screener, and enter information in Athena. CHWs can connect patients to community resources, connect them to other CHAS Health staff, make an internal referral or arrange for an in-person meeting with a CHW for help applying for other programs. CHWs document intake notes on patients they get in touch with by adding care management appointments to the patient's chart that indicate what resources they connected the patient with and if they had follow-up emails or calls. They continue documenting new care management appointments to a patient's chart each time.

Due to some data limitations within their EHR, CHAS Health also created a tracker to show qualitative actions taken from referrals and track each referral and outcome. It identifies a patient's SDOH need and what steps taken to support them. Each CHW has a tab in the tracking spreadsheet.

CHW	Patient ID	Date referral was received	Outreach Outcome	SDOH Need	SDOH Need	What steps were taken to support patient? Please initial and date each entry.
Jasmin	5555555	9/25/23	First Call	Transportation	Legal	LMTCB 9:15 AM 9/25/23

PRAPARE CHW Tracker & key

Outreach Outcome	
First call	Patient was called and did not answer the phone.
Second Call	Patient was called again and did not answer the phone.
Letter sent	Patient was sent letter after not answering the phone twice. Referral was closed.
Pt did not need resources	Patient declined any support.
Pt was referred internally	Patient was referred to or an appointment was made for them to meet with a CHAS staff.
Pt was referred externally	Patient was referred to an outside organization to support their SDOH need.
Pt received email/text resources	CHW sent the patient SDOH information over text, email, or in the mail.

SDOH Need	
Food	
Transportation	
Housing	
Legal	
Childcare	
Clothing	
Employment	
Other	If other, write in the note section.

STAFFING & TRAINING

The CHW team has four full-time CHWs dedicated to this work. Their top priority is PRAPARE, however they also support some other SDOH work including mobile food markets and going off-site to visit patients. There are five additional CHWs who support PRAPARE part-time and respond to referrals from the clinics at which they are located.

When assigning staff to the PRAPARE CHW Team, CHAS Health looks for CHWs with good communication skills who are very resourceful. They work with the newly hired CHWs to build their understanding and knowledge of community resources available to patients. In addition, they connect with CHAS Health call center staff to learn how to use the phone system, attend monthly CHW trainings and complete Washington State Department of Health's CHW training. CHAS Health also created a CHW PRAPARE Referral Job Aid to walk CHWs through the PRAPARE referral follow-up process.

CHAS Community Health Worker PRAPARE Referral Job Aid

CHAS CHW Team

CHALLENGES

The biggest challenges with the screening program are reconciliation from the iPad to Athena and ensuring that Medical Assistants make the referral to CHWs. Medical Assistants always have to reconcile from the iPad to Athena and must click a button to access data. It cannot be fixed on the back end so it must be done manually. Also, sometimes there is a delay with the information on the iPad being sent to Athena so Medical Assistants must wait for it to come to their computers.

To help address these challenges, they have retrained staff including in CHAS PRAPARE Data Reconciliation and Referral Process document which walks staff through the process of completing an e-check in, completing the Pre-Screener PRAPARE data reconciliation, and placing the PRAPARE referral to the CHW to address SDOH needs. Also, CHAS Health's business intelligence team daily generates a PRAPARE Screener Reconcile & Referral Report that shows any missed reconciliation tasks or missed referrals.

CHAS PRAPARE Data Reconciliation and Referral Process

OUTCOMES

CHAS Health goes to two data sources to look at outcomes from their screening program – a data dashboard and the PRAPARE CHW Tracker (see example above) used by CHWs to show qualitative actions taken from referrals and track each referral and outcome. The data dashboard tracks high-level data for PRAPARE and a data analyst is devoted to this work. They look at: how many patients complete the pre-screener and PRAPARE screening, how many CHW PRAPARE management appointments were made, and PRAPARE scores, such as what proportion of patients that completed the PRAPARE assessment who were in high-risk categories. They also pull data from the PRAPARE CHW Tracker kept by CHWs.

PROMISING PRACTICE TO SHARE

At CHAS Health, the PRAPARE CHW Team is key to addressing patients' social needs because they have such a deep understanding of community needs and resources, the ability to connect them, and promote health equity. Medical Assistants and other clinical staff are not on the PRAPARE CHW Team but they are an important part of the PRAPARE process and champion the work. Everyone is working together to support patients' social needs so there will be more success with clinical outcomes. Addressing health equity and social drivers impacting patients are priorities at CHAS Health. They focus staff and organizational resources on those priorities so they can promote health equity for patients.

At CHAS Health the "secret to success" to address patients' social needs is the CHWs themselves. They acknowledge an element of luck in hiring their CHWs. They have a passion to support patients and help in any way they can. They demonstrate confidence, preparedness, and excitement about the work. Also, their kindness, generosity, empathy, and willingness to listen helps them to connect well with patients and to understand what they need and their priorities. As a result, CHWs' calls with patients build patients trust with CHAS Health.

RESULTS TO DATE

CHAS Health's PRAPARE CHW Team's goal is to support patients to address SDOH needs. They measure reaching the goal by looking at whether they have done due diligence in connecting with patients who requested support to help connect them to resources. They are collecting qualitative data, including tracking stories about what CHWs are saying about how the calls are going and what patients' needs are. They are also collecting quantitative data, including looking at how many patients completed the pre-screener and making sure no one is missed who wants support on SDOH. They are proud to report that to date 667 full PRAPARE screeners have been completed and they have received 4,413 referrals that the CHWs have responded to!

Successes Of PRAPARE CHW Team:

- CHAS Health staff collaborate and make adjustments to refine the screening program. They are close to having a well-run system with CHWs, Medical Assistants, clinics and data teams working together to make it a success.
- Many patients connect with CHWs and have their SDOH resource needs met.
- There are many stories that show how CHWs identified patients needing a little extra support, helped them to identify what their needs were and addressed them.

Challenges Of PRAPARE CHW Team:

- A large number of patients have identified SDOH needs and want support from CHWs. CHAS Health is evaluating how to support CHWs to meet the needs and what staffing level is needed, especially with the expected screening roll out to dental and behavioral health settings. They are looking at data for evidence-based approaches to staffing.
- It is often hard to connect with patients. There are many patients that CHWs cannot get in touch with despite repeated attempts. That is why they developed a letter to patients, work with findhelp to keep resources up to date, and develop partnerships with community-based organizations.

Lessons Learned Using PRAPARE CHW Team:

- CHWs have reported having some "life changing" calls with patients and connecting with them in surprising and real ways.
- Trust is built on CHWs' calls with patients and months later they will call back to ask other questions because they view CHWs as reliable and understanding resources.
- CHWs have more success asking PRAPARE screener questions to patients in casual conversation rather than strictly reading the questions verbatim.

Next Steps Using PRAPARE CHW Team:

- CHAS Health is onboarding new CHWs to continue supporting the PRAPARE work.
- They are considering how things will change when they offer screening in dental and behavioral health settings and expect it to be challenging. The ultimate goal is to successfully roll out social needs screening to all CHAS Health patients!

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