Engaging Community Health Workers & Leveraging Existing SDOH Screening Efforts: Lessons Learned from PRAPARE Implementation in West Virginia

JULY 2019

The West Virgina Primary Care Association (WVPCA) participated in the PRAPARE Train the Trainer Academy to support health centers in West Virginia with using PRAPARE. They shared the stories of two health centers and their journeys on how they implemented PRAPARE. The first health center discusses the process to use PRAPARE with a current program with Community Health Workers. The second health center reviews how they incorporated PRAPARE into their previous SDOH screening efforts.

Using PRAPARE with Participants of Community Health Worker Program

Williamson Health and Wellness (WHW) began administering PRAPARE to patients enrolled in their Community Health Worker Program (CHWP). Participants of the CHWP have multiple chronic conditions which require additional support and assistance to manage. Community Health Workers make home visits on a weekly basis where they regularly assess the social environment of the patient and provide much needed support and enabling services.

What Worked Well:

- Screening Environment: Patients are screened in their home by a CHW that they know and trust.
- Engagement of CHWs to Screen: The Community Health Workers were assessing food security, housing security, transportation and many other aspects of PRAPARE but they did not have a tool to document the responses nor a way to aggregate the data. Having the PRAPARE Smart Form in eClinical Works allows the screening to be completed easily during the visit.

Impact of PRAPARE at Williamson Health and Wellness:

The Community Health workers have noted that the biggest need identified from using PRAPARE has been food insecurity. Williamson Health and Wellness have expanded the farmers market and have also increased the usage of the mobile farmers' market. Community Health Workers have access to fresh fruits and vegetables to take to patients during home visits.

Transportation is always an identified need in rural West Virginia, and the aggregate data from PRAPARE may help with obtaining future funding for expanded services.

Next Steps:

Using PRAPARE within WHW has been beneficial and WHW plans to implement PRAPARE screenings throughout the health

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center in the near future. By starting small, WHW was able to understand how to use PRAPARE while developing a workflow for screening and follow-up with patients needing resources. WHW plans to use PRAPARE data to continue to meet the needs of their community by identifying the most pressing needs of its patients and potential community partners to support patients.

PRAPARE Implementation at Valley Health

For the last few years, Valley Health has been screening patients for a few social determinants of health. The primary focus was on food, housing and transportation. It became apparent that the way the questions were phrased was not eliciting an accurate response from our patients. For example, "Do you have any issues with food?" Food insecurity is nuanced and there is a spectrum of challenges patients experience in terms of accessing nutritious food. The health center wanted to use more precise questions that would result in a more comprehensive assessment of patients and their social needs.

Valley Health had its first PRAPARE Implementation Committee meeting in October 2018. The committee was comprised of front desk and nursing coordinators, case managers, operations, medical providers, and EHR clinical trainers.

Implementation Committee:

The committee felt that given the common needs for resources in the community (transportation, housing, and food) they wanted to focus on these specific areas with some additional questions, and different wording adapted from the PRAPARE tool. Valley Health has over 30 clinic locations making implementation challenging. The committee decided to pilot the new screening at select locations to identify and resolve workflow issues. The selected sites varied in geographic locations. Those sites were East Huntington, Cedar Grove (other side of Charleston), Hurricane, Wayne, and Fort Gay. The pilot started on January 14, 2019 and Valley Health implemented PRAPARE screenings in all locations on April 22, 2019.

Workflow:

- A health reminder for the PRAPARE screener pops up semi-annually for all patients.
- Patients are screened during the nursing triage process and the information is documented in the patients' medical record. Custom forms were built for data extraction and analysis.
- The results go into the provider's note so they can address identified needs with the patient.
- If the patient "screened positive" related to housing, money, resources, and transportation, the nurse or front office staff would either provide resources or make a referral to a Behavioral Health Patient Advocate for more in-depth, long-term care of the patient.
- Completing the screening satisfies the health reminder and will reappear again in 6 months.

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Feedback from Staff:

- Workflow was easy to integrate and customize given previous SDOH screening efforts.
- Patients were initially confused about why they are asked these questions and understood the purpose and intent of PRAPARE screenings after an explanation was provided.
- Staff felt like the change in wording elicited a more accurate response from patients.
- Some staff indicated confusion on which answers to select for patients receiving SNAP benefits or accessing a food pantry.

Impact of Using PRAPARE and Next Steps:

By April 2019, Valley Health was able to administer PRAPARE to 8,555 unique patients. Of them, 206 patients reported housing insecurity. The data also showed that not as many patients screened positive for food insecurity as hypothesized. Valley Health will monitor the data and customize wording to be culturally appropriate for the population served. In terms of next steps, Valley Health plans to increase the number of case managers along with an increase in locations with case managers. Next, Valley Health will use data collected from all sites to identify the most pressing needs of patients, which will then be used to develop collaborations in the community to enhance access to resources. Finally, the health center will begin to use Z codes to customize the health reminder to pop up more frequently for anyone screening positive rather than the blanket semi-annual PRAPARE screening of patients.

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