COMPASS COMMUNITY HEALTH
a new direction

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Compass Community Health's Implementation of PRAPARE with SBIRT for Patients with Behavioral Health Needs

Compass Community Health (CCH) is located in Portsmouth, Ohio, where 89% of the population served is severely addicted to alcohol and/or illegal drugs. Also, 62% of CCH's patients are in the midst of some sort of life trauma ranging from homelessness, domestic abuse, long-term unemployment, and are living far below the poverty level. Substances include heroin, methamphetamines, opiates, cocaine, marijuana, benzodiazepines, and alcohol, with usage being significantly higher than other communities with similar demographic compositions.

To provide the patients with appropriate services to meet their needs, the staff at Compass Community Health began SBIRT (Screening, Brief Intervention and Referral for Treatment) in 2016. The goal was to reduce morbidity and mortality of alcohol, other drug use, and depression through early intervention and integration of medical and behavioral health approaches. CCH staff saw the direct positive outcomes and results of the SBIRT screening and wanted to further impact the lives of the patients they served by focusing on the socioeconomic circumstances that contribute to the trauma and substance abuse. CCH decided to implement PRAPARE to better understand their patients' needs and provide them with appropriate resources and services. PRAPARE was introduced to the staff in July 2017 with no resistance as staff saw it as another opportunity for impact with this specific population, especially when implemented alongside SBIRT screening. With the implementation of both SBIRT and PRAPARE, substance abuse treatment has become the primary and distinguishing focus of CCH's core community outreach strategy.

Incorporation of PRAPARE into SBIRT Workflow and Stratifying by Level of Risk

Training and workflow implementation were identical for both SBIRT and PRAPARE. Because of the similarities, staff felt comfortable and confident in administering both tools to patients. The CCH clinical staff directly involved in SBIRT and PRAPARE implementation included the Clinical Director, Psych Nurse Practitioner, SBIRT Nurse, Care Coordinator, Licensed Social Worker, and the Outreach and Enrollment Specialist.

CCH has a designated RN who completes both SBIRT and PRAPARE screenings. SBIRT and PRAPARE are completed during a patient's first clinic visit and updated annually thereafter unless a specific need is identified. The nurse will collect the information during the waiting time before the patient sees the provider. The Outreach and Enrollment Specialist refers and connects patients to resources and services. When patients are referred to other community services, the staff follow-up with the patient and/or their referral source to attempt to connect them again.

Compass Community Health Staff

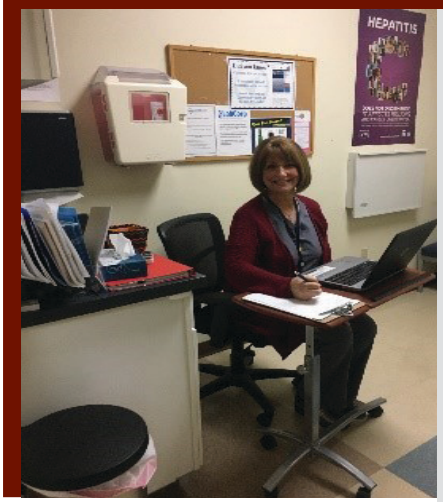
Clinical Director	• Leads PRAPARE implementation
Providers and Nurses	• Understand the PRAPARE tool, its purpose, what information the PRAPARE screening will provide, and how it impacts the clinical outcomes of the patients
SBIRT Nurse	• Performs PRAPARE data collection using motivational interviewing techniques and serves as the point of contact for the providers and Care Coordinator on socioeconmic related items
Care Coorindator and LISW	• Assist with patient follow-ups and connecting patients to community resources
Outreach and Enrollment Specialist	• Assist with the development of the Community Resource File

The CCH staff developed a risk stratification model using PRAPARE data to segment their population into risk tiers. Based on this model, they continually track the number of patients with four or more social determinant risks and the number of closed-loop referrals.

Under CCH's risk stratification model and with their specific patient population, patients with 0-3 soioceonomic risks are considered "low risk" and receive follow-up as needed or annually. Patients with 4-6 socioeconomic risks are considered "moderate risk" and require follow-up at their next office visit. Patients with 7 or more are considered "high risk" and receive follow-up at their next visit, routine phone calls, and must have a closed-loop referral. The data is tracked on CCH's department dashboard and shared with the Quality Team and CCH Board monthly and annually.

Stress Level	Incarcera-tion hx	Refugee	Feel Safe Where Live	Afraid of partner or ex partner	Status notes	Follow-Up
A LITTLE BIT	YES	NO	YES	NO		
QUITE A BIT	NO	NO	YES	NO		
A LITTLE BIT	NO	NO	YES	YES	Community resources given	Remade contact with transportation services. Still trying to connect with Domestic Violence Shelter, pt not ready.
SOMEWHAT	YES	NO	YES	NO		
VERY MUCH	NO	NO	YES	NO		
VERY MUCH	YES	NO	YES	NO	Ref to BH counselor	Pt appt Mar 5th at 10:15am
A LITTLE BIT	YES	NO	YES	NO		
VERY MUCH	NO	NO	YES	NO		
A LITTLE BIT	YES	NO	YES	NO		
SOMEWHAT	NO	NO	YES	NO		
A LITTLE BIT	YES	NO	YES	NO		
NOT AT ALL	NO	NO	YES	NO		
QUITE A BIT	YES	NO	YES	NO		
SOMEWHAT	YES	NO	YES	NO		
VERY MUCH	NO	NO	YES	NO		
A LITTLE BIT	YES	NO	YES	NO		
SOMEWHAT	NO	NO	YES	NO		
SOMEWHAT	NO	NO	YES	NO		
NOT AT ALL	YES	NO	YES	NO	Appt with O&E specialist	Pt did not show for appt
VERY MUCH	YES	NO	NO	YES	Seeing BH counselor	Appt Feb 28th at 1pm
NOT AT ALL	NO	NO	YES	NO		
NOT AT ALL	NO	NO	YES	NO		
A LITTLE BIT	YES	NO	YES	YES	In rehab	
NOT AT ALL	NO	NO	YES	NO		
SOMEWHAT	YES	NO	YES	YES	In rehab	
A LITTLE BIT	YES	NO	YES	NO	In rehab	Left services
SOMEWHAT	YES	NO	YES	NO	In rehab	
SOMEWHAT	YES	NO	YES	NO	2 YRS DRUG FREE	
VERY MUCH	YES	NO	YES	NO	Appt with BH counselor	Appt Mar 1st at 9am
QUITE A BIT	NO	NO	YES	NO		
SOMEWHAT	NO	NO	YES	NO	IN TRANSITIONAL	completed, living in own apartment now
VERY MUCH	NO	NO	YES	NO	Declined counseling	
A LITTLE BIT	YES	NO	YES	NO	In rehab	
A LITTLE BIT	NO	NO	YES	NO		
QUITE A BIT	YES	NO	YES	NO	In out pt therapy	
SOMEWHAT	NO	NO	YES	NO	Referred to O&E	Appt today (3/18)
A LITTLE BIT	NO	NO	YES	NO		
SOMEWHAT	NO	NO	YES	NO	In Rehab	
QUITE A BIT	YES	NO	YES	NO	Seeing BH counselor	
QUITE A BIT	YES	NO	YES	NO	In rehab	Left services
A LITTLE BIT	YES	NO	YES	NO	In Rehab	
QUITE A BIT	NO	NO	YES	NO	Referred to BH counseling	Pt No Show for Appt
A LITTLE BIT	YES	NO	YES	NO	In Rehab	
SOMEWHAT	NO	NO	YES	NO		

Example of CCH's Patient Database for Follow-Up



Fonda Lewis, CCH's SBIRT Nurse

Always Start with the Conversation

The SBIRT nurse, Fonda Lewis, is instrumental in the success of PRAPARE implementation at Compass Community Health. Fonda has the ability and makes an effort to connect with all of CCH's patients. Fonda has been at CCH for four years and previously worked at a local OBGYN clinic for 23 years.

Fonda's unique approach to building trust has made patients at CCH feel comfortable answering questions and not feeling overwhelmed. Fonda explains fully what the information in PRAPARE and SBIRT will allow providers to do with the goal of better and targeted care for their specific needs.

"Always start with the conversation" is Fonda's motto when implementing PRAPARE and collecting sensitive information from patients, which is why patients and staff appreciate her thoughtfulness and compassion. Fonda also works directly with the providers in discussing PRAPARE results and thinks through next steps for referrals to the Care Coordinator, LISW, or Outreach and Enrollment Specialist. She is not only a trusted staff member for the patients but also among the CCH staff.

Responding to and Addressing the Needs of CCH's Patients

Compass Community Health has partnered with various organizations in the Scioto County community, including the Salvation Army, Potter's House (local food bank), area restaurants, and more. CCH is also an active participant in the Scioto County Health Coalition, which allows the staff to discuss specific needs of their patients identified from SBIRT and PRAPARE. Community-based organizations and businesses during these meetings have the opportunity to connect directly with CCH and work to provide their resources and services. CCH created a community resource file that is a living document of organizations and services that is updated weekly on the shared drive in the clinic. Printed copies of the community resource file are avaible at the front desk for all patients.

Impact of Using PRAPARE with SBIRT

By implementing both SBIRT and PRAPARE, there has been significant positive impact to Compass Community Health's clinical quality outcomes, rentention rates, and financial outcomes. Though CCH's leadership and staff are impressed with the clinical results that have been accomplished since 2016, the team prides themselves on the lives they have changed and saved. CCH believes that the success with incorporating both SBIRT and PRAPARE in their clinic is attributed to their ability and determination to connect their patients to the needed resources in the community.

13% **IN ONE YEAR, CCH REDUCED THEIR NO SHOW RATE BY 13%**

Patient Impact Stories

After implementing PRAPARE, Compass staff helped a previously non-verbal patient who was homeless and living in her car find an apartment and get her access to medications. Staff even got her a cat for social support. She now comes to her appointments talking and smiling.

One of Compass's patients walked barefoot for 20 miles to escape a domestic violence situation because she knew the nurse who had implemented PRAPARE with her and helped her address some of her other needs would help her again.

> "It's not always about dollar amount but all about increasing the care we deliver. Your bottom line will ultimately be the impact and that's how we continue to serve the patients who need us."
>
> - Erin Trapp, Clinical Director

Getting the Word Out: CCH Shares Their Story

Because of Compass's efforts with PRAPARE and meeting the needs of their patients, they were highlighted in an article and podcast from the Public News Service to discuss the complex patients in the midst of the opioid epidemic. To read more, click here.

Ohio Health Centers Use New Screening Tool to Improve Patient Health

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July 1, 2019 - Mary Schuermann Kuhlman, Public News Service (OH)

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COLUMBUS, Ohio — Where a person lives, works and plays can shape their overall health outcomes. And in Ohio, Community Health Centers are working to identify how social determinants may be affecting their patients.

Medical staff at the centers are using a screening tool called "PRAPARE" during routine office visits to detect social, economic and environmental variables in a patient's life. Erin Trapp, clinical director with Compass Community Health in Portage County, said by using this tool, they discovered one patient had been living in her car.

"It's a matter of survival for her; following our care plan and getting her medication was not a priority," Trapp said. "So, we were able to link her with different community resources, and she is one of our success stories now. She actually has a job, she has an apartment."

There are 55 Community Health Centers in Ohio that provide care to more than 800,000 people. (sebra/Adobe Stock)

PRAPARE stands for the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. It's estimated just 20% of health outcomes are attributed to clinical care, while social determinants account for the remaining 80%.

Dr. Ron Yee, chief medical officer with the National Association of Community Health Centers, explained the goal is to connect patients to local resources and interventions that can improve their situation, whatever it may be.

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