Population Health Assessment Engine (PHATE) Performance Improvement Activity

(Please note that this activity is still awaiting approval from the American Board of Family Medicine)

(To complete this activity, you need access to PHATE)

Introduction

Thank you for your interest in this Performance Improvement Activity. There are numerous efforts to better connect patients seen in primary care with existing community resources.[1] We hope that the following materials and activities will help you get a better understanding of how to accomplish this in your clinic.

Objectives:

- Define population health and social determinants of health
- Demonstrate how to use population health tools
- Describe how those tools can be used to improve the delivery of care

If you have any questions about this activity, please email Jennifer Rankin at jrankin@healthlandscape.org.

Overview of tasks (anticipated time):

1) Review population health and geospatial concepts by reading the documents, "Introduction to Population Health" and "Introduction to Geospatial Concepts". (60 minutes)
2) Review "Nuts and Bolts 03 – Introduction to the Population Health Assessment Engine", "Nuts and Bolts 04 – My Community", and "Nuts and Bolts 05 – Community HotSpots". (60 minutes)
3) Identify 10 individuals (instructions provided below), assess their unmet needs, and refer them to community resources (60-120 minutes)

Before starting, you will need to decide which assessment tool to use: PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) or PCAM (Patient-Centered Assessment Method). Both of these are free.

	PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences)	**PCAM (Patient-Centered Assessment Method)**
Who completes the instrument?	Patients	Clinicians PCAM can be completed by a single physician or a team
Number of questions	21	12
What types of information are assessed?	Family and home Money and resources Social and emotional health	Health and wellbeing Social environment

		Health literacy and communication Service coordination
Where can I find the tool?	PRAPARE one-pager	PCAM online

Which tool do you want to use (PRAPARE or PCAM)?

_____

Please use "PHATE PIA Sample Spreadsheet – PRAPARE" or "PHATE PIA Sample Spreadsheet – PCAM", depending on which tool you select.

Step 1: Select a PRIME measure:

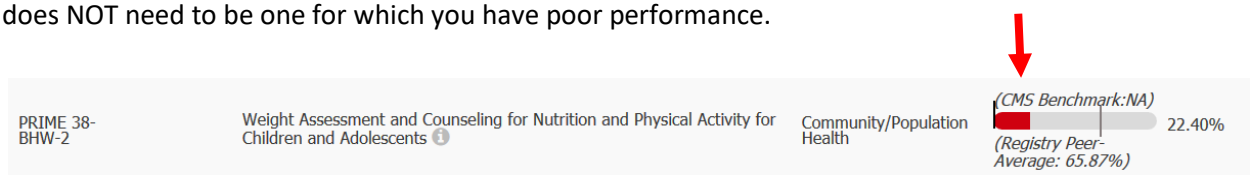
1) Decide if you want conduct this activity for all patients in a practice, location, or seen by a clinician.

   Practice name:

   Location (individual site name or all):

   Clinician (individual name or all):

2) Select a PRIME measure. Consider your own interests, the needs of your patients and community, the resources in your community, the extent to which community resources may affect the measure, and those measures for which you have poor performance. In PRIME, the measures for which you have poor performance are highlighted in red. The measure you select does NOT need to be one for which you have poor performance.



   PRIME measure ID:

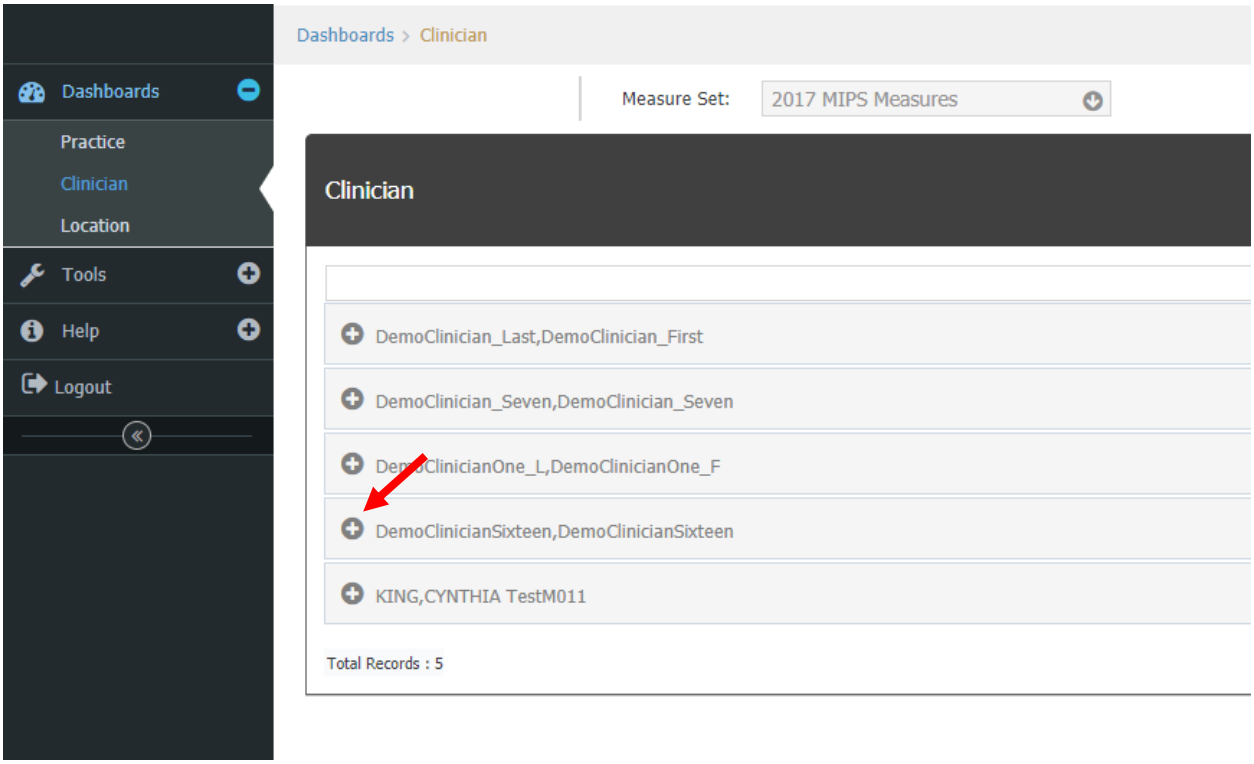
   PRIME measure label:

Step 2: Identify 10 patients who are missing this measure or have poor control:

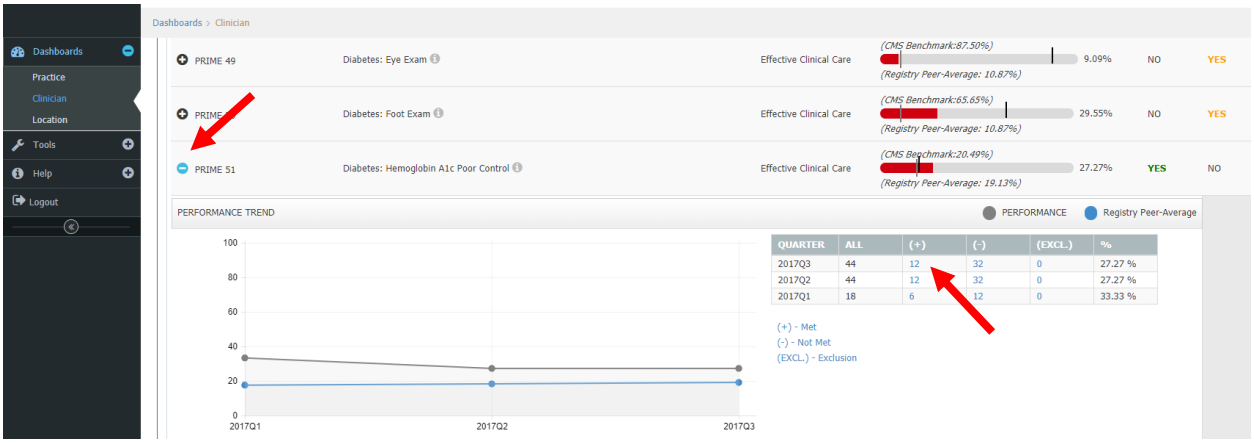
Note: The following exercise will go through the process using poor diabetes control as an example, but you may select any PRIME measure. Additionally, this example describes identifying patients for a specific clinician; however, you can look at all patients coming to a clinic if desired.

1) View your PRIME 51 score for poor hemoglobin A1c control

Find your name in the clinician roster



Click on the + icon next to PRIME 51 (Diabetes: Hemoglobin A1c Poor Control). This is the percentage of patients 18-75 years of age with diabetes who had a hemoglobin A1c > 9.0% during the measurement period.



% of your patients with HbA1c > 9% (or with a gap in service or poor disease control) in the most recent quarter: _____

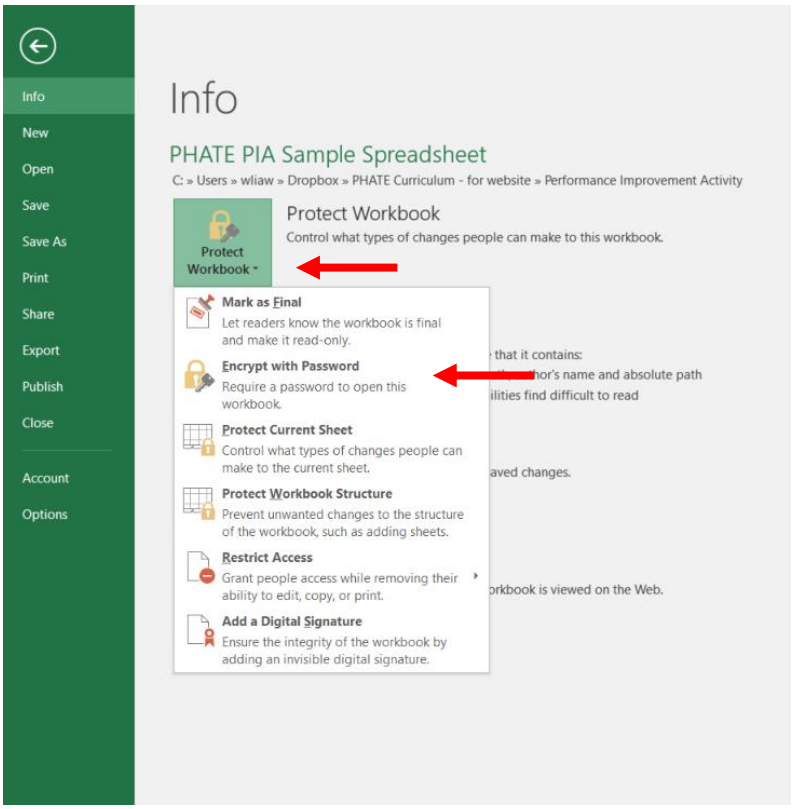
2) Click on the hyperlinked number under the (+) column. This opens a window with the individual names and medical record numbers (MRNs) of those with poorly controlled diabetes.

3) Select 10 patients. You may need to include patients from multiple quarters in order to reach 10. Enter their Medical Record Numbers (MRN) into the spreadsheet. If desired, you can use the sample spreadsheet, titled “PHATE PIA Sample Spreadsheet”. There are two different spreadsheets depending on whether you have selected PRAPARE or PCAM.

	A	B	C	D
1				
2	**Patient**	**Zip Code**	**Census Tract**	**Community Vital Sign**
3	1			
4	2			
5	3			
6	4			
7	5			
8	6			
9	7			

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you should not keep personal health information (such as names, addresses, and medical record numbers) in this file.[2] You will need a method for linking these patients with the patient number on the spreadsheet as you will need to contact these individuals at a later date.

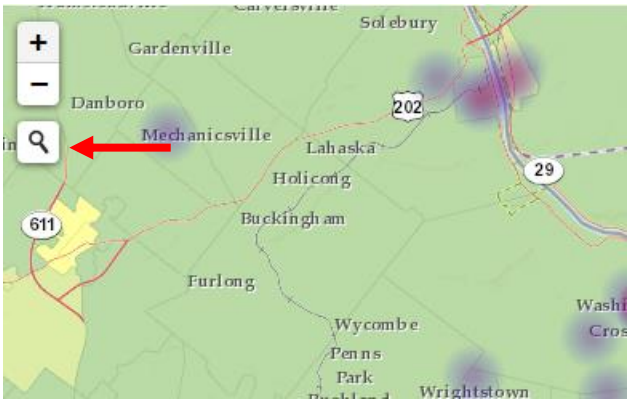
In Microsoft Excel 2016, you can encrypt the file by selecting “File”, then “Protect Workbook”, and then “Encrypt with Password”.



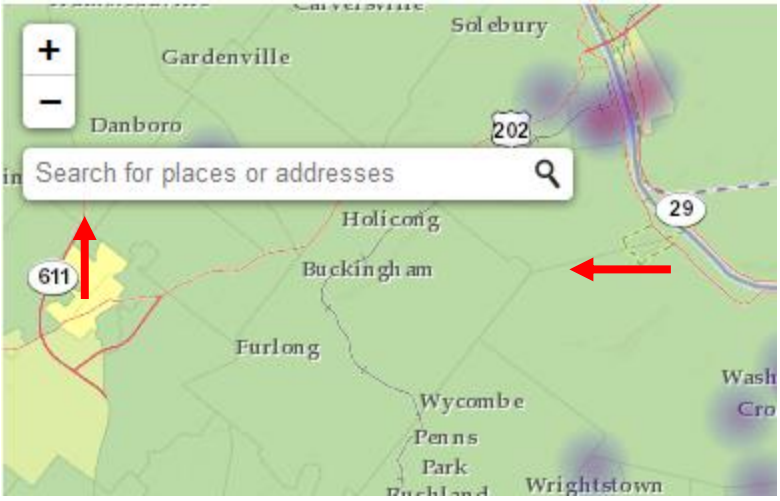
Step 3: Identify the zip codes and census tracts of these patients:

1) Identify the census tracts of patient addresses

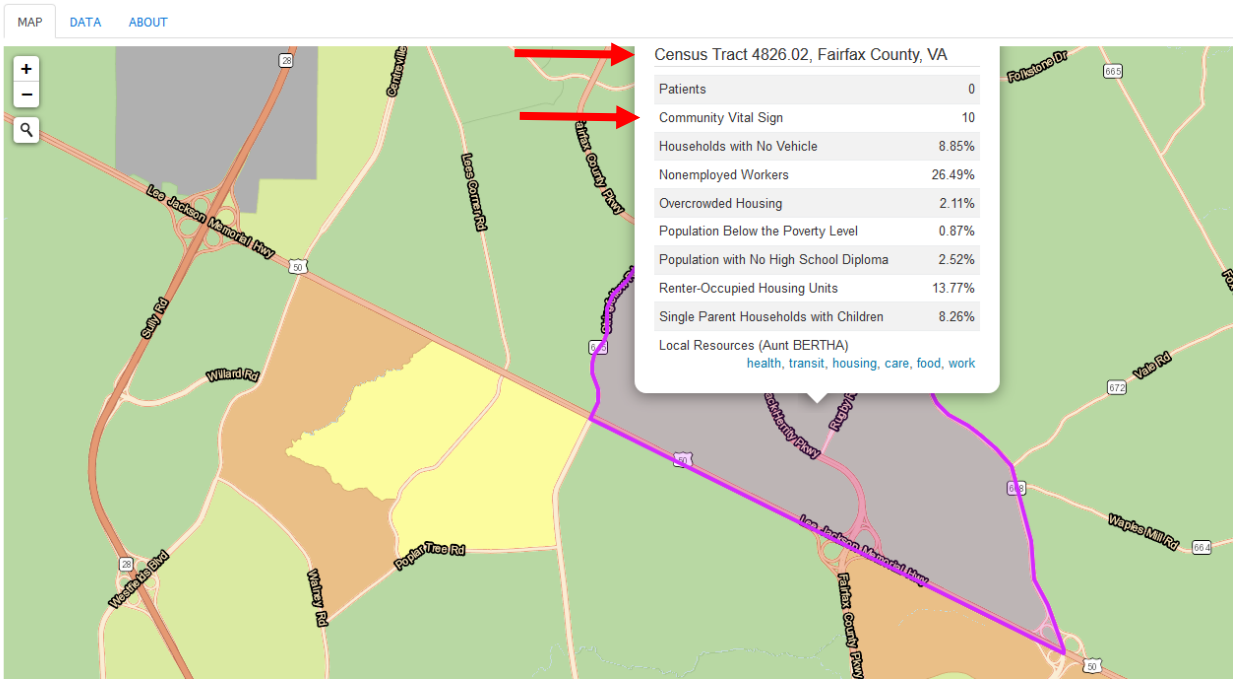
   For this activity, you will need access to the addresses of your patients. First, click on the magnifying glass icon in PHATE



   Enter the address.

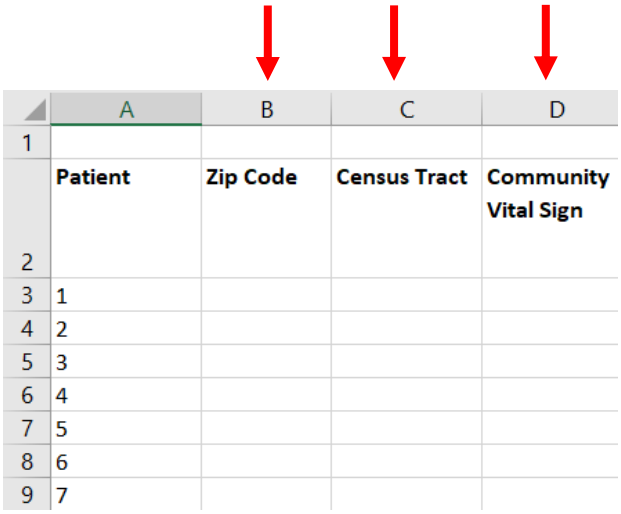


PHATE will zoom into the census tract associated with that address



2) For each census tract, use PHATE and note the census tract community vital sign[3] on your spreadsheet

Enter the zip code, census tract number, and community vital sign value into the spreadsheet.



	A	B	C	D
1				
2	**Patient**	**Zip Code**	**Census Tract**	**Community Vital Sign**
3	1			
4	2			
5	3			
6	4			
7	5			
8	6			
9	7			

Step 4: Have these patients complete PRAPARE (Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences) or PCAM (Patient-Centered Assessment Method):

PRAPARE

1) PRAPARE is an assessment tool for social determinants and was developed by the National Association of Community Health Centers.[4] Contact the patients on your list and obtain responses to PRAPARE. Patients can respond in person during an appointment or over the phone.

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Paper Version of PRAPARE for Implementation As of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?

2) Add patient responses to the spreadsheet. Some patients may respond that they do not want assistance or do not have any needs.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1					Issues Identified									
2	Patient	Zip Code	Census Tract	Community Vital Sign	Housing (Y/N)	Work (Y/N)	Insurance (Y/N)	Utilities (Y/N)	Food (Y/N)	Child Care (Y/N)	Transportation (Y/N)	Social and Mental Health (Y/N)	Personal Safety (Y/N)	Other (Y/N)
3	1													
4	2													

PCAM

1) Complete PCAM[5] for each patient. PCAM can be completed by a provider or the health care team.

Patient Centered Assessment Method (PCAM)

Vs2 February 2015

Research version for scoring

ID _____ Date: __ __/ __ __ __/2 0 __ __

Nurse/Clinician:

Instructions: Use this assessment as a guide, ask questions in your own words during the consultation to help you answer each question. Circle one option in each section to reflect the level of complexity relating to this client. To be completed either during or after the consultation.

Health and Well-being			
1. Thinking about your client's **physical health needs**, are there any symptoms or problems (risk indicators) you are unsure about that require further **investigation**?			
No identified areas of uncertainty or problems already being investigated **1**	Mild vague physical symptoms or problems; but do not impact on daily life or are not of concern to client **2**	Mod to severe symptoms or problems that impact on daily life **3**	Severe symptoms or problems that cause significant impact on daily life **4**
2. Are the client's **physical health problems** impacting on their **mental well-being**?			

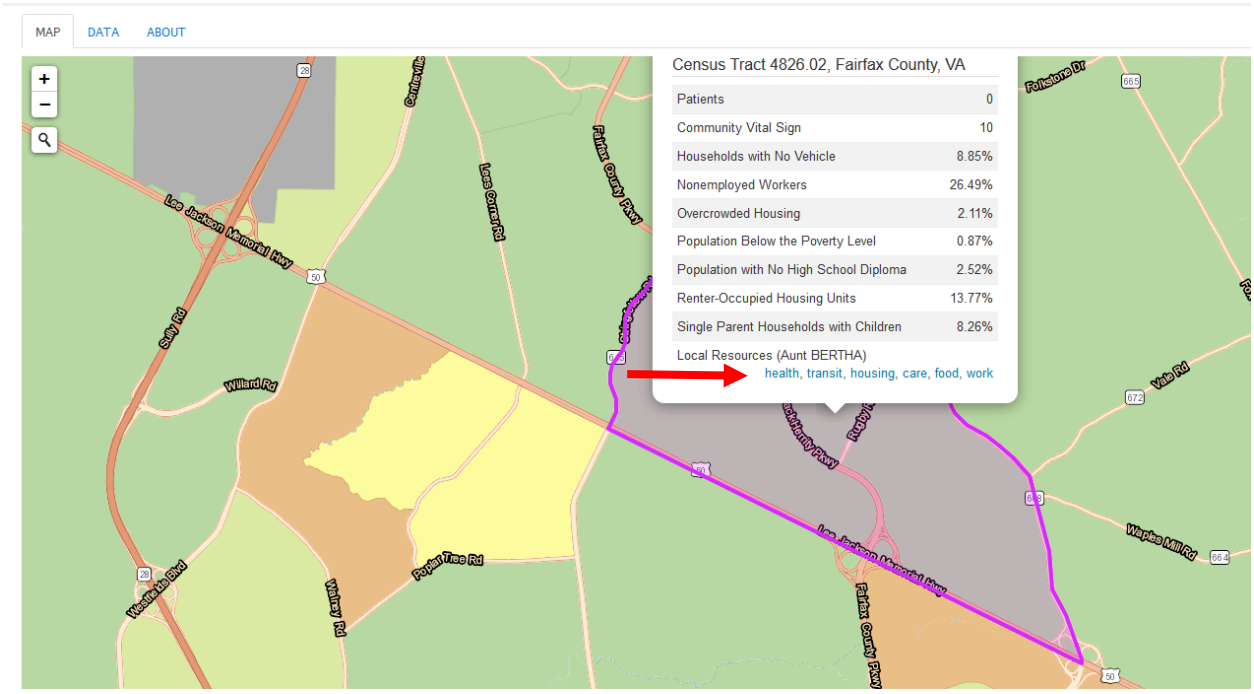
2) Insert your responses into the spreadsheet

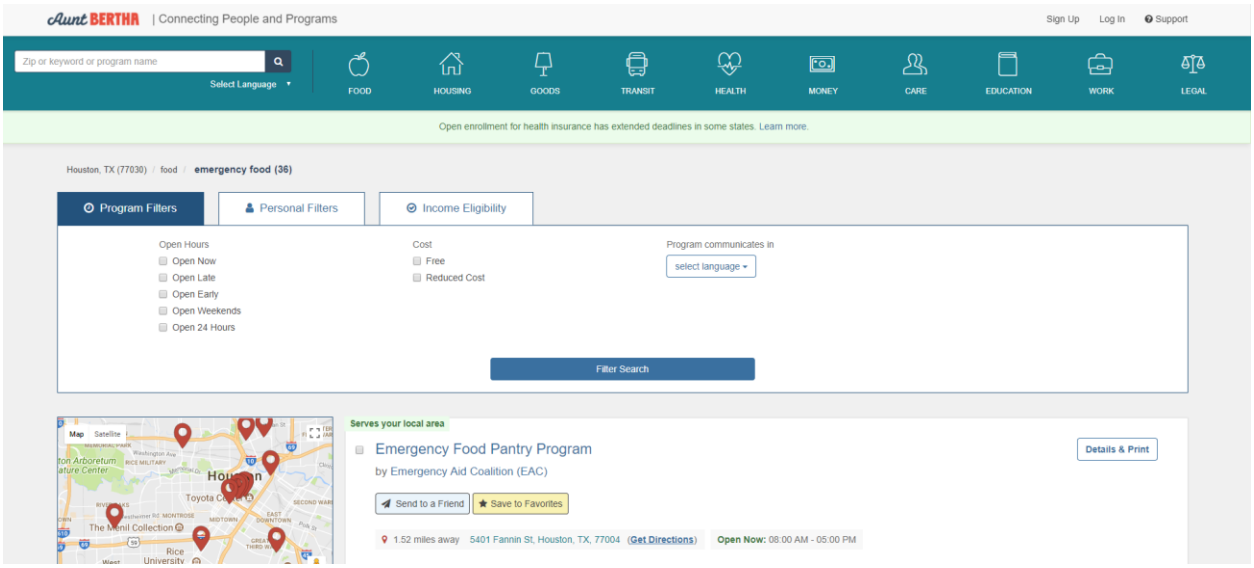
	A	B	C	D	E	F	G	H	I	J	K
1					PCAM responses						
2	Patient	Zip Code	Census Tract	Community Vital Sign	Physical health needs (1-4)	Physical health needs impacting mental wellbeing (1-4)	Lifestyle impacting mental wellbeing (1-4)	Other concerns about mental wellbeing (1-4)	Home environment - safety and stability (1-4)	Daily activities impacting wellbeing (1-4)	Social network (1-4)
3	1										
4	2										
5	3										

Step 4: Develop a response to identified needs

PRAPARE: Identify appropriate community resources:

1) Use Aunt Bertha to identify appropriate community resources. Aunt Bertha is a website that lists community organizations by location and the services provided. When selecting a census tract, you can access links to Aunt Bertha on the pop-up windows.





2) Provide patients with information for the appropriate community resources.

3) Document referrals in the spreadsheet

	O	P	Q	R	S	T	U	V	W	X
1	**Referrals Made**									
2	**Housing (Org Name)**	**Work (Org Name)**	**Insurance (Org Name)**	**Utilities (Org Name)**	**Food (Org Name)**	**Child Care (Org Name)**	**Transportation (Org Name)**	**Social and Mental Health (Org Name)**	**Personal Safety (Org Name)**	**Other (Org Name)**
3										
4										

Date that you first started calling patients: _____

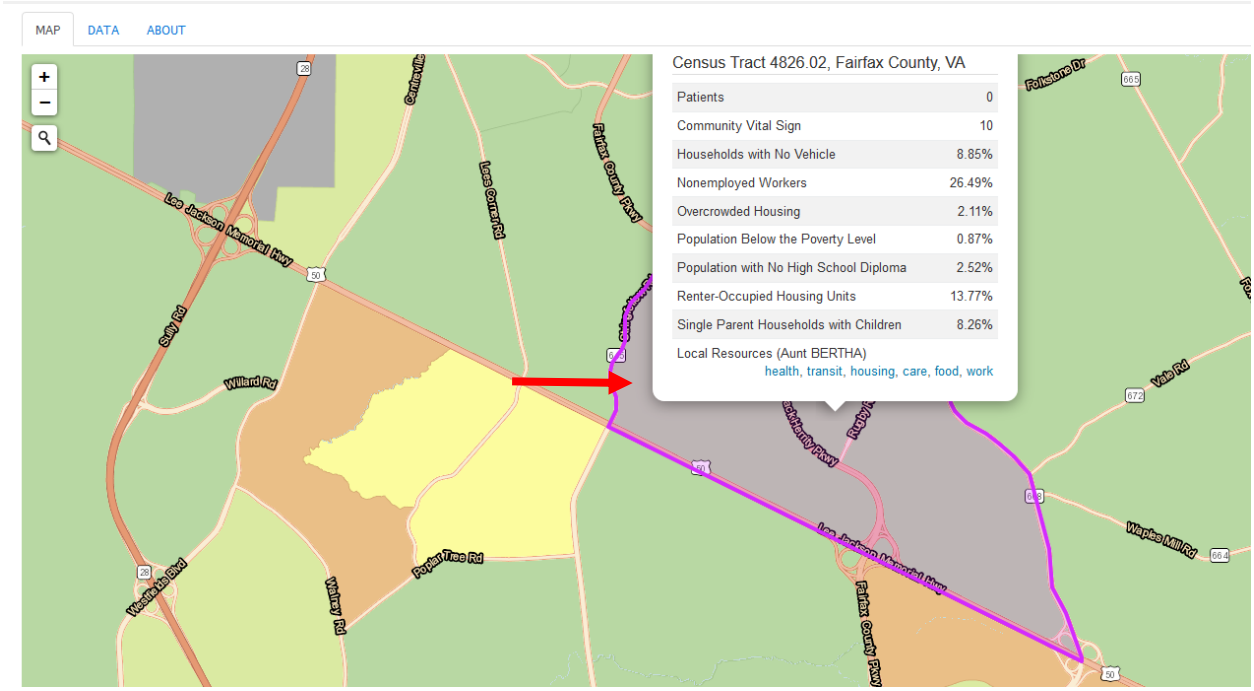
Total number of patients referred: _____

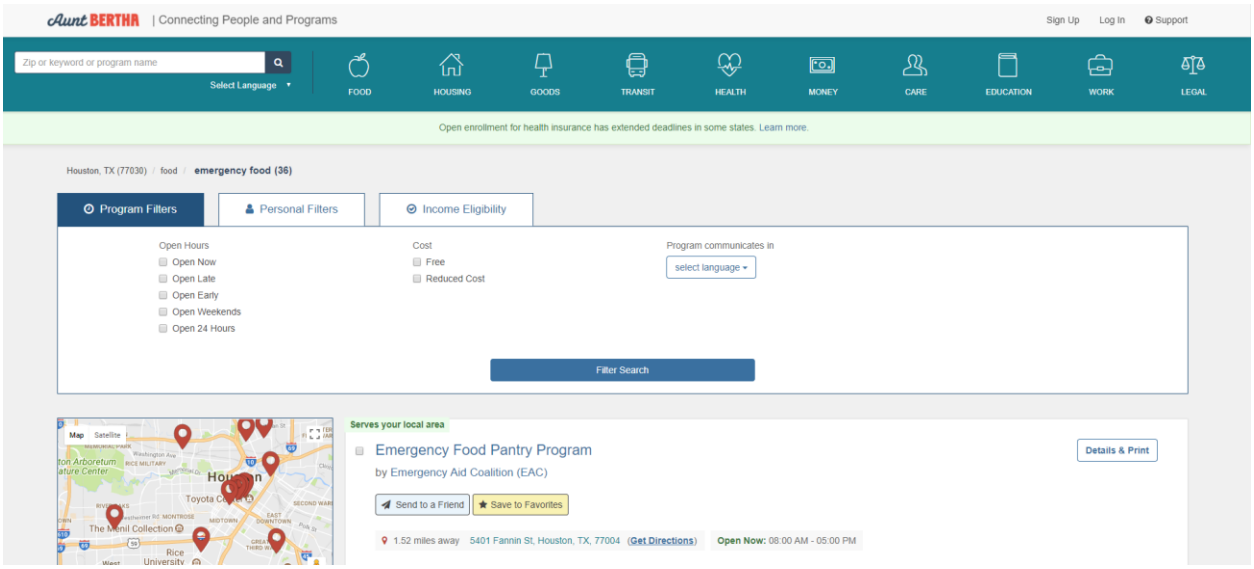
PCAM: Develop action plans for each patient

1) Based on your PCAM results, complete the "Actions Taken" sections for the 10 patients.

	A	B	C	D	O	P	Q	R	S	T
1							**Actions taken**			
2	**Patient**	**Zip Code**	**Census Tract**	**Community Vital Sign**	**Do other services need to be involved to help this client? (1-4)**	**Are current services involved with this client well coordinated? (1-4)**	**What action is required? (Consider screenings, alcohol, smoking, exercise, isolation, caregiver support, mental health counseling, etc.)**	**Who needs to be involved? (Consider the primary care physician, therapist, family members, public assistance, etc.)**	**Barriers to action? (Consider the patient's readiness to change, family circumstances, anxiety, fear, etc.)**	**What action will be taken? (Consider referrals, observation, discussing in future visits, providing local resources)**
3	1						1) 2) 3) 4)	1) 2) 3) 4)	1) 2) 3) 4)	1) 2) 3) 4)

2) You may need to use Aunt Bertha to identify appropriate community resources. Aunt Bertha is a website that lists community organizations by location and the services provided. You can search for specific resources using the patient's zip code or by clicking on the links on the census tract pop-up window.





Write down the date that you first started implementing your plans:

_____

Step 5: After two weeks, follow up with the patients:

PRAPARE

1) Call patients to see if they have made contact with the community organizations
2) Document their responses in the spreadsheet.

	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	**Patient Made Contact with the Organization**									
2	**Housing (Y/N)**	**Work (Y/N)**	**Insurance (Y/N)**	**Utilities (Y/N)**	**Food (Y/N)**	**Child Care (Y/N)**	**Transportation (Y/N)**	**Social and Mental Health (Y/N)**	**Personal Safety (Y/N)**	**Other (Y/N)**
3										
4										

Write down the date that you first started following up with patients:

_____

Number of patients that have made contact with the community organizations.

_____

PCAM

1) Call patients to see if any of the plans have been implemented
2) Document their responses in the spreadsheet.

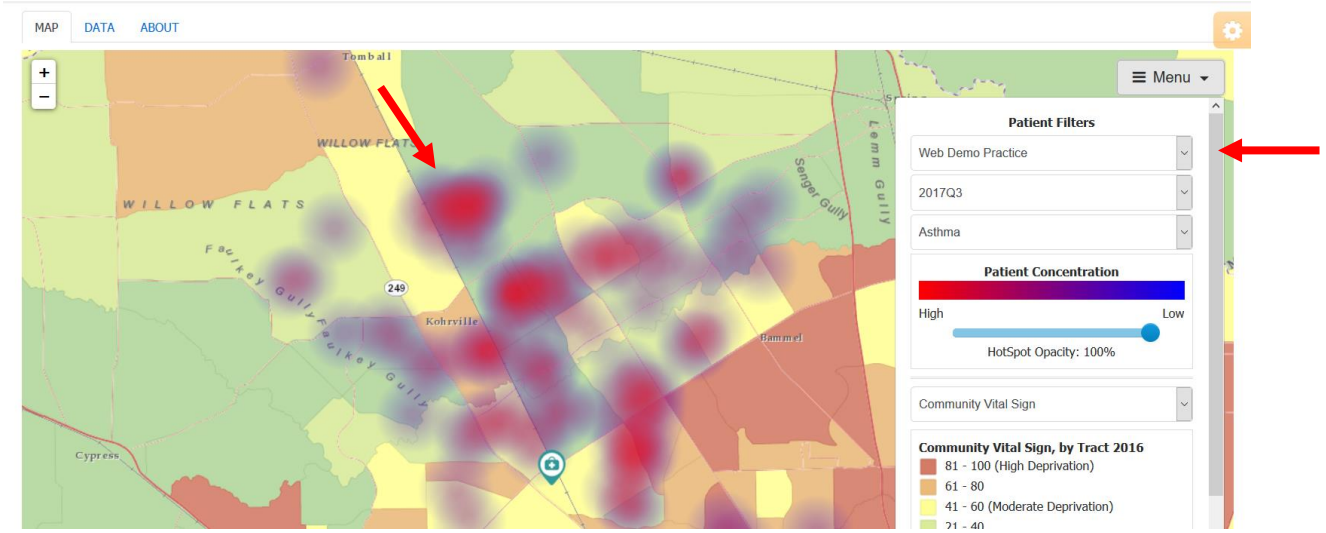
U
Follow up
What happened as a result of your actions?
1) 2) 3) 4)

Write down the date that you first started following up with patients:

_____

Step 6: Compare your patients to the Community HotSpots map:

1) In PHATE, view the Community HotSpots map for this performance measure. Ensure that the practice, quarter, and measure match what you previously selected.



2) Note on your spreadsheet whether the patient is living in a hot spot (the red circles on the map).

	A	B	C	D	E
1					
2	**Patient**	**Zip Code**	**Census Tract**	**Community Vital Sign**	**Is the Census Tract in a Hot Spot? (Y/N)**
3	1				
4	2				

3) Did you refer multiple patients to the same community resource?

   Yes or No

   If yes, which organization?

4) If you answered yes to question (3), describe how you could refer future patients to this community organization (consider screening, how the referral is made, and follow up).

References:

1. Institute of Medicine C on IP. *Primary Care and Public Health: Exploring Integration to Improve Population Health*. Washington (DC): National Academy Press; 2012.

2. US Department of Health & Human Services. *Summary of the HIPAA Privacy Rule*.; 2003. https://www.hhs.gov/sites/default/files/privacysummary.pdf. Accessed January 8, 2018.

3. Butler DC, Petterson S, Phillips RL, Bazemore AW. Measures of Social Deprivation That Predict Health Care Access and Need within a Rational Area of Primary Care Service Delivery. *Health Serv Res*. 2013;48(2pt1):539-559. doi:10.1111/j.1475-6773.2012.01449.x

4. National Association of Community Health Centers. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. NACHC. http://www.nachc.org/research-and-data/prapare/. Published 2017. Accessed October 1, 2017.

5. Department of Family Medicine and Community Health, University of Minnesota, Minneapolis, MN, USA, Pratt R, Hibberd C, et al. The Patient Centered Assessment Method (PCAM): integrating the social dimensions of health into primary care. *J Comorbidity*. 2015;5(1):110-119. doi:10.15256/joc.2015.5.35