Serve the People Community Health Center

PHLN Year 2 Project Aim

Serve the People Community Health Center will increase referrals for food insecurity from 0% baseline to 25% as of February 1, 2020.

Measures for Success

- # of patients identified as food insecure
- # of food insecure patients provided with a referral
- # of food insecure patients who utilized the referral
- # of patients who skipped or refused to answer food insecurity question
- Avg. # of PRAPARE SDH factors per food insecure patient

Changes

Tested Changes

Social Needs Screening

- 30 Diabetic patients
- All providers
- Screen every day for one month
- One Screener

- One time mini test run
- 5 Diabetic patients
- One Provider
- Modify goal based on results

Resource Vetting

- Assess 3 external directories
- Vet 5 internal org's per PRAPARE category
- 1 person dedicated

- Assess 2 external directories
- Vet 2 internal org's per PRAPARE category
- 2 people dedicated

Implemented Changes

Social Needs Screening

- 10 patients with scheduled appt.
- 2 providers
- Screen twice a week for one month
- 2 screeners

Resource Vetting

- Assess 2 external directories
- Vet 2 internal org's per PRAPARE category
- 2 people dedicated

Using Data for Improvement

1

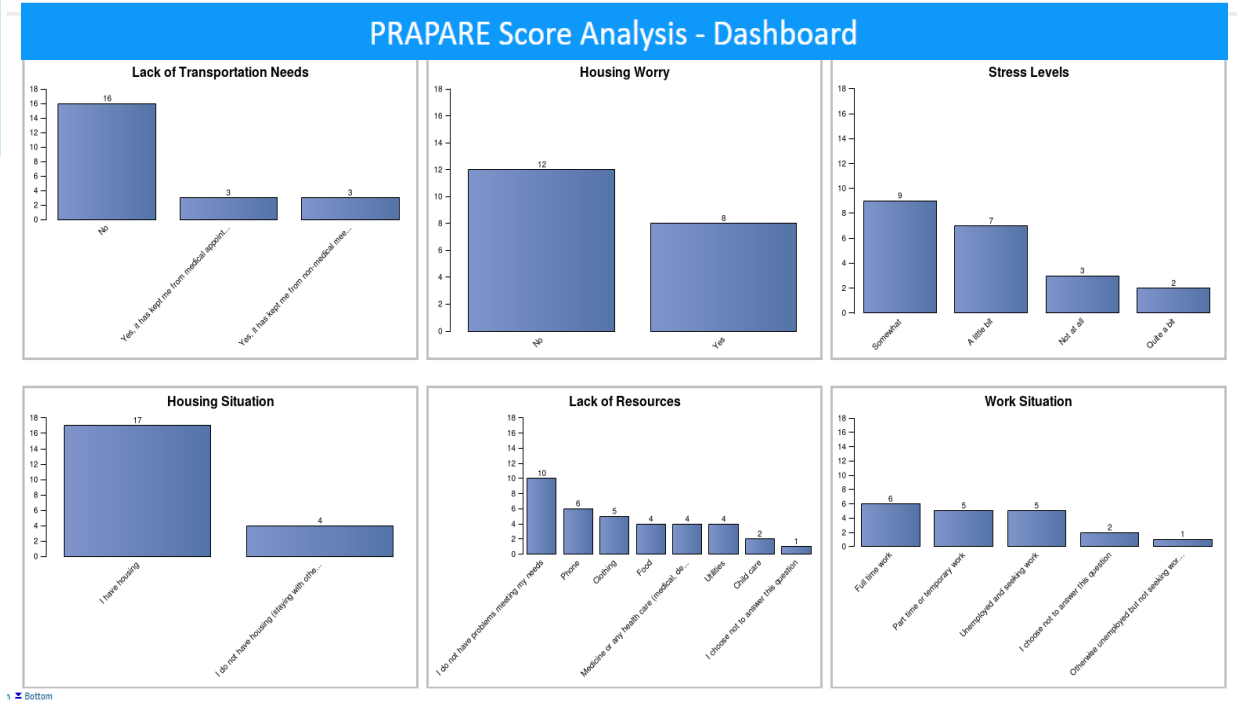
RAW FREQUENCY MEASURES
that can identify the most common social determinants for your patients.

2

PROCESS EVALUATION MEASURES
that can identify missing data and help you assess the feasibility of PRAPARE questions for your patients.

3

POPULATION CHARACTERIZATION MEASURES
that can help you better understand your patients' complexity in terms of how many social determinant risks your patients are facing as well as the most common social determinant risks in your patient populations.



"I am honored to be part of this group, that our voices are heard."

"I've met many people who have diabetes and have problems controlling their health due to these social factors we're discussing. These things must be addressed. For us to be here shaping how you all address these needs is something I am grateful for. "

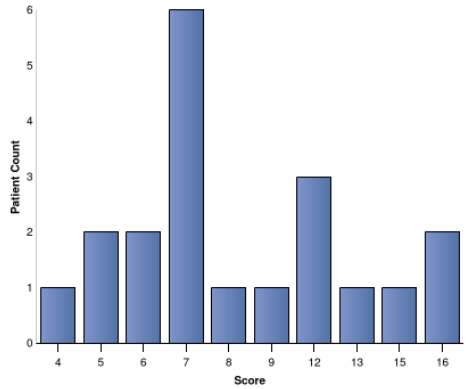
"I think it is through these efforts, like this group, like group visits, that patients can trust the clinic, feel comfortable and motivated to improve their health."

PRAPARE Score Analysis - Dashboard

Date Range: Sep 1, 2019-Nov 26, 2019

Total # Patients PRAPARE Documented: 19
Average PRAPARE Score: 9.05

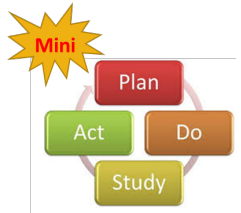
Score	Patient Count	Score Percentage
4	1	5%
5	2	10%
6	2	10%
7	6	30%
8	1	5%
9	1	5%
12	3	15%
13	1	5%
15	1	5%
16	2	10%
Overall - Summary	**19**	**100%**



Strategies for Success

1 State Assessments

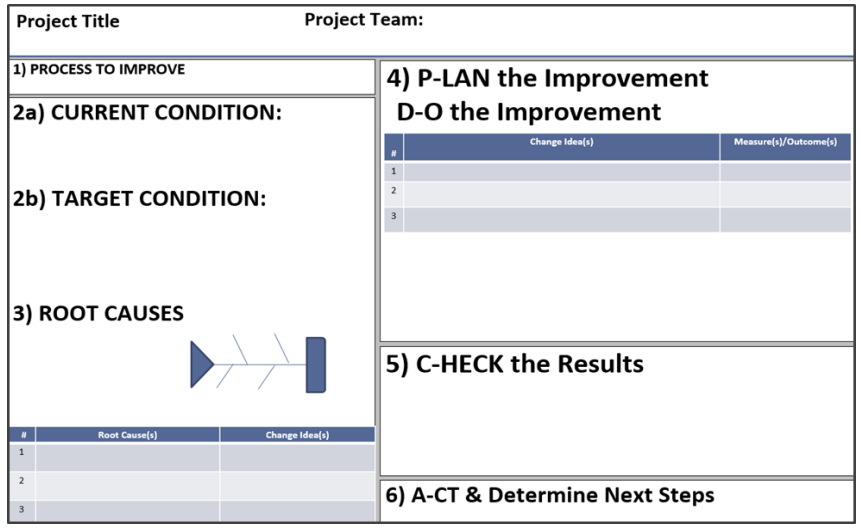
2 Mini PDSA'ing



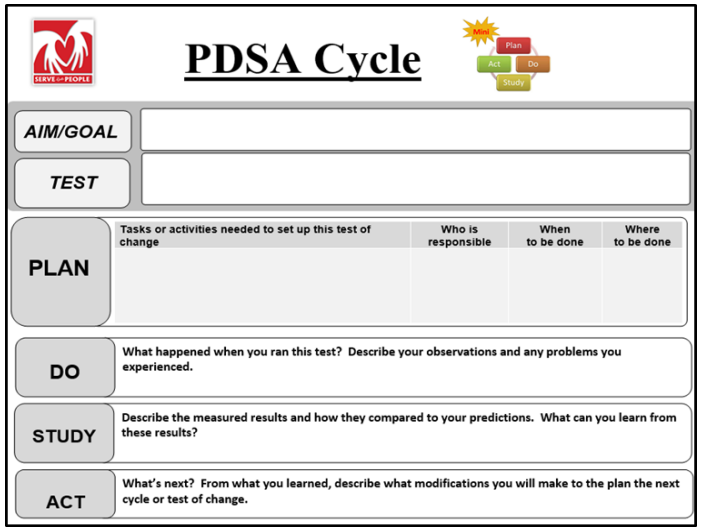
3 Patient Advisory Group

4 Concrete Milestones

Key Tools & Resources



- The A3 assessment is a problem solving and continuous-improvement approach
- This helped elucidate our current condition and root causes
- Provides a visual, easy to process display of progress



- Mini PDSA's
- Provides concrete, manageable systems of change
- Simple & scalable = happy team
- Provides effective insight in response to the unknown

- A comprehensive Patient Handbook allowed for clear expectations, goals and productive discussions.
- Patient involvement was a win-win

Next Steps

Spreading

- Spreading A3 & Mini-PDSA's to Quality Improvement Program
- Patient Advisory Group for clinically relevant projects/initiatives
- Spreading Population Health focus to Hypertension patients down the road

Sustaining

- Hiring a Project coordinator
- Other Funding Sources
- Staff changes

Current Challenges or Barriers

1. Staff Availability