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Finding 10,000 ways that won't work: facilitating adoption of universal social screening in primary care

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SOPHIA MUN
My name is Sophia Mun. I am a research project manager at the Kaiser Permanente Washington Health Research Institute here with my colleague, Ariel to talk about our work with social health screening.

ARIEL SINGER
Hi, everyone. I'm Ariel and I'm a practice facilitator on this project working with our two sites where we've been implementing universal social health screening in primary care at KP, Kaiser Permanente, in Washington. So I wanted to submit my reputation for being the practice facilitator who talks about really random things on the way to practice transformation. So we're gonna start by talking about Thomas Edison today. So what most people don't actually know about Thomas Edison is that he did not in fact invent the light bulb. It was--the light bulb was invented in 1840 by a British scientist named Warren De La Rue who had invented a light bulb, efficient light bulb that had a coiled platinum filament. But the cost of platinum was so high that it couldn't become a commercial success. So then what went on to be, the issue was not inventing the light bulb, but inventing a filament that had enough durability and a low enough cost to be commercially viable. And that is what Thomas Edison accomplished. And it took him, there was other kind of efforts, you know, people tried different things, they were, could not be commercially successful. And he tried many different materials to come up with a filament that could work including cardboard, carbonized, with cardboard, carbonized with compressed lamp wax, different grasses, canes such as hemp and palmetto. And on the way, you know, he's trying all these things, he's failing, he's failing, he's failing. And he gets asked, "how does it feel to, you know, have all these challenges as an inventor?" And he said, "I have not failed 10,000 times. I have successfully found 10,000 ways that don't work." And so, and I feel like that's what we accomplished at KP Washington. Also, we found many, many ways that don't work to get people to do social health screening universally and primary care, especially during this pandemic. So Edison did eventually succeed in finding out that a carbonized bamboo filament could work as a commercially viable light bulb product. So we similarly did not invent social health screening, but we did, as I said, find 10,000 ways that will not work to get primary care practices to do it. OK. Today, I think this is still me, right? OK. So today we are going to be sharing a little bit about the background for this project, the objectives, what we tried how that went for us, what ultimately worked, and our key takeaways about that.

SOPHIA MUN

Great. Sure, I'll start by just introducing our team really quickly and who we represent at Kaiser. So we come to you from the ACT Center within the Kaiser Permanente Washington Health Research Institute. So our research group really works to improve the health for our members and our communities by streamlining the path from research into practice. So we do a lot of work with the KP Washington delivery system on, you know, implementation projects and quality improvement work. So that social health screening was just one piece of our larger portfolio.

ARIEL SINGER
OK. So this is a little snapshot of KP Washington's vision for integrated social health. And for those of you who have not been living under a rock for the past five years ago, you've probably heard about, you know, people talking about social determinants of health and acknowledging the degree to which they impact health outcomes and really the relatively modest contribution of health care itself to health outcomes. So this is how we've been articulating KP Washington's goals to develop a new clinical standard that will both reliably and equitably identify people who need some support and we can personalize care for them. There's also the intention of building a population health strategy so that we can take social health factors to account for risk stratification and outreach for those who might be at greater risk because of social circumstances, as well as being able to build new insights into community level challenges and to think about what KP might be able to do as a community partner and contributor on the community health side of the organization to make meaningful contributions to address those challenges. So our approach, we started with a codesign process. We worked with a panel of patients to get their input on what they thought our social health process should look like. We also met with some primary care clinic staff to talk through the prospective workflow and get their input and ideas for improvement. We went through an iterative process of refining our actual screening document and worked with our patient panel to make improvements to that as well as this iterative process of improving the workflow and our Epic tools in the medical record. And then our pilot, we've tried not to call it a pilot too much because that gives the, the sense that like, oh, we're just gonna see if this is gonna be a thing that works. And so we've been trying to talk about it as we're launching at two clinics not piloting at two clinics. So like kind of, you know, trying to set ourselves up for spread. And so we have been working with these two sites, one in Olympia, Washington over here on the west side of the state and then also in Spokane in the northeastern corner of Washington. So we have a lot of similarities in our approach with these two clinics and then a lot of big differences between the two clinics. So the the clinic over here on the left is the Spokane Clinic, they're called Riverfront. And they are a small to medium sized clinic with 11,000 patients being served in primary care. And one key difference in the workflow is that they have their front desk staff distribute forms to patients when they arrive for check-in. In Olympia, it is a much larger clinic. They essentially have like three primary care practices operating within this one building. They serve 45,000 primary care patients. And in that clinic because of the size and the complexity, they have other, you know, a bunch of other specialties in that building. They do not have their front desk staff, distributing forms, they have medical assistance doing that in clinic. So that was a big difference in the workflow, but general workflow is that

we had an e-check in process that people could fill out this questionnaire if they were going to check in for their visit online before they came in. We've had about 25 to 30% of people doing that throughout the project. And then when they arrive at the clinic, if they're still due for their screening, they're given either, it started as paper and now we have iPads, which we'll talk about a little bit. And then if they've done it on paper, the medical assistant is responsible for transcribing the results into the medical record. The provider is meant to view those screening results and provide social risk informed care. So, trying to shape the patient's care plan according to their social circumstances, The medical assistant is prompted by the EMR to place a referral to the community resource specialist if the patient indicates that they want help with anything. The iPad thing came around last summer and in this time and across both both sites, we had a significant amount of leadership and staff transition in churn. But certainly the leadership churn has been very impactful across both sites. So in terms of our practice facilitation approach, we convened local implementation teams with representatives from the different roles in the primary care clinic. We held an on-site kickoff at both clinics to introduce what we're doing, what we expect it to look like, what we're hoping they'll contribute. And then we had an eight month, I think the, the timeline was a little bit different across the two clinics. It sure seems like it was longer than eight months. I looked at them. I'm like, really? We had this practice facilitation period where we were trying to meet weekly with these teams and then kind of taper off. And so that was the plan for our approach. Okay, so now I'm gonna turn it over back over to Sophia.

SOPHIA MUN
Great. So in the middle of all that, our ACT Center team also decided to launch a rigorous evaluation of our social health programs at KP Washington. So in August 2022, we started a randomized trial where we, because we wanted to learn which types of patients needed that more proactive and intensive support that our clinics, community resource specialists could provide and what patients could get their needs supported by a national call center. And in the interest of time, I won't go into their randomization schema. But I mentioned this because, you know, this is a scientific evaluation. We need a certain sample size to be powered and you know, to be powered to detect statistically significant differences. So this really required both of the clinics to be screening at the high rates that we needed. And for the clinic teams to really adopt both the existing and new evaluation related workflows. All right. So this is the story of two clinics. Data is our bread and butter, of course. So we really tracked the screening data over time to see what types of changes need to be made, what types of process improvement plans need to be put in place. So this is just a large snapshot of what screening looked like week by week between July 2021 through January 2023. The orange line represents Riverfront. The blue line represents Olympia and that gray line at top is just our target screening rate of 80%. So we are trying to get both of the clinics up to 80%. And as Ariel mentioned, I feel like we tried about 10,000 different ways to get the clinics there. So I try to boil down some of our key tactics and organized it by theme. So we'll kind of review that slide by slide. So the first theme kind of centers around on-site presence, this was virtual practice facilitation. So our so our on-site presence is pretty limited. But, you know, we did go on site at the beginning of implementation to do a kickoff meeting, introduce the concept of social health and Riverfront, you know, had a pretty good start, a

little bit of a dip. Olympia just really dipped for a while. So that was challenging. And as a all mentioned at Olympia specifically, it's a really MA driven workflow. We're really relying on the MAs to distribute those forms. At the same time, the MA who was on our LAT had pretty poor attendance. She wasn't, you know, she was getting pulled in a lot of different directions during this really burdensome time for primary care. So we weren't actually sure how much the MAs knew about the social health workflow. So we went on site to really talk with all of the MAs figure out what their plan was for screening and, you know, it had an acute increase in screening rate, but dipped back again. And then we had some more days of on site support specifically at Olympia in the summer months of 2022. And I think, you know, that was kind of helping a little bit. I think it suggested to us that a little bit more regular on-site presence was helpful to kind of cumlatively increase that rate over time. And then of course, the social health evaluation launched in August of 2022. So we were at both sites to introduce that new workflow and not a lot of success there either, as you can see. The second theme is around technology enhancements. So, you know, we tried a few different tactics specifically again on Olympia to get that MyChart version of the questionnaire automatically assigned for patients because before that MAs were manually assigning those. And we just knew that wasn't really happening despite, you know, pretty high e-check in rate at both clinics. So we tried that. A little bit of an increase but not really, not quite the difference we wanted to see. And in February, so the MAs on both LAT teams indicated to us that it'd be really helpful to have some language in their pre-visit summary that indicates that a patient was still due for social health screening. So we were really excited about that. We're like, this is gonna make the difference. We were finally able to get that Epic enhancement in and it didn't make a huge difference unfortunately. So, tried that didn't really work. And then in May 2022 we actually opened up social health screening to the rest of the two Olympia primary care teams. We had only been piloting with one team at the time, but we again needed more screening for the evaluation. So we opened it up and it seems like, you know, the other two teams when we implemented that screening process, it was a very low touch implementation. We didn't provide intensive support. We just kind of gave them the workflows, the training materials did like one meeting and just let them run with it. And we actually kind of did and cumulatively kind of increased the rate over time. So that was nice to see. I'll skip over these. So our next theme was around working with leadership teams. We did a lot of work to try to, you know, meet with, especially Olympia, with the senior leadership to get their buy in and have them present about this work on behalf of our team to their teams. We tried that at a few different time points and as you can see, there's an acute increase, but it dips again. So that wasn't as successful as we had wanted. I think what really helped with Riverfront is that, you know, the screening rates were kind of ranging between the 60 to 70% range. So we decided to meet with the front desk staff at Riverfront along with their manager to talk about the workflow specifically to them, do some Epic trainings. And that really set us on the path to success with Riverfront. So that was really helpful for us. And then finally, performance feedback and incentives. So at KP Washington, we have this thing called virtual high fives. So these are points that you can kind of award to anybody within the system and those points of monetary value. So we decided to take advantage of that and awarded, you know, V fives to teams at various time points and be like, hey, you're doing a great job. Here's

some V five points, we'll send some more when you reach this screening percent or this screening percent. And it worked generally for Riverfront. Olympia, a little bit of a different story. These stars kind of represent all the different time points that we tried to to send those V five points. But what really helped with River--with Olympia, sorry, is that ultimately, we decided to send individualized performance feedback to all the medical assistants. So every month we're like, hey, this was your screening rate for this month. Great job you got 80%. Here's some V fives. Or if they didn't reach 80%, we're like, hey, this is your screen rate. It was about 45%. Next month, if you're able to get 80% we'll send you V fives. So after about five months of that, we were finally able to get Olympia at 80% in January of 2023.

ELIANE UCHISON
So I think the moral story is what ultimately worked

SOPHIA MUN
was that, you know, on-site presence helps. but the increases can't be sustained just from those periodic on-site times. We really need to maximize automation and clinicwide implementation. Very targeted and timely performance feedback makes a huge difference along with individualized performance incentives. At least for our teams.

JENNIFER AIELLO
So our key takeaways. First of all, to just

ARIEL SINGER
fall back on the tried and true methods and sending that individualized timely, this is your data made the most difference. And I, I really think also with that incentive and as part of this evaluation, we have subsequently been doing interviews with a lot of workforce members as well as patients this year. And we heard that from some people in Olympia, like some of the medical assistants being like, yeah, we people wanted to be five. That's why they finally started doing it. It really was that simple. So some of our other key takeaways. This is the same message from yesterday. You have to adapt to the local circumstances. I was actually quite shocked at how different these two clinics were. And then also even within Olympia, these three teams practicing within the same building have been very different from each other in their performance and their uptake and their way of responding to this effort. So, you know, you just have to respond to what's happening right in front of you. Never discount the power of front desk staff. That's a really big one for us. We really, really, really wish that Olympia would have their front desk staff doing this because it's clearly a better approach. Automate as many functions as possible. People are super busy, the more we can take off their plates the better and even something that seems kind of straightforward is very complicated. This iPad implementation, people were excited about it. It was gonna be an opportunity for patient-entered data in the clinic instead of the MAs having to then you know, take the paper forms and enter the data. But we've had a lot of issues with things like wifi connectivity or the iPad timing out before someone's done or people like skipping through pages and not answering the questions or going through the questions, but they're not pressing submit at the end and things like that, that are just

complicated even though it's like, cool iPads, everybody knows how to use that. we're done. And then lastly, even though virtual facilitation is certainly possible, and we ultimately were able to make it work with a mostly virtual approach. We also in conducting all of these workforce interviews heard pretty consistently from staff types that when we asked about like their implementation experience and recommendations for the future is to have on-site presence and have people locally acting as champions, promoting this reinforcing it, et cetera. And what we found that was part of our goal with this local implementation team approach. And what we found is that it was very hard to enlist people to do that with their peers, like the medical assistants that were involved were really not interested in being in that role and it just it didn't work very well. So we really think that having an on-site champion who's committed to that role and not just kind of getting roped into it is probably the better approach. So some of our next steps that we recommend for KP Washington based on our experience, what we observed as well as these workforce interviews that we've conducted is to increase the on-site presence of the community resource specialist, which is the staff role to whom these people are being referred after testing positive. Use some kind of brief initial screener or prescreening to identify the people who want assistance. So as of August 22nd, I just pulled this data off of our dashboard. Last week, we've had nearly 60,000 screenings that were completed at these two clinics and 3,690 people who said they wanted help. So it's like 6% that's a lot of screening to do for a pretty small number of referrals. So there may be an opportunity to make that more efficient. More practice facilitators. You know, don't just ask the local leaders to add this to their job. They definitely do not have the time for that. And that's, that's certainly the perspective that we, that was our observation and then in talking to them, they said, like, you know, don't ask us to just be responsible for this. And then also offer more on site training, implementation support, communication, et cetera. This is again something we heard from the medical assistants. And Sophia and I...this is, you know, a, a layer of our experimentation that we didn't go into is we have tried so many ways to communicate on teams and trying to get, you know, elbow our way into their meetings. We're sending emails, trying to get the information to them and we created scripts and we created job aids and all of these things. And then when we talked to the medical assistants, they're like, it would have been really helpful to have a script.

SPEAKER 1
And so we did succeed in getting the information to

ARIEL SINGER
them and having someone on site who can walk around and talk to people and give them things would be much more effective because I just don't think they have the time and bandwidth to be paying attention to the non clinical kind of, you know, teams, things that they're getting or their emails. So the last thing which we want to say, which we feel might, we, we thought might be familiar to some of you is that just because you do an implementation pilot and you learn a lot about what will and will not work does not mean that the enterprise is going to take that information and act based on your learnings and recommendations. And we are, we think because of budget constraints, it's very likely that

there won't be practice facilitation support for social health spread at KP Washington going forward, at least not in the near term. And so we have learned a lot. We learned 10,000 ways that don't work and we think the enterprise might end up choosing one of those ways that don't really work because of their pressures, which we don't want to minimize, you know, that's a very real thing. But that's kind of how, where this story currently stands is that we, we've learned a ton about what to not do and what to do. And the future is uncertain for this work at KP Washington.

TIFF WEEKLEY
OK. And it looks like you've taken all time for questions right now. I'll have to move into the next folks. I'm sure you two will be available for anyone that wants to find you afterwards.

ARIEL SINGER
So, thank you.