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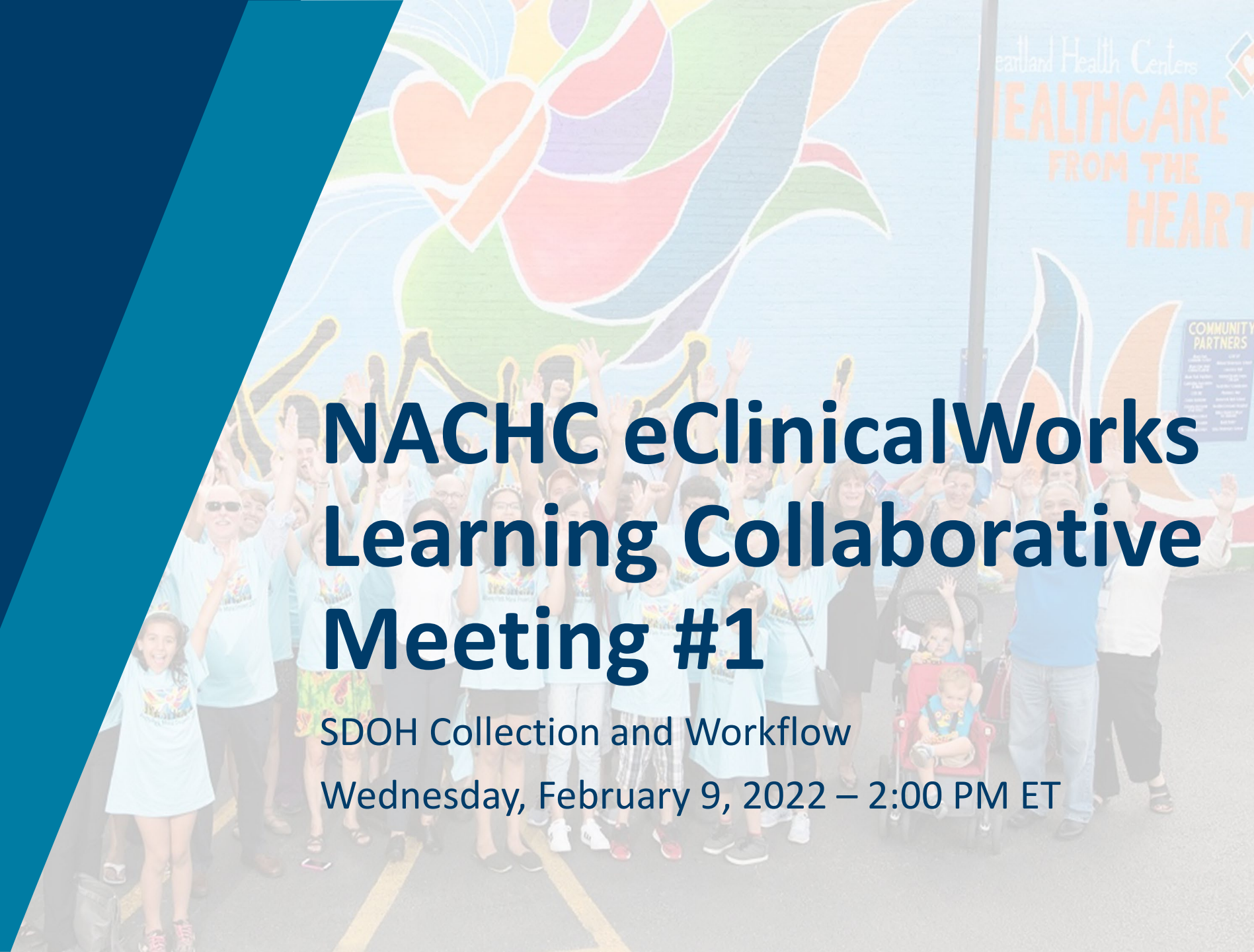

NACHC eClinicalWorks Learning Collaborative Meeting #1

SDOH Collection and Workflow

Wednesday, February 9, 2022 – 2:00 PM ET

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

Agenda

1. Welcome & Introductions
2. Meeting Goals
3. Learning Collaborative Health Centers
4. Project Overview
5. PRAPARE Smart Form Deep Dive & Best Practice Workflows
6. Next Steps

Meeting Goals

- Identify partners and project teams
- Define the project goal and scope
- Establish key dates and milestones
- Define the learning collaborative approach
- Health Center’s provide current SDOH status, challenges, and pilot ideas
- Understand the PRAPARE Smart Form
- Review best practice workflows

- **NACHC eClinicalWorks Social Determinants of Health Learning Collaborative**

MEET THE TEAM

Phillip Stringfield
Health Center Operations Training Specialist
NACHC

Stephanie Rose
Senior Director of Operations
HealthEfficient

Rachel Benatar
Assistant Director of HIT Programs
HealthEfficient

Learning Collaborative Health Centers

- **Albany Area Primary Health Care, Inc.,** GA *(GAPHC)*
- **City of Philadelphia,** PA *(Health Federation of Philadelphia)*
- **Heart of Florida Health Center, Inc.,** FL *(Community Health Centers Alliance, Inc)*
- **Horizon Health Care Inc,** SD *(GPHDN)*
- **Pancare of Florida, Inc.,** FL *(Community Health Centers Alliance, Inc)*
- **Regional Health Care Clinic, Inc.,** MO *(MCPHC)*
- **Rockbridge Area Free Clinic,** VA *(Virginia Community Healthcare Association)*
- **Saint Croix Regional Family Health Center,** ME *(MPCA HCCN)*
- **Southeast Alabama Rural Health Associates**, AL *(Alabama Primary Health Care Association)*
- **Total Health Care, Inc.,** MD *(QUAL IT Care Alliance)*

High Level Project Overview

- Screen and Address Social Determinants of Health
- Document patient's SDOH in eCW using PRAPARE
- Adopting Best practice workflows
- HIT Configuration
- Complete a minimum of 30 screenings

- **NACHC eClinicalWorks Social Determinants of Health Learning Collaborative**

Project Goals

- Assess current SDOH status
- Review existing workflows and identify opportunities to capture SDOH
- Identify and map resources and health center support for each question, as applicable
- Implement (or expand) SDOH screening for a minimum of 30 patients
- Incorporate patient's SDOH needs in their care plan
- Document SDOH referrals if required, and close the loop
- Conduct PDSA cycles at a pilot or practice level

Data Reporting

- **Monthly updates**
  - Improvements
  - Challenges
  - Barriers
  - TA needs
  - Lessons learned

- **PDSA Cycle**
  - Number of patients with PRAPARE (or other SDOH tool) screening completed during the month
  - Break down of needs identified (food, transportation, medication, housing, etc)
  - Number of patients who were referred (internal/external) for an identified SDOH need
  - Number of SDOH referrals closed
  - Number of patients with a SDOH Z Code documented as an assessment or problem

Health Center Slide

Share the status on:

- SDOH collection
- PRAPARE screening tool
- Response to social needs or barriers to care

- Improvements
- Challenges or Barriers
- TA needs
- Lessons learned

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Timeline

Monthly Schedule. Includes Group Learning Collaborative (LC) sessions, individual practice facilitation, health center work and data submission.

	January	February	March	April	May
Group Training		LC#1 Collection and Best Practice Workflows	LC#2 Workflow & Enabling Services Mapping & Peer Sharing	LC#3 Closing the Loop & Peer Sharing	LC#4 Provider Coding & Data Analysis & Peer Sharing
Health Center Support				Office Hours	Office Hours
Health Center Activity	Complete Needs Assessment & Sign MOU	Install PRAPARE Smart Form & identify potential pilots	Complete CDS QI & Resource Mapping Worksheet	PDSA Cycles- workflow and configuration changes	Health Center Staff Training & Start PDSA Cycle – Collect data on ≤ 30 patient
Data		Update Health Center PPT slide	Update Health Center PPT slide	Update Health Center PPT slide	Submit end of month data Present Storyboard

Assembling the Right Team

- Executive Champion
- Provider Champion
- Health Center Project Lead
- Project Team Members
  - Operations
  - QI
  - Enabling Services/Social Services
  - Clinical
  - IT/EHR Specialists
  - Data Analyst

Discussion

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PRAPARE Smart Form Deep Dive

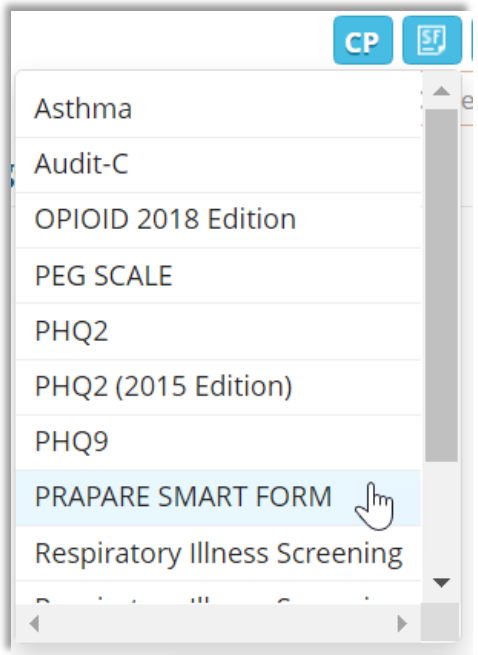
PRAPARE Measures

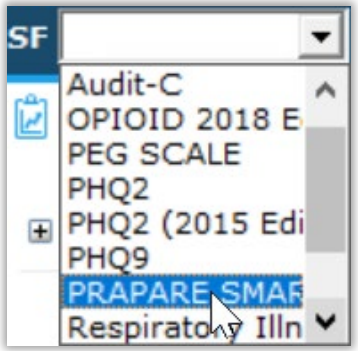
- Race
- Ethnicity
- Veteran Status
- Farmworker
- English proficiency
- Income
- Insurance
- Housing

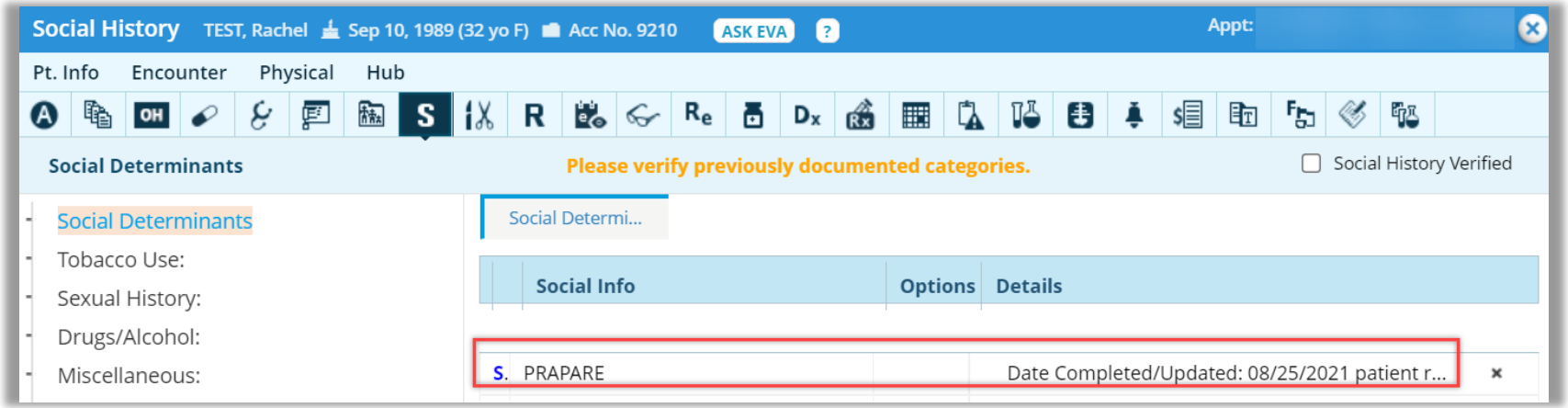
- Education
- Employment
- Material Security
- Transportation
- Social Integration
- Stress

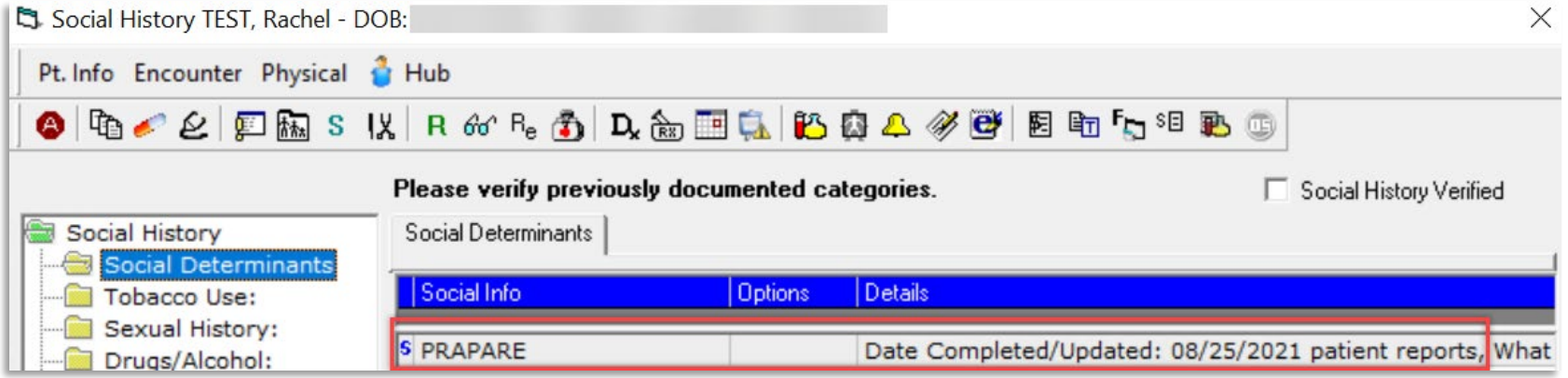
- Incarceration history
- Refugee status
- Safety
- Domestic Violence

eClinicalWorks PRAPARE Smart Form

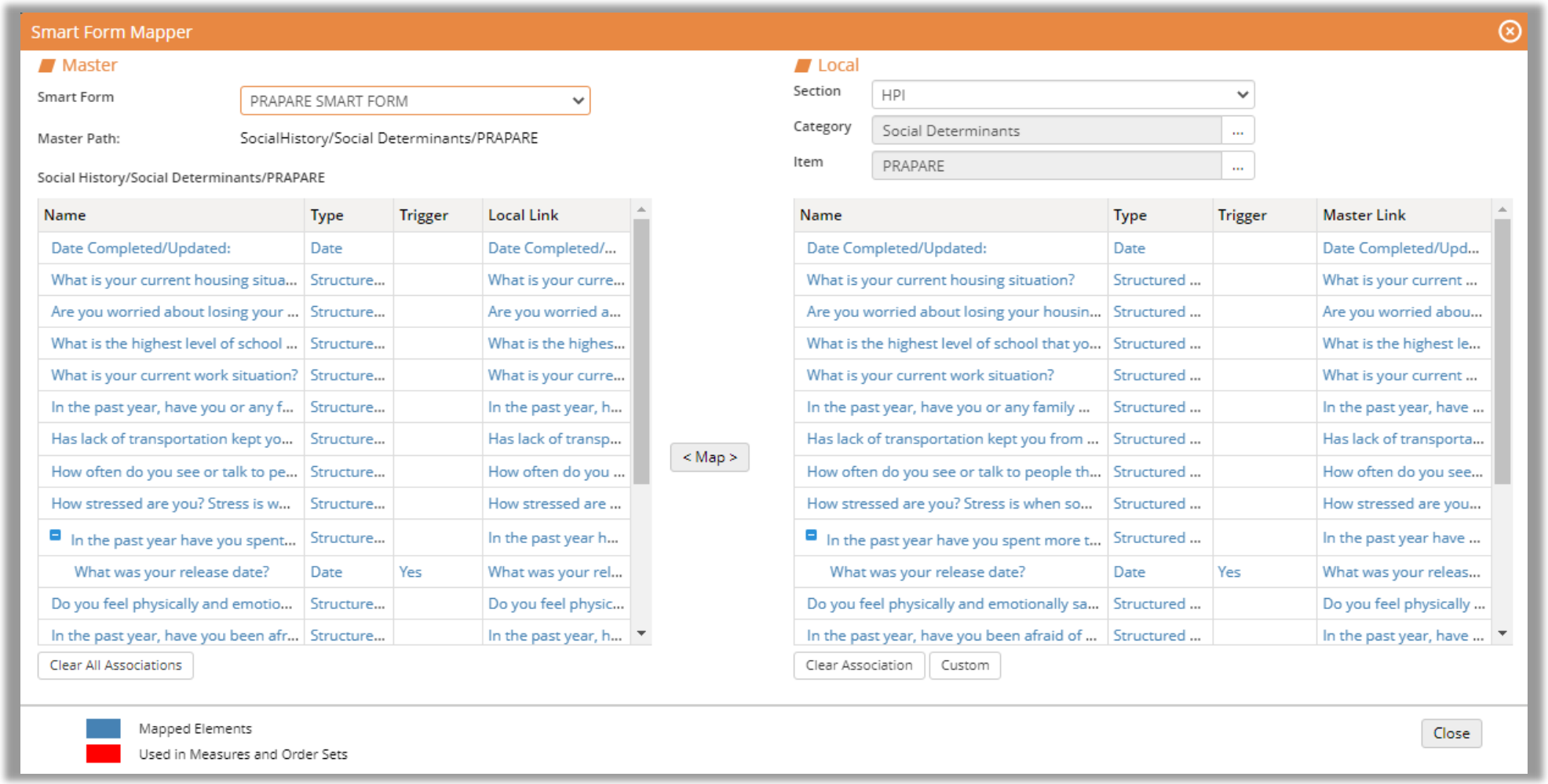




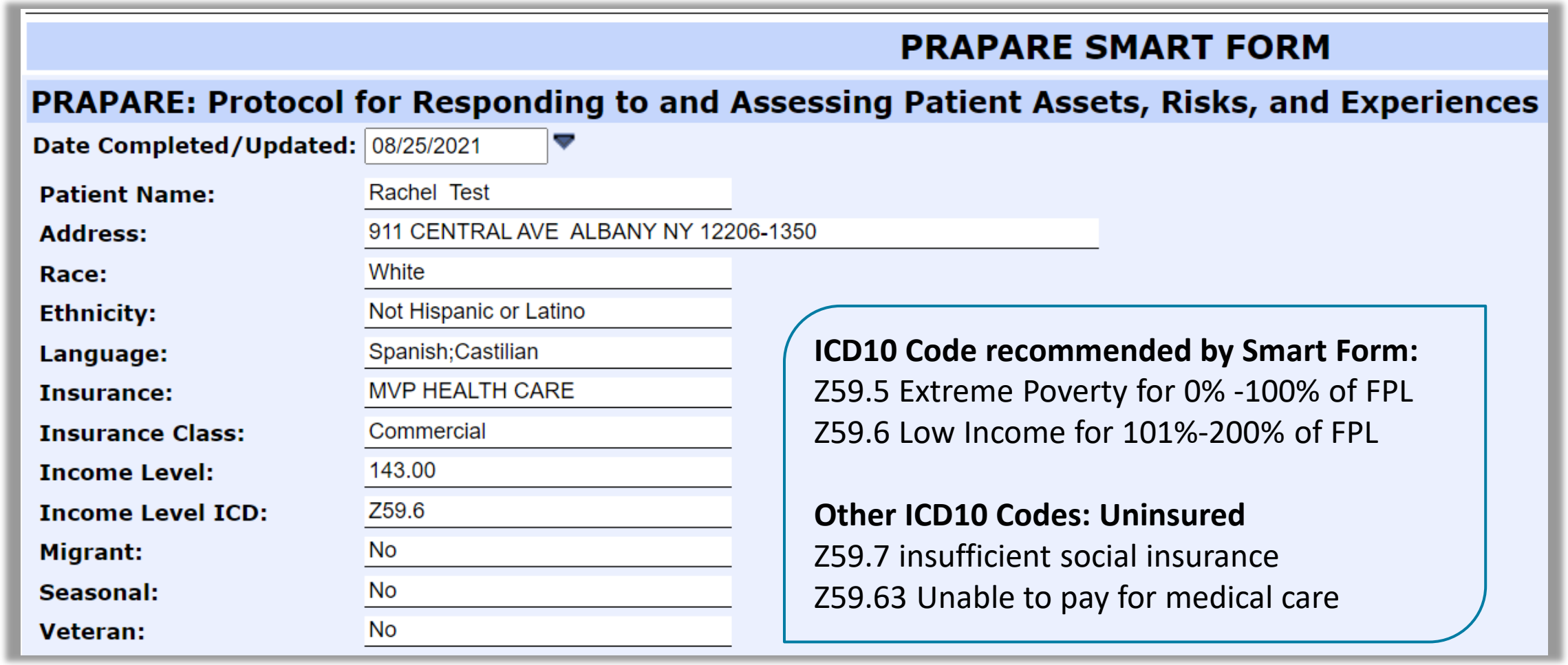




eClinicalWorks Configuration



Demographics/UDS Related Questions



PRAPARE SMART FORM

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Date Completed/Updated:	08/25/2021
Patient Name:	Rachel Test
Address:	911 CENTRAL AVE ALBANY NY 12206-1350
Race:	White
Ethnicity:	Not Hispanic or Latino
Language:	Spanish;Castilian
Insurance:	MVP HEALTH CARE
Insurance Class:	Commercial
Income Level:	143.00
Income Level ICD:	Z59.6
Migrant:	No
Seasonal:	No
Veteran:	No

ICD10 Code recommended by Smart Form:
Z59.5 Extreme Poverty for 0% -100% of FPL
Z59.6 Low Income for 101%-200% of FPL

Other ICD10 Codes: Uninsured
Z59.7 insufficient social insurance
Z59.63 Unable to pay for medical care

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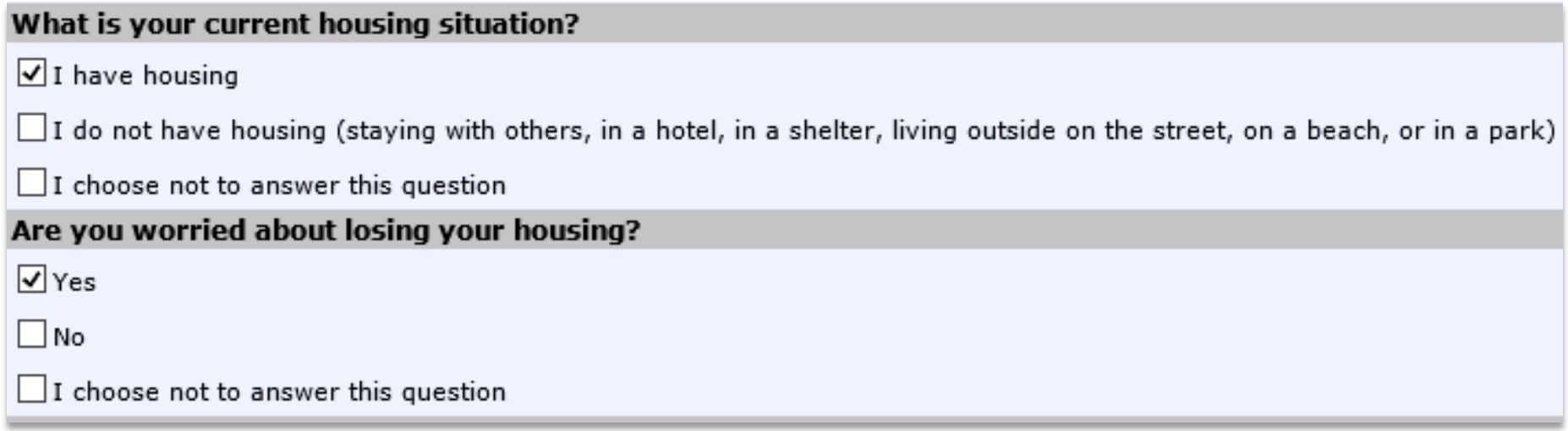
Money & Resources

Housing Situation

Related ICD10 Codes:
Z59.0 Homelessness
Z59.81 Housing Instability



What is your current housing situation?

- [x] 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, or in a park)
- [ ] I choose not to answer this question

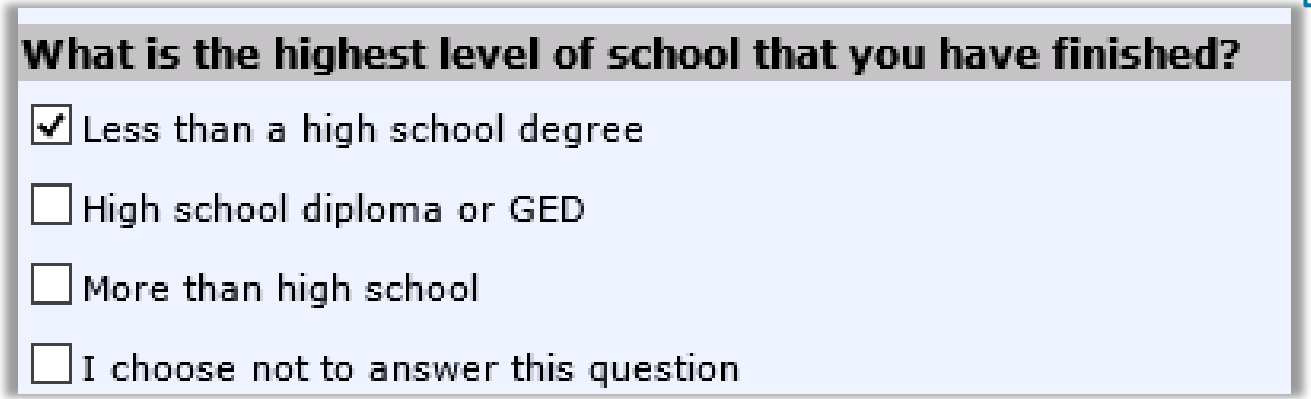
Are you worried about losing your housing?

- [x] Yes
- [ ] No
- [ ] I choose not to answer this question

- **Care Impact**
  - Housing insecurity is associated with poor health and nutrition, and lower ability to manage chronic conditions
  - Homelessness is associated with more frequent ER use and hospitalizations
  - Influences mental and behavioral health
  - Identifies need for resources to prevent eviction/foreclosure
  - Sub-standard housing has a potential impact on lead poisoning, asthma triggers, and others
- **Enabling Service Example:**
  - Referral to housing services

Education

Related ICD10 Code:
Z55.5 Less than a high school diploma
Z55.0 Illiteracy and low-level literacy
Z55.9 Problems related to education and literacy

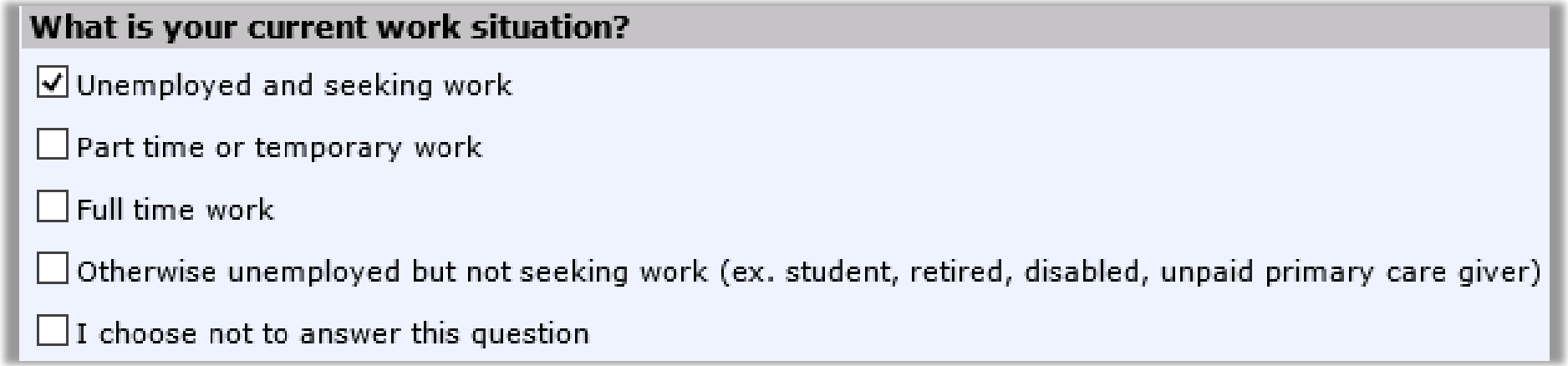


- **Care Impact**
  - Tailor teaching methods and hand outs
  - Parental education level can impact child health outcomes
  - Potential to need higher level of care management
  - May need special forms of outreach such as telephone instead of letter or portal message

- **Enabling Service Examples:**
  - Referral to education services and care management
  - Adult education programs
  - Job skill programs

Employment

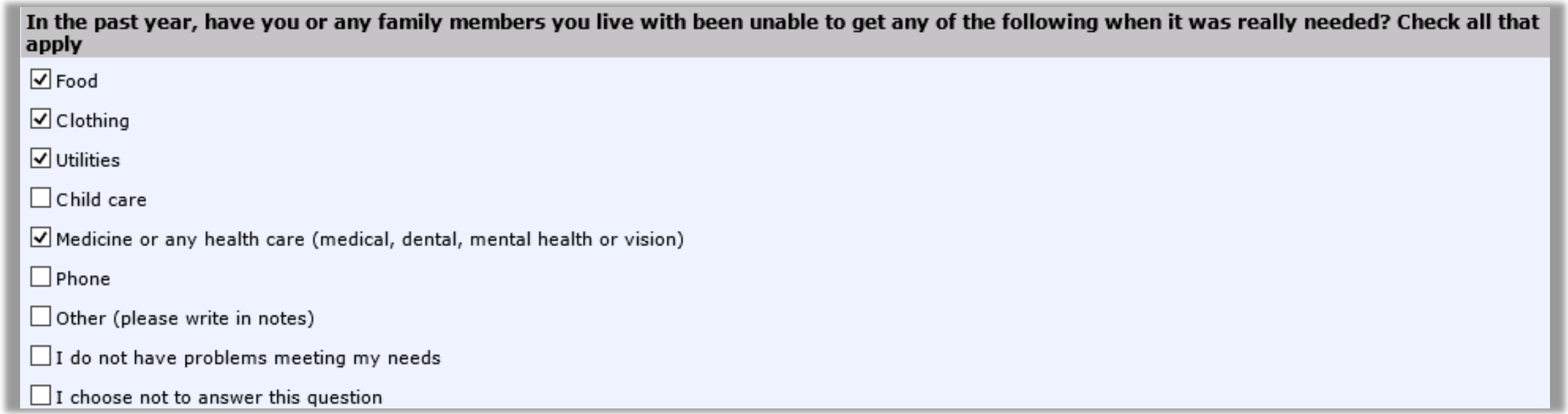
Related ICD10 Code: Unemployed and seeking work
Z56.0 Unemployment, unspecified
Z56.9 Unspecified problems related to employment
Z56.89 other problems related to employment



- **Care Impact**
  - Unemployment – unhealth behaviors, high morbidity, higher ER use
  - Potential exposure to toxins at work
  - Stressor that can compromise mental and behavioral health
  - Potential impact ability to follow through with appointments/no-show
- **Enabling Service Examples:**
  - Referral to mental or behavioral health
  - Job skills, employment and workforce development
  - Youth development programs
  - Facilitated Medicaid enrollment

Material Security

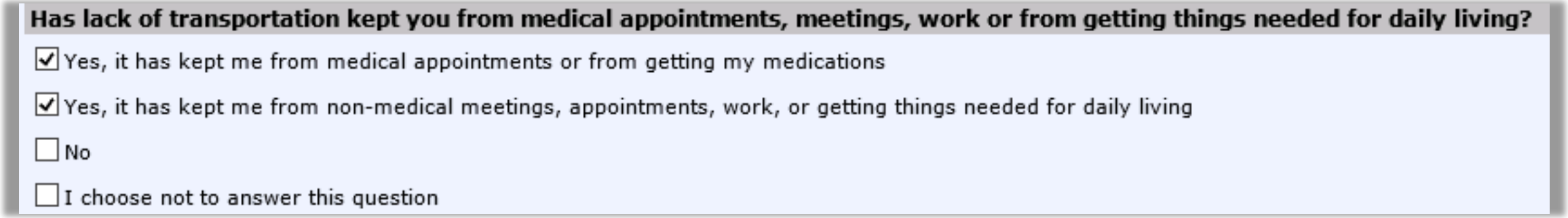
Related ICD10 Codes:
Z59.41 Food Insecurity
Z59.1 Inadequate housing for utilities
Z63.6 Dependent relative needing care at home



- **Care Impact**
  - Patient may have to choose between a basic need and medication
  - Poor/non-compliant diet
  - Potential impact ability to follow through with appointments/no-show
- **Enabling Service Examples:**
  - Referral to local food banks, WIC, Access to healthy foods
  - Community or health center resources

Transportation

Related ICD10 Codes:
Z75.3 Unavailability and inaccessibility of health-care facilities
Z75.4 Unavailability and inaccessibility of other helping agencies



- **Care Impact**
  - Potential impact ability to follow through with appointments/no-show
  - Impacts ability to get to and from work, and access healthy food options

- **Enabling Service Examples:**
  - Referral to transportation resources and bus vouchers
  - Medicaid transportation

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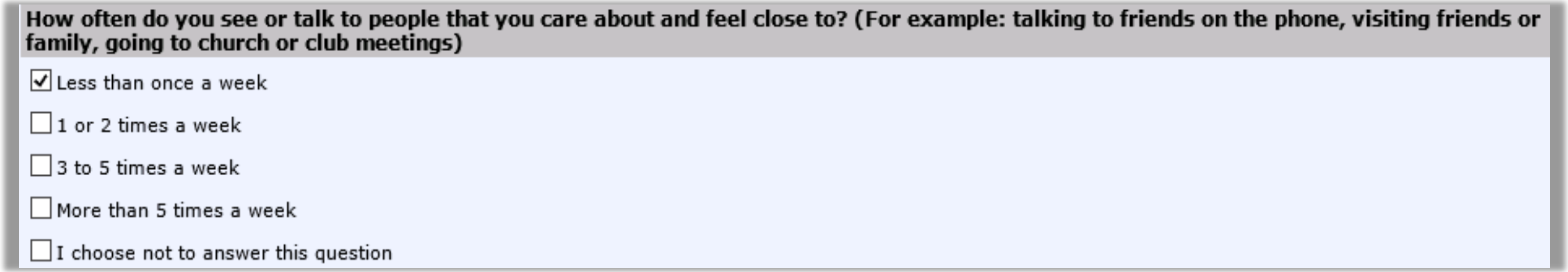
Social & Emotional Health

Social Integration

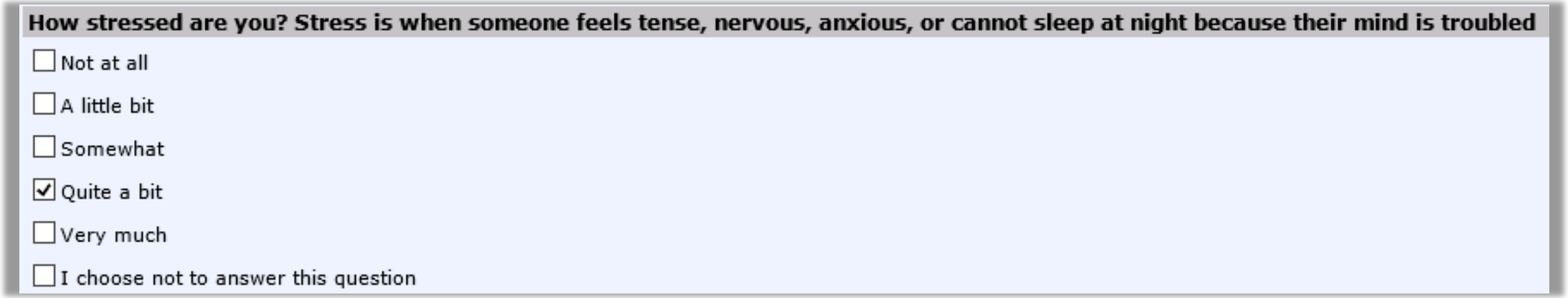
Related ICD10 Code:
Z63.9 Problem related to primary support group
Z60.8 Other problems related to social environment



- **Care Impact**
  - Influences mental and behavioral health
  - May need care management
  - Lack of support network and negative impact on health
- **Enabling Service Examples:**
  - Enrollment in health center or community programs/services
  - Family and social support
  - Religious or other types of organizations

Stress

Related ICD10 Code: "Very much"
Z73.3 Stress, not elsewhere classified
F43.9 Reaction to severe stress, unspecified



- **Care Impact**
  - Influences mental and behavioral health
  - May need care management
- **Enabling Service Examples:**
  - Enrollment in health center or community programs
  - Referral to mental or behavioral health
  - Physical activity and exercise

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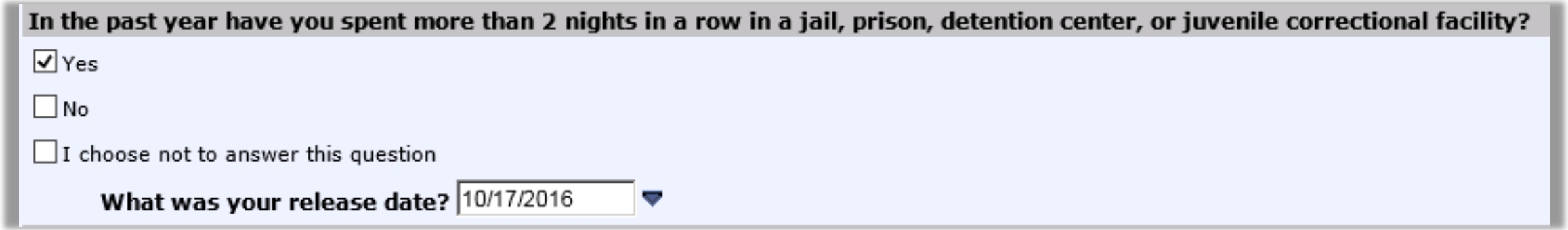
Additional Questions

Incarceration

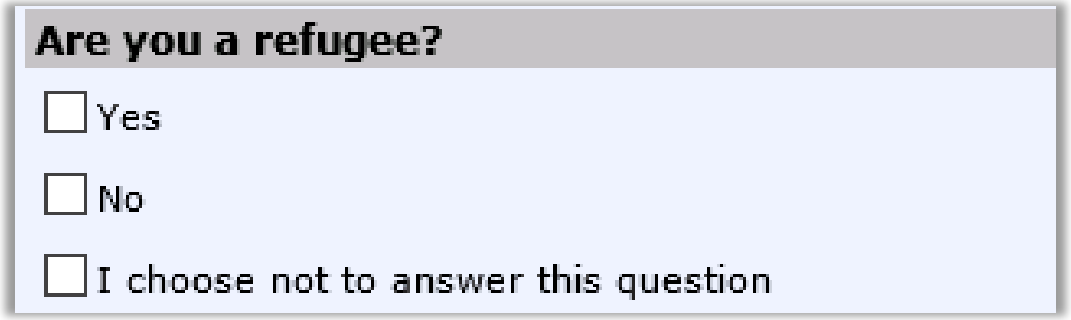
Related ICD10 Code:
Z65.2 Problems related to release from prison – "Yes"



- **Care Impact**
  - Influences mental and behavioral health
  - May need care management
  - Exposure to infectious diseases
- **Enabling Service Examples:**
  - Enrollment in health center or community programs
  - Referral to mental or behavioral health
  - Family and social support, community organizations
  - Job skills, employment and workforce development

Refugee Status

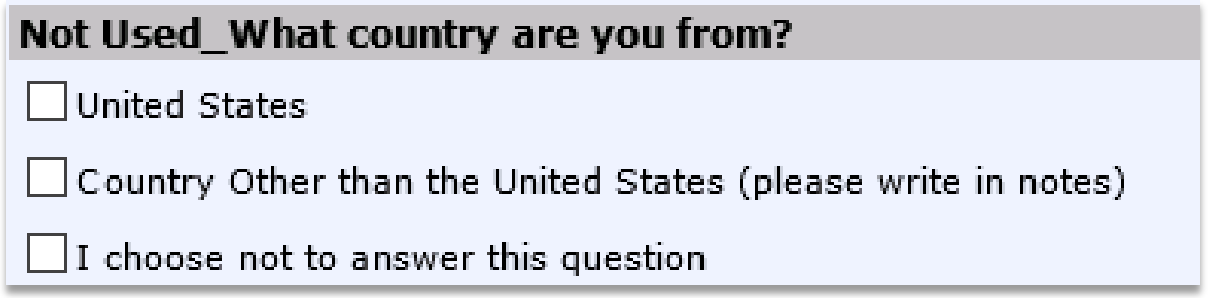
Related ICD10 Code:
Z65.3 Problems related to other legal circumstances
Z65.4 Victim of crime and terrorism
Z65.5 Exposure to disaster, war and other hostilities



- **Care Impact**
  - Higher risk of experiencing a range of illnesses and more urgent need for health care
  - Complex health needs
  - Behavioral and mental health impact
- **Enabling Service Examples:**
  - Interpreter services
  - Housing, transportation, food and other services
  - Refugee community organizations
  - May be eligible for certain services provided for refugees that other immigrants do not receive

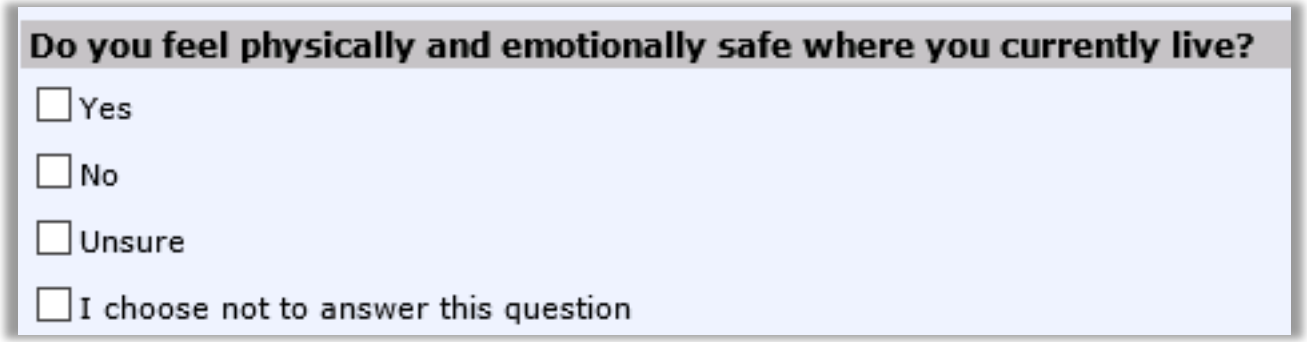
Country of Origin

Removed from NACHC PRAPARE Form



Safety

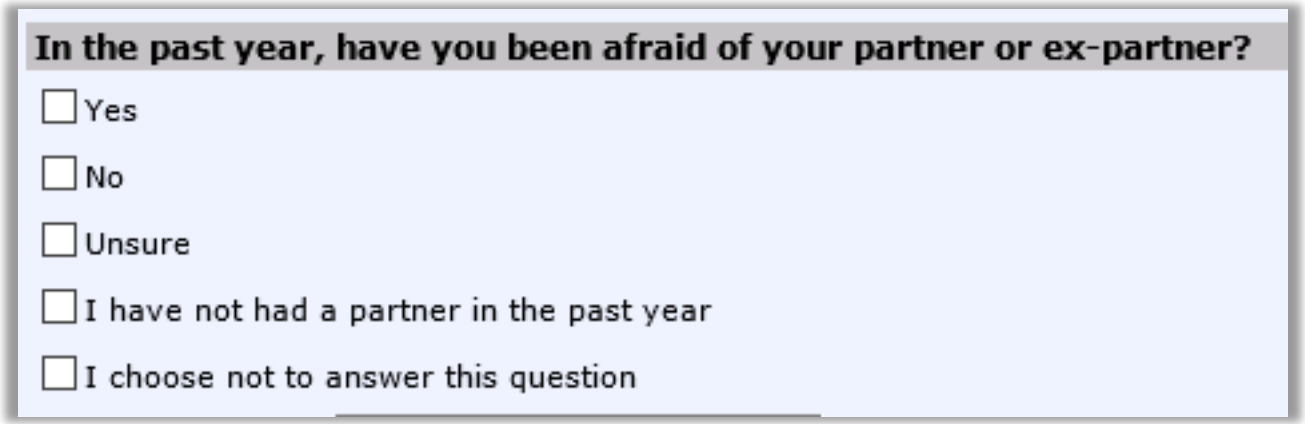
Related ICD10 Codes: "No"
Z63.0 Problems in relationship with spouse or partner
Z91.41 Personal history of adult abuse



- **Care Impact**
  - More likely to have poor health outcomes
- **Enabling Service Examples:**
  - Law enforcement
  - Family and social support
  - Youth Development programs
  - Community programs

Domestic Violence

Related ICD10 Codes: "Yes"
Z63.9 Problems related to primary support group
Z63.0 Problems in relationship with spouse or partner



- **Care Impact**
  - More likely to have poor health outcomes
  - Influences mental and behavioral health
- **Enabling Service Examples:**
  - Referral to support groups
  - Law enforcement
  - Legal-aid

PRAPARE Tally Score

Element	Tally Point
Race	Not White/Caucasian
Ethnicity	Hispanic
Primary Language	Not English
Insurance	Not Commercial
Income Level	0-199% Poverty
Migrant	Yes
Seasonal	Yes
Veteran	Yes
Housing	I do not have housing
Worried about losing housing	Yes
Education	< High School High School

Element	Tally Point
Employment	Unemployed seeking work Part Time or unemployed
Material Security	1 point for each need
Social Integration	Less than 1x week 1-2x week
Stress	Quite a bit or Very Much Somewhat
Incarceration	Yes
Transportation	Yes, Appointments Yes, Non-Appointments
Refugee	Yes
Safety	No (Not safe)
Domestic Violence	Yes

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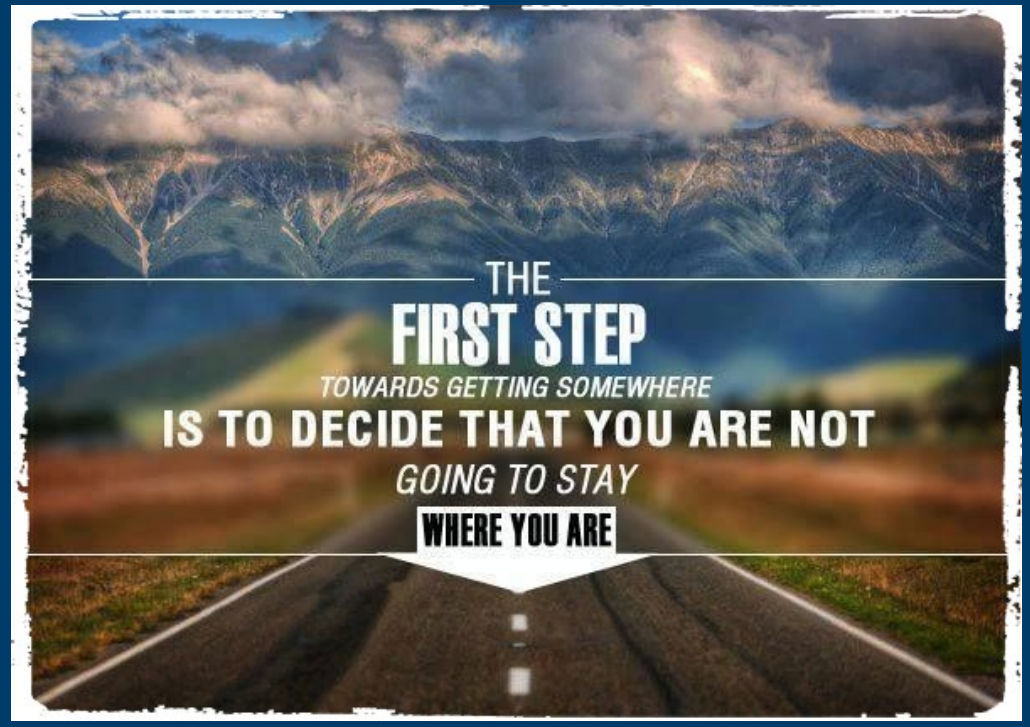
Q&A

Next Steps

- Install PRAPARE Smart Form or add Structured data
- Identify potential pilots and pilot populations
- Begin looking at existing workflow of pilot location/site
- Start gathering enabling services provided by health center (internal/external)
- Share practice SDOH status, challenges & pilot ideas at next meeting March 9th (update health center PPT slide)



For More Information Contact:

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HealthEfficient
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Appendix

Enabling Services Provided by the Health Center

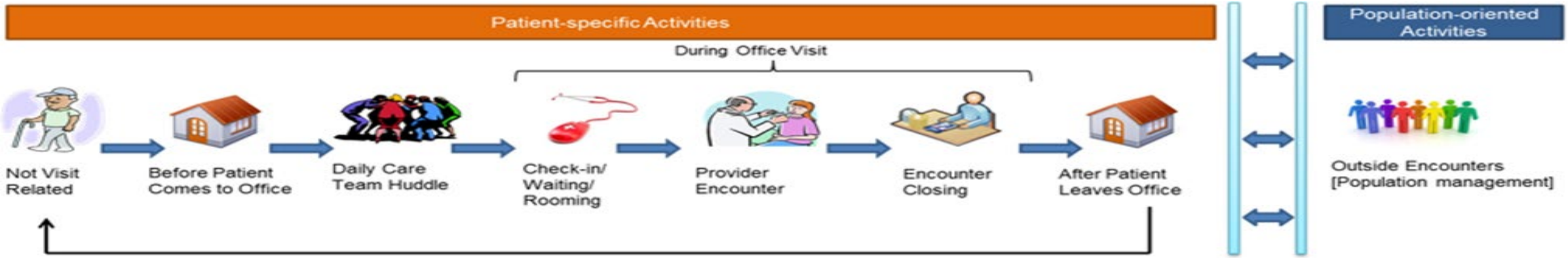
- Local Food bank
- Medicaid Transportation
- Hispanic Coalition
- Medicaid Eligibility Assistance
- Youth development programs
- Family and social support
- Access to healthy foods
- Job skills, employment, and workforce development
- Community safety, wellbeing, and involvement
- Health education
- Physical Activity and Exercise
- Nutrition education
- Healthy, safe, and affordable housing
- Recreational spaces and improved air and water quality in the community
- Adult education
- Law Enforcement
- On-site civil legal aid

***Update this slide with health center specific information

CDS/QI Worksheet

What Are We Trying To Improve? How Are We Doing Today?

Target	
Current Performance on Target	



"Activities that are foundational to current patient-specific and population management activities and/or planned enhancements - e.g., staff training, policies and procedures, EHR tool development, etc."

Outpatient Worksheet (Simplified)

	Not Visit Related	Before Patient Comes to Office	Daily Care Team Huddle	Check-in/ Waiting/ Rooming	Provider Encounter	Encounter Closing	After Patient Leaves Office	Outside Encounters [Population management]	Foundational Work
Current Information flow									
Potential Enhancements									

Resource Mapping Worksheet

Focus Area	Questions	Potential Responses	No action	Non-urgent	Urgent	Workflow	Resources to address	Order Set Internal/External Enabling Services
		Phone		X		Order Non-Urgent Referral to	If eligible assist patient with applying for free phone based on income or government benefits received.	(Z59.65) Lifeline Phone Application (Assurance Wireless)
		I do not have any problems meeting my needs	X			No Action	N/A	N/A
		I choose not to answer this question	X			No Action	N/A	N/A
Transportation	**Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?**							Bus Voucher/transportation program
		Yes it has kept me from medical appointments		X		Order Non-Urgent Referral to Care Management	Consult with patient to determine eligibility for local transportation services.	(Z59.64) County Medical Assistance Transportation County Department of Aging Transportation Call N'Ride Partners in Care Uber Program AA County Taxi Voucher Program
		Yes it has kept me from non-medical appointments		X		Order Non-Urgent Referral to Care Management	Provide information about local transportation services that are not restricted to medical appointments	Call N'Ride Partners in Care County Department of Aging and Transportation AA County Taxi Voucher Program
		No	X			No Action	N/A	N/A
		I choose not to answer this questions	X			No Action	N/A	N/A
Social and Emotional Health	**How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)**							Z60 - problems related to social environment Z62 - problems related to upbringing Community center programs
								Z63.9 Problem related to primary support