

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



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Welcome & Introductions





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PRAPARE Smart Form Deep Dive & Best Practice Workflows

Project Overview



Learning Collaborative Health Centers







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) **AREA** Regional Health Care Clinic, Inc., MO (MCPHC)

- **City of Philadelphia,** PA (Health Federation of Philadelphia)
- *** Heart of Florida Health Center, Inc.,** FL (Community *** Saint Croix Regional Family Health Center,** ME Health Centers Alliance, Inc)
- Horizon Health Care Inc, SD (GPHDN)
- ***** Pancare of Florida, Inc., FL (Community Health *Centers Alliance, Inc)*

- **Rockbridge Area Free Clinic,** VA (Virginia) *Community Healthcare Association*)
- (MPCA HCCN)

Southeast Alabama Rural Health Associates, AL (Alabama Primary Health Care Association)

Total Health Care, Inc., MD (QUAL IT Care Alliance)



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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

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



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













PRAPARE Smart Form Deep Dive

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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

СР 🖭					
Asthma					
Audit-C	Social History TEST, Rachel 🛓 Sep 10, 19	89 (32 yo F) 💼 Acc No. 9210 🛛 ASK EVA	?	Appt:	\otimes
OPIOID 2018 Edition	Pt. Info Encounter Physical Hub	iX R 🕏 😪 Re 🗂	Dx 📸 🎹 🖾 🖽 😫 🗸	🌲 s 🗐 🛅 F55 🚿 📆	
PEG SCALE	Social Determinants		documented categories.	Social Histo	ory Verified
PHQ2	- Social Determinants	Social Determi			,
PHQ2 (2015 Edition)	 Tobacco Use: 				
PHQ9	- Sexual History:	Social Info	Options Details		
PRAPARE SMART FORM ျက	- Drugs/Alcohol:		Data Carrala		
Respiratory Illness Screening	- Miscellaneous:	S. PRAPARE	Date Complet	ted/Updated: 08/25/2021 patient	r ×
	Social History TEST, Rachel - DO	DB:			
	Pt. Info Encounter Physical	🍦 Hub			
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Audit-C OPIOID 2018 E		Please verify previously docum	iented categories.	Social H	istory Verified
PEG SCALE	Social History	Social Determinants			
PHQ2 PHQ2 (2015 Edi		Social Info	Options Details		
PHQ9	Sexual History:			adated: 08/25/2021 estica	t concerts W
Respiratory Illn ¥	Drugs/Alcohol:	PRAPARE	Date Completed/U	pdated: 08/25/2021 patien	t reports, W

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eClinicalWorks Configuration

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Smart Form Mapper

	Master	
Sm	art Form	

Master Path:

SocialHistory/Social Determinants/PRAPARE

PRAPARE SMART FORM

Social History/Social Determinants/PRAPARE

Mapped Elements

Used in Measures and Order Sets

Name	Туре	Trigger	Local Link
Date Completed/Updated:	Date		Date Completed/
What is your current housing situa	Structure		What is your curre
Are you worried about losing your	Structure		Are you worried a
What is the highest level of school	Structure		What is the highes
What is your current work situation?	Structure		What is your curre
In the past year, have you or any f	Structure		In the past year, h
Has lack of transportation kept yo	Structure		Has lack of transp
How often do you see or talk to pe	Structure		How often do you
How stressed are you? Stress is w	Structure		How stressed are
In the past year have you spent	Structure		In the past year h
What was your release date?	Date	Yes	What was your rel
Do you feel physically and emotio	Structure		Do you feel physic
In the past year, have you been afr	Structure		In the past year, h

					\otimes
Local					
Section	HPI		~		
Category	Social Determinants				
ltem	PRAPARE				
Name		Туре	Trigger	Master Link	Ê
Date Cor	npleted/Updated:	Date		Date Completed/Upd	
What is your current housing situation?		Structured		What is your current	
Are you worried about losing your housin		Structured		Are you worried abou	
What is the highest level of school that yo		Structured		What is the highest le	
What is your current work situation?		Structured		What is your current	
In the pa	st year, have you or any family	Structured		In the past year, have	
Has lack of transportation kept you from		Structured		Has lack of transporta	
How ofte	n do you see or talk to people th	Structured		How often do you see	
How stressed are you? Stress is when so		Structured		How stressed are you	
In the past year have you spent more t		Structured		In the past year have	
What was your release date?		Date	Yes	What was your releas	
Do you feel physically and emotionally sa		Structured		Do you feel physically	
In the past year, have you been afraid of		Structured		In the past year, have	-
Clear Asso	ciation Custom				

Close



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< Map >

Demographics/UDS Related Questions

		PRAPARE SMART FORM
PRAPARE: Protoco	I for Responding to and	Assessing Patient Assets, Risks, and Experiences
Date Completed/Update	d: 08/25/2021 🔽	
Patient Name:	Rachel Test	
Address:	911 CENTRAL AVE ALBANY NY 12	206-1350
Race:	White	
Ethnicity:	Not Hispanic or Latino	
Language:	Spanish;Castilian	ICD10 Code recommended by Smart Form:
Insurance:	MVP HEALTH CARE	Z59.5 Extreme Poverty for 0% -100% of FPL
Insurance Class:	Commercial	Z59.6 Low Income for 101%-200% of FPL
Income Level:	143.00	
Income Level ICD:	Z59.6	Other ICD10 Codes: Uninsured
Migrant:	No	Z59.7 insufficient social insurance
Seasonal:	No	Z59.63 Unable to pay for medical care
Veteran:	No	





Money & Resources

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Housing Situation

Related ICD10 Codes:

Z59.0 Homelessness Z59.81 Housing Instability

What is your current housing situation?

✓ 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?

🖌 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 diplomaZ55.0 Illiteracy and low-level literacyZ55.9 Problems related to education and literacy

What is the highest level of school that you have finished?

- ✓ Less than a high school degree
- High school diploma or GED
- More than high school

I choose not to answer this question

• 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

What is your current work situation?

Unemployed and seeking work

Part time or temporary work

🗌 Full time work

Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver)

I choose not to answer this question

• 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

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply
✓ Food
✓ Clothing
✓ Utilities
Child care
✓ Medicine or any health care (medical, dental, mental health or vision)
Phone
Other (please write in notes)
I do not have problems meeting my needs
I choose not to answer this question

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



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Transportation

Related ICD10 Codes:

Z75.3 Unavailability and inaccessibility of health-care facilitiesZ75.4 Unavailability and inaccessibility of other helping agencies

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Yes, it has kept me from medical appointments or from getting my medications

Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living

🗌 No

I choose not to answer this question

• 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





Social & Emotional Health

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Social Integration

Related ICD10 Code:

Z63.9 Problem related to primary support group Z60.8 Other problems related to social environment

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)

✓ Less than once a week

🗌 1 or 2 times a week

🗌 3 to 5 times a week

More than 5 times a week

I choose not to answer this question

• 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

How stressed are you? Stress is when someone feels tense, nervous, anxious, or cannot sleep at night because their mind is troubled
Not at all
🗌 A little bit
Somewhat
✓ Quite a bit
Very much
I choose not to answer this question

• 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

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Incarceration

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

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?
✓ Yes
No
I choose not to answer this question
What was your release date? 10/17/2016 🔝

• 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

Are you a refugee?

🗌 Yes

No No

I choose not to answer this question

- 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



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

Country of Origin

Removed from NACHC PRAPARE Form

Not Used_What country are you from?

United States

Country Other than the United States (please write in notes)

I choose not to answer this question





Safety

Related ICD10 Codes: "No"

Z63.0 Problems in relationship with spouse or partner Z91.41 Personal history of adult abuse

Do you feel physically and emotionally safe where you currently live?
Yes
No
Unsure
I choose not to answer this question

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 groupZ63.0 Problems in relationship with spouse or partner

In the past year, have you been afraid of your partner or ex-partner?
Yes
No
Unsure
I have not had a partner in the past year
I choose not to answer this question

• 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





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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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

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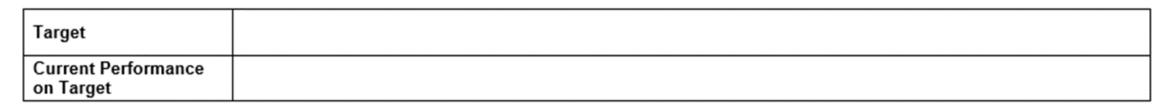
- On-site civil legal aid
- ***Update this slide with health center specific information





CDS/QI Worksheet

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





Foundational Work



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



