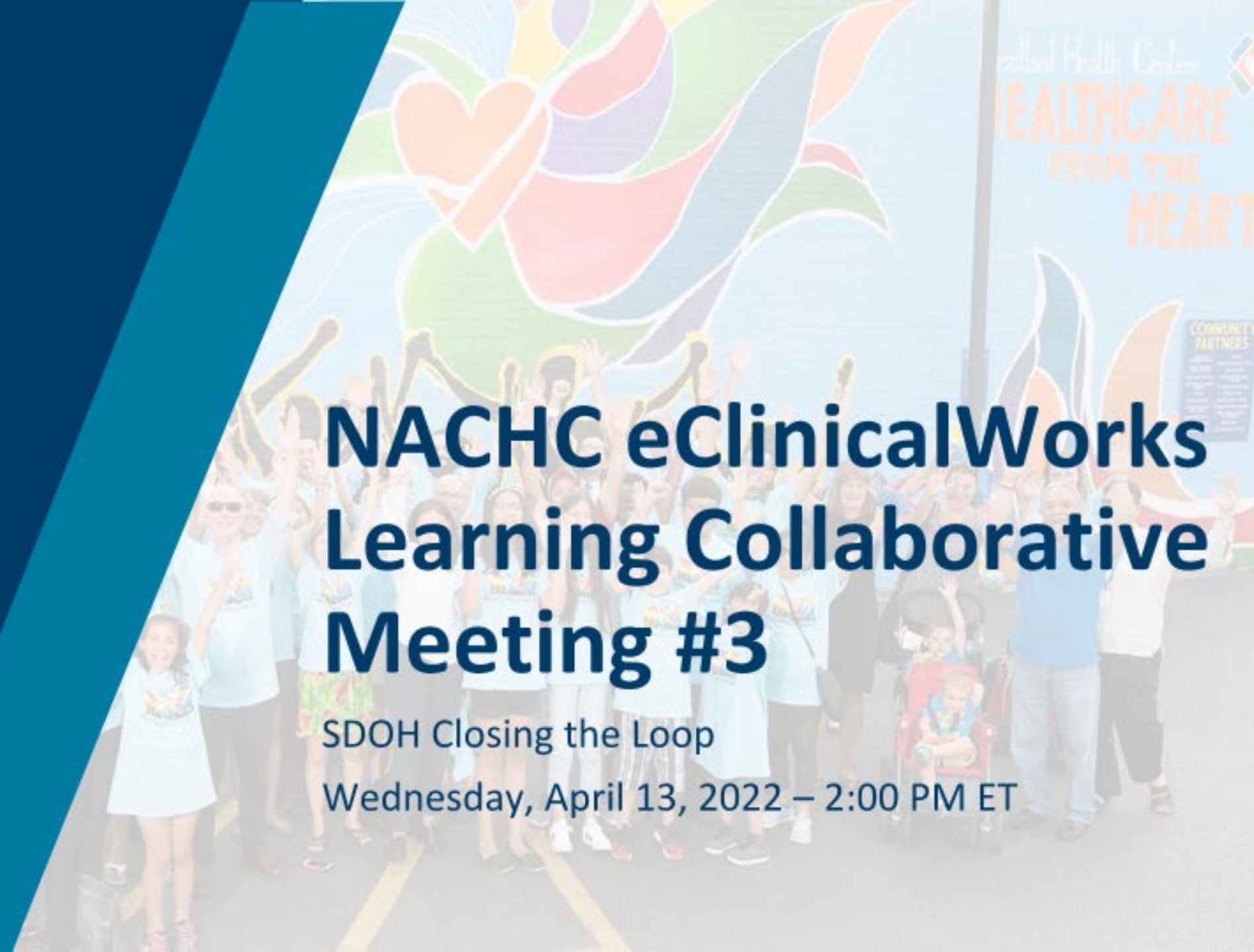
NATIONAL ASSOCIATION OF Community Health Centers®



NACHC eClinicalWorks Learning Collaborative Meeting #3

SDOH Closing the Loop

Wednesday, April 13, 2022 – 2:00 PM ET

Meeting Goals

- Health Center collaboration and peer sharing
- eClinicalWorks review SDOH API integration options
- Review process of Closing the Loop
- Review configuration and use of Order sets, Clinical rules, questionnaires and coding

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

Agenda

1. Health Center Peer Sharing
2. SDOH API integration
   Guest Speaker: eClinicalWorks
3. Closing the Loop
4. Q&A/Discussion
5. Configuration and use of EHR Tools
6. Next Steps

NATIONAL ASSOCIATION OF Community Health Centers®

Health Center Peer Sharing

Learning Collaborative Health Centers

- **Albany Area Primary Health Care, Inc.,** GA *(Georgia Primary Care Association HCCN)*
- **City of Philadelphia,** PA *(Health Federation of Philadelphia)*
- **Clinch River Health Services, Inc.,** VA *(CENEVIA).*
- **Community Health Alliance,** NV.
- **Heart of Florida Health Center, Inc.,** FL
- **Horizon Health Care Inc,** SD *(GPHDN)*
- **Neighborhood Improvement Project, Inc.,** GA.
- **NO/AIDS Task Force,** LA.
- **Pancare of Florida, Inc.,** FL *(Community Health Centers Alliance, Inc)*
- **Regional Health Care Clinic, Inc.,** MO
- **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)*
- **Talbert House Health Center,** OH *(OACHC).*
- **Total Health Care, Inc.,** MD *(QUAL IT Care Alliance)*

St. Croix Regional Family Health Center

Monthly Update Report – 4/13/2022

- **SDOH Collection**
  - V # PRAPARE Screenings:
    - 2021 – 291 Screenings
    - 2022 – 214 Screenings (YTD)

- **PRAPARE Screening Tool**
  - V Complete PRAPARE form and include additional questions (triggers).

- **Response to social needs or barriers to care**
  - V 340B Prescription Card information shared with Walgreens Pharmacist.
  - V Protocol established: when uninsured SCRFHC patients present to the pharmacy the Pharmacist will automatically assign SCRFHC prescription card as primary prescription plan.

St. Croix Regional Family Health Center

- **Improvements**
  - V Compile single resource tool accessible in EMR as custom education. Create a list of patient assistance resources for food, clothing, utilities, fuel, transportation and phone to give to patients to be mapped to SDOH Order Set.

- **Challenges**
  - V Order set development

- **TA Needs**
  - V Order set development

- **Lessons learned**
  - V Referrals to Outreach Coordinator & Care Manager will be documented in outgoing referrals. Incoming was utilized initially, and it was determined that outgoing referrals provided increase capability for tracking.

NATIONAL ASSOCIATION OF Community Health Centers®

HORIZON Health Care

Keeping communities well

Timeline

- 2.17.2022 Installation of the PRAPARE Smart Form
  Pilot sites
    - Yankton CHC
    - Aberdeen CHC
- 3.4.22 Installation of the eBO PRAPARE Package

Current plan is to screen all patients at those sites

- 3.28.22 – Began mailing PRAPARE forms out with GFE's, target audience self-pay and sliding fee patients.

-4.11.22 – To date we have not received any PRAPARE forms back

Current Obstacles

- Workflow
    - Added workflow for Front desk and Clinical Support Teams
        - Time, shorter appointment lengths make it difficult to add this screening tool amidst other screening tools teams are currently asking
    - Return of PRAPARE forms
- Healow currently being an all or nothing - not able to active for just 2 sites

Rockbridge Area Health Center

- SDOH collection: On going with plan to expand target population when new providers on board next quarter.
- PRAPARE screening tool: Given to three target populations that represented 13 % of total patient population for the quarter. Generated referrals through eCW.
- Response to social needs or barriers to care: Identified Housing and Transportation as the biggest need. CHW is working on information pamphlet for provider teams and patients.
- Improvements: Referrals based on patient not service line
- Challenges or Barriers: limited in house and in house out reach staffing for the need
- TA needs: none currently
- Lessons learned: Need for more dedicated outreach personnel

Total Health Care, Inc

Baltimore, MD

Aim: To increase the number of unique patients screened annually for SDOH using the PRAPARE screening tool from baseline (2%) to 50% by December 31, 2022.

- **SDOH collection**
  - **In March 2022, 143 PRAPARE screens completed out of 6977 patients (2.05% PRAPARE Documented)**
  - Currently done by Community Health Workers and Medical Case Managers (HIV Services)
- **PRAPARE screening tool**
  - eCW SMART Form
  - Implementing CHADIS which allows patients to complete PRAPARE screening tool prior to visits
- **Response to social needs or barriers to care**
  - Implemented findhelp (formerly known as Aunt Bertha in November 2021)

- NEXT STEPS:
  - Clinical Rule Engine Set Up
  - PDSA at Kirk Ave Health Center site

NATIONAL ASSOCIATION OF Community Health Centers®

eClinicalWorks

SDOH API Integration

Discussion

NATIONAL ASSOCIATION OF Community Health Centers®

NATIONAL ASSOCIATION OF Community Health Centers®

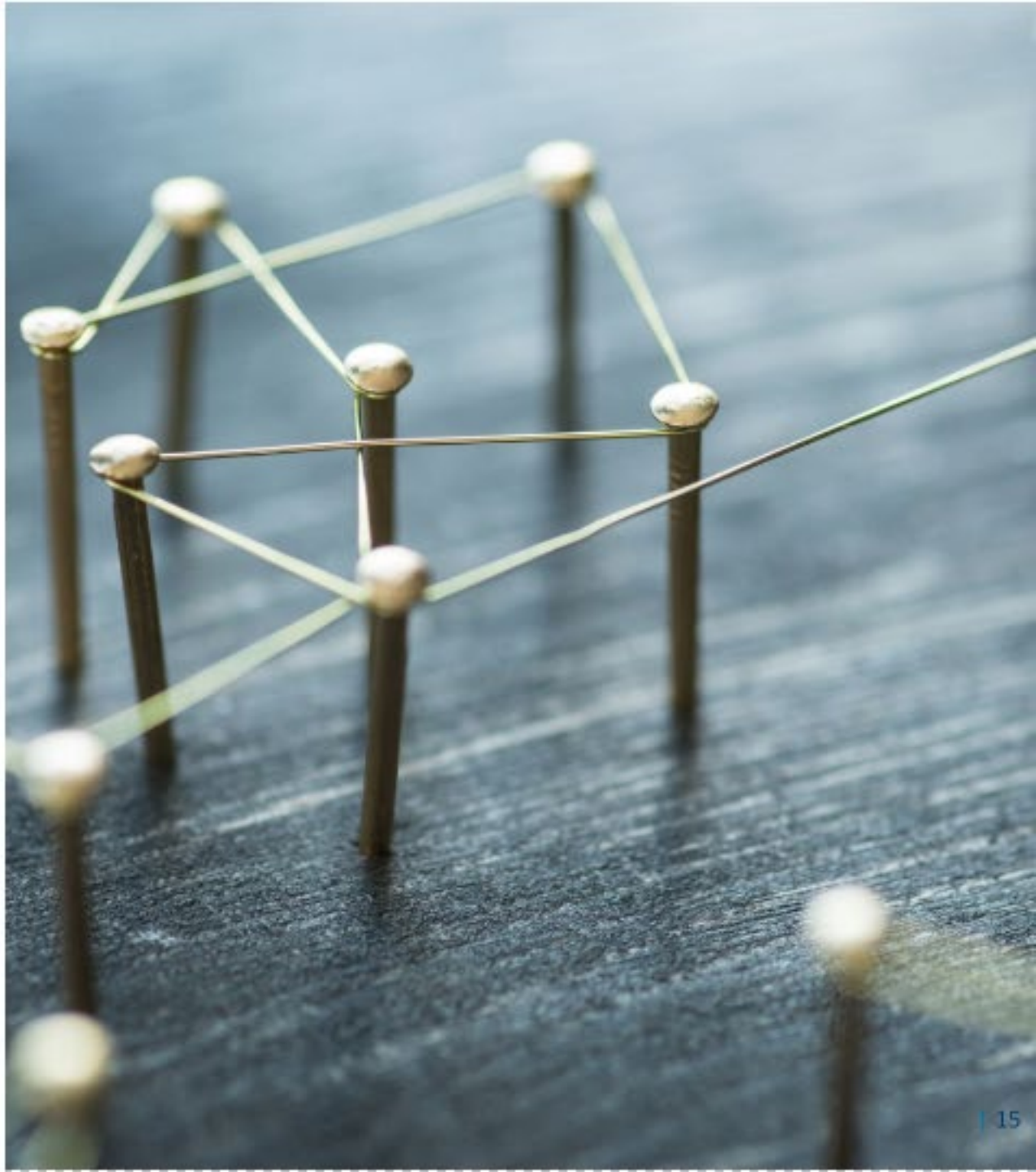
Closing the Loop

Addressing & Documenting SDOH

1. Screen Patient using PRAPARE
2. Add SDOH ICD10 code to Assessment or Problem List
3. Document Intervention for each Positive Response
4. Add SDOH CPT code + when applicable Document Referral to Track & Close the Loop

PRAPARE Workflow

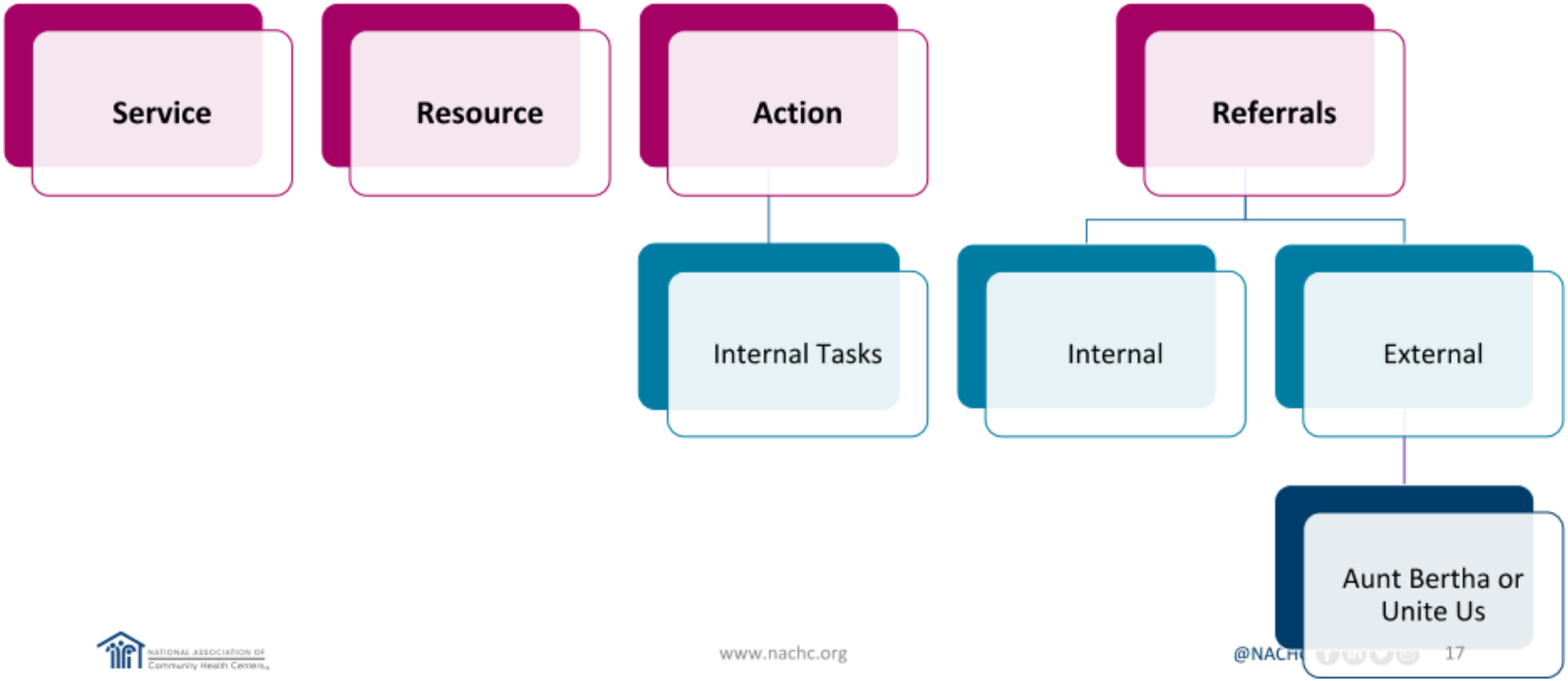
- PRAPARE Flowchart Sample



SDOH ICD 10 Codes

ICD 10	Description	ICD 10	Description
Z59.0	Homelessness	Z59.6	Low income
Z59.00	Homelessness unspecified	Z59.5	Extreme poverty
Z59.01	Sheltered Homelessness	Z63.6	Dependent relative needing care at home
Z59.02	Unsheltered Homelessness	Z59.8	Other problems related to housing/economic circumstances
Z59.81	Housing Instability, housed	Z75.3	Unavailability and inaccessibility of health-care facilities
Z59.811	Housing Instability, housed, w risk of homelessness	Z75.4	Unavailability and inaccessibility of other helping agencies
Z59.812	Housing Instability, housed, homelessness in the past 12 months	Z60.8	Other problems related to social environment
Z59.819	Housing Instability, housed unspecified	Z63	Problem related to primary support group, unspecified
Z55.5	Less than high school diploma	Z73.3	Stress, not elsewhere classified
Z55.0	Illiteracy and low-level literacy	Z65.2	Problems related to release from prison
Z56.0	Unemployment, unspecified	Z63.0	Problems in relationship with spouse or partner
Z59.41	Food Insecurity	Z65.3	Problems related to other legal circumstances
Z59.7	Insufficient social insurance and welfare support		

Documenting & Tracking to Close the Loop



NATIONAL ASSOCIATION OF Community Health Centers®

eCW SDOH Tools

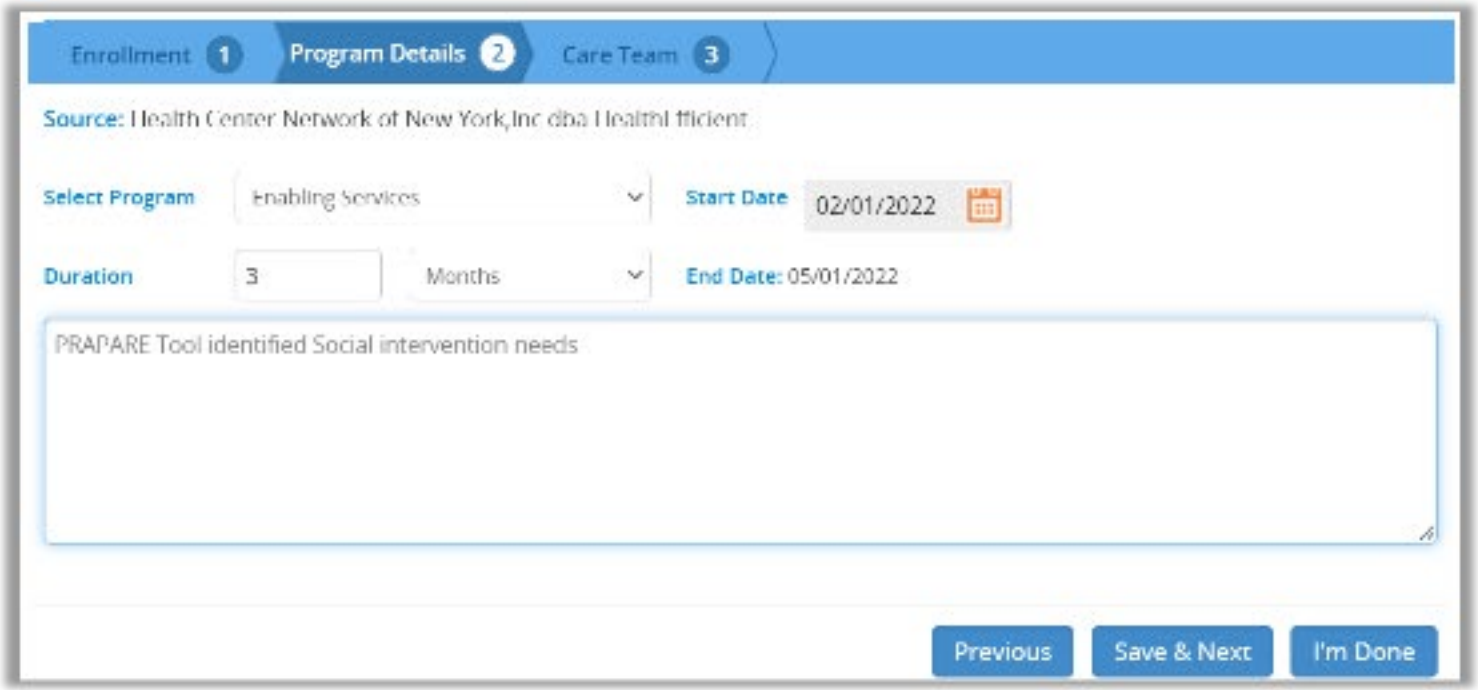
Configuration and the use of EHR tools

eClinicalWorks Configuration

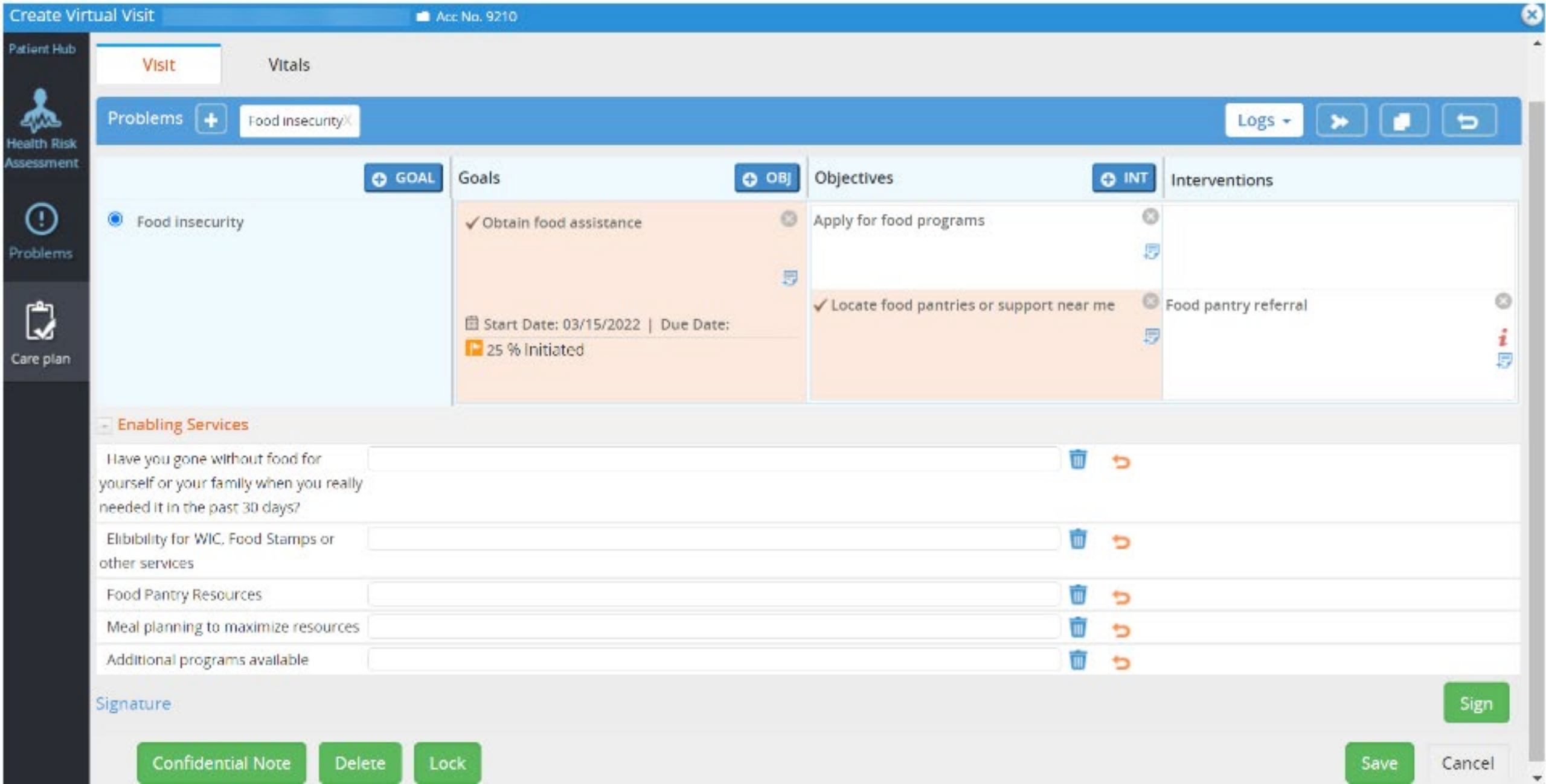
- PRAPARE Tool
- Questionnaire Designer
- NEW Kiosk Intake Mode
- Non-billable visit type for resource services
- Practice configured Alert
- SDOH Order Set
- Clinical Rules Engine
- SDOH “dummy” CPT codes
- Billing CPT code Category
- PHM SDOH Care Planning

Pop Health/CCMR Care Plan for SDOH

§ Enroll or Refer for enrollment into SDOH/Enabling Services Program
§ Identify the patient's Problems
§ Set Goals, Objectives and Interventions
§ Create a Care Plan for the patient based on the problem



Care Plan for SDOH



NATIONAL ASSOCIATION OF Community Health Centers®

Q & A

Next Steps

- Configure Order Sets, Templates, Questionnaires, Codes, Clinical Rules Engine, as needed
- Submit ticket (if applicable) to implement API
- Start PDSA cycle on PRAPARE screening
- Update Health Center slide to share on the next Learning Collaborative session on May 11, 2022

For More Information Contact:

Phillip Stringfield , M.S.
Health Center Operations Training Specialist
National Association of Community Health Centers
pstringfield@nachc.org

Rachel Benatar
Assistant Director of HIT Programs
HealthEfficient
srose@healthefficient.org

NATIONAL ASSOCIATION OF Community Health Centers®