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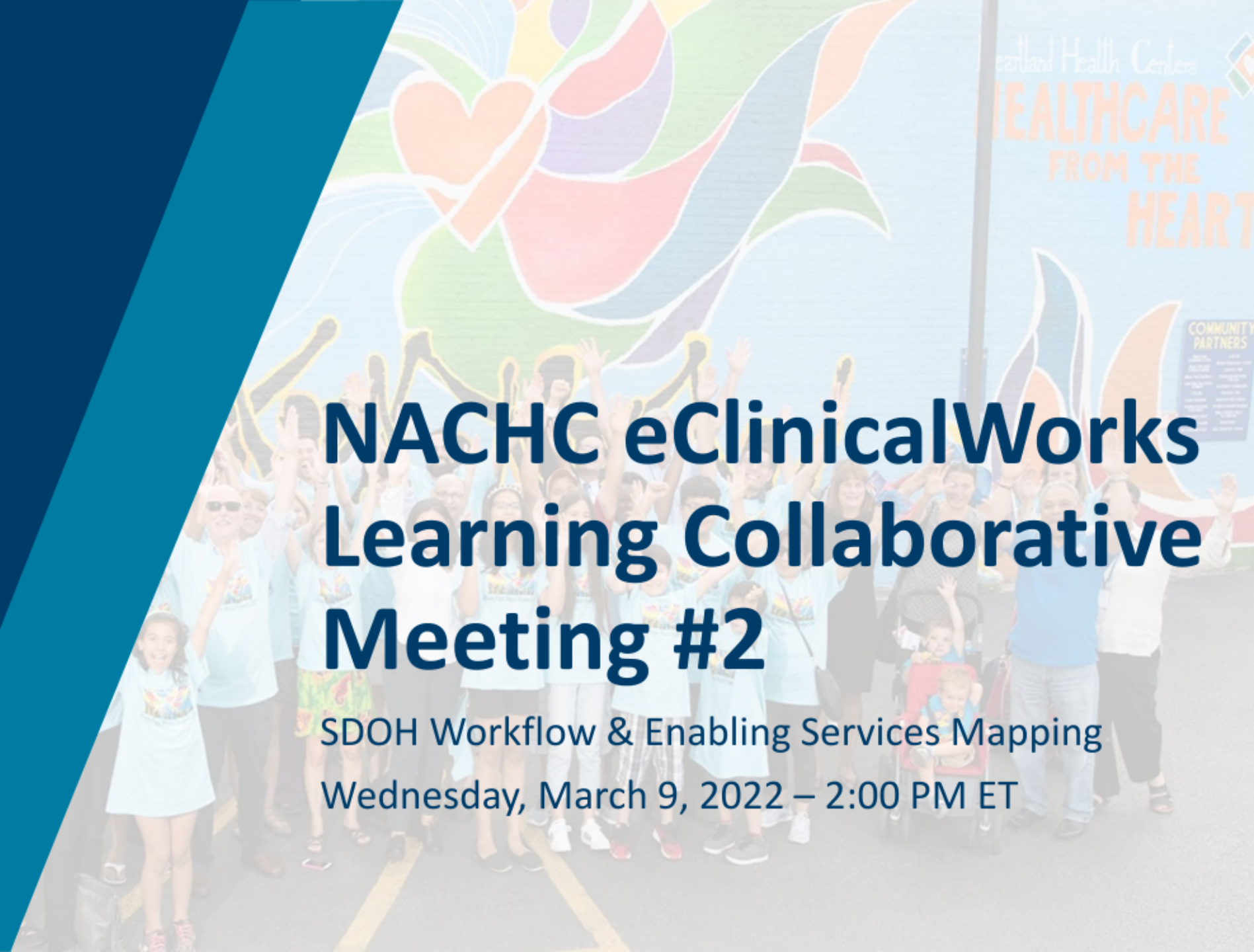

NACHC eClinicalWorks Learning Collaborative Meeting #2

SDOH Workflow & Enabling Services Mapping

Wednesday, March 9, 2022 – 2:00 PM ET

Meeting Goals

- Health Center collaboration and peer sharing
- Review current and future state workflow mapping activity to identify opportunities to capture SDOH
- Identify and map Enabling services/resources and health center support for each question

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

Agenda

1. Health Center Peer Sharing
2. Current and Future State Workflow
3. Enabling Services mapping
4. Q&A/Discussion
5. Clinical Rules Engine
6. Next Steps

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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)*

Albany Area Primary Health Care, Inc.

Status Update:

- 5,268 screenings conducted in 2021
- Surveyed includes: New patients, 3 or more chronic conditions, hospital follow-ups, ACO participants
- ECW smartform utilized by case managers/social workers
- Response to social needs or barriers to care is still a work in progress on our end

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

- Full integration for all primary care offices
- Closing the loop
- Not known at this time
- Assigning this tool to specific staff was key to effective implementation

- 714 PRAPARE questionnaires administered since May 2021
  - Administered by LCSWs and Case Managers
- Primary response to identified needs is to refer patient to case management at HFHC, or to external community resources

Technical Assistance Needs:

- **Develop effective and efficient workflow to utilize PRAPARE with all adult patients**
- **Utilize PRAPARE data for population health improvement**

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PanCare of Florida

Update 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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SDOH Collection Status

- Clinics using PRAPARE form in eClinicalWorks for enhanced SDOH status/ statistics
- Structured data question already input before PRAPARE implementation are designed to collect data also
- Still working on mapping Z-codes from PRAPARE to progress note

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PRAPARE Screening Tool Status

- 916 Patients have filled out PRAPARE
- One clinic has performed 516 PRAPARE forms (all patients fill out form)
- Next closest clinic is at just over 60 PRAPARE forms (conducted on annual wellness visits)
- Other clinics have filled out at least one
- We do not use PRAPARE at the 42(+) schools where we have nurses

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Response to Social Needs or Barriers to Care

- Response is through use of FindHelp.org
- Behavioral health providers and front office staff have accounts
- Patients not wanting to work with staff are provided information to utilize FindHelp.org on their own

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Improvements

- eCW notified that PRAPARE Dashboard slides are mislabeled
- All slides are labeled "Lack of Transportation Needs"

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Challenges or Barriers

- C-suite buy in since the reports are not "required"
- "Staff is too busy to do PRAPARE…" from multiple sources
- Not looking OTH and knowing that this most likely will become a UDS reporting requirement in the future
- Staff not fully onboard as indicated by clinic performance ranges
- Currently the FindHelp.org SDOH resources are not integrated in eCW due to version requirements. All users must remember to get the "most recent update" to their eCW to integrate with apps through HL7 interface.
- Challenge of closing the SDOH referral loop

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TA Needs

- Everyone needs a toolkit like the one developed by CHCA, Inc
- Resources including short video presentations on
  - Advantages of use
  - Ease of use
  - Workflow demonstrations (as described in PRAPARE site documentation)
  - Integration with SDOH resources which are available
  - Z code mapping in eCW using Browser and EXE versions
  - Management of patient's problem list once Z-codes are mapped

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Lessons Learned

- Buy-in from all staff after implementation was not demonstrated
- Staff needs to be held accountable in following approved workflows
- More information from the front would have helped output of information in the back end
- Guidance/ recommendations on identifying targeted patient population rather than trial and error at user levels would have helped
- Staff knowledge of policies concerning certain answers on PRAPARE would have reduced confusion on how to proceed

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HORIZON Health Care, Inc.

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

Current Obstacles

- Workflow
  - Front desk process
  - Clinical support process
- Healow currently being an all or nothing - not able to active for just 2 sites

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St. Croix Regional Family Health Center

Monthly Update Report – 3/9/2022

- **SDOH Collection**
  - Registration form contains a question: *"Do you need assistance with any of the following: Prescriptions, food, fuel, housing, transportation? ☐ Yes ☐ No".*
    (New registration forms are completed annually by all patients).
  - If answer "Yes", the Patient Service Representatives at the front desk assigns the scanned document to the Outreach Coordinator.
- **PRAPARE Screening Tool**
  - The Outreach Coordinator calls the patient to review the question and completes a PRAPARE form with the patient.
- **Response to social needs or barriers to care**
  - Documentation in notes indicating what resources provided to patients.
  - If answer to question "Yes", Outreach Coordinator creates an incoming referral to track services.
- **Improvements**
  - Activated the PRAPARE Reporting Package in eCW.
  - Activated the Clinical Rule Engine in eCW.

St. Croix Regional Family Health Center

- **Challenges**
  - PRAPARE form is too long.
  - Cannot address some of the questions asked.
- **TA Needs**
  - Clinical Engine Rule education
  - Can the following be created in eCW?
    1. Y/N question in structured data during the registration process asking the patient if they need assistance that will trigger a referral to the Outreach Coordinator.
    2. During visit the provider asks the same question that will trigger a referral to the Outreach Coordinator without creating a TE (send to History of Present Illness).

       The Outreach Coordinator receives the referral and completes PRAPARE form with patient. “Yes” answers will trigger diagnosis codes.

       From there, referrals are assigned to the appropriate agency.

       Can the clinical rule engine drill down to insurance to trigger to the appropriate agency?

St. Croix Regional Family Health Center

- Map PRAPARE form to Population Health Module (in Gaps in Care, ACO, etc.)
- Create a visit type that is unbillable for Outreach resources.
- Patient education piece published to Patient Portal.
- Trigger an order set for SDOH without it being part of an actual visit.
- Healow Check-In screenings: PRAPARE – add same question as on Registration form – link referral to Outreach.

- **Lessons learned**

Rockbridge Area Health Center

Status:

- **SDOH collection** – screening cohort of new patients visits, ED Superusers, higher acuity patient panel
- **PRAPARE screening tool –** utilizing eCW form to transcribe patient responses (English and Spanish) into EMR and generate referral to CHW to action
- **Response to social needs or barriers to care-** referral to CHW to action
  - one referral per patient with all needs that need addressing to better track/update

- **Improvements-** internal need to update local resources for clinical staff's utilization/education during visit.
- **Challenges or Barriers –** buy-in from all staff and only one CHW to action needs identified in referral
- **TA needs-** to better familiarize staff to SDOH Reporting Package in eBO
- **Lessons learned** – monthly in progress reviews with stakeholders,
  - Data tracking,
  - Consolidated referral

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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 to 50% by December 31, 2022.

- **SDOH collection**
  - 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)
    - Platform Usage (Data from November 15, 2021 - February 28, 2022)
      - Users 117; Searches 505; Connections 45; Referrals 19

- TA needs
  - Clinical Rule Engine set-up
  - PRAPARE eBO data reporting

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City of Philadelphia Ambulatory Health Services

- SDOH Collection:
  - So far, 300+ pts screened using the PRAPARE tool by one Navigator at 2 clinics.
  - Case load tracked via spreadsheets external to EMR
- PRAPARE screening tool
  - Takes less than 5 min to complete
  - The referral process can take 5-30 min, depending on what is needed
- Response to social needs or barriers to care
  - Works closely with our Community Legal Services team (not available at all sites, though)

- Improvements Needed:
  - Extend workflow to remaining 6 clinics
  - Train Social Workers in workflow
  - Develop way to document specific referral information in eCW for easy reference later

- Challenges or Barriers
  - Housing and resources for undocumented pts are limited.
- TA needs
  - Complete i2i Tracks mapping
- Lessons learned
  - Warm handoffs and in-person screenings increase success.

Workflow Options

Patient Completed

- Questionnaire
- Kiosk
- Self Check-in

Resource Appointment

- Prior to clinical appointment
- Non-Clinical staff

Rooming Process

- Clinical Staff
- Non-Clinical Staff

During Clinical Exam

- Provider

Non-Medical Appointment

- Behavioral Health
- Case Manager
- Enabling Services
- Community Health Worker

Considerations

Challenges

- Language & Tech literacy
- Leadership and Staff Buy-in
- Closing the loop

Promising Practices

- Collecting data in real time
- Utilizing EHR automation
- Community Referral platforms

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CDS/QI Worksheet

Source: Adapted from TMIT Consulting, LLC

Clinical Decision Support - CDS

"A process for enhancing health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and healthcare delivery."
Improving outcomes with CDS, 2nd Ed. HIMSS 2012

The CDS Five Rights Framework

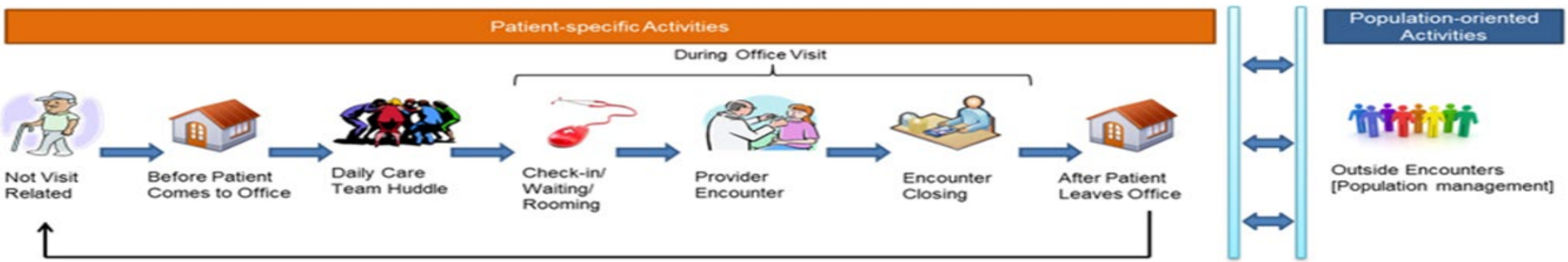
To improve targeted care processes/outcomes, CDS interventions must provide:

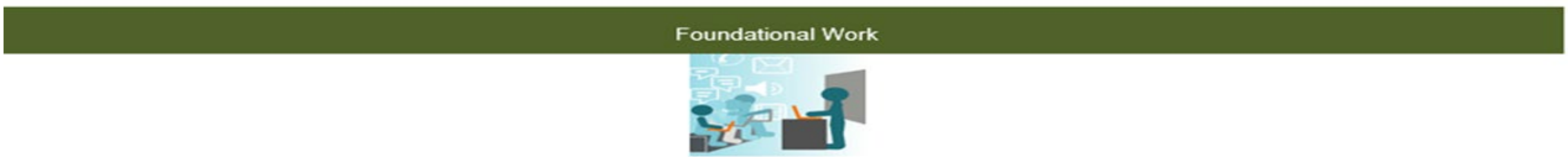
- The right information (What)
- To the right people (Who)
- Through the right channels (Where)
- In the right formats (How)
- At the right times (When)

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									

	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			Identify patients who have case manager, BH or enabling services visits.	Document race, ethnicity, language, sliding fee, migrant/ seasonal, homeless and veteran status	Identify patients that need referrals, assistance with completing forms. Create referral for patient advocate, BH and Case Manager.	Send patient to patient advocate for enabling services if a need was identified during the provider encounter. Provide transportation vouchers, housing and food pantry referrals			Uses list of enabling services
Potential Enhancements	Add posters to let patients know about enabling services	Patient Reminders Provider Reminders – what changes do you want to make?	Determine if patient has completed PRAPARE yet, review any SDOH identified on previously completed PRAPARE that may require additional follow up or impact clinical care	Ensure patient updates demographics and income screens. Educate staff on the importance of the key fields for SDOH, UDS and other incentives. MA/Nurse complete PRAPARE Tool.	Integrate PRAPARE data with clinical decision making. Utilize clinical rule engine for Z-codes. Refer patient to patient navigator, BH or Case Manager for additional support. Triage SDOH issues.	Ensure patient is scheduled for follow up appointment before leaving the office; align with patients needs (transportation/ work schedule, etc.) Provide information in preferred language.	Follow up with patient to see if they have utilized Resources and close the loop.	Run registry or other report to determine if all patients with an identified need have been connected to available resources. Incorporate PRAPARE data into chronic disease registry to determine impact of SDOH on disease. Use PRAPARE data for advocacy and community partnerships.	Complete PRAPARE form for all new patients, annual, physical exam visits. Incorporate PRAPARE data Implement clinical protocols related to SDOH Use community referral platform

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

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

Discussion

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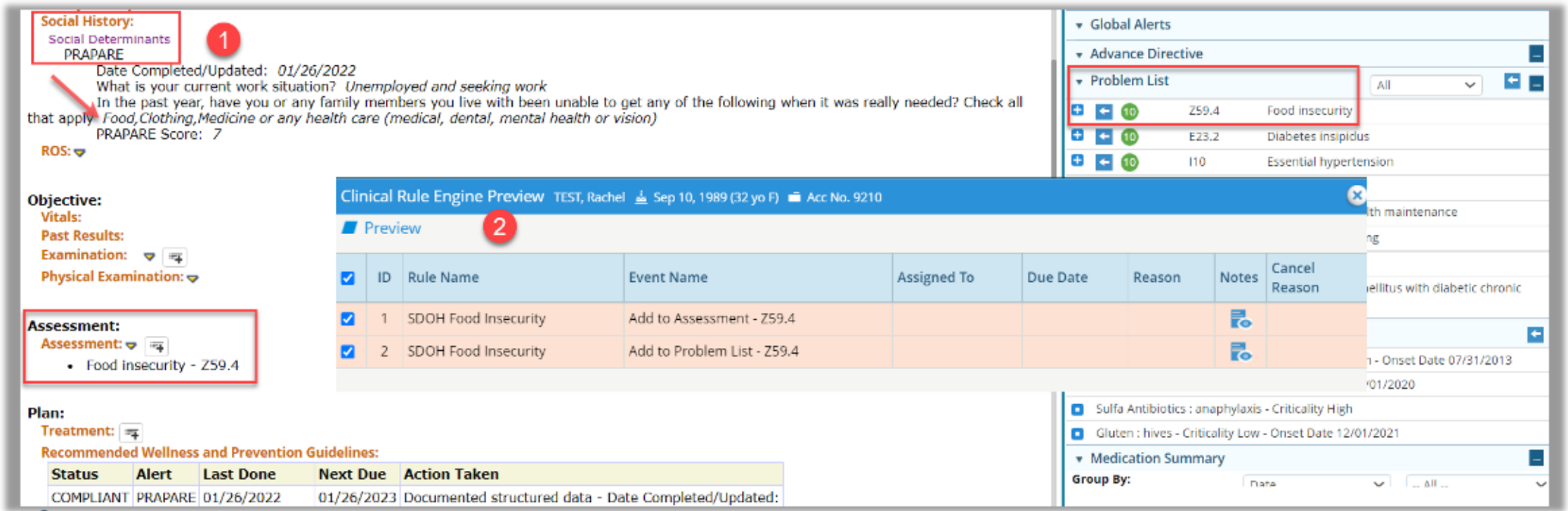
Clinical Rule Engine update

- Live Demo
- Configuration Guide



Next Steps

- Document current and proposed workflows
- Complete Resource Mapping worksheet
- Share your practice workflows and plan for PDSA cycle at next Learning Collaborative session on April 13, 2022

For More Information Contact:

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Resources

- CDS QI Worksheet word file
- Resource Mapping excel file
- Clinical Rules Engine configuration guide
- NACHC PRAPARE Toolkit
- HITEQ Resource CDS QI