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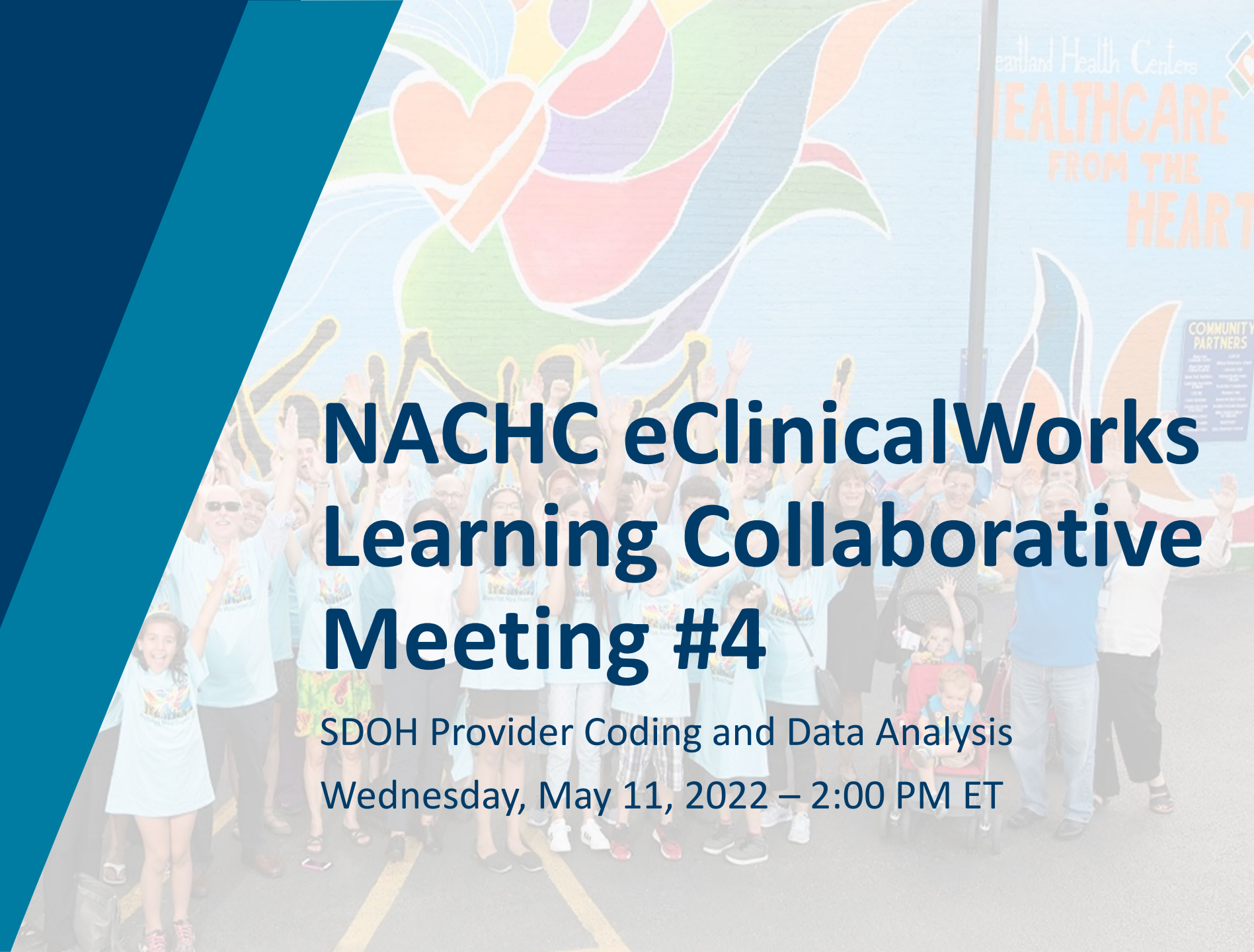

NACHC eClinicalWorks Learning Collaborative Meeting #4

SDOH Provider Coding and Data Analysis

Wednesday, May 11, 2022 – 2:00 PM ET

Meeting Goals

- Health Center collaboration and peer sharing
- Review recommendations for Provider Coding to appropriately document using Z-Codes and Smart CPT Codes
- Understand the importance of SDOH Data Analysis

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

Agenda

1. Health Center Peer Sharing
2. Recommendations for Provider Coding
   Guest Speaker: NACHC SDOH team
3. Data Analysis
4. Discussion - 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)*

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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. Setup clinical rule engine to drop ICD-10 codes.
-4.11.22 – To date we have not received any PRAPARE forms back
-4.11.22 – Reviewed updating the workflow and having the front desk distribute the PRAPARE form at check-in and the clinical support team enter the results in the Smart Form
-5.5.22 CHW scrubbing schedule in our Yankton site
-6.1.22 – Tentative Go Live date with provider referrals

PRAPARE Smart Form

- Available in English, Spanish, & Karen
- Narrowed down questions to align with the smart form in eCW.

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HORIZON Health Care

Keeping communities well

Challenges

- 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 to send via text
- Mapping in our Pop Health tool

Improvements

- With CHW scrubbing the schedule and giving patient list to front desk we have went from zero return to 11 in 3 days.
- Focused on a different way of who is screened

Lessons Learned

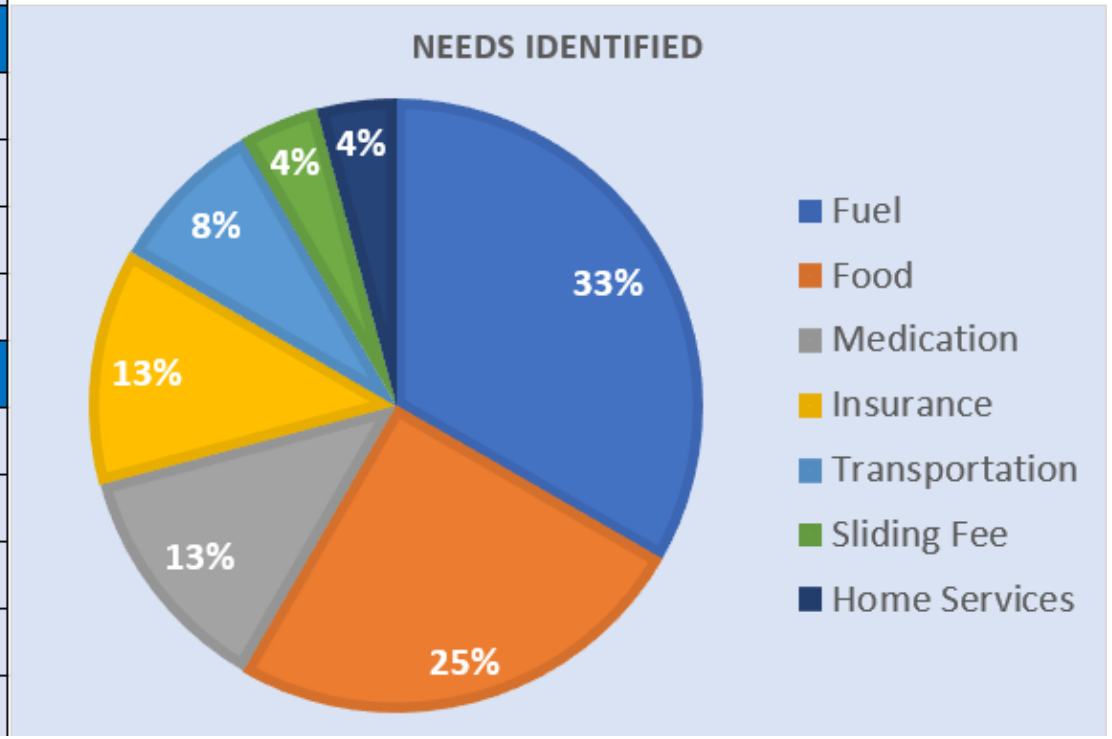
PDSA has shown us that sending out the PRAPARE form did not result in many returns

- Better patient engagement when the PRAPARE form is presented to the patient at time of appointment.
- There is a larger number of patient identified when the CHWs have scrubbed the charts ahead of time opposed to the front desk

St. Croix Regional Family Health Center

Monthly Update Report – 5/11/2022

2022	
Number of Patients Initially Screened (question asked on registration form: *Do you need assistance with any of the following: Prescriptions, food, fuel, housing, transportation?)*	2818
Number Patients with PRAPARE (or other SDOH tool)	408
Completed Referrals	
Fuel Assistance	8
Food Insecurities	4
Medication Assistance	3
Sliding Fee	1
Open Referrals	
Insurance	3
Transportation	2
Food Insecurities	2
Home Services	1
Total number of referrals to services	24



St. Croix Regional Family Health Center

- **SDOH Collection**
  - ❖ **IT is looking into a tablet for waiting room to complete screenings/smart forms**
  - ❖ **Dummy codes established for screening**

- **PRAPARE Screening Tool**
  - ❖ **Portal allows for completing smart forms and is activated**
  - ❖ **SCRFHC created as a referring provider to allow for referral tracking and management**

- **Improvements**
  - ❖ **To Do: Patient education on SDOH screening – why we ask and what we can help with**

St. Croix Regional Family Health Center

- **Challenges**
  - ❖ **Portal allows for completing smart forms completion and is activated; however, results go to specialty forms in documents but does not populate in progress note or go to staff member, it automatically is marked address and needs to populate in progress note.**
    To Do: eCW ticket needed to address this problem
  - ❖ **Plans to activate and utilize Clinical Rule Engine to trigger referral for outreach and depending on response/need**

- **TA Needs**
  - ❖ **Clinical Rule Engine and directing smart form completed via the portal to progress note or Outreach staff depending on response/need**

- **Lessons learned**
  - ❖ **Project moved along quickly with different eCW users at the table!**

Albany Area Primary Health Care, Inc.

Status Update:

- 3,467 screenings conducted to date in 2022
- Employment needs & Housing assistance are the documented highest need areas
- 642 patients have received SDOH assistance or referrals

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

- Full integration for all primary care offices
- Closing the loop
- None at this time
- Established referral links for patient assistance help staff with timely assistance.

City of Philadelphia Ambulatory Health Services

Department of Public Health

So far in 2022,

- AHS has performed **952** SDOH screenings on **589** patients at 3 of our 8 health centers.
- Most common SDOH need identified is **HOUSING**, with food as a secondary need.
- **400+** patients* received enabling services, such as case management, referrals to food pantries, legal services, insurance enrollment, SNAP applications, etc.

Improvements:

- Social Workers at each center were trained to use the PRAPARE form and SDOH Order Set.
- eCW Configuration and i2i mapping getting better.

Challenges:

- *Enabling Services aren't always documented in a structured manner.
- Practice-wide SDOH policy is needed.

TA needs

- i2i technical issues this month.
- eCW upgrade is pending (CPTs in CRE!)

Lessons learned:

- ***Keep moving forward.*** Check in frequently and incorporate feedback from staff.

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Rockbridge Area Health Center

Share the status on:

- During the first quarter of 2022, we had 346 completed PRAPARE assessments
- The most common need identified is transportation and followed by housing
- # of patients that received SDOH assistance or referrals: 38 enabling referrals
- There were 100 patients with a SDOHZ code populated in the “assessment” portion of the progress note. (First quarter)

- Improvements: Workflow was adjusted to give nursing and medical more time with patient.
- Challenges or Barriers: Internal workflow with referrals
- TA needs: No current concerns
- Lessons learned: Workflow adjustments, use of clinical engine rule

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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 (2%) to 50% by December 31, 2022.

- **For calendar year 2022, 631 PRAPARE screens administered (4% PRAPARE Documented)**
    - **2% increase from baseline!**
- **Most Common SDOH Need identified is Employment (393 unemployed responses—62% of PRAPARE screens)**
- **35 SDOH referrals via FindHelp**

Lessons Learned:

1. Additional training needed on FindHelp platform and analytics

Next Steps:

1. Implementation of PRAPARE screening across all sites at triage
2. Review community collaborations to address common SDOHs identified

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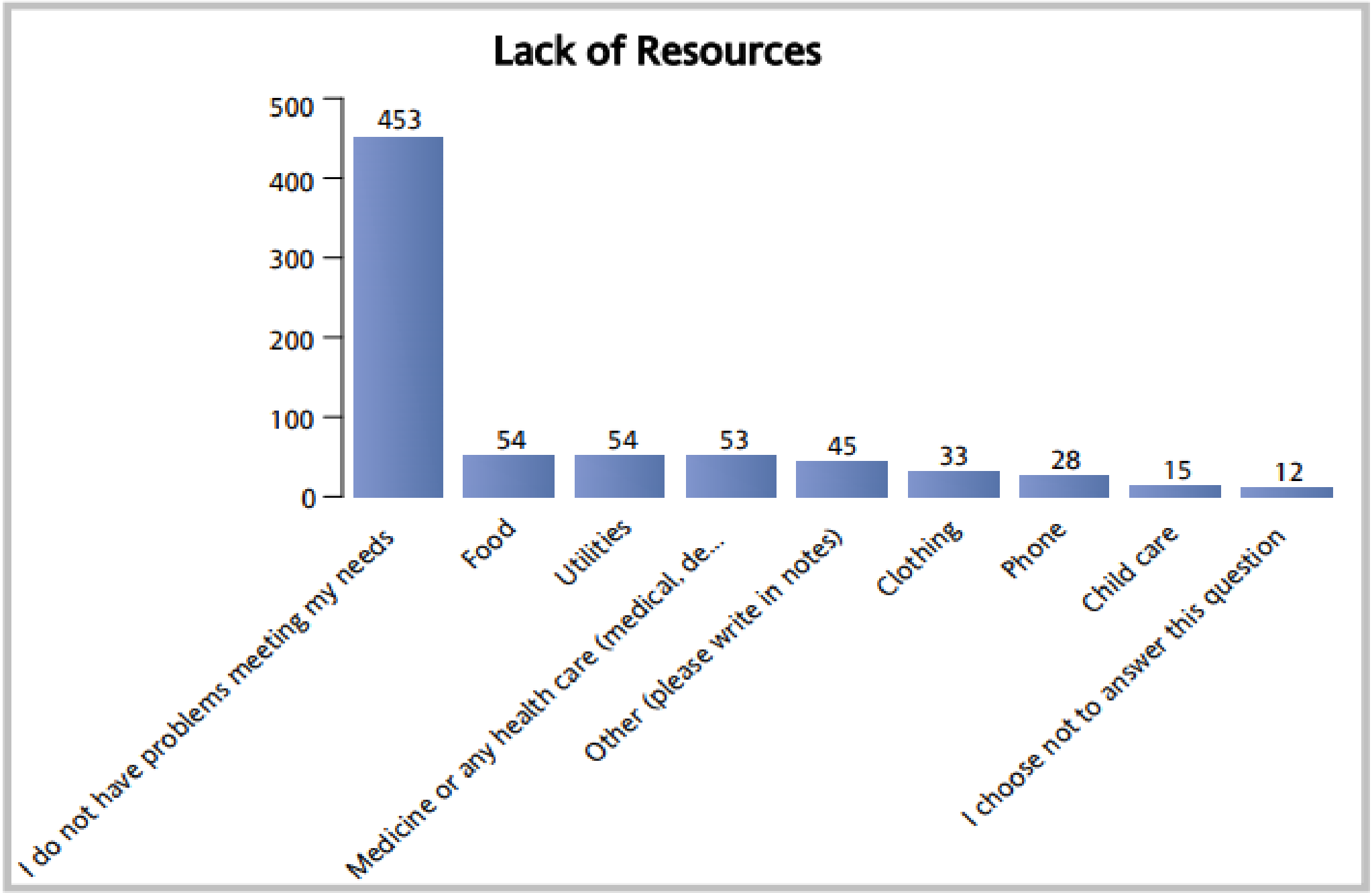
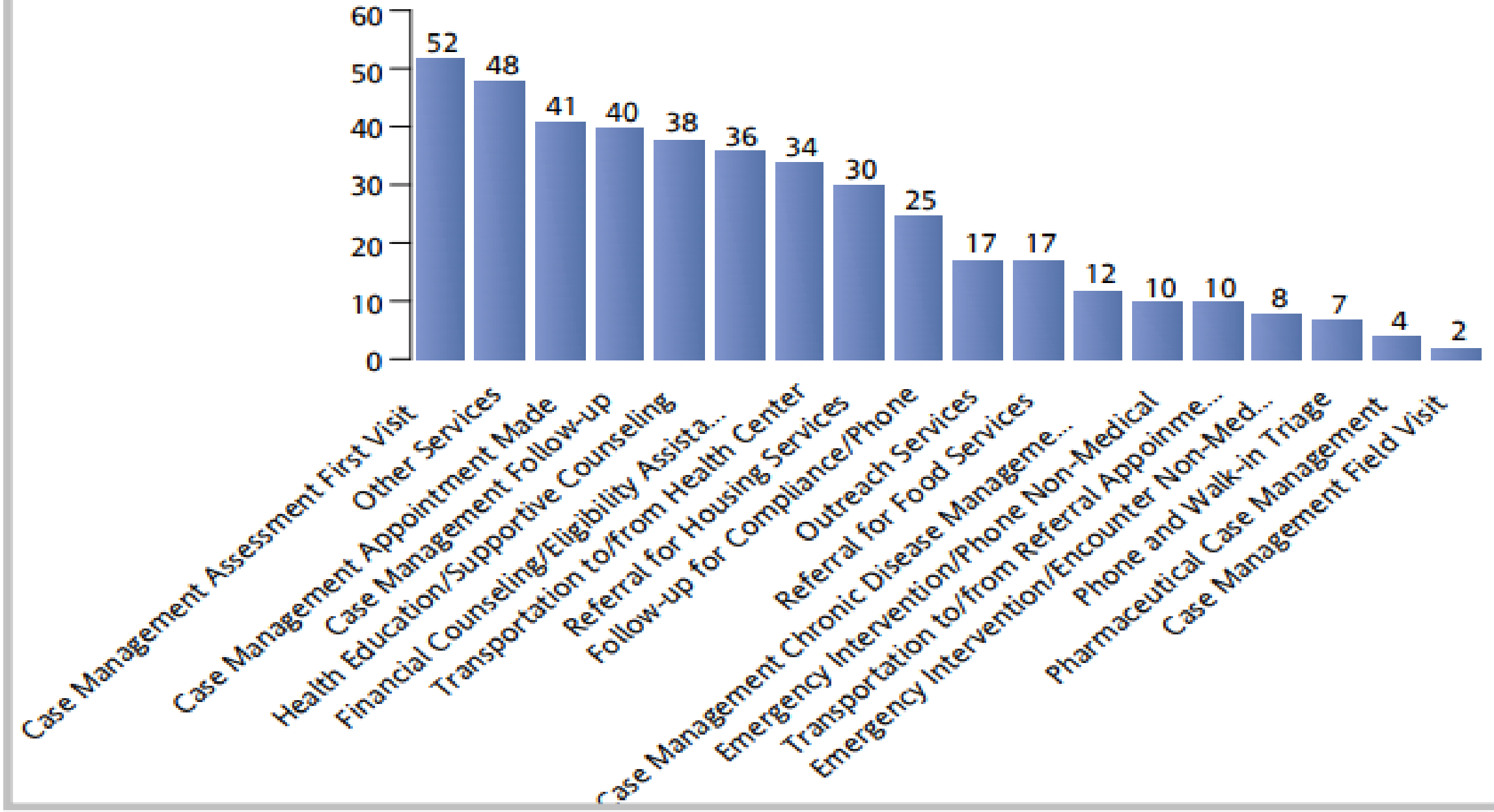
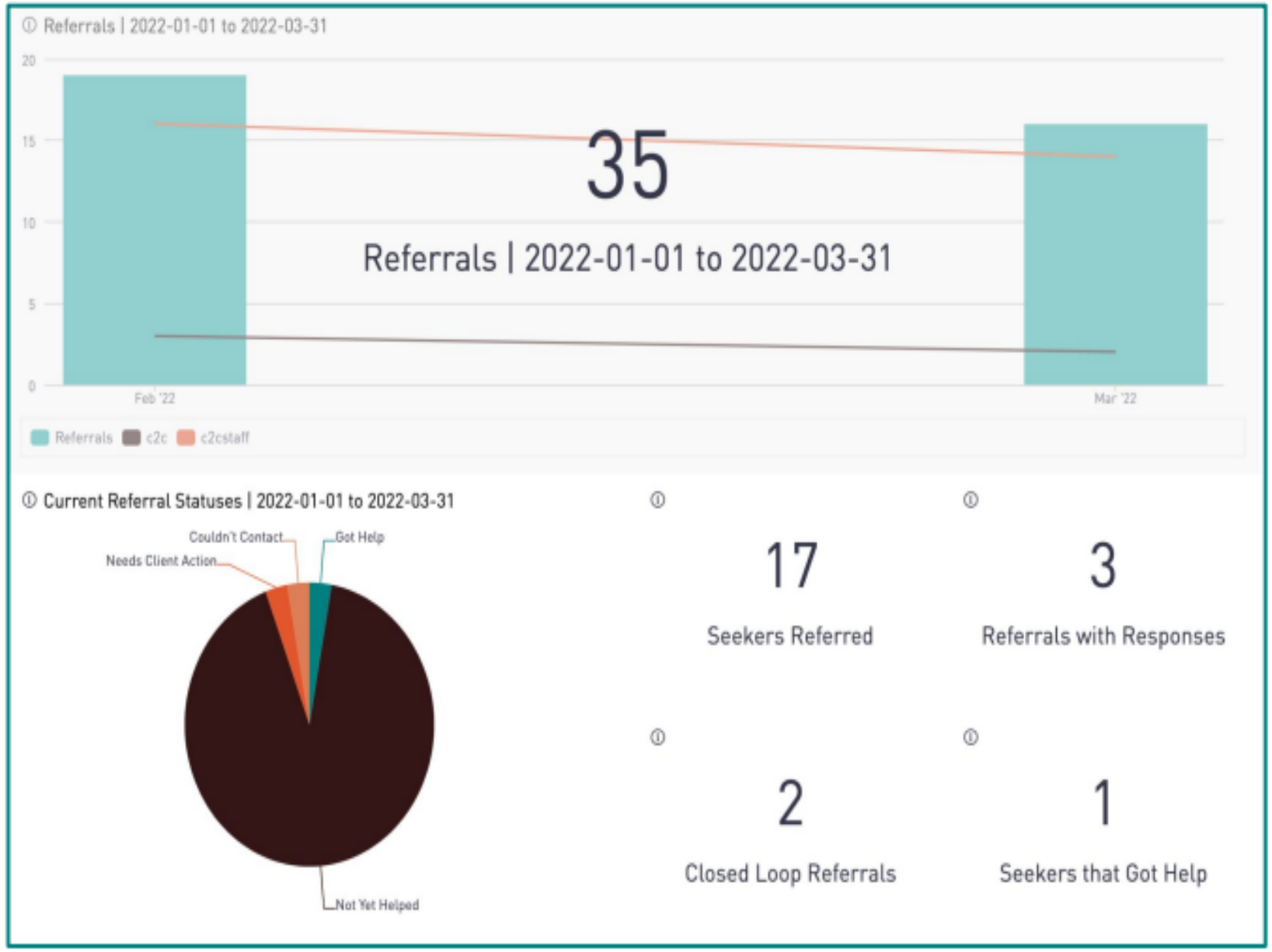

Lack of Resources
500
400
300
200
100
0
453
54
54
53
45
33
28
15
12
I do not have problems meeting my needs
Food
Utilities
Medicine or any health care (medical, de...
Other (please write in notes)
Clothing
Phone
Child care
I choose not to answer this question

Enabling Services Provided



Q1 2022 - Outcome Metrics (Referrals & Closed Loops)



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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Recommendations for Providing Coding

Yuriko de la Cruz

Program Manager, Social Drivers of Health

NACHC Public Health Priorities Division

Beth Weitensteiner, DO

Medical Director

International Community Health Services

Coding and Risk Stratification

- Why is provider coding so important and how does it align with risk stratification, value-based care and health equity?
- How have you and your team used PRAPARE with your coding efforts?
- How is coding at ICHS impacted care management efforts and how is it helping with the day-to-day clinical operations?
- What are some ways that you have addressed any hesitancy from patients?
- What have been some challenges that you and your team have encountered and what are some ways that you have addressed those challenges or overcome them?

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		

Enabling Services Accountability Project (ESAP)

Code	Enabling Service Category	Code	Enabling Service Category
SS001	Social Services Assessment	SC001	Supportive Counseling
CM001	Case Management	IN001	Interpretation
RF001	Referral	OR001	Outreach
RF002	Referral – Follow up on Social Service	IR001	Inreach
EA/FC001	Eligibility Assistance/Financial Counseling	TR001	Transportation - Health
HE001	Health Education – Individual	TR002	Transportation – Social Services
HE002	Health Education – Small Group (2-12)	OT001	Other
HE003	Health Education – (13 or more)		

Social Intervention Response Categories

Code	Social Intervention Response	Code	Social Intervention Response
SI-RE	Racial/Ethnic Support Services	SI-CL	Clothing Support Services
SI-FW	Farmworker Support Services	SI-PH	Phone Support Services
SI-VN	Veteran Support Services	SI-OM	Other Material Security Support Services
SI-IN	Interpretation Services	SI-MT	Medical Transportation Services
SI-HS	Housing Support Services	SI-NMT	Non-Medical Transportation Services
SI-FC	Financial Counseling/Eligibility Assistance	SI-SI	Social Integration Support Services
SI-ED	Education Support Services	SI-ST	Mental Health Support Services
SI-EM	Employment Support Services	SI-IN	Incarceration Support Services
SI-FD	Food Support Services	SI-RF	Refugee Support Services
SI-UT	Utilities Support Services	SI-ST	Safety Support Services
SI-CC	Child Care Support Services	SI-DV	Domestic Violence Support Services
SI-MH	Medicine or Health Care Support Services		

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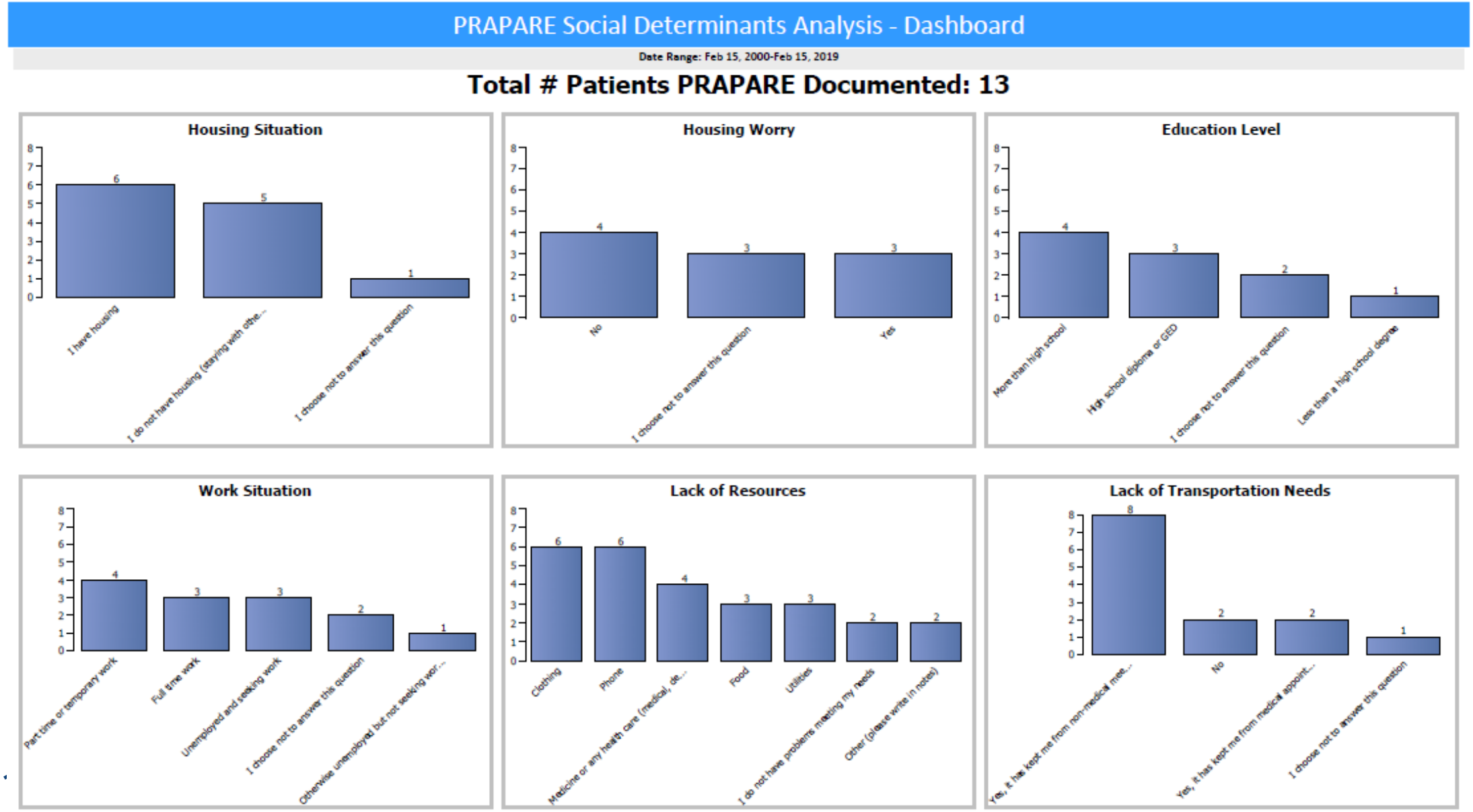
Data Analysis

eBO PRAPARE Reporting

- Patient Seen without PRAPARE Documentation
- PRAPARE Pre-Visit Planning
- PRAPARE Utilization Analysis
- PRAPARE Frequency of Diagnosis
- PRAPARE Score Analysis
- PRAPARE Poverty Level ICD Analysis
- PRAPARE Social Determinants Analysis

PRAPARE Social Determinants Analysis



PRAPARE Utilization Analysis

PRAPARE Utilization Analysis - Summary

Date Range: Feb 15, 2000-Feb 15, 2019

FacilityName	Appointment Provider Name	Year	Month	Active Patient Count	PRAPARE Patient Count	% PRAPARE Documented
Westborough Medical Associates	Smith, John	2014	Jul	1	0	0.00%
		2014 - Summary		**1**	**0**	**0.00%**
		2015	Sep	3	0	0.00%
			Nov	1	0	0.00%
		2015 - Summary		**4**	**0**	**0.00%**
	Smith, John - Summary			**5**	**0**	**0.00%**
	Willis, Sam	2009	Jan	8	2	25.00%
			Feb	2	1	50.00%
		2009 - Summary		**8**	**2**	**25.00%**
		2016	May	1	0	0.00%
			Jul	1	0	0.00%
		2016 - Summary		**1**	**0**	**0.00%**
		2018	Dec	1	1	100.00%
		2018 - Summary		**1**	**1**	**100.00%**
	Willis, Sam - Summary			**9**	**2**	**22.22%**
Westborough Medical Associates - Summary				**13**	**2**	**15.38%**
Overall - Summary				**13**	**2**	**15.38%**

PRAPARE Frequency of Diagnosis

PRAPARE Frequency of Diagnosis - Summary

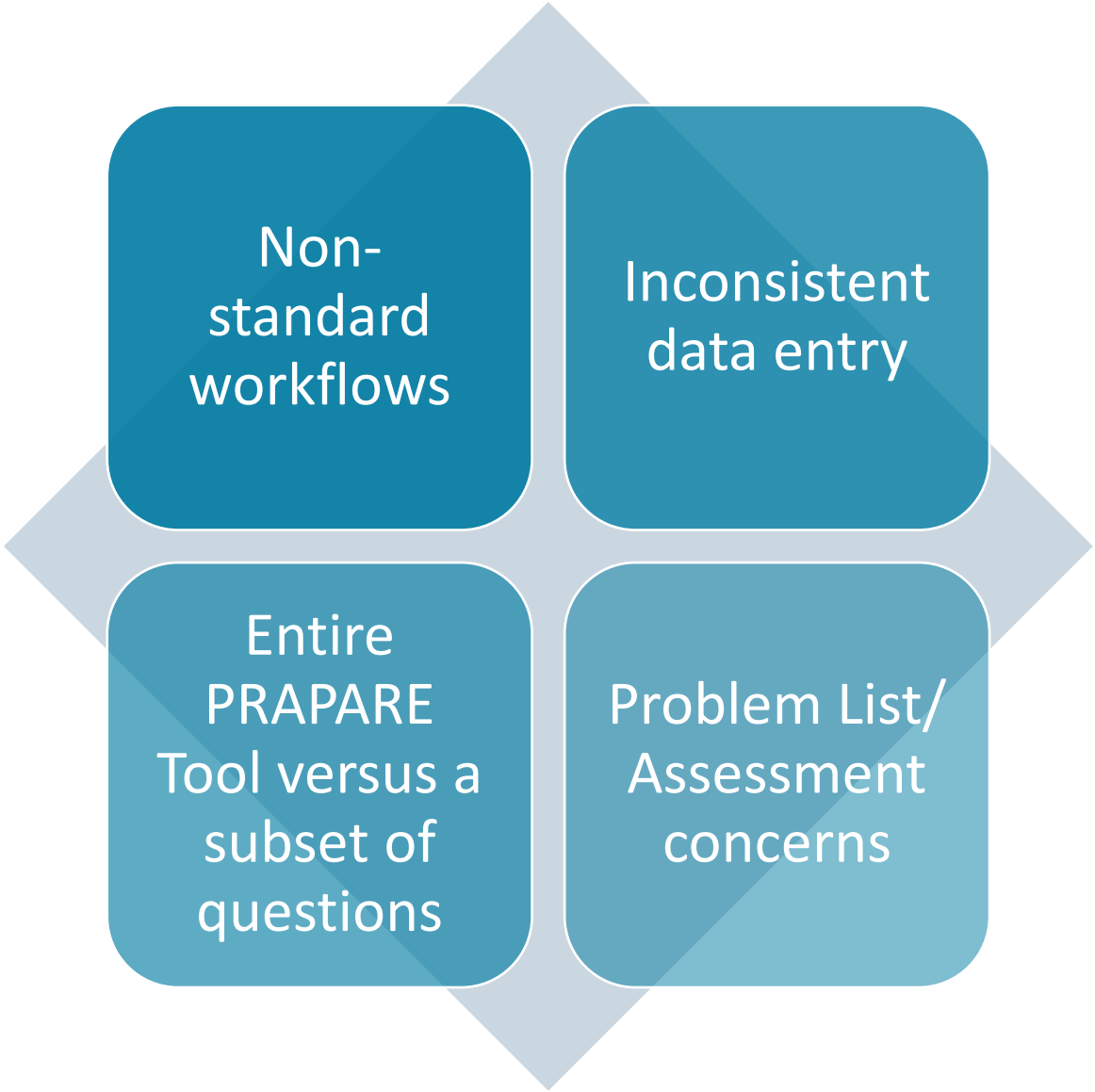
Date Range: Feb 15, 2000-Feb 15, 2019

FacilityName	Appointment Provider Name	ICD	PRAPARE Patient Count
Boca South	Jones, Mary	250.00	5
		781.0	1
		V01.0	1
	Jones, Mary - Summary		**5**
	Willis, Sam	250.00	2
		272.2	1
		275.01	1
		346.90	1
		401.1	1
		413.0	1
		427.31	1
		466.0	1
		530.81	1
		789.00	1
		847.2	1
		E000.2	1
	Willis, Sam - Summary		**2**
Boca South - Summary			**6**
St Francis Emergency Department	Willis, Sam	250.00	3
		272.2	1

Analytics – putting the data to work

- Community/Population
  - Identify the most common needs of your patients
  - Identify gaps in available existing community resources
  - Advocacy and negotiations
  - Develop health center programs
  - Prioritize social risks and needs to focus on that have the greatest positive impact on the community
- Patient Level
  - Risk stratification incorporating social risk factors
  - Stratify/segment reports by sub-populations to target services and resources

Considerations



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Best Practice Discussion

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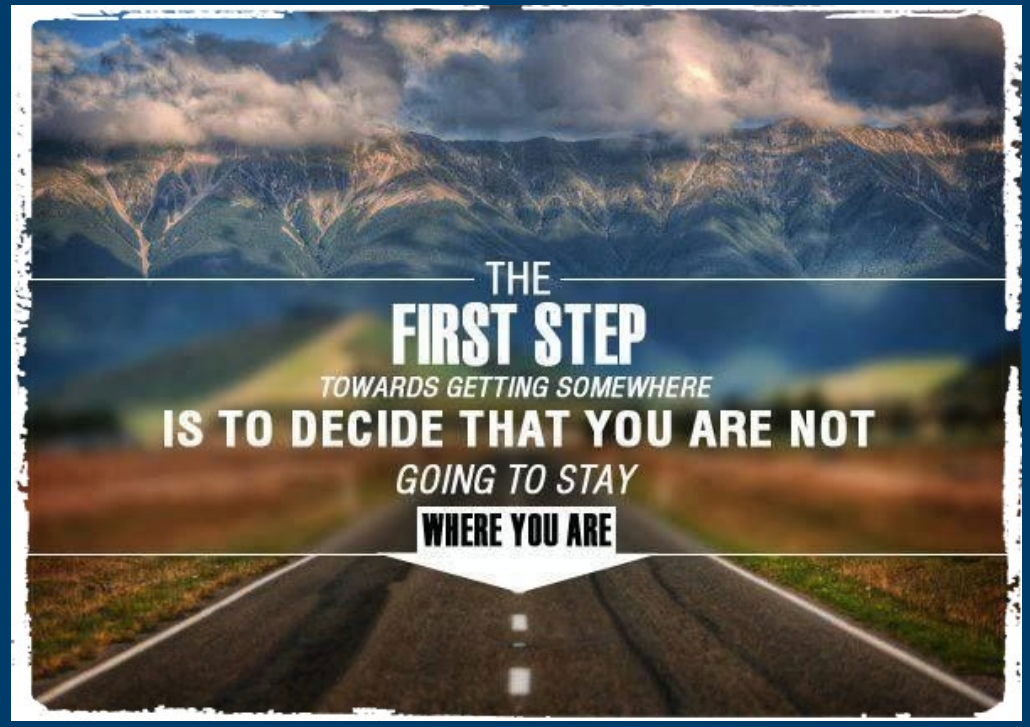
Next Steps

- Send Data and share your experience
- Analyze your Data
- PDSA cycle
- Expand PRAPARE implementation



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Q&A

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