Discussion / Question & Answer Document

Moving Health Care Upstream's *Policy Learning Lab*

November 12, 2018 Webinar: Presentation and Q&A with Parkland Center for Innovation

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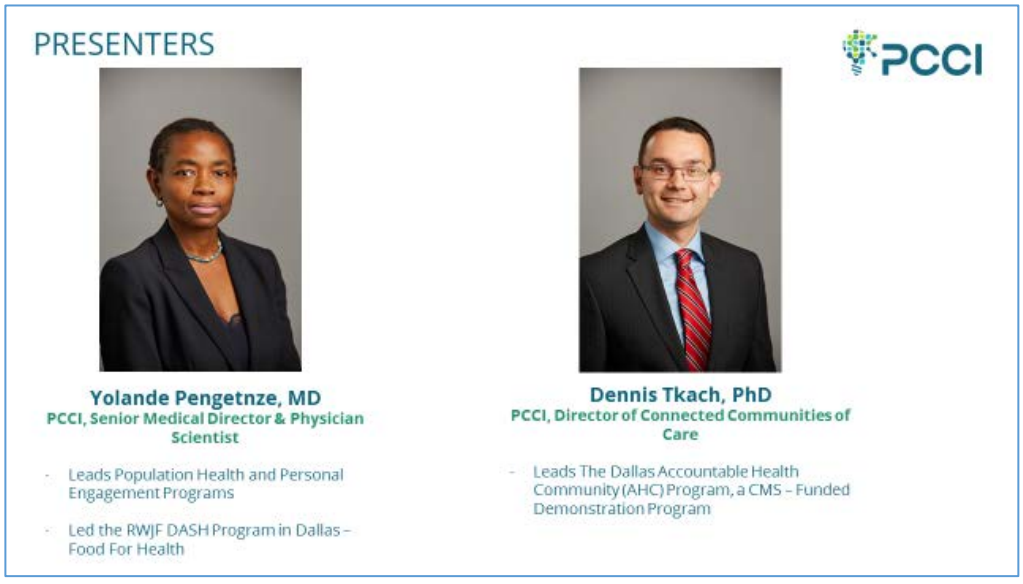
Discussion topics and questions in this document were submitted by teams in Moving Health Care Upstream's Policy Learning Lab. Responses were provided by our presenters, Dr. Yolande Pengetnze and Dr. Dennis Tkach, of Parkland Center for Clinical Innovation. Contact information for presenters is provided below. Our presenters welcome follow up questions and comments.

For more information on Moving Health Care Upstream's Policy Learning Lab, please visit: https://www.movinghealthcareupstream.org/mhcus-policy-learning-labs/



Discussion Topics / Questions & Answers

- Screening Process
  - **Determining who asks the questions and how the info is collected (paper vs. electronic), in order to get most accurate responses** – Create and adjust practical workflows tailored to each clinical setting and each SDoH domain. Electronic is overall preferable to streamline data collection, editing, storage, and analysis. Preferred electronic platform should be simple, easy for data recording, extraction, and reporting. However, in some settings, might consider recording on paper and transcribing onto electronic format. But, make every effort to start with electronic data collection.
    - In the case of the Accountable Health Communities (AHC) work, the level of desired workflow integration at participating sites was the determining factor for the approach we took. Specifically, the least disruptive workflow was adopted for each site.
      - In some cases, this was a paper-based workflow with data entry process taking place later in the day. An example of this case is handing out the surveys at the time of patient registration at a clinic. While patients wait in the lobby and the waiting area, they complete the forms and either return them back to the registration desk, or the forms are collected by screening associate staff.
      - In other cases, where the workflow allows for screeners to engage the patients in the exam room (while they are waiting for the physician), the screener would utilize the computer available in the exam room to conduct the survey and capture the information.
  - **Sample protocols/agendas for staff training related to the screening process and their specific role** – Wherever possible, we utilize the "train the trainer" model. This approach helps mitigate effects of staff turnover of staff absences. The training itself has two components to it:
    - First, trainees review and study the goals of the program, the details of the workflows and the guidelines set out to implement those workflows.
    - The second component of training is learning how to execute the workflows using the technology platform supporting the program. This training involves a detailed walkthrough of the software platform functionality, performing simulated patient activities (e.g. mock patient registration, screening, program enrollment, profile updates, case management activities, etc.).
    - Upon completion of training, the trainees are asked to perform a set of tasks – a test – that earns them a certification to conduct the program workflows in the field
  - We found that the most effective approaches are to conduct the training as a group-based activity. The training typically lasts 4 to 6 hours and at times, we split the training activities into multiple days, covering the programmatic level and workflow details on day 1, and dedicating day 2 to execution of the workflows through the use of the technology platform.

  - **What best practices have you developed/used to ensure patients fill out questions accurately?**
    - **Do you have sample scripts/processes for introducing patients to the screener (whether paper or electronic) in a manner designed to get the most accurate/honest information available** –

    The best approach to ensure accurate collection of information is rooted in the trust established between the patient and screener. While straight forward, this notion is very nuanced. The survey

requests sensitive information that patients may not be ready, or feel comfortable, sharing. There are several strategies that we employed to ensure patient buy-in:

- In cases where we needed to bring on additional staff to support the screening workflows, we were very careful to select candidates who have had experience engaging with community members (especially vulnerable populations), who upheld and acted out our organization's core values, who demonstrated empathy, compassion and who were approachable. We also ensured that the screeners were able to communicate in the native language (Spanish) that the vast majority of our population speaks.
- The actual location of the screen matters. When patients take surveys on their own and fill them out in the lobby (as some of our workflows dictate), the patients may be reluctant to fully engage with the survey. To address this concern, we have trained our screening associates staff to monitor the lobby and those taking the survey while walking around and proactively offering help to those patients.
- There are questions on the survey that are more sensitive in nature than others (e.g. personal safety). In these cases, we have worked with our screening sites to provide private areas (vacant "mommy rooms", conference rooms, etc.) for the screener to engage the patient and complete the survey.

In terms of our approach to introducing the survey, we made sure that the language is aligned with the reading/education level of our population. We describe the purpose of the program and review the data sharing needs for the project. We emphasize that this is not a welfare program and that their data will only be shared with the program partners, and only for the purposes of the program.

- **What format did you decide to use and what factors were part of your decision (electronic or paper)?** – Please see the response to question 1. Ultimately, the data we collect is gathered in a secure, HIPAA compliant, cloud-based referral and case management system, Pieces Iris™. We strive to have all of our workflows adopt the electronic platform, as the platform serves as the backbone of our Connected Communities of Care model. The goal of the model is to enable real time exchange of patient information (clinical and social) among all care provider partners (clinical and community based). Our platform has been used in the community for over 5 years with significant levels of adoption.
- **When does the screener take place - Prior to the patient's visit?-**
- Program guidelines indicate that screening can take place prior, during, or shortly after the visit, depending on the setting, per CMS recommendations. However, it is difficult to connect with the patients following their visit. Telephonic outreach is less effective in getting patient buy in to participate in the survey. Given these findings, we determined that the best approach is to screen the patient at the time of their clinical visit, when they are present and engaged.
    - **Timing, frequency and follow up to screening for FI and other SDOH** – Screening at every clinical encounter with navigation for high-risk members. There are no pre-scheduled follow-up screening, however, patient is re-screened every time they come in contact with the health system
- **Are there examples of integrating food insecurity screening with the other social determinants of health**- Yes. patients are screening for at least five core SDoH, including HUFTA. In Dallas, in addition, we screen for levels of physical activity, education assistance, employment need, financial strain, mental/behavioral needs.

- **Integration into EMR (EPIC, specifically)**
    - What EMR are you using?- most clinical partners use EPIC.
    - **What was your journey to integration within the EMR— sequence of key steps, important lessons learned, etc.-** This is currently a work in Progress
    - **iPads nor Microsoft PRO integrate with EPIC. Microsoft GO tablets will integrate with EPIC. For those using EPIC, are there other tech options we should consider to collect FI/SDOH information from patients?** – The integration question is not really a hardware question, rather a platform integration challenge. The best option is to use a software platform that integrates not only with Epic, but offers integration with the major EMRs (Epic, Cerner, McKesson, Allscripts, eClinicalWorks, etc.)
    - **How does it trigger a BPA?-** it depends on every organizations. We currently do not trigger BPAs in our model, however, the platform is set up to enable flagging functionality based on logic rules.
    - **Are FI/SDOH items within the screeners linked to other screenings, such as the readmission screener** – Yes. SDoH screening is linked with Risk Status screening (i.e., self-reported recent history of ED visit within the preceding 12 months). The screen can easily be integrated with other screeners, if needed. Would caution against having too many questions for any patient at any point in time – so, the shorter the screener, the better.
- **Visualization/Dashboard– within EHR/EPIC – Healthy Planet**
    - **Are there resources available about the type of education and training for providers about how to respond to a highlighted domain within EPIC/Healthy Planet/Examples of next steps by providers when there is a single or multiple SDOHs highlighted**- Yes. We work with Clinical sites to customize the response to SDoH by adapting evidence-based guidelines to their clinical workflows. What works for a large provider with many resources (e.g., referral to Social Workers) might not work for a single provider practice (e.g., twice per week, review positive screens and refer them, through Pieces Iris™, to appropriate agencies). Also, provider training and workflows depend on the type of SDoH identified: "child abuse" mandatory report to CPS within a short timeframe is different from "food insecurity" for which delayed referral is acceptable.
    - **Should we identify both the need and whether help is wanted from patients within Healthy Planet** – we are not using Healthy Planet. However, in Pieces Iris™, we do identify both the need and the patient's desire for intervention, or lack thereof.
- **Workflow**
    - **Once patients screen positively:**
        - **What information, resources, or interventions are provided and who provides it** – The screening personal provides information by creating a Community Resources Referral from a preexisting template using resources within the Community Resources Inventory. The Community Resource Inventory is a feature of our software platform. It is a crowd-sourced (curated, and quality-controlled) database of local community service providers offering information regarding the location, services provided, hours of operation and contact information for each listing.
        - **Can referrals/resources be generated within EPIC to provide** support – Yes, once Pieces Iris™ is integrated with EPIC.
        - **Identify partnering healthcare systems – link with adult care systems**
        - Pieces iris™ can identify partner social organizations and pull reports on overlapping members/cross-referrals from different health systems once the proper data sharing agreements among those organizations are in place.
        - **Are there successful approaches to addressing a positive screen**

- **Deploy a person or team of SWs, CHWs, care coordinators**- Yes. Referral through Pieces Iris™ to social services, navigation to social services, and monitoring of referral outcomes +frequent touch points with patients by CHW/SW/Care Coordinators

  - **Models of Collaboration**
    - **Food Bank**- we collaborated with the North Texas Food Bank and its 227 partner organizations for food insecurity. Additionally, partnering with homeless relief agency and rehabilitation facilities
    - **Food pharmacy** – no current collaboration with a food pharmacy. Would love to hear your experience.

- **Do we have the resources for addressing food insecurity, smoking, and other SDOH** –
- We have some understanding of it, there seem to be gaps in services compared with needs. However, we expect to learn more about community capacity to address SDoH as the Dallas AHC program progresses. We'll find out how community resources fare under the expected surge in demand from the AHC screening and referral interventions. The Quality Improvement aspect of the Dallas AHC grant is set up to assess community resources availability to address needs and define a sustainability plan for the future. Stay tuned!
  - **How do other organizations integrate services within their workflow**- at food pantries, we have worked out integrating screening as part of the services workflow, facilitated by the Pieces Iris™ platform.
- **Closed loop process** – a streamlined technology that provides visibility into community resources and allows for electronic referral and monitoring goes a long way to facilitate the process of closed loop referral. Pieces Iris™ does allow for closed loop referral. If not available, phone referrals and follow-up are needed. In-person referrals are possible if health and social systems are physically integrated.
- **How to operationalize the warm hand off from clinical staff to the financial or social services** – use a technology as above or else, define clear manual workflows.

- **Compliance**
  - **How do you get past the HIPPAA privacy concerns for patient referrals to outside agencies** – We do everything we can to ensure that we remain HIPAA compliant. This is crucial to the success of a model that links clinical sites together with community providers. The handling of patient information and implications of HIPAA are the primary items to resolve prior to the launch of any similar program. A careful understanding of the HIPAA legislation, and the required workflows will dictate the proper approach. For instance;
    - In the case of the platform being used to support our Connected Communities of Care model, since the software does not integrate with the partner EMRs, no patient-specific clinical information is being stored or shared. Also because it is technically a standalone application, it does not qualify as part of the protected record set as covered by HIPAA. That said, the information is still PHI and we put in place workflow precautions to ensure security of the patient information.
    - Patients are consented, and the platform is HIPAA secure. However, if the activity is deemed a Quality Improvement Program, Patient consent would not be required. However, subtleties of patient consent or data sharing, as it pertains to sensitive subjects such as Mental disease, substance abuse disorder, domestic violence, etc.
  - **If a SDOH domain is positive and something happens in the home and child is neglected is your organization held liable** – any legal liability from consequences of a known but unresolved social

problem? Might all reside in whether or not appropriate policies and procedures exist and were implemented, or if providers were trained to those policies and procedures. Liability might fall on the weakest link. In either case, the developed workflows need to address such situations (e.g. if a safety need is identified during a screen, the screener is to hand off the patient to the site's social worker, who then will follow established protocols to address the situation). Typically, in the clinical setting, the goal is to integrate the SDoH workflows into the daily operations of the clinical sites and as such, leverage the already existing processes for handling such situations.

- **What are the requirements to report caregivers if they are screened positive** – Child Protective Services Reporting Requirements for positive screening. E.g., Child Abuse reporting is mandatary and immediate, sometimes prior to patient discharge). Other SDoH with positive screening do not require any reporting to authorities.

- **Measurements of Success**
  - Are there evaluation models – The evaluations models for the Accountable Health Communities Model are still being developed. However, CMS will be evaluating the efficacy of the program based on the reduction of total care costs for those patients who were screened and navigated under the Model. To enable this evaluation, during the screening we collect the Medicare and Medicaid IDs of our patients – these identifiers will be used to align the programmatic performance data (e.g. patient-specific needs identified, services received, etc.) with the Medicare and Medicaid claims data. Historic data analysis will be used as the baseline measurement.
  - The populations involved in the Model are also very diverse. Evaluators will therefore attempt to create synthetic control and intervention groups from the data based on similar demographics and geographies.
  - ROI – Our ROI measures are very straight forward at this time. We will compare the investment made in the model with the associated reduction of ED utilization at participating hospitals, and the consequent avoidance of cost. Additionally, we will track Social ROI, by evaluating the number of lives touched by this program, number of needs resolved, etc.
  - User experience feedback – We will host monthly steering committee meeting for all the frontline staff executing the model workflows. Our QA staff will also work directly with the frontline staff to gather stories, insights and their feedback. At a programmatic level, we will gather feedback during the AHC Advisory Board meetings.