

## The Community Health Care Association of New York State's (CHCANYS) Training Strategies to Support PRAPARE Implementation in Diverse Practice Settings

JULY 2019

In 2017, The Community Health Care Association of New York State (CHCANYS) received private funding to provide practice facilitation to 10 New York City Federally Qualified Health Centers (FQHC), to implement the PRAPARE tool and capture standardized data on patients' social determinants of health (SDOH). CHCANYS leveraged select modules from the NACHC PRAPARE Implementation and Action Toolkit, and mixed individualized coaching with peer learning calls and learning events, to help the FQHCs develop a SDOH workflow. CHCANYS assisted the 10 FQHCs to pilot their SDOH workflow at a minimum of one site with an identified patient cohort. In addition, CHCANYS supported mapping of the FQHC's PRAPARE Smart form from the EHR to the Center for Primary Care Informatics (CPCI) – the CHCANYS data warehouse which runs on Azara Healthcare's DRVS software. All 10 FQHCs used eClinicalWorks (eCW) as their electronic health record system, and CHCANYS' experience working with these centers served as the driver for its application to the PRAPARE Round II Train the Trainer (TtT) Academy. CHCANYS sought to build on alignments between its SDOH training/technical assistance and the PRAPARE Round II TtT Academy curricula, to increase expertise, strengthen capacity and knowledge around coaching models that best support the implementation of PRAPARE in diverse practice settings.

CHCANYS worked with 1 FQHC during the Round II TtT Academy – Care for the

Homeless. Care For the Homeless (CFH) was 1 of the 10 health centers that participated in CHCANYS' initial PRAPARE initiative. Care For the Homeless is a FQHC, a 330H grantee and PCMH level III recognized practice. During its initial work with CHCANYS, CFH developed a SDOH workflow that was implemented at 5 sites with a cohort of shelter-based and homeless patients and administered by behavioral health providers (licensed clinical social workers). The PRAPARE Round II TtT Academy implementation workplan established between CHCANYS and CFH focused on sustaining this workflow and spreading it to all 14 sites within CFH's network.

### Training Model and Approach:

**Step 1:** CFH convened a project team to engage in Round II and address project milestones identified on the TtT implementation workplan.

**Step 2:** CFH and CHCANYS collaborated to agree on a meeting schedule to review the implementation workplan and milestones. Monthly project meetings were confirmed and conducted in a combination of on-site and remote coaching sessions. CFH and CHCANYS also made use of conference calls and emails on an ad hoc basis to communicate about project developments.

**Step 3:** CFH and CHCANYS collaborated to identify a project management tool to be used for the purposes of tracking milestones and identifying workplan successes and challenges. A Smartsheet template using

elements from the implementation workplan was developed by CHCANYS and shared with CFH project team virtually. CFH and CHCANYS used the Smartsheet to specify milestone details, leadership actions and the staff training needs associated with the health center's SDOH expansion initiative. The Smartsheet was updated after each coaching session by CHCANYS and reviewed during subsequent sessions to track progress.

**Step 4:** CFH project team members were assigned tasks, according to their role, aimed at ensuring that project milestones were realized in a timely manner. The health center utilized its Director of Behavioral Health to lead the Round II TtT initiative. This staff member was new to the organization and was not part of the health center's prior work with CHCANYS around implementing the PRAPARE tool.

As the health center project lead, the new staff member was responsible for re-messaging PRAPARE across the health center network, re-defining the SDOH workflow to the expansion sites, and engaging internal stakeholders to ensure continued buy-in for the project by leadership. Other members of the Round II TtT Academy project team included a Provider Champion, EHR/CPCI lead, PCMH administrator, Director of Practice Management and Nurse Managers, these project members were enlisted to provide training to site-based staff around understanding the value in collecting patients' social determinants of health, administering the PRAPARE tool and documenting patients' responses in the EHR.

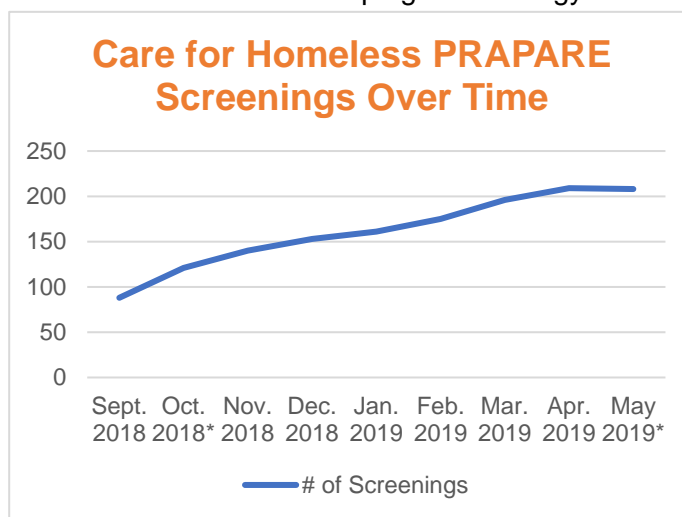
**Outcomes:**

Care For the Homeless was not able to achieve its overall goal of spreading use of

**Acknowledgements**

*This project was made possible with generous support from the Kresge Foundation.*

the PRAPARE tool from the initial 5 sites to the entire network (14 sites) during participation in the PRAPARE Round II TtT Academy. The health center was challenged by staff turnover which affected its ability to maintain a project team to work on the initiative, devote protected time to redefine and test a new SDOH workflow and train additional staff required to spread implementation of the PRAPARE tool. However, Care for the Homeless was successful in sustaining its existing SDOH workflow and developing a strategy for



reporting on SDOH data and sharing CPCI reports with internal stakeholders.

*\*PRAPARE Round II Train the Trainer Academy involvement; ~72 % increase from Oct. 2018 to May 2019. Note: Total Patients May 2019- 6,416. Data source: CPCI DRVS Azara Health*

The health center's adaptive reserve was undermined by the departure of the Behavioral Health Director who served as the project lead. The impact of this departure was exacerbated by the additional loss of the project's provider champion (Behavioral Health), and other administrative staff (EHR/CPCI lead and PCMH administrator) shortly after. In the absence of key project team roles, competing health center priorities converged to challenge initial leadership

*“PRAPARE helped the health center to inform their approach to population health management, [and] implementing PRAPARE has enabled the health center to reflect on patients’ complexity and current upstream clinical challenges. The health center’s Chief Medical Officer stated that ‘inclusion of the Social Determinants of Health factors in individuals’ problem lists is critical to reflecting the social complexity resulting in many of their clinical conditions.’” -- CHCANYS Team*

buy-in for expanding SDOH work. Some of these priorities included the opening of new health center sites, changes to the organization’s hierarchy, transitioning from a centralized oversight of health center sites to nurse-led practices. There was a temporary lapse in project oversight at the health center level as staff roles were transitioned and site infrastructure was re-addressed. In response to these challenges, CHCANYS convened a series of telephone conferences with health center leadership to identify strategies to maintain project momentum by re-scaling the work in alignment with the health center’s reduced capacity and real-time adaptive reserve. The health center agreed to proceed with the project utilizing a smaller team whose focus shifted from spreading SDOH screening across all sites to sustaining the prior SDOH workflow and developing a data strategy for a small cohort of patients.

CHCANYS and Care for the Homeless adapted the Academy’s implementation workplan to reflect the new, smaller, project team and minimized milestones. CHCANYS modified individualized coaching to include training and technical assistance to the reconstituted project team members and provided them with customized instruction on how to establish a SDOH data strategy to analyze data on the patient cohort. CHCANYS conducted several remote training sessions with the health center around validating SDOH data and running reports from the CPCI data warehouse. This training enabled the health center to increase its HIT capacity and proficiency in

understanding patients’ social needs. CHCANYS also leveraged its relationship with the New York Statewide Health Center Controlled Network (HCCN) to create an individualized SDOH Guide<sup>1</sup>, detailing how Care for the Homeless could use CPCI functionality to gain insight into patient complexity by identifying SDOH trends and patterns within the chosen cohort.

#### **Health Center Next Steps:**

Care for the Homeless’ next step is to continue the SDOH measure validation and run SDOH reports on CPCI. The health center hired a new Health Information Management Specialist and CHCANYS worked with new HIM staff on SDOH data validation and ensuring that SDOH fields were mapped correctly; please refer to the SDOH Guide on CPCI DRVS Azara<sup>1</sup>. This is an example of an implementation strategy that was adapted to meet the health center’s new needs. Moreover, the health center plans to expand the implementation of the PRAPARE tool in a trauma-informed context and person-centered approach in the near future.

#### **Value-Add of Train the Trainer Academy**

The PRAPARE Round II Train the Trainer Academy offered the opportunity for CHCANYS and Care for the Homeless to collaborate with peers and other organizations at the national and regional level. Through the TtT Academy, CHCANYS acquired tools, skills and expertise on coaching models that best

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support the implementation and expansion of the PRAPARE tool in diverse practice settings from Academy colleagues and facilitators. CHCANYS plans to implement the knowledge gained through participation in the Academy in current and future iterations of its PRAPARE support projects.

Moreover, participation in the PRAPARE Round II Train the Trainer Academy aligned with other PCA/HCCN goals focused around assisting health centers to collect SDOH data and develop a spread effort toward

population health management. The academy work was incorporated into ongoing training and technical assistance to health centers around implementing the PRAPARE tool, CHCANYS plans to spread ongoing efforts to help additional FQHCs use SDOH data for delivery transformation and payment reform.

**References:**

1. CHCANYS SDOH Guide on CPCI DRVS Azara, please see attached.

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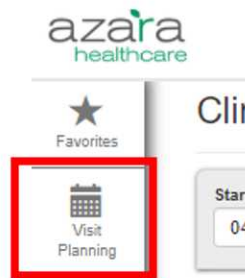
## Where you can find SDOH data

- 1) On the patient level (Care Management Passport)
  - a. When you select a patient in the care management passport, the patient history will appear, which includes Social Determinants of health

### Social Determinants of Health, 7

HOMELESS	FOOD	TRANSPORT-MED
EDU	HISP/LAT	LANGUAGE
MIGRANT		

- 2) On the Patient Visit Planning (PVP) Report



- a. The PVP report will indicate SDOH items already captured (on the left below) and alert the practice if the assessment is missing (on the right below).

Augustine, Greg				2 Scheduled Appointments			
12:30 PM   Wednesday, April 10, 2019				Export this Provider to PDF			
Pelosi, Ty				Visit Reason: Annual Visit			
MRN: 5373265	Sex at Birth: M	Phone: 413-793-9596	Last Well Visit: 1/3/2019	PCP: Doe, Jane			
DOB: 3/19/1967 (52)	Gender Identity: Other	Language: English	Portal Access: 10/27/2017	Payer: Medicare			
	Sexual Orientation: Straight (no...)	Risk: Low (20)		Care Manager: Kristi Ballance			
<b>Diagnoses (8)</b>				<b>Alert</b>	<b>Message</b>	<b>Most Recent Date</b>	<b>Most Recent Result</b>
AMI	COPD	HTN-E	Pap Anal	Missing			
ASM	DM	IVD	Gonorrhea	Missing			
CAD	HIV		LDL	Out of Range	1/3/2019	150.0	
			AUDIT	Missing			
			CAT	Missing			
<b>Risk Factors (6)</b>				<b>SDOH Needs Assessed</b> Missing			
ANTICOAG	IDDD	SMI					
Chronic Opioid Tx	MSM	TOB					
<b>SDOH (13)</b>				<b>Open Referral w/o Result</b>	<b>Specialist/Location</b>	<b>Ordered Date</b>	<b>Appt. Date</b>
HOUSING	CHILDCARE	STRESS	Allergist	Ellen Bell / Burlington	1/3/2019	1/27/2019	
FOOD	TRANSPORT-	RACE	Gastroenterology	John Smith / Boston	1/3/2019	1/16/2019	
UTILITY	MED	MIGRANT	Nutritionist	Jim Cohen / Boston	1/3/2019	1/29/2019	
PHONE	TRANSPORT-		Radiology	Samantha Frost / Brookline	1/3/2019	1/16/2019	
MATERIAL	NONMED		Gastroenterology	Jim Cohen / Boston	11/7/2018	11/8/2018	
SECURITY	ISOLATION		Nutritionist	Jim Cohen / Burlington	8/22/2018	8/28/2018	



3) In the Registry on the side panel for a patient list  
**(Registries → Social Determinants of Health (SDOH))**

- ★ Favorites
- Calendar Visit Planning
- Person Care Management
- Dashboard Dashboards
- Report Reports
- Bar Measures
- Registry Registries**
- Admin

- Primary Care: Adult
- Primary Care: Adult Female
- Primary Care: Adult Male
- Anticoagulation
- Asthma
- Depression
- Diabetes
- Flu - Adult
- HIV
- Hypertension
- Immunizations
- Methadone Medication
- Chronic Pain
- Office Based Opioid Treatment
- Opioid Medication - Potential Misuse
- Pain Management
- Primary Care: Pediatrics
- Risk Registry Default
- Social Determinants of Health (SDOH)**
- Pregnant\_Patients
- Custom Registries

a. This will open the below screen.

Registries - Social Determinants of Health (SDOH) ⓘ ☆ 📄 📧

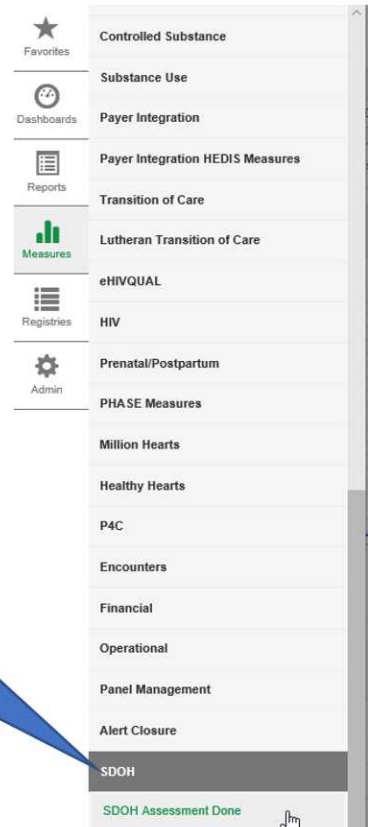
Start Date: 04/03/2019 End Date: 04/10/2019 Centers: Centers Providers: Providers [Update]

View: Registry Value Sets

Center Name	Name	Questionnaire Completed Date	Age	MRN	Gender Identity	SDOH Tally	SDOH Triggers
Neighborhood Health Center	Hazouri, Laine	4/6/2019	20	5944972	Transgender Female/ Male-to-Female	15	HOMELESS HOUSING FPL<200% PHONE MEDICARE CLOTHING TRANSPORT-NONMED ISOLATION SAFE STRESS EDU RACE HISP/L LANGUAGE MIGRANT
Neighborhood Health Center	Hoshali, Robt	4/4/2019	27	5143610	Female	13	HOUSING FOOD UTILITY PHONE MATERIAL SECURITY CLOTHING ISOLATION VIOLENCE STRESS EDU R HISP/LAT MIGRANT
Neighborhood Health Center	Radej, Grant		24	7269529	Male	10	HOMELESS FPL<200% FOOD UTILITY PHONE TRANSPOR MED ISOLATION VIOLENCE STRESS EDU
Neighborhood Health Center	Cagney, Martin	4/5/2019	37	4882616	Other	11	FPL<200% FOOD MATERIAL SECURITY MED/CARE CHILDCARE CLOTHING TRANSPORT-NONMED ISOLATION STRESS LANGUAGE MIGRANT
Family Health Center	Glock, Kristie	3/16/2019	30	8454709	Transgender Female/ Male-to-Female	15	HOUSING FPL<200% FOOD UTILITY PHONE MATERIAL SECURITY MED/CARE CLOTHING TRANSPORT-NONMED ISOLATION RACE LANGUAGE MIGRANT
Access Community Health	Trivané, Lenora		30	4613832	Other	7	FPL<200% FOOD UTILITY ISOLATION RACE HISP/LAT MIGRANT

1 of 12 pages (67 items) Page Size: 6

- 4) In the Measures on the side panel for aggregate information about;
  - a. Percentage of all patients seen by the health center who also completed a Social Determinants of Health Assessment (called **SDOH Assessment Done**) – make sure to click on SDOH first to open up additional options



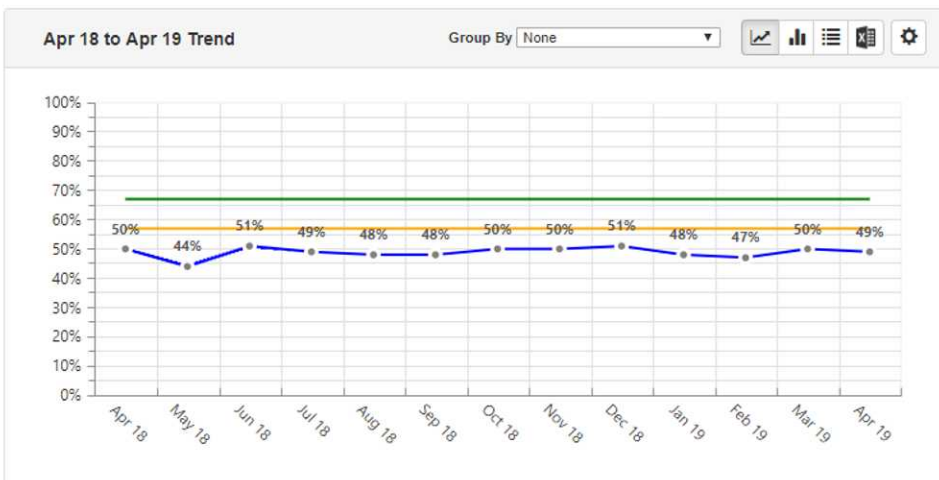
This list is quite long, you may need to scroll down to get to where you need

- i. Once you click on the selection above, it will open the page below

### Social Determinants of Health Assessment Done i

Like most reports on Azara you can also filter by specific timeframes (e.g. year, quarter, etc.), providers, locations, etc. here

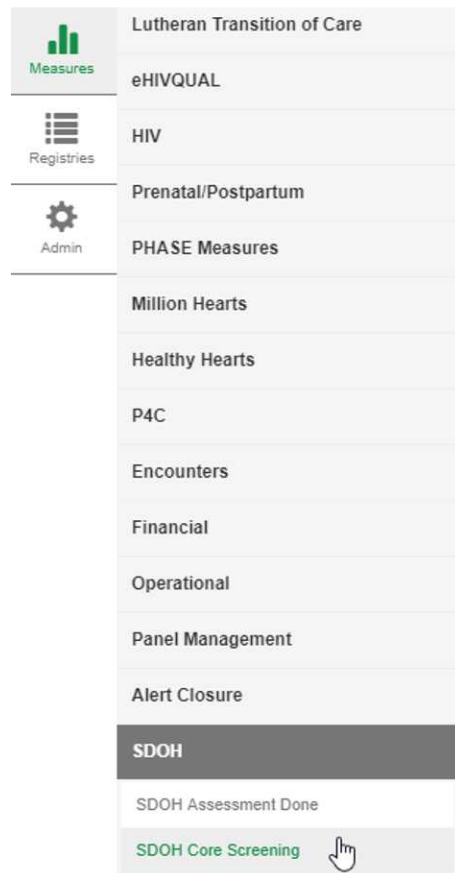
View: [Measure Analyzer](#) [Detail List](#) [Value Sets](#) Target:  Primary Target : 67.0% Secondary Target : 57.0%



**Apr 19 Result**

- Selected : 50% i
- Best Center : 52% i
- Network Average : 50% i
- Center Average : 50% i

b. Percentage of patients who had a SDOH screening that met specific criteria



Lutheran Transition of Care  
 Measures  
 eHIVQUAL  
 HIV  
 Registries  
 Prenatal/Postpartum  
 Admin  
 PHASE Measures  
 Million Hearts  
 Healthy Hearts  
 P4C  
 Encounters  
 Financial  
 Operational  
 Panel Management  
 Alert Closure  
**SDOH**  
 SDOH Assessment Done  
 SDOH Core Screening

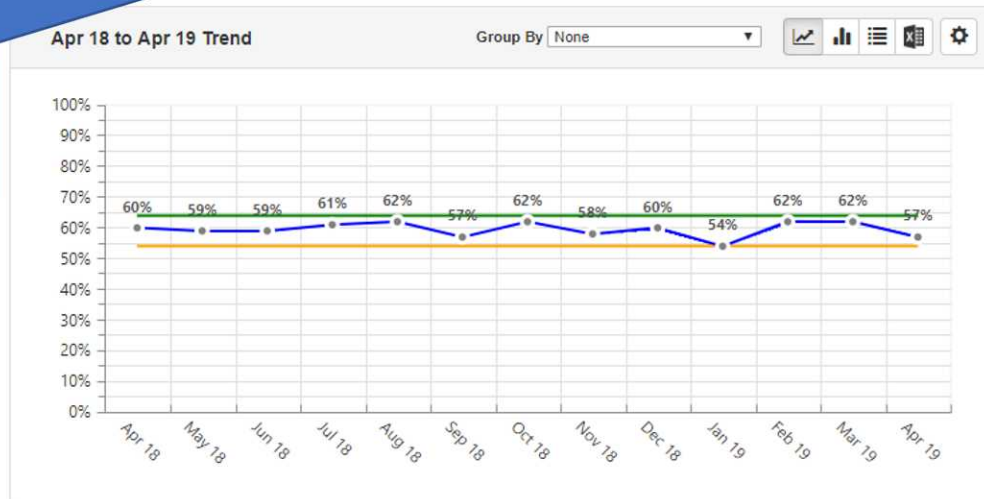
i. Once you click the above, it will open the page below

### Social Determinant of Health Core Criteria Screening i

Period Type: Month | Period: April 2019 | Centers: Centers | Providers: Providers | [Update](#)

View: [Measure Analyzer](#) **[Detail List](#)** [Value Sets](#) | Target: Demo | Primary Target: 64.0% | Secondary Target: 54.0%

You can select "Detail List" for a list of patients that meet the denominator criteria

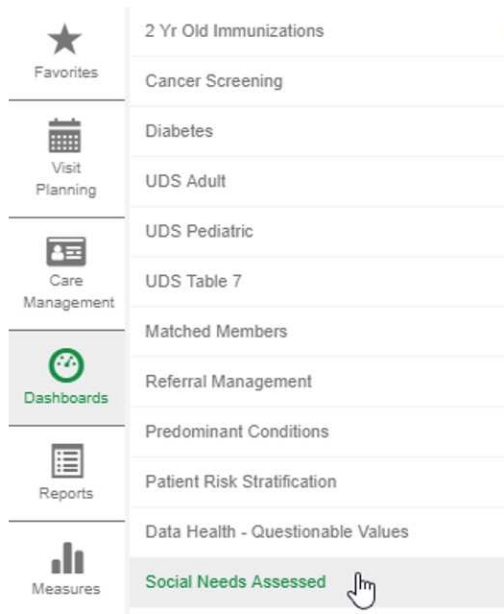


Apr 19 Re:

- Selected : 57
- Best Center :
- Network Ave:
- Center Avera

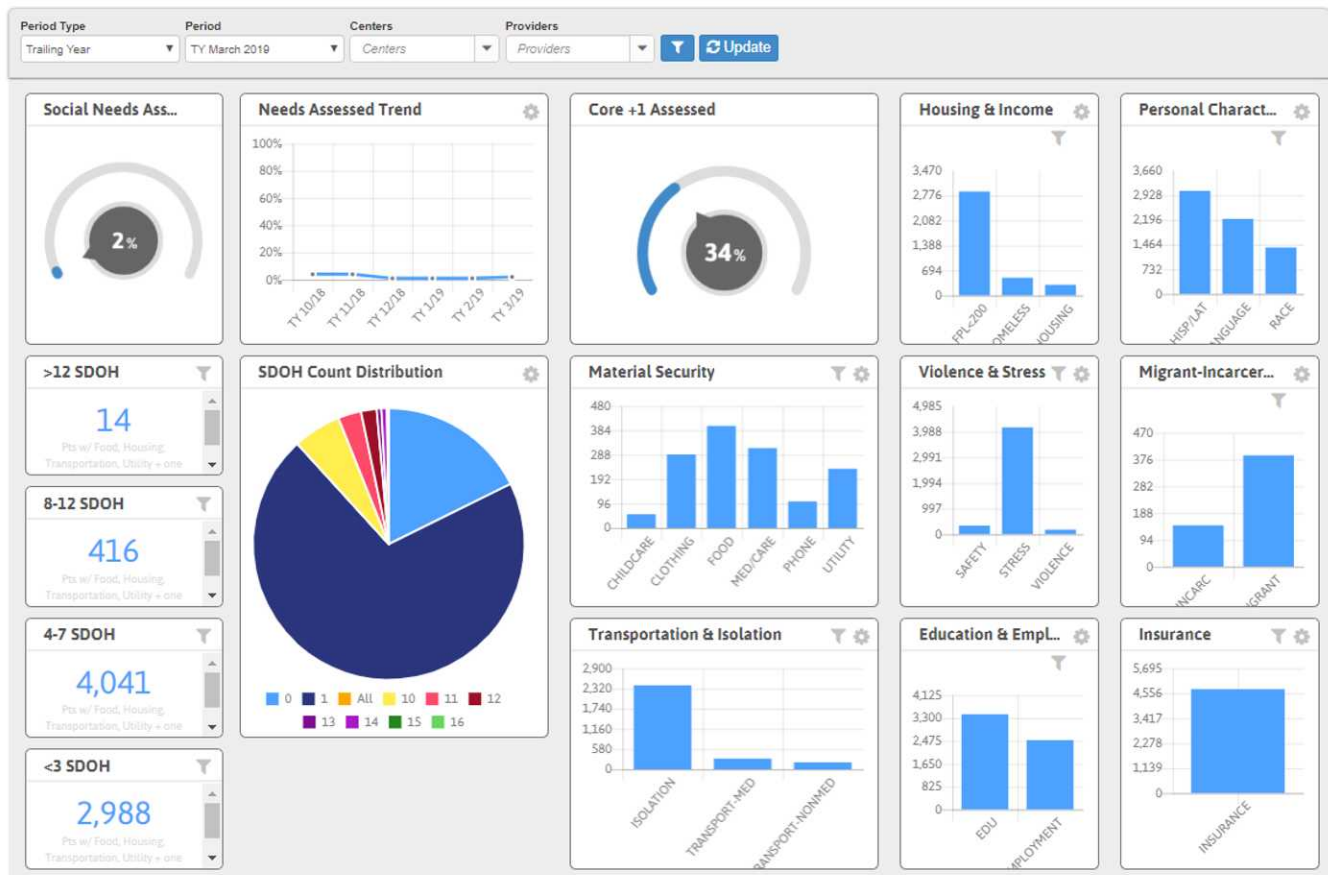


5) Lastly, SDOH information can be found in the dashboards panel (**Dashboards → Social Need Assessed**)



- a. A page with multiple widgets will open.
  - i. When you hover your mouse over a widget, a short explanation of what the widget is measuring will appear

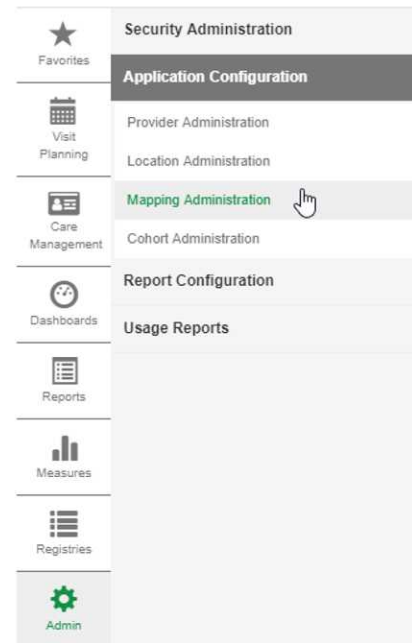
Dashboards - Social Needs Assessed !



## Validation of SDOH Data

You would validate SDOH data the same way you would validate any type of measure in Azara.

- 1) Select the Mapping Administration Option (**Admin → Application Configuration → Mapping Administration**)



- 2) Depending on how PRAPARE or another SDOH form is mapped in your eHR, the mapping category you select may be different.
  - a. The categories you select will likely stem from **Race, Ethnicity, Migrant Status, Language, Homelessness Status** and **Maintenance (Structured Clinical Data)**.
  - b. When you select your mapping category, also select the center (if applicable), and time frame you would like to map for. (Note: If you select a timeframe in which what you're mapping has not start in your eHR, you will also not be able to find anything in Azara.)

### Unmapped Values by Mapping Category ⓘ

Mapping Category  
All

Center  
Family Health Center

Time Period  
Last Year

	Unmapped EHR Values
	0
	1
	0
	0
	0
	3
	2
	23

- c. When you select the above, the below screen will open.

Select the category you want to map into Azara

## Mapping Administration ?

Mapping Category: Maintenance (Structured Clinical I) ▼
 Center: Family Health Center ▼
 Time Period: Last Year ▼

Select the center (if applicable)

Select the timeframe of when you want to map the items for



## Mapping Summary

Below is a summary of DRVS standard values mapped from your EHR. Click on any value to see the EHR detailed mappings.

[Mapped DRVS Values \(400\)](#)
[DRVS Values With 0 Count \(39\)](#)

Info	Mapped Maintenance (Structured Clinical Data) Value	Distinct Count
<span>?</span>	Unmapped	23
<span>?</span>	Smoking Status	2
<span>?</span>	A1c	1
<span>?</span>	Ab screen	1
<span>?</span>	ADHD Self Management	1
<span>?</span>	Adherence To Treatment	1
<span>?</span>	Advance Care Planning Discussion	1
<span>?</span>	Advance Care Planning Document	1
<span>?</span>	Advance Directives	1
<span>?</span>	Alcohol Screening	1
<span>?</span>	All First Molars Non-Sealable	1
<span>?</span>	ALT	1
<span>?</span>	Anal Sexual Activity	1
<span>?</span>	Anxiety Screen	1
<span>?</span>	AOD Follow-Up	1

These indicate the values that can be mapped into Azara. Select the row you would like to map details into. (Your selection is always highlighted)

This indicates the number of details that exist in the value

Clicking any of these values will open up selections for you to map the text into; please see below

## EHR Mapping Details

The table details all unmapped and mapped items from your EHR based on the selected row in the table to the left.

[Unmapped \(23\)](#)
[All](#)

Mapped Maintenance (Structured Clinical Data) Value	Count	Source EHR Text
Unmapped	656	308
Unmapped	653	13
Unmapped	637	Financial Strain -Food OCHIN
Unmapped	634	171
Unmapped	626	67
Unmapped	626	101
Unmapped	622	55
Unmapped	619	47
Unmapped	616	251
Unmapped	612	238
Unmapped	605	Ignore
Unmapped	599	297
Unmapped	597	173
Unmapped	595	Financial Strain - Utilities OCHIN
Unmapped	592	190
Unmapped	587	7

The # of times the text shows up in your eHR

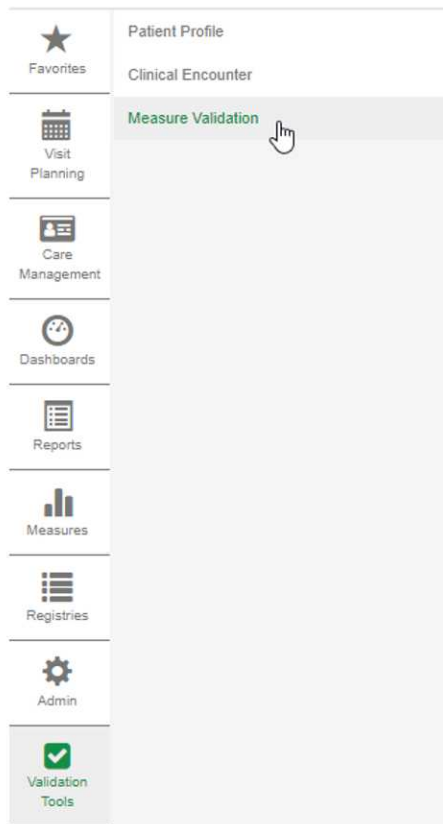
This is the text or value that shows up in your eHR

- d. When you click “unmapped,” options will appear below. When you select a particular value, the eHR text will be mapped to that value. (Please Note: Not all values that exist in your eHR can be mapped to Azara. For those items, you can leave it unmapped or put it in archive.)

Mapped Maintenance (Structured Clinical Data) Value	Count
Unmapped	
A1c	
Ab screen	
ADHD Self Management	
Adherence To Treatment	

- e. The above process will have to be repeated as many times as needed for your purposes.

- 3) After everything is mapped correctly into Azara, you need to validate whether Azara is picking up items you need it to. (**Validation Tools → Measure Validation**)





b. The below screen will appear. Click on “Create New Workbook.”

Measure Validation Workbooks

**Create New Workbook**

Name	Center	Status	Create Date	Created By	Measure Count
Provider Incentive Comp Validation	Neighborhood Health Center	Open	12/4/2017 3:51:23 PM	mika.napawy@szarahealthcare.o	10

c. Options will appear asking how you would like to create the workbook.

Measure Validation Workbook **Name the Validation Workbook**

Prior to creating a workbook, please ensure that all measures have been processed for the chosen period. To create a blank workbook, please select # of patients. Once a workbook has been created, workbook name cannot be changed and no additional measures can be added.

**Name:**

**Center:**

**Default Period Type:** Trailing Year

**Period:** TY March 2019

**Service Line:** All Service Lines

**Measures To Include:**  Standard  Custom

**# of Patients:** 5

**Create**

**Measures**

Type to search for a measure

**Selected Measures**

Name	Category	Options

Select the period you want to validate

Selecting Standard will automatically pull data for UDS measures, select custom to put in your own measures

When you're all set, click create

Type in the measures you would like to validate. For the purposes of this project, select "Social Determinants of Health Core Criteria Screening" and "Social Determinants of Health Assessment Done"

Select the number of patients you would like to validate. Please note that the number selected will indicate in the numerator, denominator or exclusions (if any). E.g. A selection of 5 will yield up to 15 patients to validate

d. A workbook will open to look similar to the below.

Measure Validation Workbook - Test [Back to List](#)

Numerator

Name	MRN	Sex at Birth	Date of Birth	Medicaid-Number	Usual Provider	Inactive	Deceased	Most
agement								

1 of 1 pages (5 items)

Denominator

Name	MRN	Sex at Birth	Date of Birth	Medicaid-Number	Usual Provider	Inactive	Deceased	Most

1 of 1 pages (5 items)

Exclusions

No Exclusions Found.



- e. The workbook can be pulled into an excel document where you would validate information stored in Azara with the eHR.
- 6) If there are any issues, or items are not correctly mapped, please create a ticket with Azara.
  - a. You would do this by selecting on the top right corner of the screen “Report an Issue.”



- b. You will be asked to create an account specific for tickets and additional questions. The browser for tickets will look like the below.



## Azara Home

What do you need help with?



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Ask a question about a report, data within a report, or general q...



[Report an Issue - Azara Support](#)

Report an issue with a report or with an undesirable behavior in...



[Request Access - Azara Support](#)

Request a new account, assistance with logging on, or addition...