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

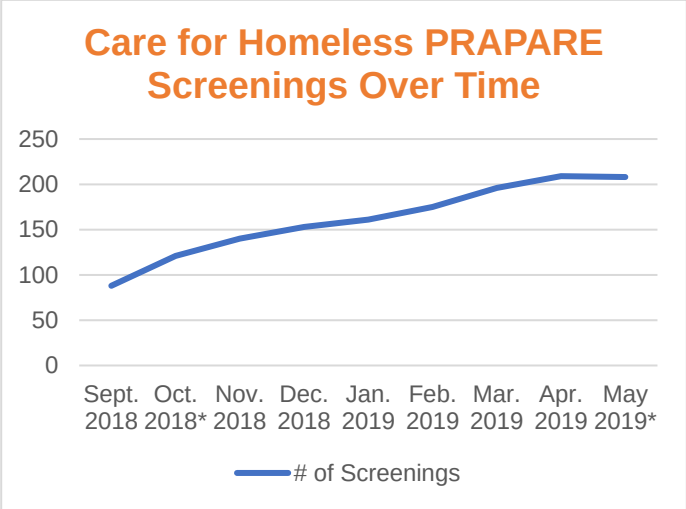
elements from the implementation workplan was developed by CHCANYS and shared with CFH project team virtually. CFH and CHCANYS used the Smartsheet to specify milestone details, leadership actions and the staff training needs associated with the health center's SDOH expansion initiative. The Smartsheet 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 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

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"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 to 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[1], 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[1]. 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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COMMUNITY HEALTH CENTER FQHC QUALITY

Where you can find SDOH data

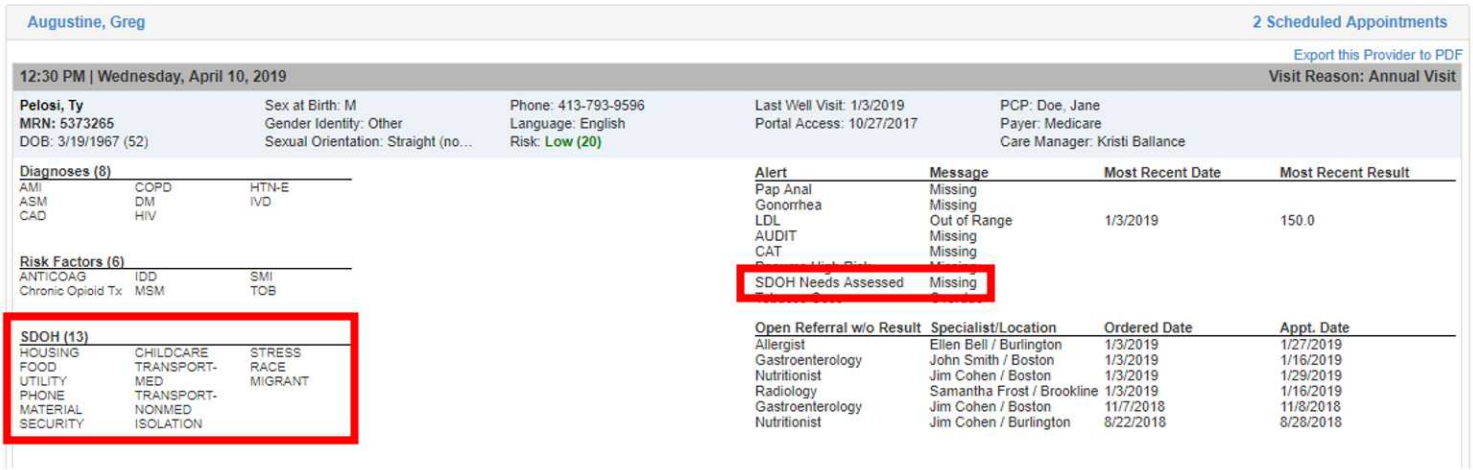
1) On the patient level (Care Management Passport)
    a. When you select a patient in the care management passport, the patient history will appear, which includes Social Determinants of health

Social Determinants of Health, 7

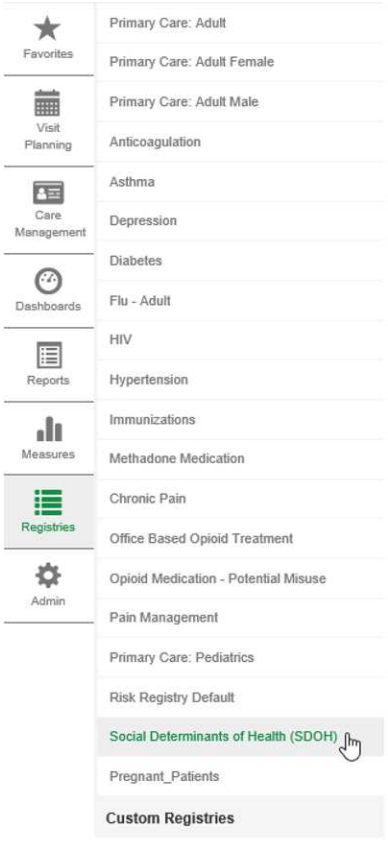
HOMELESS	FOOD	TRANSPORT-MED
EDU	HISP/LAT	LANGUAGE
MIGRANT		

2) On the Patient Visit Planning (PVP) Report

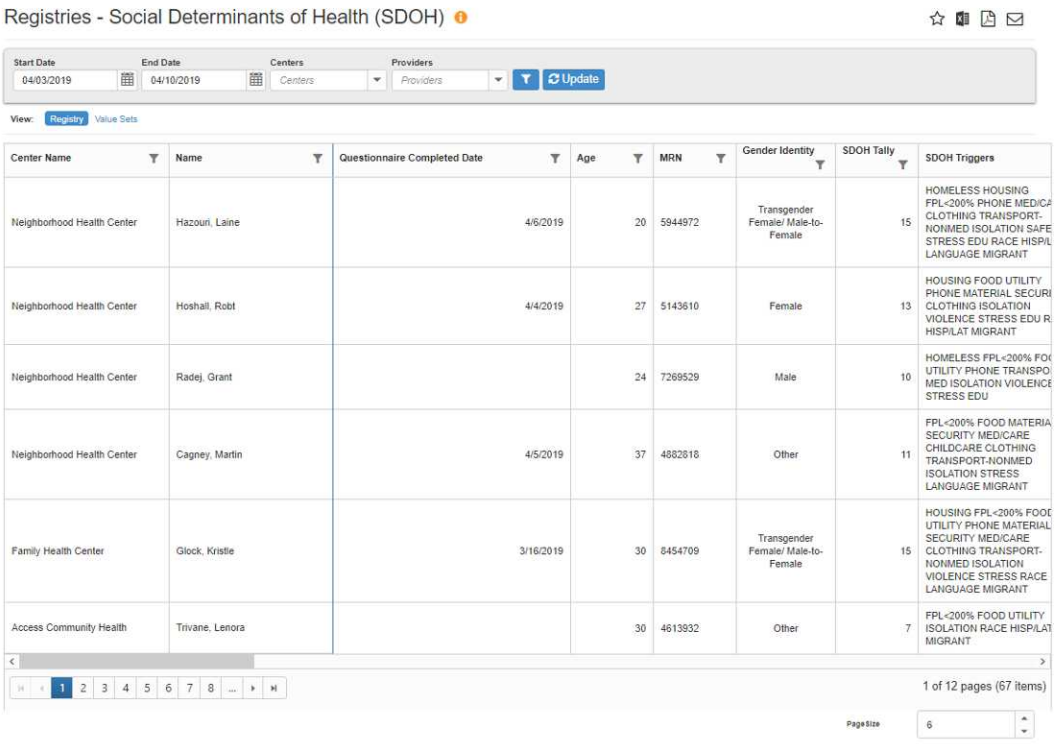
    a. The PVP report will indicate SDOH items already captured (on the left below) and alert the practice if the assessment is missing (on the right below).



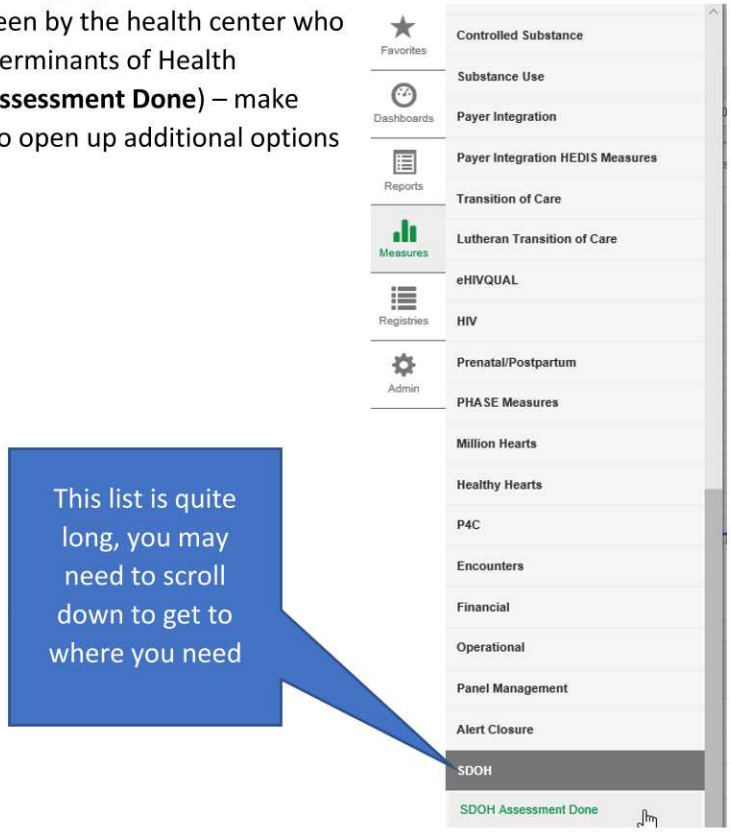
3) In the Registry on the side panel for a patient list (**Registries → Social Determinants of Health (SDOH)**



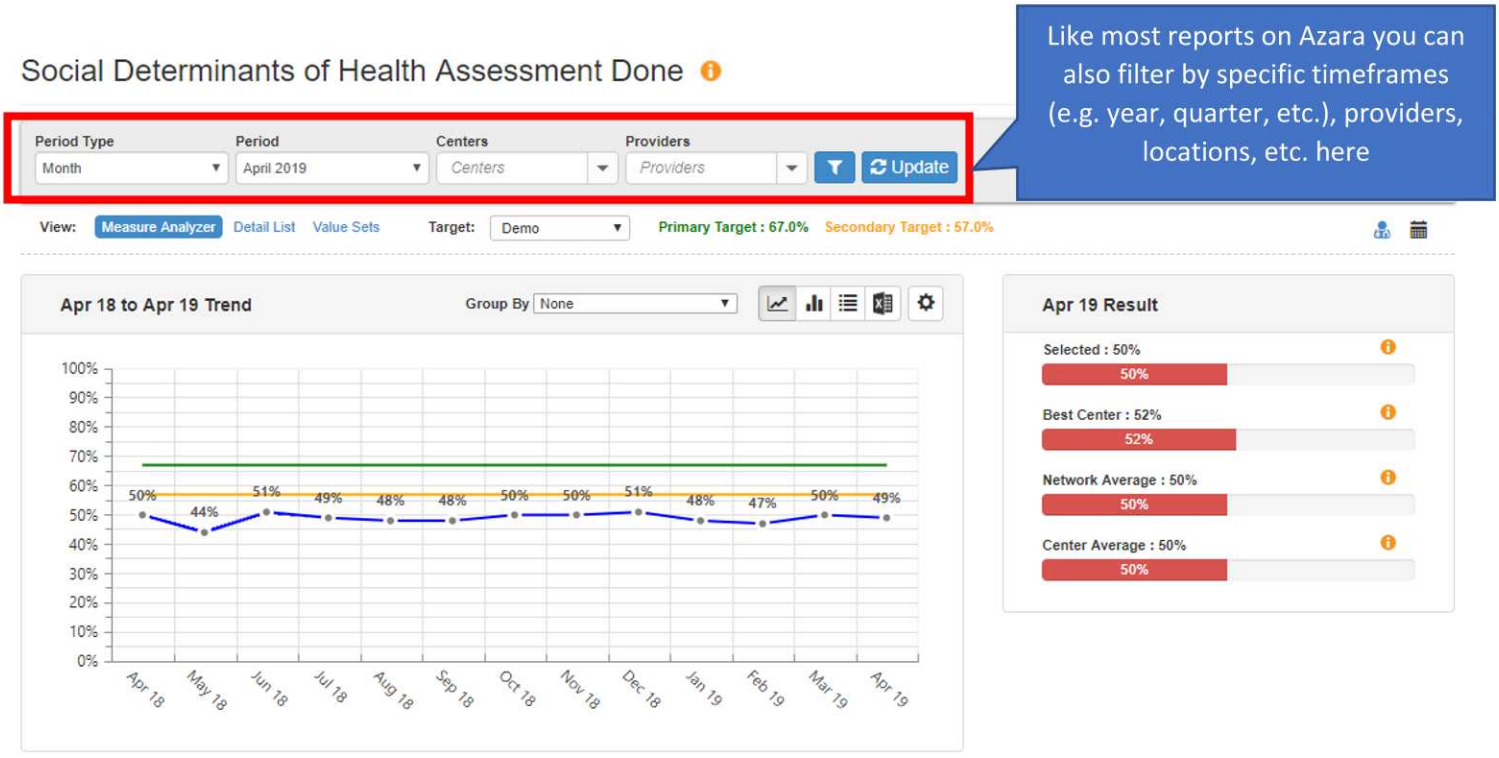
a. This will open the below screen.



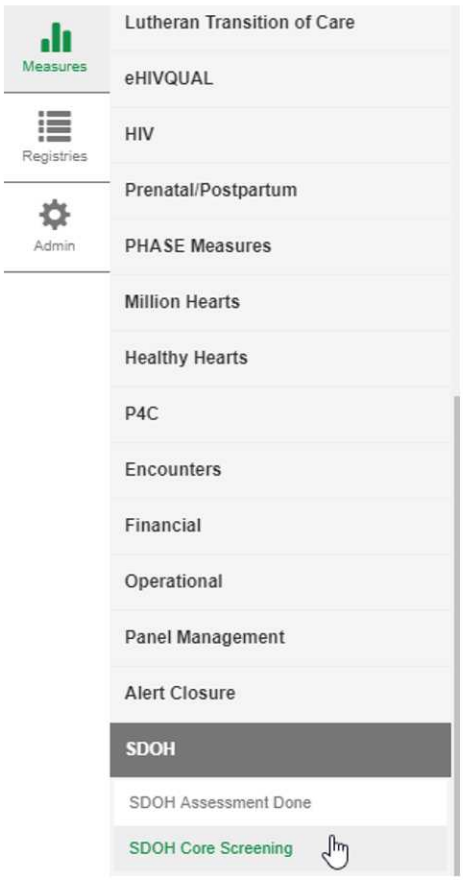
4) In the Measures on the side panel for aggregate information about;
   a. Percentage of all patients seen by the health center who also completed a Social Determinants of Health Assessment (called **SDOH Assessment Done**) – make sure to click on SDOH first to open up additional options



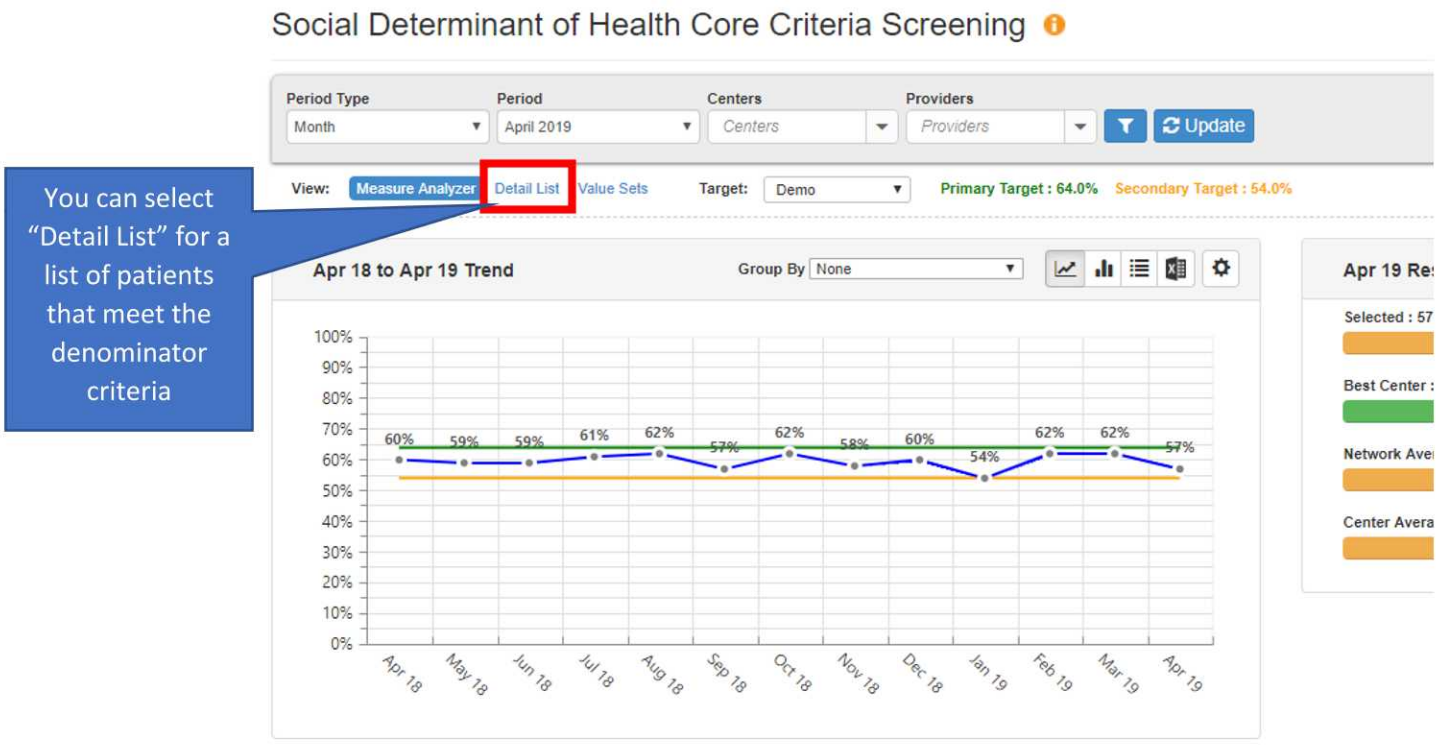
   i. Once you click on the selection above, it will open the page below



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

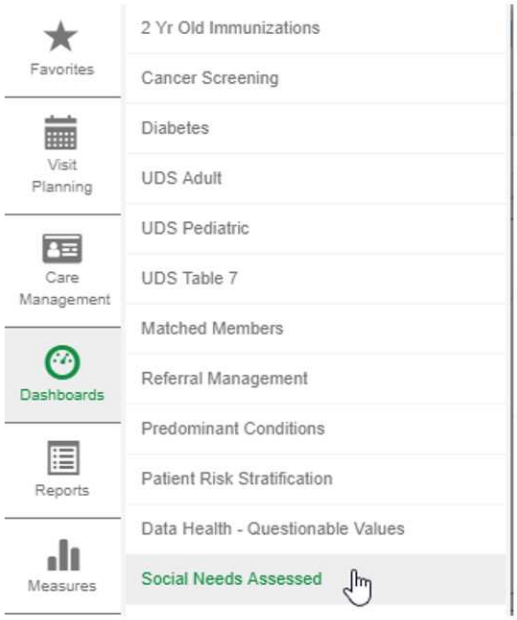


i. Once you click the above, it will open the page below

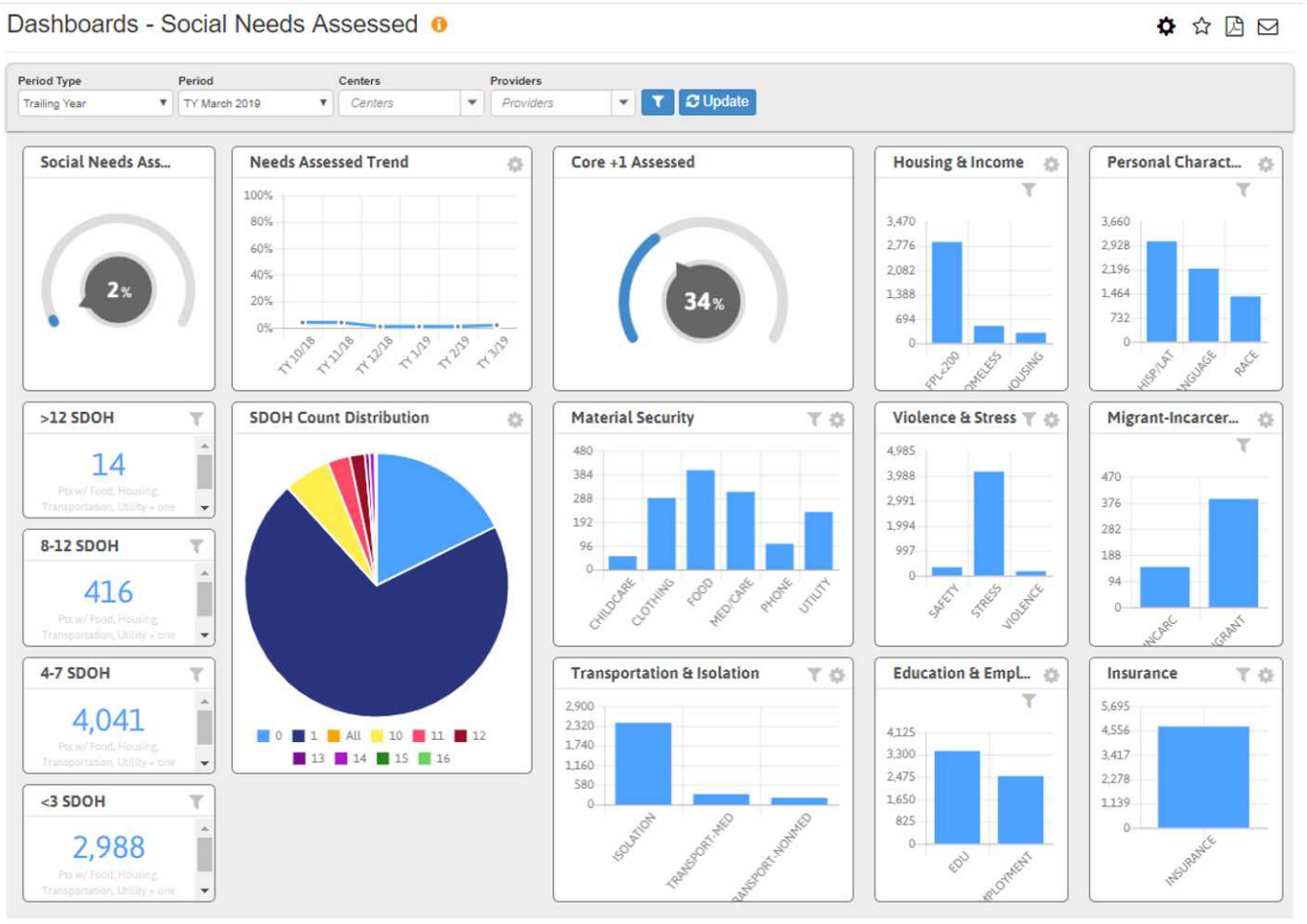


You can select "Detail List" for a list of patients that meet the denominator criteria

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



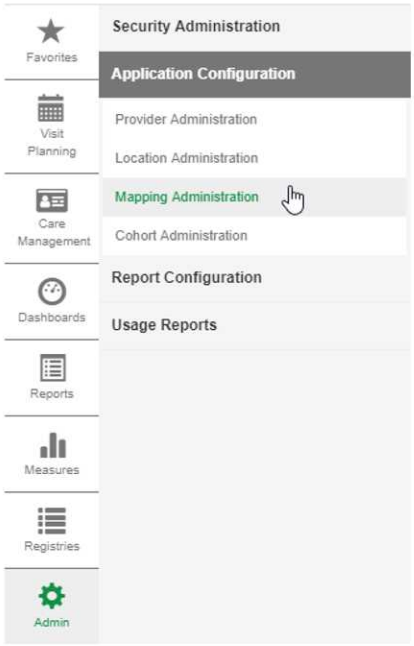
a. A page with multiple widgets will open.
   i. When you hover your mouse over a widget, a short explanation of what the widget is measuring will appear



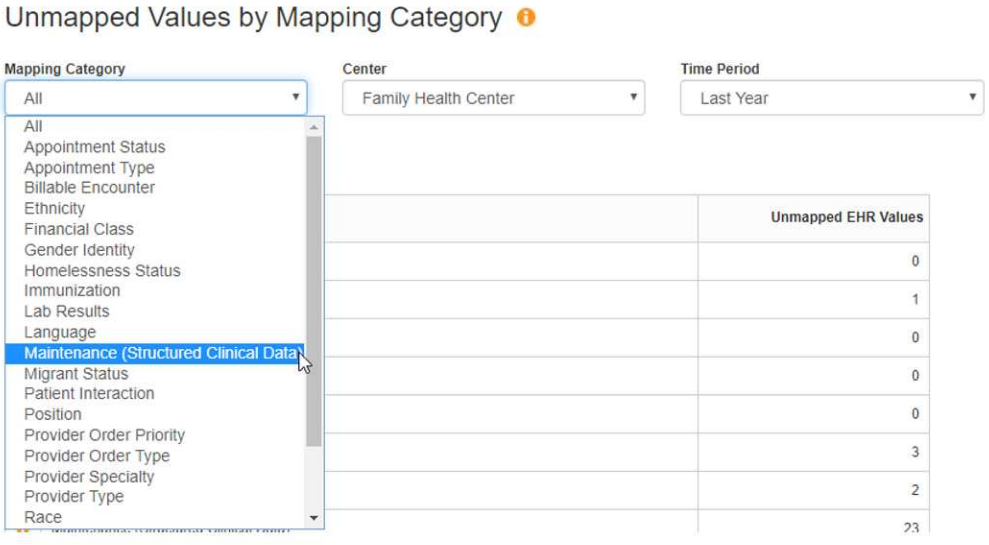
Validation of SDOH Data

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.)



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

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COMMUNITY HEALTH CENTER FQHC QUALITY

Select the category you want to map into Azara

Select the center (if applicable)

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

Mapping Administration

Mapping Category: Maintenance (Structured Clinical [

Center: Family Health Center

Time Period: Last Year

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
	Unmapped	23
	Smoking Status	2
	A1c	1
	Ab screen	1
	ADHD Self Management	1
	Adherence To Treatment	1
	Advance Care Planning Discussion	1
	Advance Care Planning Document	1
	Advance Directives	1
	Alcohol Screening	1
	All First Molars Non-Sealable	1
	ALT	1
	Anal Sexual Activity	1
	Anxiety Screen	1
	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.

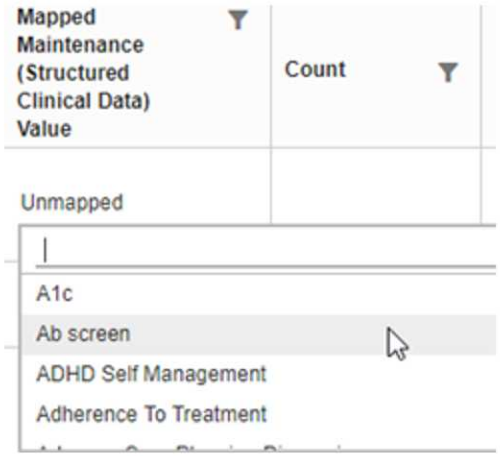
Unmapped (23) | All

The # of times the text shows up in your eHR

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

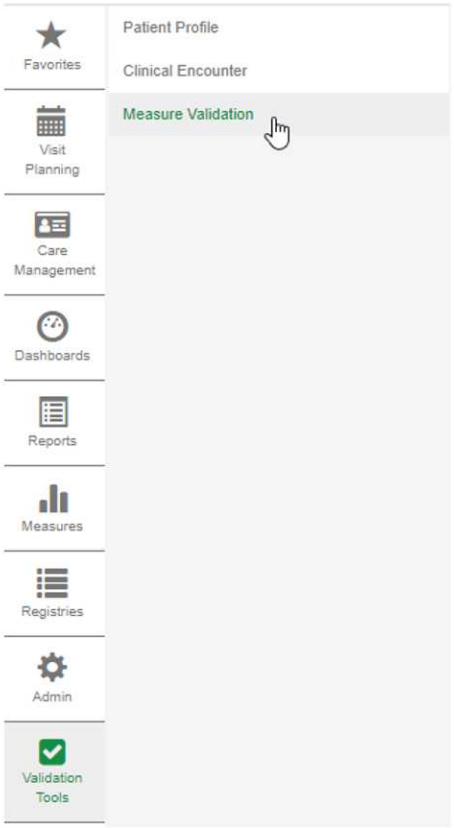
Mapped Maintenance (Structured Clinical Data) Value	Count	Source EHR Text
Unmapped	656	308
Unmapped	653	13
Unmapped	637	Financial Strain -Food OCHIN
Unmapped	634	171
Unmapped	626	67
Unmapped	626	101
Unmapped	622	55
Unmapped	619	47
Unmapped	616	251
Unmapped	612	238
Unmapped	605	Ignore
Unmapped	599	297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

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.)

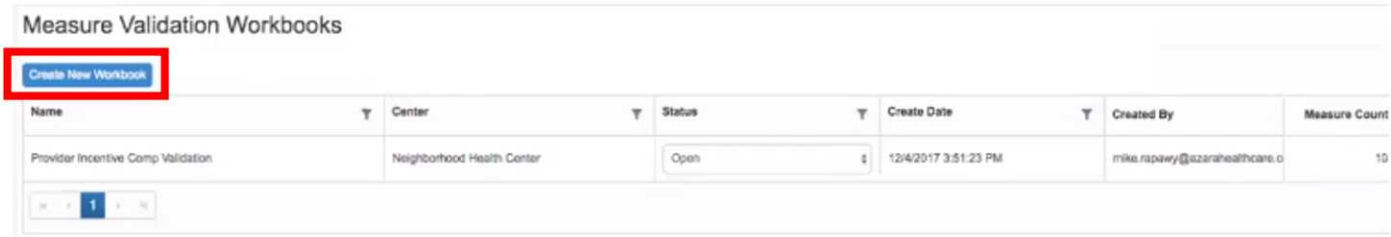


e. The above process will have to be repeated as many times as needed for your purposes.

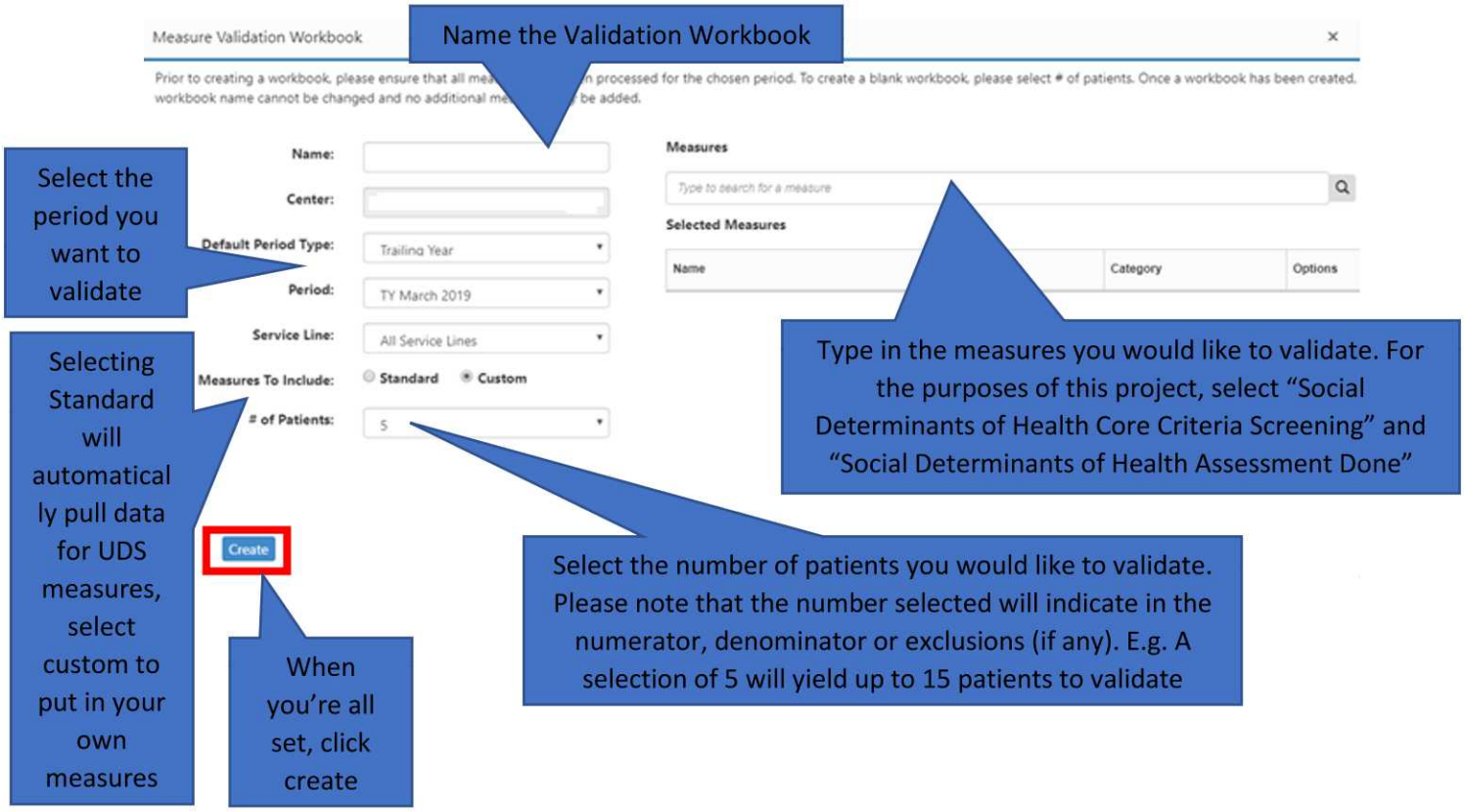
3) After everything is mapped correctly into Azara, you need to validate whether Azara is picking up items you need it to. (**Validation Tools → Measure Validation**)



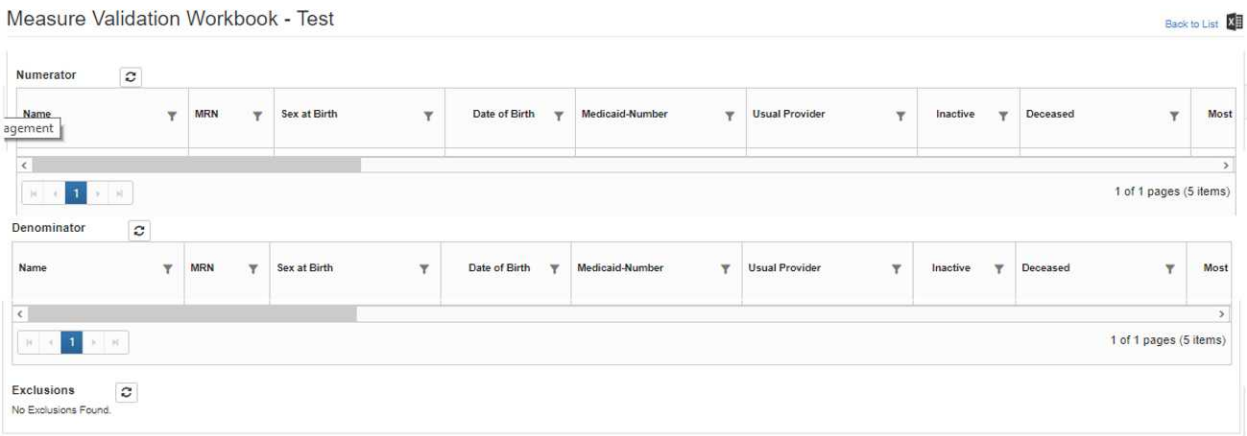
b. The below screen will appear. Click on "Create New Workbook."



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



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



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.