WEBINAR

Enabling Services Data Collection:
Documenting Health Center Interventions
in a Value-Based Payment Environment

Tuesday, May 26
8:00 a.m. HT / 11:00 a.m. PT / 2:00 p.m. ET

AAPCHO
Association of Asian Pacific Community Health Organizations

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

CHCANYS
Community Health Care Association of New York State

ENABLING SERVICES DATA COLLECTION: DOCUMENTING HEALTH CENTER INTERVENTIONS IN A VALUE-BASED PAYMENT ENVIRONMENT

May 26, 2020
2:00 p.m. EDT

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Overview

Purpose:

Highlight the importance of documenting social determinants of health (SDoH) interventions to demonstrate the value and scope of health center enabling services (ES).

By the end of the webinar, participants will be able to:

1. To promote the importance of standardized data collection strategies for SDoH and enabling services in a VBP environment
2. To share strategies and instill confidence in a health center's ability to document enabling services interventions in a standardized way
3. To showcase a real-life example of how PCAs and health centers are promoting and implementing data collection and standardized documentation for SDoH and ES

NCA Introductions

Kristina Wharton, MPH, MPA
Project Manager
HOP

Albert Ayson, Jr., MPH
Associate Director, Training & Technical Assistance
AAPCHO

Joe Lee, MSHA
Training & Technical Assistance Director
AAPCHO

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PCA Guest Speakers

CHCANYS
Community Health Care Association of New York State

Gabriela Gonzalez, MAS
Program Manager
Clinical Excellence and Innovation
CHCANYS
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Mercy Mbogori, MPA
Assistant Director
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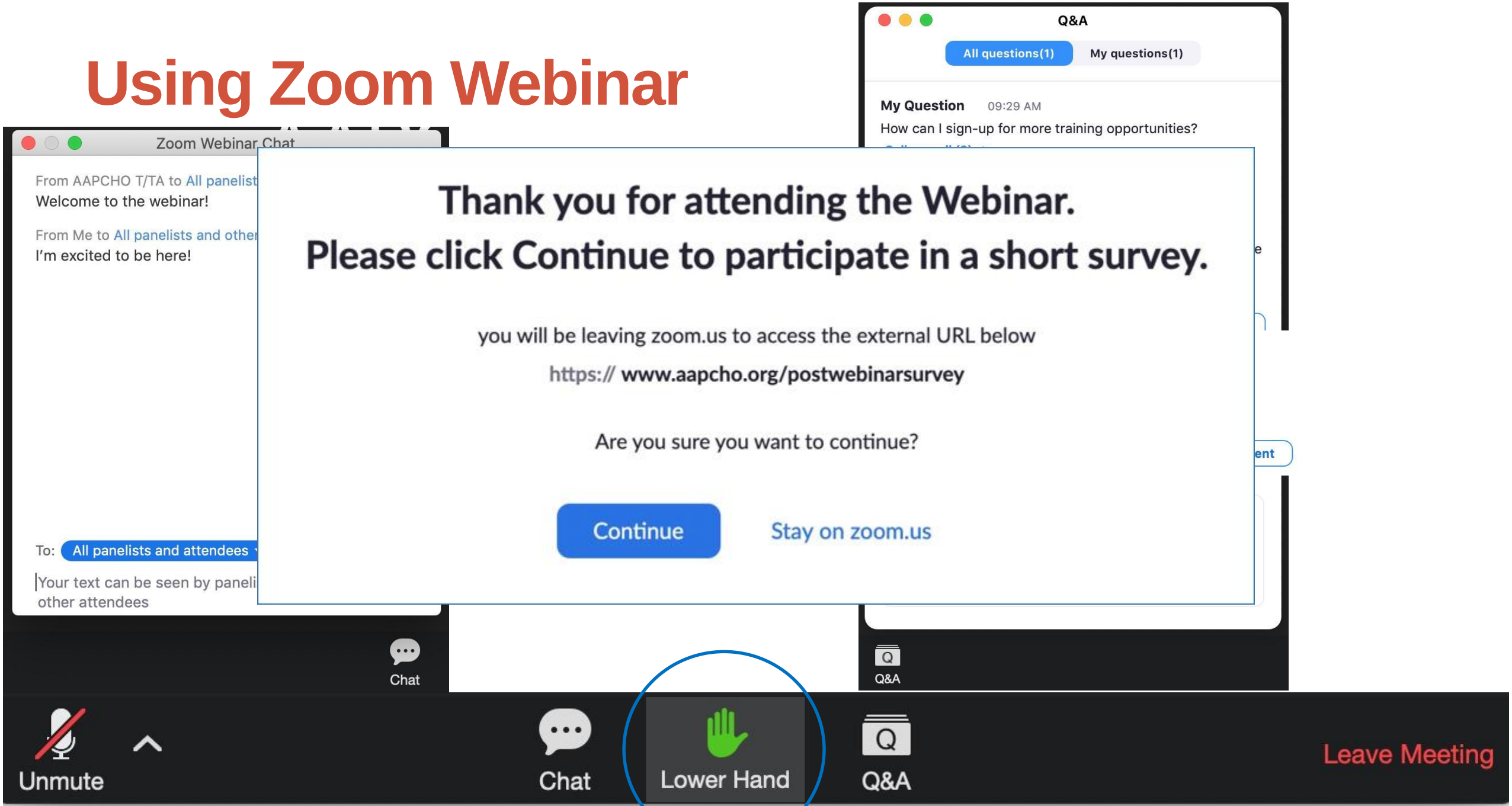
Agenda

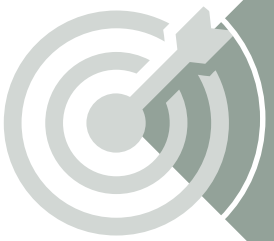
1) Welcome & Introductions
2) SDoH and ES in a Value-Based Payment Environment
3) Enabling Services Data Collection & Standardization
4) PCA Perspective: CHCANYS
5) Q&A
6) Announcements and Closing

Using Zoom Webinar



Social Determinants of Health and Enabling Services in a Value-Based Payment Environment

SDoH and ES in a Value-Based Payment Environment



Define “Value-Based Care” and identify payment and delivery models

Describe the role of Value-Based Care in outreach and enabling services

Provide specific examples of Value-Based Care models and the relevance to health center outreach and enabling services staff

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What is Value-Based Care?

What is Value?

$$V_p = \frac{Q_p \times S_p}{C \times T}$$

V = Value
C = Cost
Q = Quality
T = Time
S = Service
P = Perceived

Value-Based Care

- Value-based programs reward health care providers with incentive payments for the *quality of care* they give
- Use data and metrics to measure quality improvements and performance
- Aim to improve individual and population health outcomes while reducing costs in the long term

- Source: Centers for Medicare and Medicaid Services. *What are the Value-Based Care Programs?* 2020. Accessed at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs

Why Health Centers?

Cost Savings

- FQHCs deliver cost savings

The ACA

- Critical Role of FQHCs Post-ACA
  - Expanded Medicaid (in some states)
  - Marketplace

The Health Center Model

- Outreach & ES key to the health center mission

COMMUNITY HEALTH CENTER FQHC QUALITY℠

How does VBC apply to Health Centers?

1. Social Determinants of Health and Enabling Services Data
2. Payment Models
3. Health Center Operations and Flow
4. Value and Role of Community Health Workforce

Differences Between the States

- States are the laboratories
  - Different state policies
  - Different implementations of federal policy
- CMS, private payors and state legislators are the scientists
- *Examples:*
  - *Medicaid expansion*
  - *1115 waivers*
  - *CMS CMMI APCP*

Center for Medicare & Medicaid INNOVATION

POLL QUESTION

What types of value-based care, models and/or payment are you providing or engaging with at your health center?

(please check all that apply)

- We collect SDOH data on our patients
- We engage in population health activities
- Patient-Centered Medical Home (PCMH)
- Accountable Care Organization (ACO)
- Medicaid Managed Care Organization(s)
- Medicare Managed Care Organization(s)
- Shared savings programs
- Other?

Social Determinants of Health & Enabling Services Data

- **ICD-10 Z Code & Documentation of SDOH**
- *Significance for:*
  - Population health
  - Value-based payment

ICD-10 Z Code	SDOH Documentation
Z59.0,	Homelessness
Z59.1	Inadequate housing
Z59.5	Extreme poverty
Z75.1	Person awaiting admission to adequate facility elsewhere
Z75.3	Unavailability and inaccessibility of health-care facilities
Z76.2	Encounter for health supervision and care of other healthy child
Z99.12	Encounter for respirator dependence during power failure

Social Determinants of Health & Enabling Services Data

Enabling Services Data Collection Tools

PRAPARE

Source: http://www.nachc.org/research-and-data/prapare/

PRAPARE Core Measures	
Race	Education
Ethnicity	Employment
Migrant and/or Seasonal Farm Work	Insurance
Veteran Status	Income
Language	Material Security
Housing Status	Transportation
Housing Stability	Social Integration and Support
Address/Neighborhood	Stress
PRAPARE Optional Measures	
Incarceration History	Safety
Refugee Status	Domestic Violence

Social Determinants of Health & Enabling Services Data

Enabling Services Data Collection Tools

CMS Accountable Health Communities Health-Related Social Needs Screening Tool

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

5 Core Domains of the AHC HRSN	8 Supplementary Domains AHC HRSN
Housing instability	Financial strain
Food insecurity	Employment
Transportation problems	Education
Utility help needs	Family and community support
Interpersonal safety	Physical activity
	Substance use
	Mental health
	Disability

Payment Models: Health Center PPS vs. APM

The **Prospective Payment System** ensures minimum payment rate based on individual costs to provide services and are cost adjusted annually

Alternative Payment Methodology (APM) allows for use of different payment structure identified by the state and does ensure that the APM is not lower than the traditional PPS payment

Source: Waldman B, Bailit MH, Dyer MB. "State Medicaid Approaches for Defining and Tracking Managed Care Organizations Implementation of Alternative Payment Models", Robert Wood Johnson Foundation, February 6, 2018.

Payment Models: FFS vs. Capitated

Fee-for-service (FFS) Payment Structure:

- Payment model where payor reimburses provider for each billable service rendered.

Capitated Payment Structures:

- A payment system where there is an established per member per month (capitation) payment for specified services provided.

FFS

Advantages:
Ensures adequate reimbursement for services rendered

Disadvantages:
Incentivizes health systems to provide and bill for more services regardless of demonstrated need.

Capitated

Advantages:
Incentivizes quality of care and managing population or panel health.

Disadvantages:
May under-reimburse for care of panel that needs more services than is covered in the capitated payment schedule.

Payment Models: MCOs

Managed Care Organizations (MCOs) are a health care delivery model organized to manage cost, utilization and quality

- **Medicaid managed care** deliver Medicaid health benefits and additional services through *contracted arrangements between state Medicaid agencies and MCOs* that accept a set per member per month (capitation) payment for these services

Source: Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

Health Center and Managed Care: National Trends

- According to the 2018 UDS Table 9D on patient revenue:
  - **60% of all Medicaid payments were Medicaid MCOs**
    - 20.3% of all Medicaid payments from capitated MCOs and
    - 39.8% of all Medicaid payments from fee-for-service (FFS) MCOs
    - 20% of all Medicare payments to health centers were derived from Medicare MCOs
  - A total of **114,191,672 MCO member months** were covered by health centers

Health Center Managed Care: **2018**

- **14.60%**

  of FQHC total collections were from Medicaid MCOs (Capitated model)

- **24.21%**

  of FQHC total collections were from Medicaid MCOs (FFS)

Source: 2018 UDS

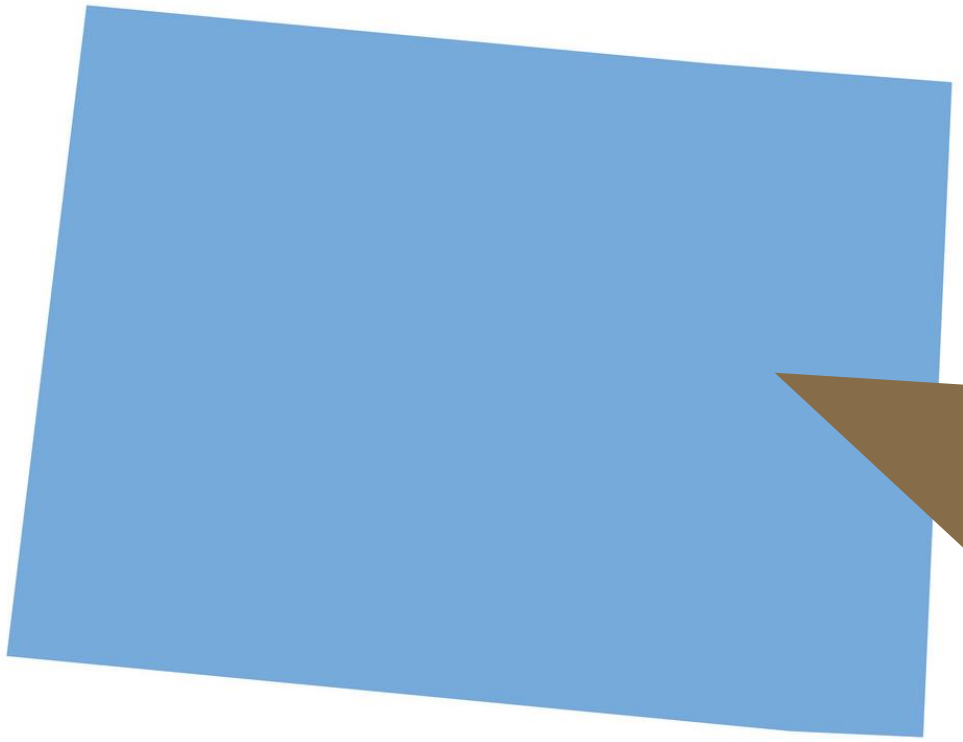
Managed Care Utilization		Medicaid	Medicare	Other Public	Private	Total
		(a)	(b)	(c)	(d)	(e)
13a.	Capitated Member Months	50,051,413	1,112,147	354,970	2,102,494	53,621,024
13b.	Fee-for-service Member Months	53,138,091	2,820,340	878,169	3,734,048	60,570,648
13c.	Total Member Months	103,189,504	3,932,487	1,233,139	5,836,542	114,191,672

Payment Models: ACOs

- ACOs are collaborative groups or partnerships of providers that share responsibility
- Shared patient population or a across a common geographic region
- ACOs are evaluated for performance relative to expected costs versus actual costs
- The ACO model is built on top of a fee-for-service system *or* a capitation system

Bailit MH, Waldman B. "Safety–Net Provider ACOs: Considerations for State Medicaid Purchasers", Robert Wood Johnson Foundation, January 27, 2016.

ACO: Example



State-Specific Example: In ***Colorado,*** FQHCs participate as part of Accountable Care Collaborative and are eligible to receive P4P based on quality performance for:

- Reduced ED visits
- Increased post-partum visits
- Increased well-child visits

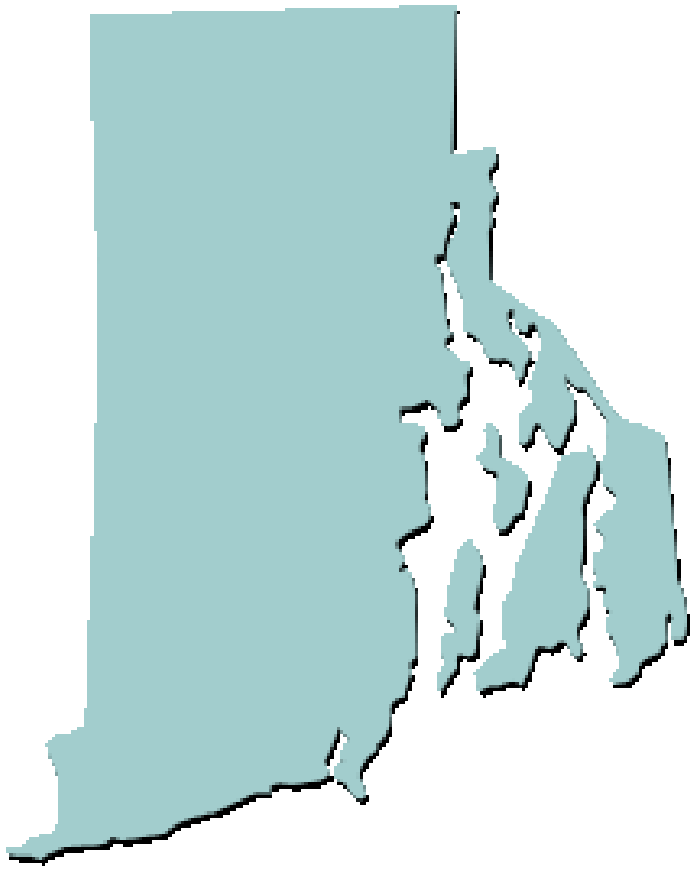
(Waldman, 2016)

Bailit MH, Waldman B. "Safety–Net Provider ACOs: Considerations for State Medicaid Purchasers", Robert Wood Johnson Foundation, January 27, 2016.

Payment Models: Shared Savings through ACOs

Rhode Island – Three FQHCs individually certified as Accountable Entities and will have potential to share in savings

(Waldman, 2016)



Bailit MH, Waldman B. "Safety–Net Provider ACOs: Considerations for State Medicaid Purchasers", Robert Wood Johnson Foundation, January 27, 2016.

Health Center Operations and Flow

Currently **76%** of FQHCs hold an accredited PCMH Recognition *(2018 UDS Data)*

- **The Patient-Centered Medical Home (PCMH)** uses a patient-centered approach to primary care delivery using:
  - Care coordination models
  - Health information technology
  - Care team utilization to support
  - Population health
  - Quality improvement

The Advanced Primary Care Practice (APCP) PCMH Demonstration

- CMMI demonstrated value in PCMH transformation in FQHCs
- 434 Sites
- Provided enhanced PMPM Medicare care management payment

Source: Centers for Medicare & Medicaid Services

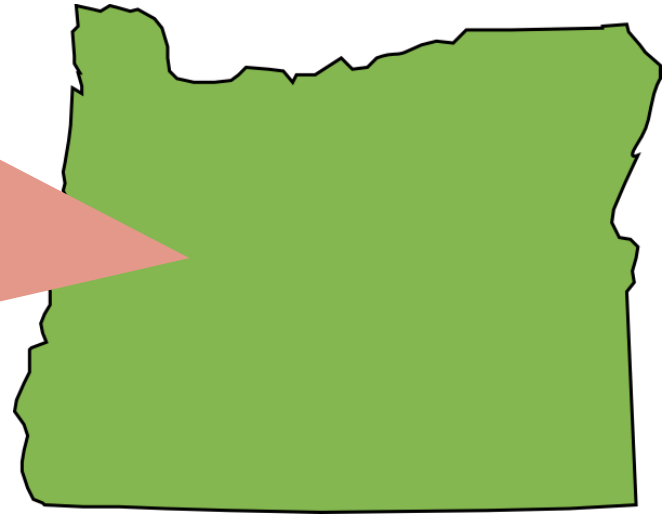
FQHC Advanced Primary Care Practice Demonstration. CMS, 2018. Accessed at: https://innovation.cms.gov/initiatives/fqhcs/

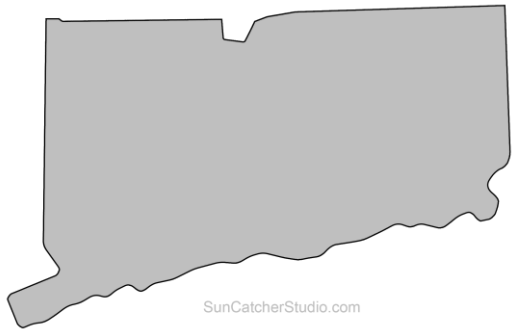
Example: Health Center Operations and Flow

State-Specific Example: Connecticut, Missouri and Oregon

FQHCs are eligible to receive supplemental payments for care management

(Waldman, 2016)





Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

Payment + Operations: Primary Care Capitation

- Capitation initiatives allow FQHCs to provide services – including enabling services - not traditionally reimbursable under fee-for-services
  - Services produce cost savings overall to the health center
- Primary Care Capitation is a model that provides both flexibility and predictable flow of funds to health centers
- Sometimes tied to PCMH model services

Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

Example: Primary Care Capitation

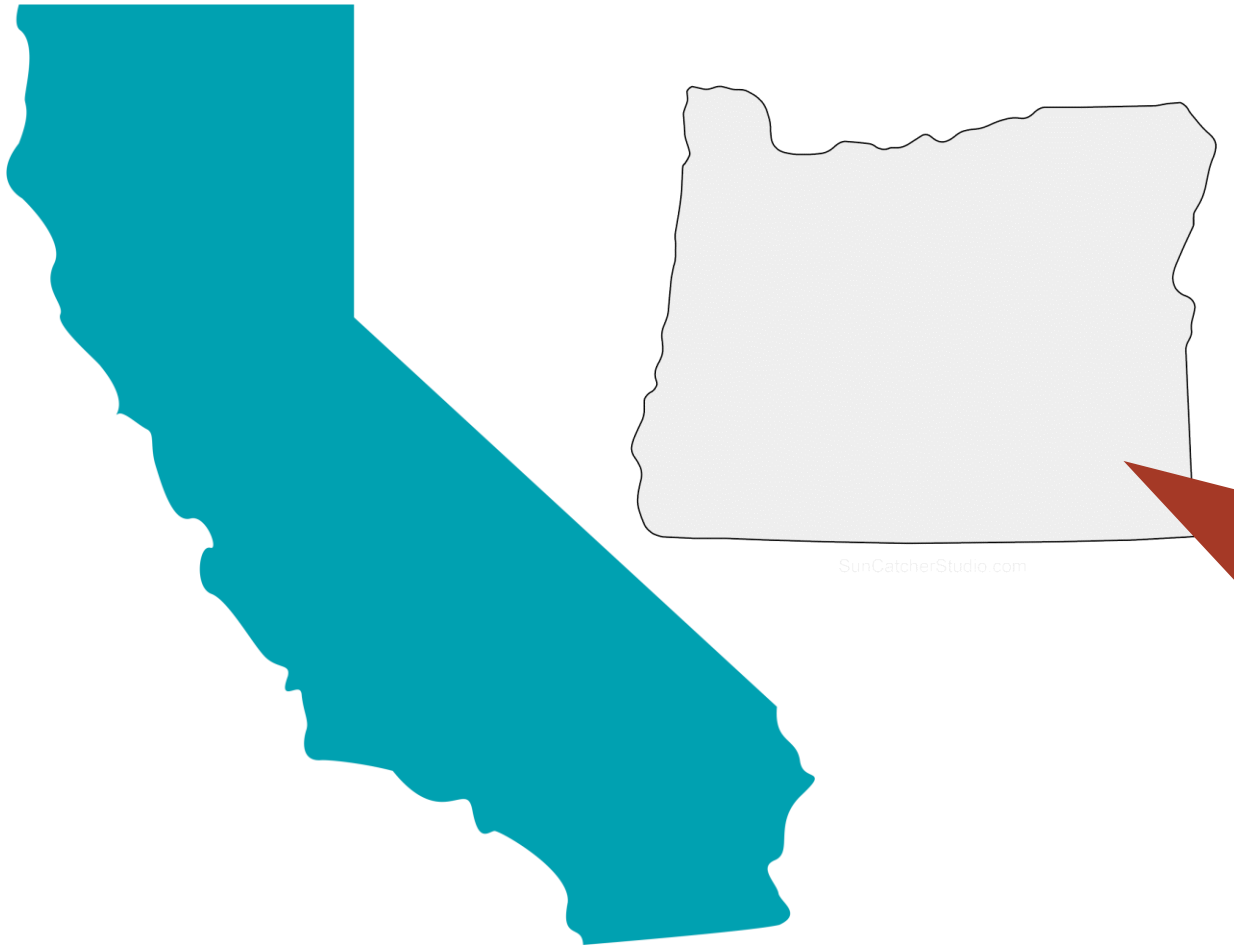
State-Specific Examples:

Massachusetts - FQHCs actively participate in model; leverages PCMH as foundation. Majority are only eligible for shared savings based on size of patient panel.

(Waldman, 2016)

Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

Example: Primary Care Capitation



State-Specific Examples:

Oregon and California - specific FQHC payment reform initiatives that provide PMPM based on expected spending *(Waldman, 2016)*

Waldman B, Dyer MB, Waldinger J. "Implementing State Payment Reform Strategies at Federally Qualified Health Centers (FQHCs)", Robert Wood Johnson Foundation, December 15, 2015.

Questions for Consideration

Is your health center collecting SDOH or Enabling Services data? Via EHR?

Is your health center a part of an HCCN supporting the collection and use of this SDOH data?

Is your health center a PCMH? Are you receiving any supplemental or shared savings funding that supports your enabling services costs?

Look at your health center's payor mix: What proportion of your payments come from Medicaid MCOs (FFS and/or capitated)? Medicare or other MCOs?

Is your health center engaged in an ACO?

What services is your PCA providing around VBC opportunity?

More Resources available at:

https://outreach-partners.org/resources/

Enabling Services Data Collection & Standardization

Why **Enabling Services** are important…

AAPCHO's Enabling Services Accountability Project

PARTICIPATING CENTERS:

- Charles B. Wang Community Health Center (New York, NY)
- International Community Health Services (Seattle, WA)
- Kalihi-Palama Health Center (Honolulu, HI)
- Waianae Coast Comprehensive Health Center (Waianae, HI)

*Acknowledgement: New York Academy of Medicine (NYAM) , National Association of Community Health Centers (NACHC), et al.

AAPCHO

AAPCHO's Enabling Services Accountability Project (cont.)

Goals

- Develop standardized enabling services (ES) data collection protocols
- Describe utilization of ES at health centers
- Evaluate the impact of ES on health access, outcomes, and utilization of primary care
- Disseminate findings to health centers and policymakers to guide effective resource allocation
- Facilitate research and expansion opportunities to other health centers and networks

Learn more at: enablingservices.aapcho.org

Definitions & Categories

- **Enabling Services:** Non-clinical services that are specifically linked to a medical encounter or the provision of medical services for a patient at your health center. *"Enabling" patients to improve access and health outcomes.*
- Standardized collection allows for better tracking of these unique services across health centers for national evaluation and advocacy

15 categories of services

- *Social Services*
- *Case Management*
- *Referral – Health*
- *Referral - Social*
- *Financial Counseling*
- *Health Education, 1-1*
- *Health Ed, 2-12*
- *Health Ed, 13+*
- *Supportive Counseling*
- *Interpretive Services*
- *Outreach*
- *Inreach*
- *Transportation – Health*
- *Transportation – Social*
- *Other*

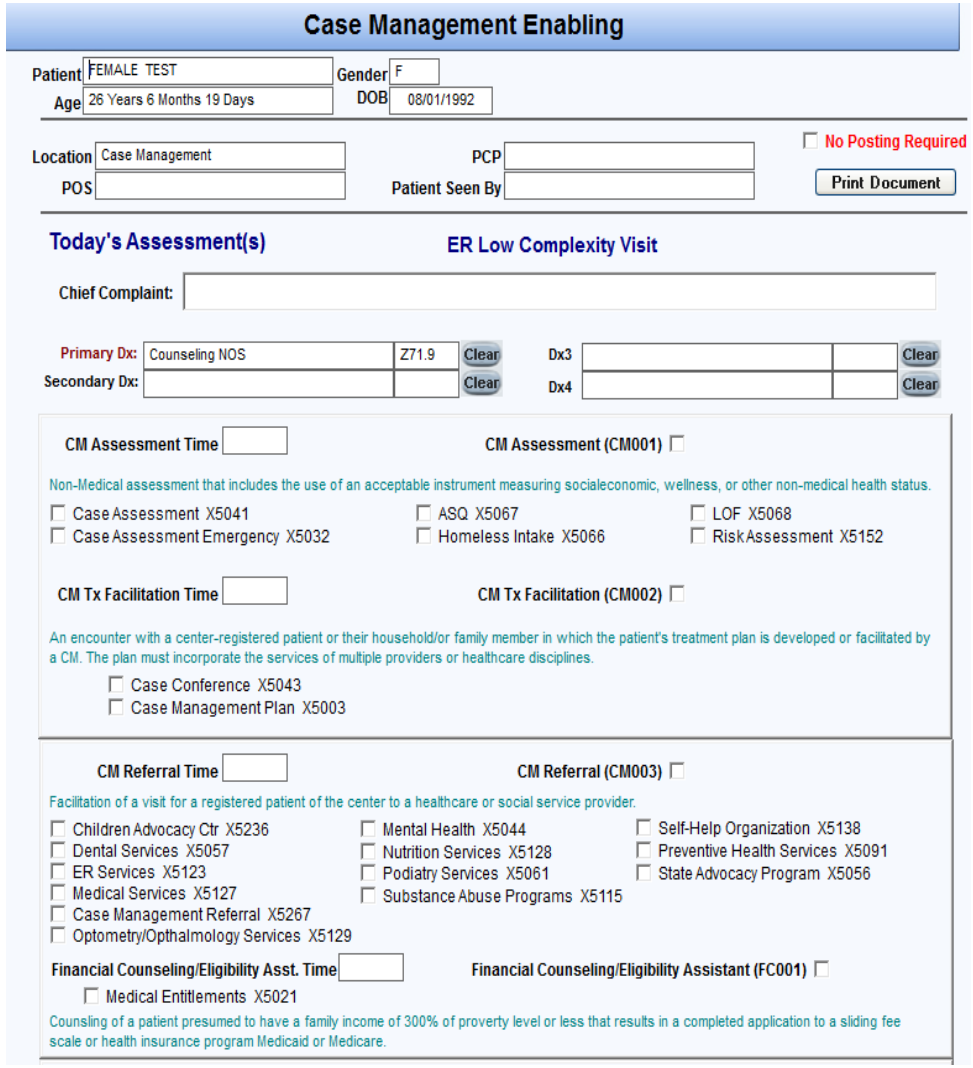
Old ES Categories	Revised Categories	Code
Case Management Assessment (CM001)	Social Services Assessment	SS001
Case Management Treatment and Facilitation (CM002)	Case Management	CM001
CM Referral (CM003)	Referral- Health	RF001
	Referral- Social Services	RF002
Financial Counseling/ Eligibility Assistance	Financial Counseling/Eligibility Assistance	FC001
Health Education/Supportive Counseling *Individual *Group	Health Education- Individual (one-on-one)	HE001
	Health Education- Small Group (2-12)	HE002
	Health Education- Large Group (13 or more)	HE003
	Supportive Counseling	SC001
Interpretation	Interpretation	IN001
Outreach	Outreach	OR001
	Inreach	IR001
Transportation	Transportation- Health	TR001
	Transportation- Social Services	TR002
Other	Other	OT001

POLL QUESTION

Where would you say your organization currently is in collecting standardized enabling services data for specific initiatives (i.e. clinical quality improvement, practice transformation, value-based payment, etc.)?

- Beginning our journey (familiar with the basic concepts, but not sure how to put them into practice)
- Halfway down the road (some policies and procedures, but not full integration with other organizational priorities)
- Close to the finish line (strong skills, strategies, policies and organizational commitment, and looking for small refinements and to share knowledge)

Sample ES Implementation Protocol: Waianae Coast Comprehensive Health Center (Hawaii)



Case Management Enabling

Patient: FEMALE TEST | Gender: F
Age: 26 Years 6 Months 19 Days | DOB: 08/01/1992

Location: Case Management | PCP:
POS: | Patient Seen By:

☐ No Posting Required | Print Document

Today's Assessment(s) — ER Low Complexity Visit

Chief Complaint:

Primary Dx: Counseling NOS | Z71.9 | Clear | Dx3: | Clear
Secondary Dx: | Clear | Dx4: | Clear

CM Assessment Time: | CM Assessment (CM001) ☐

Non-Medical assessment that includes the use of an acceptable instrument measuring socialeconomic, wellness, or other non-medical health status.

☐ Case Assessment X5041 ☐ ASQ X5067 ☐ LOF X5068
☐ Case Assessment Emergency X5032 ☐ Homeless Intake X5066 ☐ Risk Assessment X5152

CM Tx Facilitation Time: | CM Tx Facilitation (CM002) ☐

An encounter with a center-registered patient or their household/or family member in which the patient's treatment plan is developed or facilitated by a CM. The plan must incorporate the services of multiple providers or healthcare disciplines.

☐ Case Conference X5043
☐ Case Management Plan X5003

CM Referral Time: | CM Referral (CM003) ☐

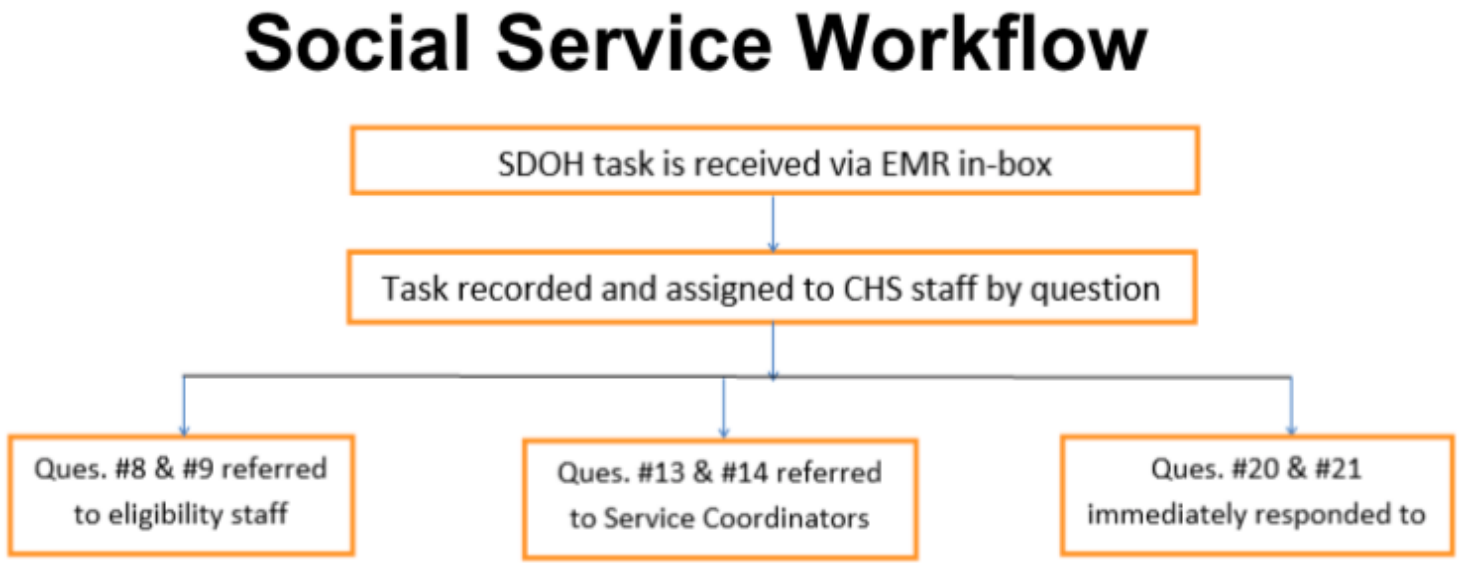
Facilitation of a visit for a registered patient of the center to a healthcare or social service provider.

☐ Children Advocacy Ctr X5236 ☐ Mental Health X5044 ☐ Self-Help Organization X5138
☐ Dental Services X5057 ☐ Nutrition Services X5128 ☐ Preventive Health Services X5091
☐ ER Services X5123 ☐ Podiatry Services X5061 ☐ State Advocacy Program X5056
☐ Medical Services X5127 ☐ Substance Abuse Programs X5115
☐ Case Management Referral X5267
☐ Optometry/Opthalmology Services X5129

Financial Counseling/Eligibility Asst. Time: | Financial Counseling/Eligibility Assistant (FC001) ☐

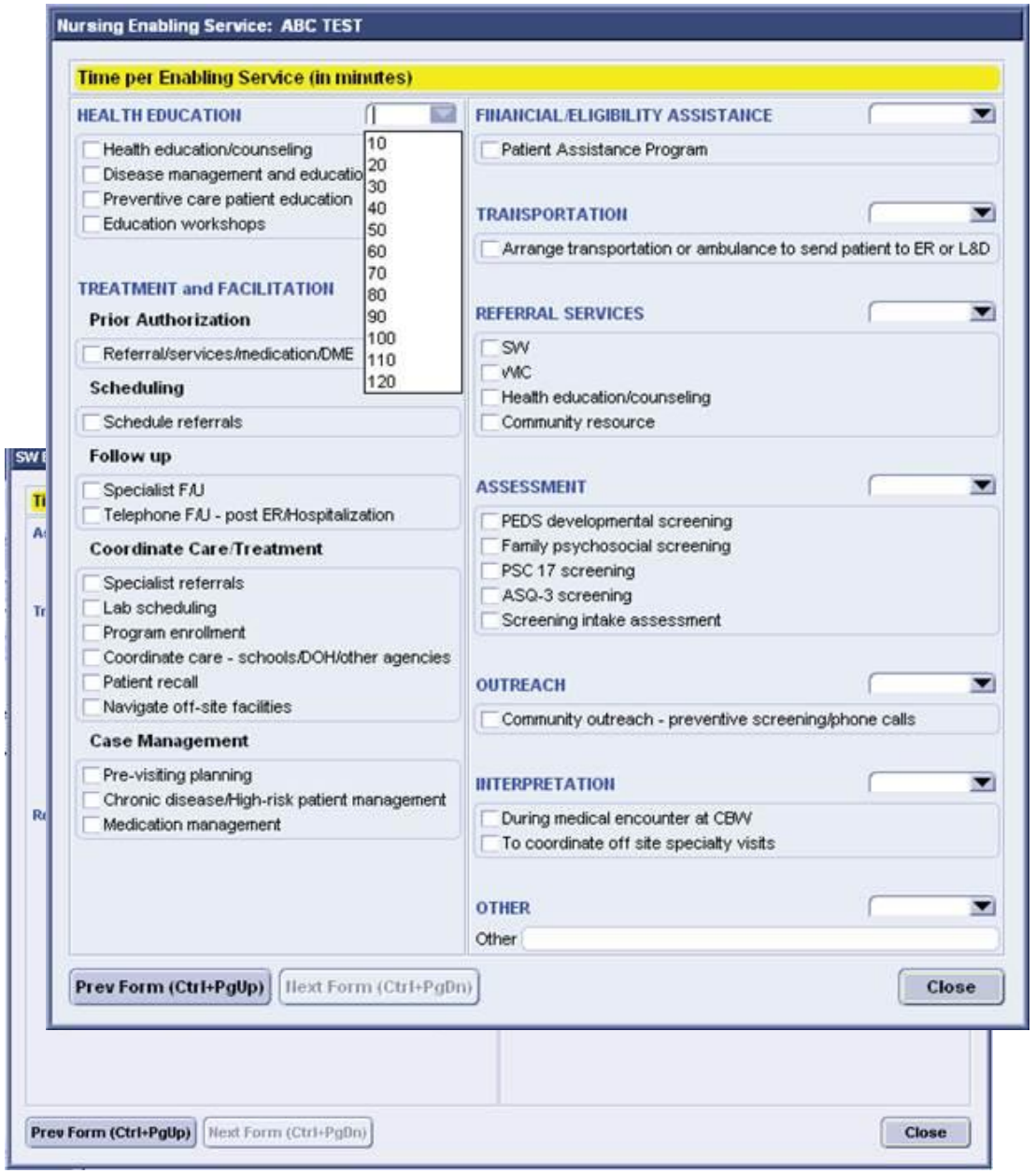
☐ Medical Entitlements X5021

Counsling of a patient presumed to have a family income of 300% of proverty level or less that results in a completed application to a sliding fee scale or health insurance program Medicaid or Medicare.



- **Community Health Services (CHS) Department**
  - Over 200 enabling codes developed and tracked.
  - Each set of staff has their own workflow
  - Resource list available
  - Collaboration with community service providers

Acknowledgement: Leinaala Kanana, Waianae Coast Comprehensive Health Center

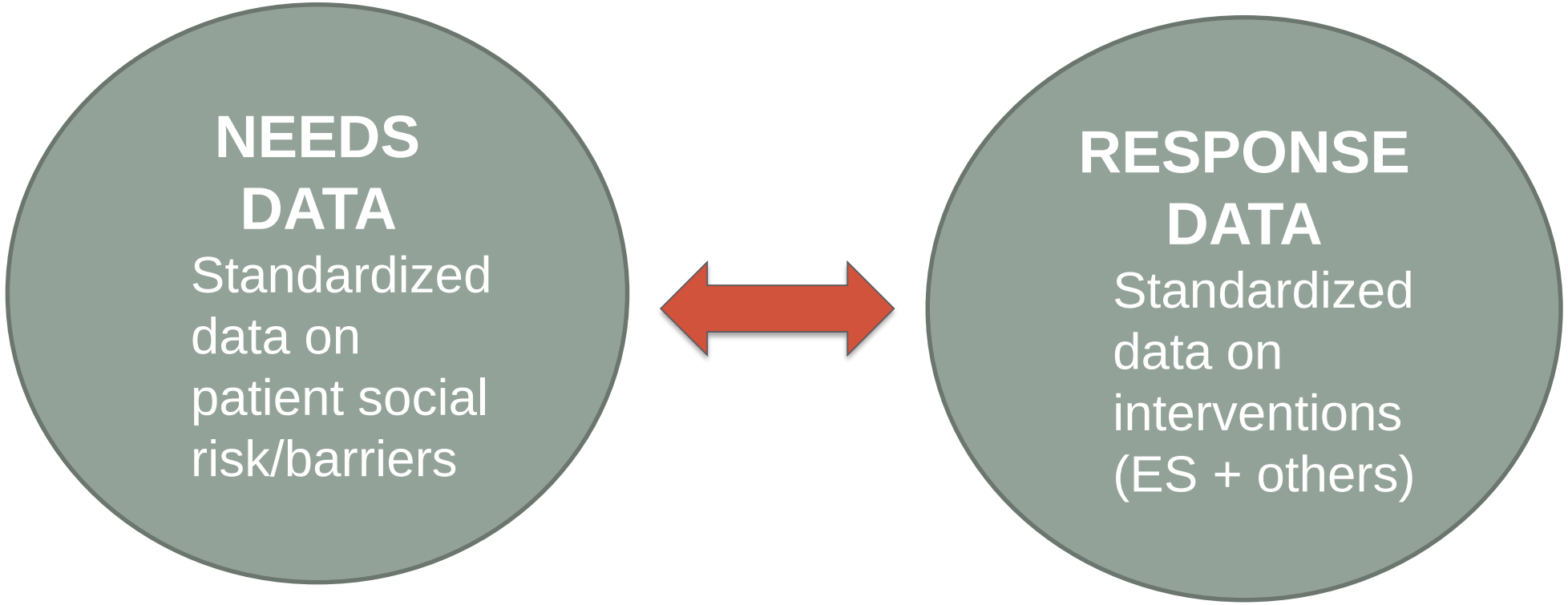


Sample ES Implementation Protocol: Charles B. Wang CHC (New York)

Social Work Department:

- Social Workers conduct a biopsychosocial assessment to assess the social determinants for every patient who was referred to Social Work Department for service.
- The enabling service taxonomy is used to capture the services delivered at the end of every encounter.
- In 2017, SW delivered 22,911 unit of enabling services for approximately 11,000 patients.
- Top three enabling services:
  1. **Treatment and Facilitation**: 11,647 units; avg. time spent: 17 minutes
  2. **Assessment**: 9,416 units; avg. time spent: 14 minutes
  3. **Referral**: 626 units; avg. time spent: 12 minutes

Acknowledgement: Manna Chan, Charles B. Wang CHC



BOTH are necessary to:

- ✓ Demonstrate health center value to payers
- ✓ Seek adequate financing
- ✓ Better target and/or improve services
- ✓ Achieve integrated, value-driven delivery system and reduce total cost of care

NCA-PCA/HCCN Partnership

- Training of Trainers Approach
- T/TA Examples
- Categories
- Implementation Packet:

  http://www.aapcho.org/resources_db/enabling-services-data-collection-implementation-packet/

- Meeting with PCA/HCCN Partners (Dec 2017)

Strategies to get started: PCA/HCCNs

How could/should **PCA/HCCNs** support ESDC?

- T/TA on collecting ES data & using the tool
- Direct process improvement facilitation (data fields; workflow)
- Understand vendor capabilities for collecting & reporting data
- Provide tools to view or aggregate the data
- Lead advocacy efforts with the data
- Support for finding funds
- Coordinate training
- *Anything to add/ask?*

Strategies to get started: Health Centers

How could/should **health centers** adopt ESDC?

- Achieve buy-in from senior leadership
- Integrate into electronic health record system
- Retrieve IT/CI support
- Dedicate Staff—for data collection and analysis
- Protect Time—for data collection, education and training
- *Anything to add/ask?*

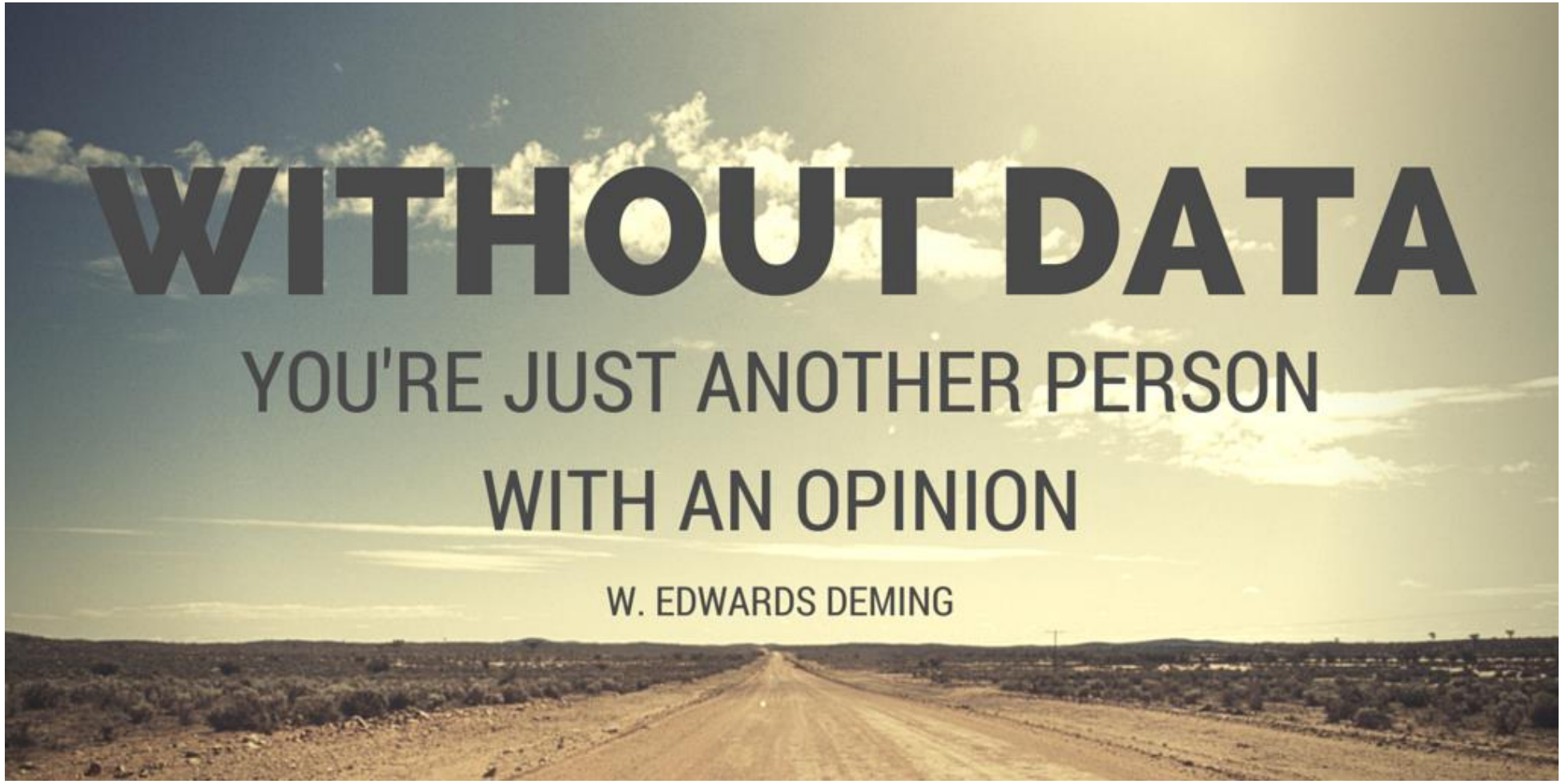
Questions for consideration

For PCA/HCCNs:

- To what extent are your member health centers currently tracking enabling services?
- What would be needed to promote adoption of the standardized ES tracking protocol in your state?
- What would be needed to promote adoption of the standardized ES tracking protocol on a national scale?

For Health Centers:

- What kind of T/TA might be needed from NCAs to support this work among health centers?
- How do you see PCAs / HCCNs engaging as partners in this work?


WITHOUT DATA
YOU'RE JUST ANOTHER PERSON
WITH AN OPINION
W. EDWARDS DEMING

Publications on Enabling Services

Publication Title	Year
AAPCHO. “Cultural Language Access Standards and Enabling Services in Asian American, Native Hawaiian and Pacific Islander Serving Health Centers: 2017 Report”	2017
Escaron, A. L., Chang Weir, R., Stanton, P., Vangala, S., Grogan, T. R., & Clarke, R. M. (2016). Testing an adapted modified Delphi method synthesizing multiple stakeholder ratings of health care service effectiveness. Health Promo. Prac., 17(2), 217–225.	2016
Chang Weir, R., Li, V., Song, H., Ponce, N., Meng, Y. (2015). The Impact of Enabling Services on Improving Health Outcomes at Community Health Centers. Harvard Asian American Policy Review Journal, 25: 38-50.	2015
Escaron AL, Weir RC, Stanton P, Clarke RM. Defining and Rating the Effectiveness of Enabling Services Using a Multi-stakeholder Expert Panel Approach. J Health Care Poor Underserved. 2015;26(2):554–76. doi: 10.1353/hpu.2015.0035.	2015
AAPCHO. “Enabling Services Best Practices Report”	2014
AAPCHO & NACHC. “Highlighting the Role of Enabling Services at Community Health Centers: Collecting Data to Support Service Expansion & Enhanced Funding”	2010
Chang Weir, R., Emerson, H. P., Tseng, W., Chin, M., & Caballero, J. (2010).Utilization of Enabling Services by Asian American, Native Hawaiian, and Pacific Islander Patients at Community Health Centers. American Journal of Public Health, 100(11): 2199-2205.	2010

PCA PERSPECTIVES: CHCANYS

CHCANYS
Community Health Care Association of New York State

Community Health Care Association of New York State (CHCANYS)

OUR VISION

Every New York State community has primary care that encompasses all aspects of each patient's health and well-being.

OUR MISSION

Champion community-centered primary care in New York State through leadership, advocacy, and support of Community Health Centers.

CHCANYS

COMMUNITY HEALTH CENTER FQHC QUALITY

NYS Community Health Centers

- Nearly 70 Health Center Organizations
- Serving more than 2.4 million patients at over 800 sites across the state
- 1 in 9 New Yorkers seeks services at a community health center

CHCANYS

COMMUNITY HEALTH CENTER FQHC QUALITY

Social Determinants of Health & Enabling Services

Value Statement

It is a critical part of an evolving value-based care strategy that will empower FQHCs to be better positioned to negotiate enhanced reimbursement and value-based contract arrangements for high-need patients that will better support patient care delivery, and to advocate for health policy development around patients' social determinants of health.

NYS FQHCs Current State

- PRAPARE is the most popular tool used among NYS FQHCs and Medicaid MCOs*
- 37 out of 78 (47 %) NYS health centers reported that they are collecting SDH data.
- 21 health centers have the SDOH Module in Azara Healthcare Center for Primary Care Informatics (CPCI).

*Source: Medicaid Access & Coverage to Care in 2018.
Link: https://www.medicaidinnovation.org/_images/content/2019_Annual_Medicaid_MCO_Survey_Results_FINAL.pdf

CHCANYS

COMMUNITY HEALTH CENTER FQHC QUALITY

CHCANYS Support

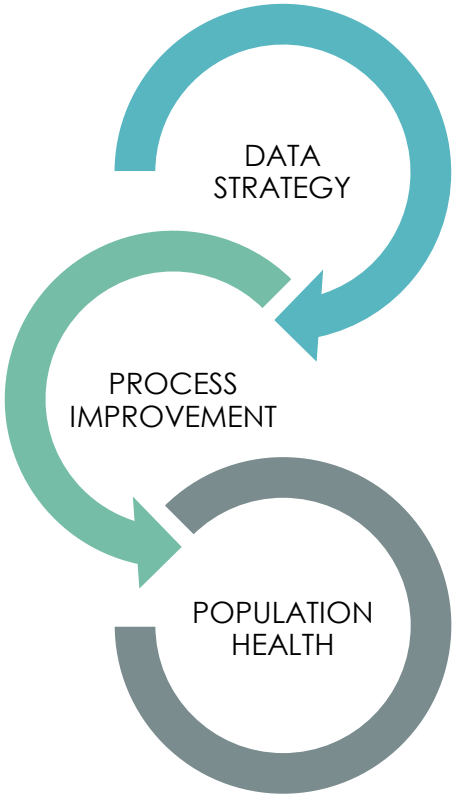
- Implementation of a standardized electronic SDH screening tool, PRAPARE
- Integration of ICD-10 SDH coding guidelines to document patient complexity
- Technical assistance to support FQHC build capacity to visualize, analyze and prioritize patients' social needs data for population health management
- Improvement of documentation of enabling services positioned to address and coordinate patients' social needs
- Promising practices for referral management and developing community-based partnerships to ensure that both social and medical needs of patients are met

CHCANYS

COMMUNITY HEALTH CENTER FQHC QUALITY

Training and Technical Assistance

- Tier I: Not Prepared/Early Stages
- Tier II: Moderately Prepared
- Tier III: Highly Prepared



CHCANYS

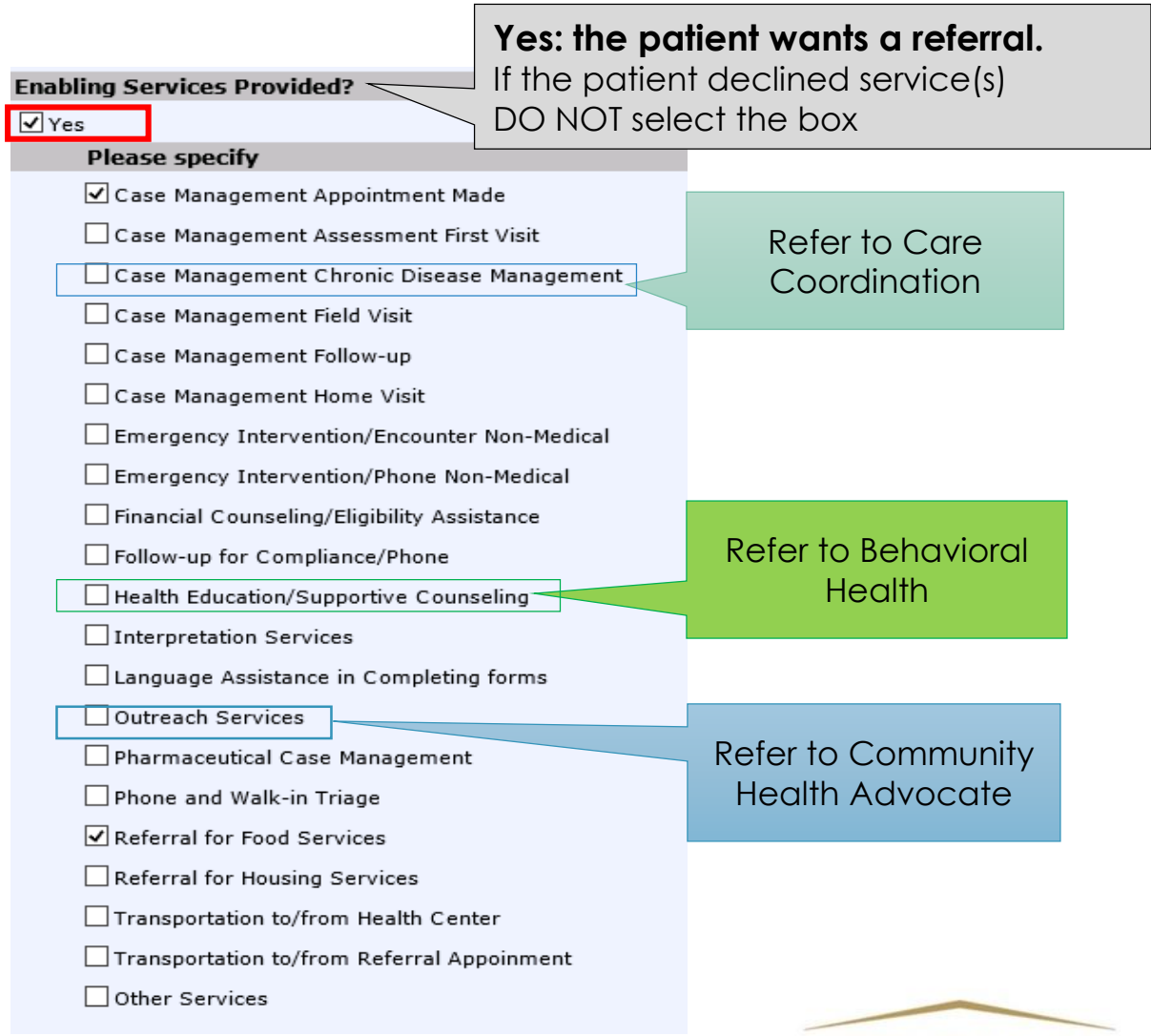
COMMUNITY HEALTH CENTER FQHC QUALITY

Tier I: Enabling Services in eClinical Works

Enabling services are defined as "non-clinical services that aim to increase access to healthcare and improve health outcomes," and include services such as health education, interpretation, and case management.

Services may include:

- Internal or External Services to address patients' social needs.
- Community Resources Referrals
- Supportive Staff



CHCANYS

COMMUNITY HEALTH CENTER FQHC QUALITY

Polling Question:

Are you tracking referrals to internal resources or external community-based organizations in structured EHR fields?

Select all that apply

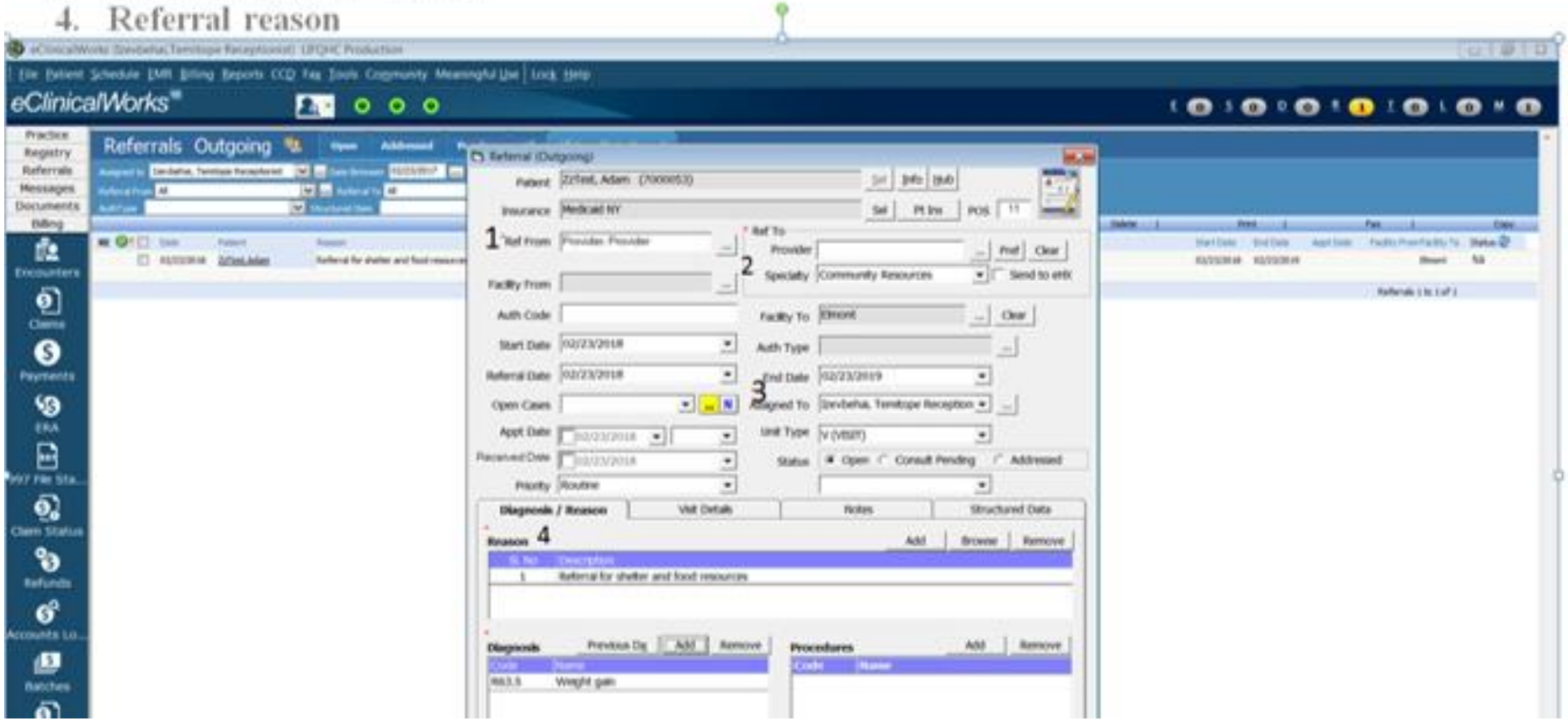
- Yes, my organization is documenting internal and external referrals in structured EHR fields
- Yes, my organization is documenting internal and external referrals using free text in non-structured EHR fields
- My organization is currently brainstorming ways to document external referrals to community-based organizations focused on patients' social needs.
- No, my organization does not make external referrals to community-based organizations to address patients' social needs

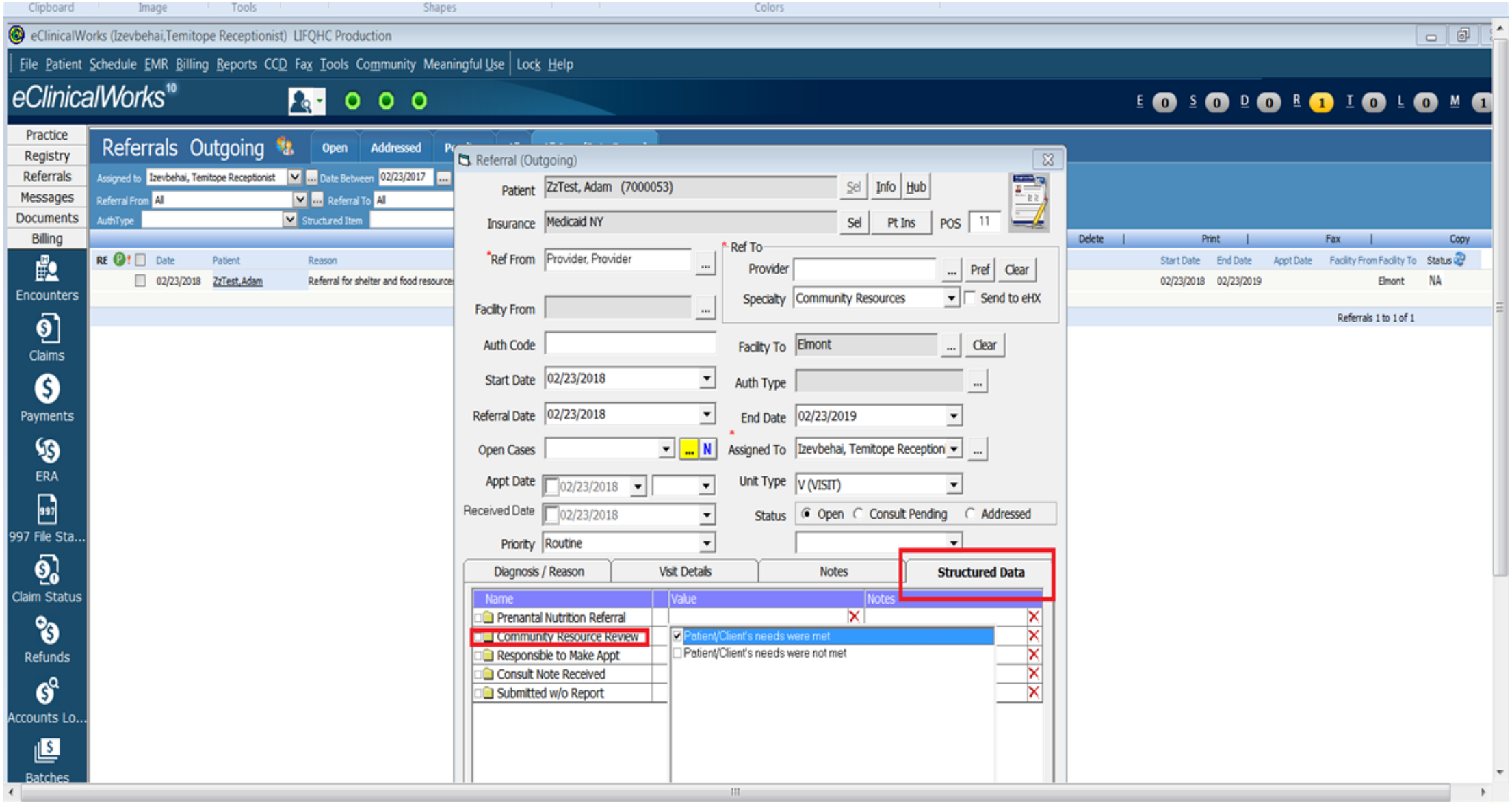
CHCANYS

COMMUNITY HEALTH CENTER FQHC QUALITY

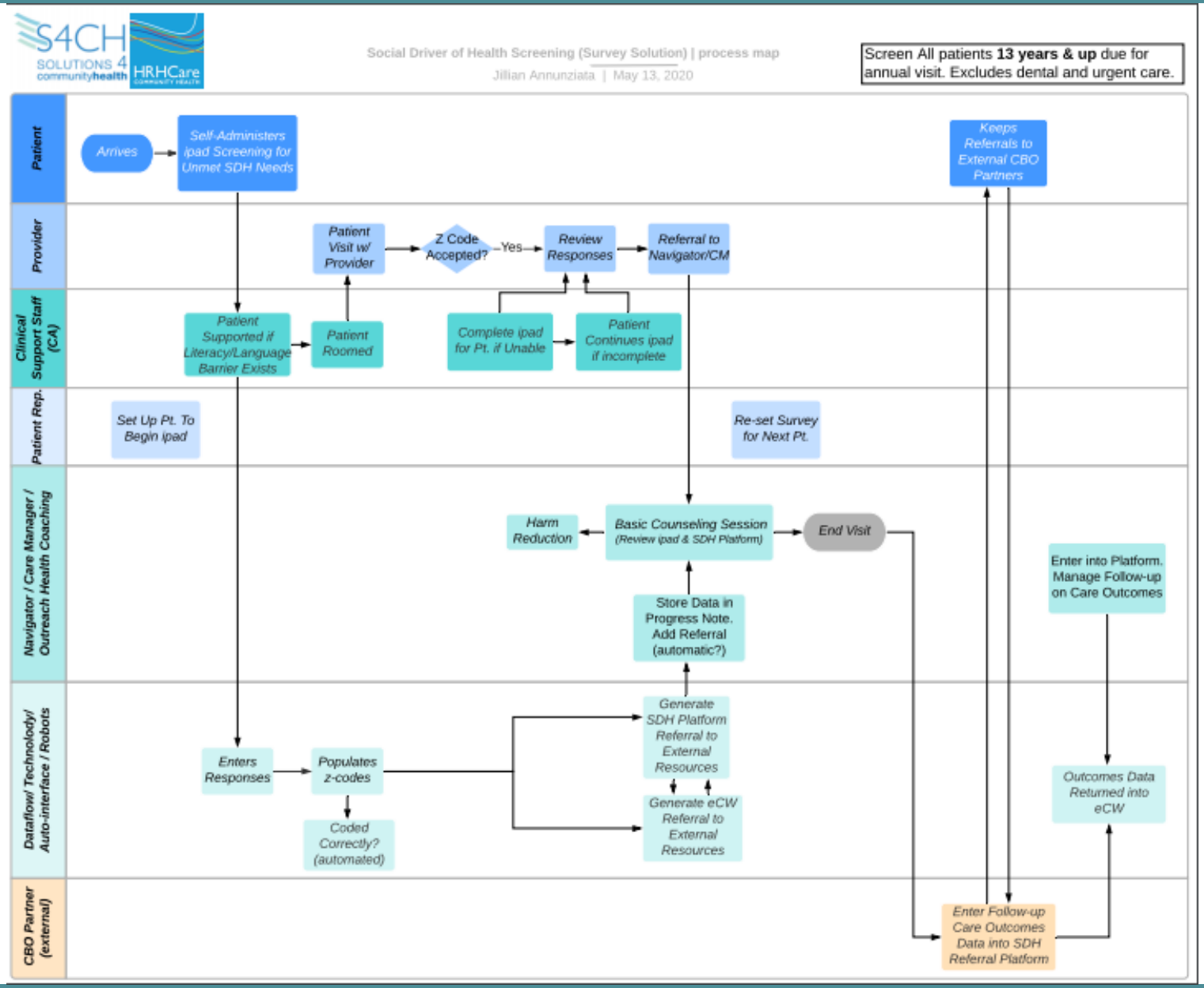
Tier II: Referral Documentation in eClinical Works

1. Referral from (Provider)
2. Specialty (Community Resources, CHA)
3. Assigned to (Your name)
4. Referral reason




eClinicalWorks (Izevbehai,Temitope Receptionist) LIFQHC Production
File Patient Schedule EMR Billing Reports CCD Fax Tools Community Meaningful Use Lock Help
eClinicalWorks
Practice
Registry
Referrals
Messages
Documents
Billing
Encounters
Claims
Payments
ERA
997 File Sta...
Claim Status
Refunds
Accounts Lo...
Batches
Referrals Outgoing
Open
Addressed
Assigned to Izevbehai, Temitope Receptionist
Date Between 02/23/2017
Referral From All
Referral To All
AuthType
Structured Item
Date
Patient
Reason
02/23/2018
ZzTest,Adam
Referral for shelter and food resources
Referral (Outgoing)
Patient ZzTest, Adam (7000053)
Sel
Info
Hub
Insurance Medicaid NY
Sel
Pt Ins
POS 11
Ref From Provider, Provider
Facility From
Auth Code
Start Date 02/23/2018
Referral Date 02/23/2018
Open Cases
Appt Date 02/23/2018
Received Date 02/23/2018
Priority Routine
Ref To
Provider
Pref
Clear
Specialty Community Resources
Send to eHX
Facility To Elmont
Clear
Auth Type
End Date 02/23/2019
Assigned To Izevbehai, Temitope Reception
Unit Type V (VISIT)
Status Open Consult Pending Addressed
Diagnosis / Reason
Visit Details
Notes
Structured Data
Name
Value
Notes
Prenatal Nutrition Referral
Community Resource Review
Responsible to Make Appt
Consult Note Received
Submitted w/o Report
Patient/Client's needs were met
Patient/Client's needs were not met
Delete
Print
Fax
Copy
Start Date
End Date
Appt Date
Facility From
Facility To
Status
02/23/2018
02/23/2019
Elmont
NA
Referrals 1 to 1 of 1

Tier III



PDF: https://files.constantcontact.com/b6bde37a401/88fa3464-eed6-4898-8a63-0e4ad81aa8bf.pdf

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Visit our Social Determinants of Health Webpage.

Thank You

QUESTIONS & ANSWERS

Questions for Speakers

Open Discussion

- **What types of non-clinical services are you already providing that may not be represented in your data reporting?** How much ROI might be missing?

- **In what areas could NCAs, PCAs, HCCNs improve their assistance or impact in the area of ESDC?** Are you currently supported in this area by your own local PCA/HCCN?

- From the implementation example you heard today**, what stood out as the most feasible approach to introducing a new process?** What might be the biggest barrier to a similar implementation process? How might it be tailored to suit your organization?

Resources

- **outreach-partners.org/resources**

- **enablingservices.aapcho.org**
  - Implementation Toolkit
  - ES Research Studies
  - Webinars
  - Health Center Training Opportunities

- **nachc.org/prapare**

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Partnerships

THANK YOU & KEEP IN TOUCH!

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

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Value-Based Care: *KEY TERMS AND DEFINITONS*

- **Accountable Care Organization (ACO):** A group of health care providers who voluntarily share responsibility for the care delivered and health outcomes of a defined patient population. ACOs typically include primary and specialty care providers and are held accountable for costs and outcomes.
- **Alternative Payment Methodology (APM)** allows for use of different payment structure identified by the state and does ensure that the APM is not lower than the traditional PPS payment. States can set different rates for services medical, behavioral and dental services provided within the PPS.
- **BPHC:** The Bureau of Primary Health Care (BPHC, "the Bureau") is the specific branch of HRSA within US DHHS that administers the health center program.
- **Capitated Payment Structure:** A payment system where there is an established per member per month (capitation) payment for specified services provided.
- **Care Coordination:** Organization of activities promoting patient health care and other services impacting their health across different providers or organizations.
- **Community Health Worker (CHW):** Health Center staff who connect patients to care and engage in outreach, health education, navigation, and care coordination who are often members of the communities served, culturally aware and speak the language(s) of the community. CHWs, also referred to as *promotoras/es de salud* or outreach workers, are not required to have clinical backgrounds.
- **CHIP:** Children's Health Insurance Plan, a state-run Medicaid program for children.
- **Collective Impact:** Collective impact is a committed group of players across different sectors that come together to achieve a common agenda for solving a specific social problem, using a structured form of collaboration.
- **Community-based Point of Care:** Point of care is the timely delivery of health care products and services to patients where they are located or receiving other services. Delivering care where the community lives, works, or spends time helps alleviate the need for some patients to travel to services.
- **Electronic Health Record (EHR):** Patient health and medical charts maintained in an electronic system. Common EHRs amongst health centers include: Epic, GE Centricity,
- **Enabling Services (ES):** Non-clinical services that aim to increase access to healthcare and improve health outcomes," and include services such as health education, interpretation, and case management.
- **Enabling Services Data Collection (ESDC):** The systematic collection of data to understand patient needs and to support enabling services (see "Enabling Services).
- **Federal Poverty Level (FPL):** The threshold of poverty (based on income and family size) determined annually by the U.S. Department of Health and Human Services.
- **Fee-for-Service (FFS) Payment Structure:** Payment model where payor reimburses provider for each billable service rendered.
- **Federally Qualified Health Center (FQHC/CHC/HC):** A national program funded under Public Health Service Act 330 to create safety-net primary care providers required to provide care

regardless of a patients' ability to pay or insurance status or type serving medically underserved communities.

- **Health Information Technology (HIT):** Any technology used to manage information promote medical care or patient health, such Electronic Health Records, population health management systems, other health-related information databases.
- **Health Center Controlled Network (HCCN):** A collaboration of multiple health centers and sometimes PCAs or ACO partners to purchase, develop, tailor, and use an EHR and other HIT together with economies of scale and collective bargaining power gained by partnership.
- **Health Resources and Services Administration (HRSA):** US Department of Health and Human Services branch under which the Health Center Program is administered.
- **Health Center Program:** Any Public Health Service Act, Section 330 grantees. Also referred to as community health centers or Federally Qualified Health Centers.
- **Health Professional Shortage Area (HPSA):** A HPSA is an urban or rural area, population group, or medical or other public facility which has received federal designation as having a shortage of health care providers.
- **Look-a-like:** An FQHC that meets all of the eligibility requirements of an organization that receives a Health Center Program grant but does not receive Health Center Program grant funding.
- **Managed Care Organization (MCO):** Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs that accept a set per member per month (capitation) payment for these services.
- **Medically Underserved Area/Population (MUA/P):** A medically underserved area (MUA) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts that the Department of Health and Human Services (HHS) has designated as having a shortage of health services for residents.
- **MPW:** Medicaid for pregnant women.
- **Medicaid MCO:** Medicaid managed care deliver Medicaid health benefits and additional services through *contracted arrangements between state Medicaid agencies and MCOs* that accept a set per member per month (capitation) payment for these services.
- **NEMT:** Non-Emergency Medical Transportation
- **Patient-Centered Medical Home (PCMH):** A model that promotes the use of care teams to deliver patient-centered, coordinated primary care. By incorporating a variety of staff with a range of skills and expertise, the care team is able to manage the full spectrum of a patient's needs.
- **Primary Care Association (PCA):** State and regional organizations serving health centers. A PCA is a regional, state, or local organization which works in close concert with, and represents the interests of, nonprofit community clinics and health centers and advocates for the health needs of their distinctive populations and geographic areas, most importantly those who face barriers to care due to poverty, language, or geographic isolation.
- **PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences):** A social risk assessment and screening tool co-developed by the National

Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, and Oregon Primary Care Association, which includes a chapter on collecting enabling services data.

- ***Promotoras/es de Salud:*** See "Community Health Worker"
- **Prospective Payment System (PPS):** Ensures minimum payment rate based on individual costs to provide services and are cost adjusted annually
- **Social Determinants of Health (SDOH):** Defined by the World Health Organization (WHO), SDOH are "the conditions in which people are born, grow, live, work and age," and refer to issues such as food insecurity, health insurance access, housing instability, education, legal services, and other factors and needs influencing a person's health.
- **Rural Health Clinic (RHC):** The RHC program strives to be the major provider for primary care services for Medicaid and Medicare patients in rural communities which tend to have health disparities due to geographic isolation and low physician density. RHCs can be public, private, or non-profit entities.
- **Special Population (Special Medically Underserved Population):** HRSA may award funding or designation under sections 330(g), (h), or (i) of the PHS Act for the delivery of services to a special medically underserved population.
- **Uniform Data System (UDS):** The UDS is the specific data collection and reporting requirements for Health Center Program grantees developed by the Health Resources and Services Administration (HRSA) to track the patient population and effectiveness of the health care services of the Health Center Program. The annual data reporting to FQHC administrator and funder, HRSA, that is required under the PHS 330 health center grant requirements.
- **UDS Mapper:** Uniform Data System mapping tool developed by HRSA BPHC and the John Snow Institute.
- **Value-Based Care:** Value-based programs reward health care providers with incentive payments for the *quality of care* they give, using data and metrics to measure quality improvements and performance. They aim to improve individual and population health outcomes while reducing costs in the long term.
- **Z codes:** A class of ICD-10 codes, are used to document health center patient social determinants and non-clinical needs. The ICD-10 Official Guidelines for Coding and Reporting identify which codes maybe assigned as principal, secondary or later diagnosis and outline the different codes descriptions and uses.