SDOH Screening & Referrals to Support Diabetes Control

Module 2: Care Team Optimization

January 25, 2023 2:00pm EST

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Housekeeping

Captions

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Questions

Please add your questions and comments for the group or speakers into the “Chat”.

Technical Issues

Please raise your hand or message us in the chat if you need assistance.

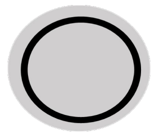
Recording

This session will be recorded and available to view with all supporting materials on the learning series Google Site.

Live Transcript

Chat

Raise Hand



Recording

Continuing Education Credits

- Offered in partnership with the Clinical Directors Network
- Attend entire session & complete the 5-question quiz
- CE quiz will be available after completing the session evaluation
- Please complete the evaluation regardless if you seeks CEs

Agenda

- Module 1: SDOH Screening
  Wednesday January 18th, 2:00 pm-3:00 pm EST
- **Module 2: Care Team Optimization**
  Wednesday January 25th, 2:00 pm-3:00 pm EST
- Module 3: Referrals to the Community & Closing the Loop
  Wednesday February 1st, 2:00 pm-3:00 pm EST

Learning Objectives

By the end of this module, learners will be able to…

1. Explore promising practices for mapping an SDOH screening process and other screening processes that align with the goals of diabetes management.

2. Describe roles and responsibilities for SDOH screening to organize care team optimization.

3. Identify tools/resources to ensure consistency, productivity, and data capture when operationalizing SDOH screening workflows.

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Director, Training & Technical Assistance

National Nurse-led Care Consortium

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

Patient Experience

Outcomes/Productivity

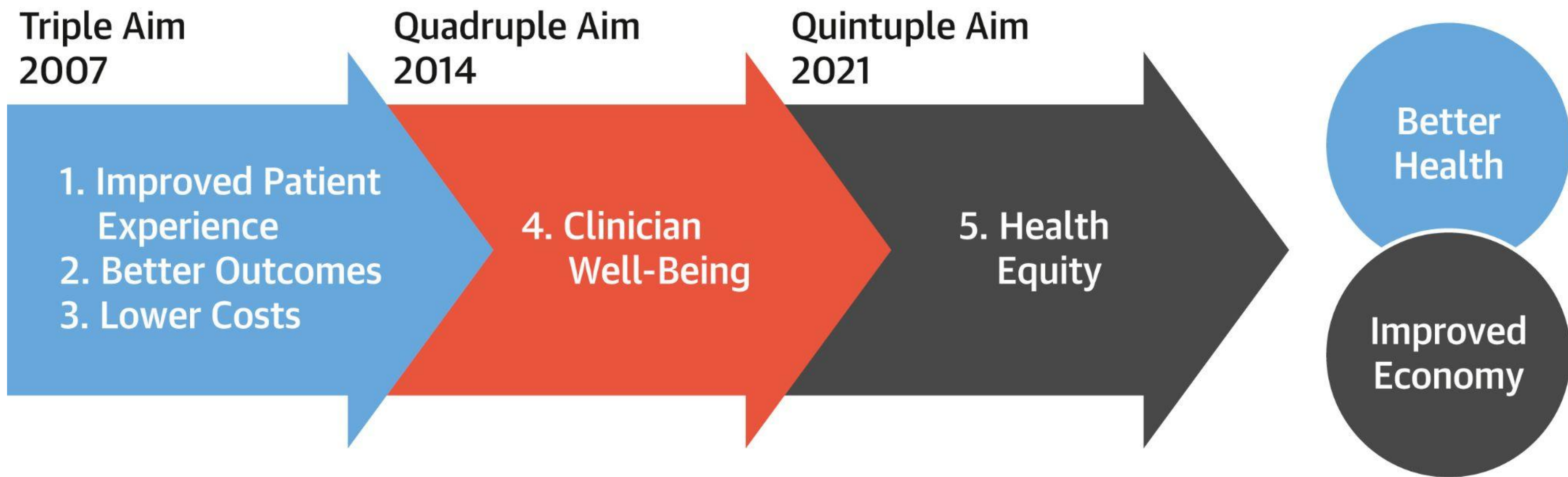
Reduce Costs

Provider Experience

Health Equity

The Quintuple Aim of Healthcare

Nundy, S. (2022, November 29). *Healthcare needs the quintuple aim*. MedCity News. Retrieved 2023, from https://medcitynews.com/2022/11/healthcare-needs-the-quintuple-aim/



Itchhaporia, D. (2021, November 30). *The evolution of the quintuple aim: Health equity, health outcomes, and the economy*. Journal of the American College of Cardiology. Retrieved 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8608191/

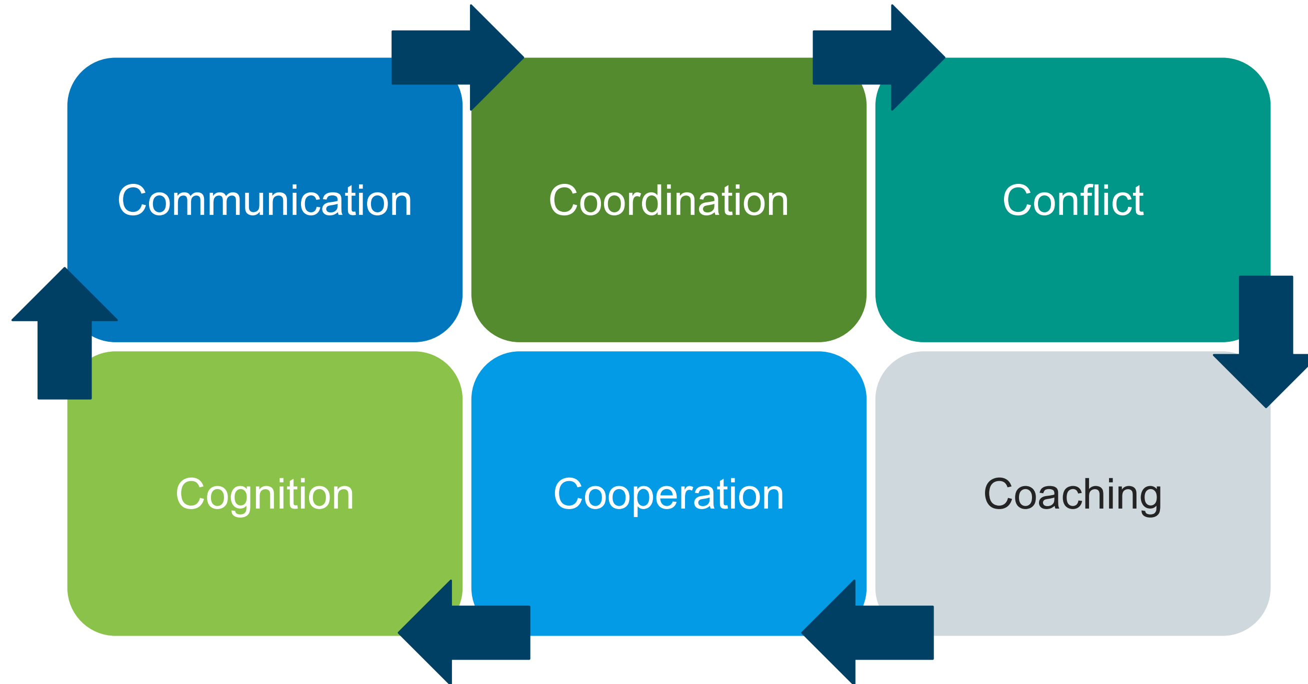
Foundations of the Care Team

Core Principles & Values of Effective Team-Based Care

- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and other outcomes

Mitchell, P., Wynia, M., Golden, R., McNellis, B., Webb, C. E., Rohrbach, V., & Von Kohorn, I. (2012). *Core principles & values of effective team-based health care*. Institute of Medicine of the National Academies. Retrieved 2023, from https://nam.edu/wp-content/uploads/2015/06/VSRT-Team-Based-Care-Principles-Values.pdf

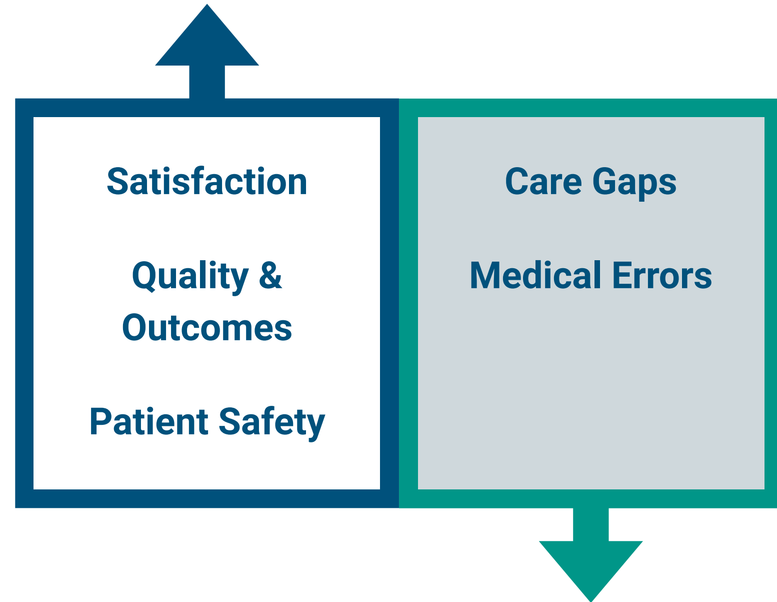
The 6 C’s of Effective Teamwork



Salas, E., Shuffler, M. L., Thayer, A. L., Bedwell, W. L., & Lazzara, E. H. (2015, July 1). *Understanding and improving teamwork in organizations: A scientifically based Practical Guide*. Shocker Open Access Repository Home. Retrieved 2023, from https://soar.wichita.edu/handle/10057/11474

Effective Team Communication

CLEAR & CONSISTENT COMMUNICATION



Effective Communication for Team Based Care

01	**Frequency**	• Once, as little as necessary
02	**Timing**	• Just in time, when needed
03	**Duration**	• Concise, organized
04	**Accuracy**	• Accuracy
05	**Focus**	• Respectful, task oriented

Ineffective Team Communication

Communication errors can lead to...

Increased employee turnover and absenteeism	Project failures and failed change management	80% of serious medical errors during transfer
35-40% malpractice claims (1.7 billion healthcare malpractice costs)	3rd leading cause of death in U.S.	Overutilization & overtreatment

IOM 2006, 2001; Budryk 2016; Kem 2016; Joint Commission Center 2012; Gordon, Deland & Kelly 2015; Hughes, O'Daniel & Rosenstein 2006

Care Team Role Clarification

Engage ALL care team staff in process, including patients

Scope & Responsibilities

Role explicit

NOT staff (person) related

Make use of professional competencies, scope of practice laws, and licensure

Role Interdependence

Understanding of how each role fits within the work of the team

Know what others' roles are

EHR

Standardized across EHR

"Mirror" settings for all staff in access and operational documentation

Responsible = does the task, one per row

Accountable = "bucks stops here", not necessary

Consulted = prior to task, team effected

Informed = after the fact, care continuum

SDOH Screening Activity	Pt Registrar	RN	Provider	Clinical Super
Distribute the SDOH questionnaire to patients	R	I, C	C	I
Refer patients to other team members for supplemental counseling and referral	C	I, C	R	A
Keep current on research		C	R	I
Assess patients' SDOH and their readiness to find help		R	A	
Provide counseling, with a focus on identifying strategies to overcome obstacles and reduce stress		R	A	
Implement quality audits and monitor key implementation activities	I	I	I	R
Schedule or arrange for appointments with communitybased resources	R	A	I	

Nurse Practitioner

- Independent panel of patients
- Not billed “incident to”
- Work to top of licensure

Medical Assistant

- Expanded role in initial assessment
- Follow-up of tests
- Workflow management

Pharmacist

- Expanded role in home visiting
- Medication education and reconciliation

Registered Nurse

- Expanded role in self-care teaching
- Chronic illness management
- Billable visits

Care team role optimization considers population and care team workflow

Community Health Workers in the Care Team

CHWs/Peer Workforce: Recruiting and Hiring for SDOH Screening

- CHWs are uniquely qualified to build strong relationships, speak the language, and empathize with complex SDOH situations
- **Case Study: Generations Family Health Center**
    - CHWs used screening tools within EHR to document SDOH which led to the ability to produce usable needs, referrals, and results/outcome data
    - Results
        - A1C blood glucose control improved 48% for hispanic individuals aged 18-39
        - Uncontrolled diabetes declined to 11.6% for migrant farmworker population
        - Improved management of medication for people experiencing homelessness
        - Increased COVID-19 testing and vaccinations

National Health Care for the Homeless Council (NHCHC), MHP Salud, & Corporation for Supportive Housing (CSH). (2021). *Community health worker/peer workforce: Recruiting and hiring for ...* NHCHC, 2023, from https://nhchc.org/wp-content/uploads/2021/07/CHWs-Peer-Specialist-Recruiting-and-Hiring-for-Social-Determinants-of-Health-Screening52.pdf

Best Practice Recommendations for CHW SDOH Screening

- Hiring & Recruiting
  - Low barrier practices
  - Consider representation of patient population
- Integration & Training
  - Collaborate with CHW programs that offer peer support training and certification
  - Continuous, on-the-job training that includes team building
  - Include and value CHW perspectives/knowledge of lived experience (monetary, too)
  - Provide supervisor training for those overseeing CHWs
- SDOH & Resource Referrals
  - Warm hand-off with CHW support
  - Updated and culturally informed
  - Data collection and tracking in EHR for enhanced care coordination

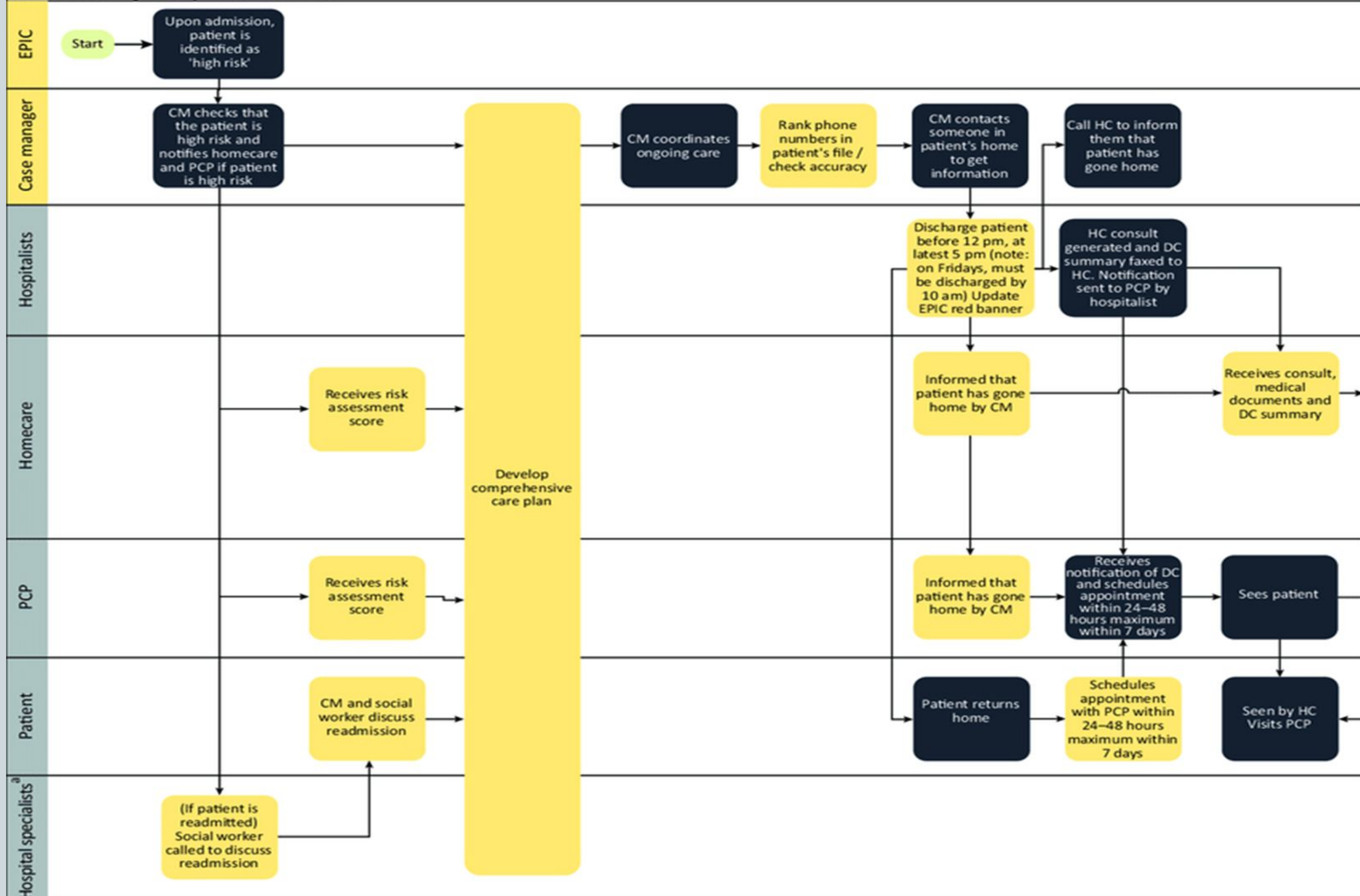
National Health Care for the Homeless Council (NHCHC), MHP Salud, & Corporation for Supportive Housing (CSH). (2021). *Community health worker/peer workforce: Recruiting and hiring for ...* NHCHC, 2023, from https://nhchc.org/wp-content/uploads/2021/07/CHWs-Peer-Specialist-Recruiting-and-Hiring-for-Social-Determinants-of-Health-Screening52.pdf

Operationalizing SDOH Screening Workflows

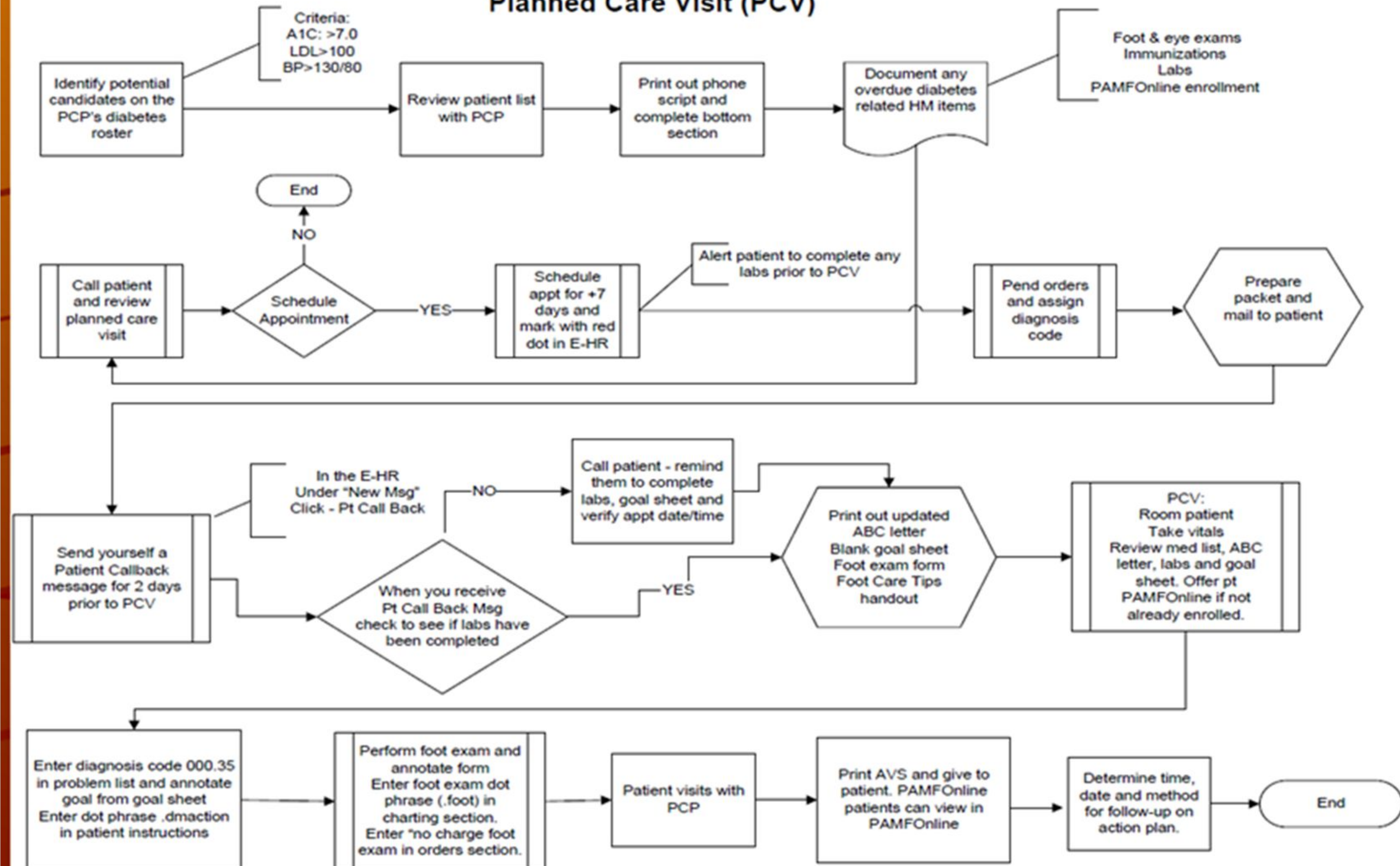
Identify Opportunities to Address SDOH

How does your practice currently identify and document SDOH?	In what ways does your practice currently help address patient's SDOH?	What systems do you have in place to ensure SDOH are addressed at patient visits?
❑ Whose responsibility is this?	❑ Screen for SDOH	❑ Review prompts in EHR
	❑ Maintain up-to-date records of community-based resources	❑ Identify SDOH as part of a patient's vital signs
	❑ Refer patients to community -based resources	❑ Maintain a registry of patients by categories of SDOH
	❑ Engage patients about how to overcome their SDOH	❑ Use flags, memos, and alerts in charts

Care Activity (SDOH Screeninbg)	Who? (care team)	What? (information)	Where? (data location in EHR)	When? (workflow)	EHR/IT customization required
Before arrival	Part of previsit chart prep-MA/Provider	due for SDOH screening? Last Screening date?	structured field in EHR? Flowsheet? Associated with Visit type?	Pre-Visit Planning	Are there system Prompts/flags/Alerts/CDS set up in system?
Daily Care Team Huddle		SDOH screening: due, followup?		daily huddle	
Check In				SDOH tied to visit type (AWV, NP)	Visit type template setup?
Waiting	Patient self completes. Meet with Pt. Navigator (if available part of team)	SDOH screening Form completed.How do you manage low literacy? Non-English speaking patients?	Paper then scan? Patient Portal? Structured in EHR?	may need to access language line if medical interpreter not available	multilanguage SDOH tool
Rooming	Medical Assistant.	reviews SDOH tool, scores, highlights Dx item relevant- Z-codes assigned to screening tool.	Adds Z-codes to problem list, CPT code to billing.		add Z-codes to SDOH template
Provider Encounter		SDOH orderset, generate referral	OV documentation: Template with codes included? How are counseling or other interventions for SDOH documented?	OV during Assessment and Plan	build Order set, link to Community Referral platform or resources
Encounter Closing		Community Referral Resources provided		check out	
Coding/Billing		SDOH Z codes, CPT codes	Charge slip	completion of OV encounter	
After Patient Leaves Office	Referral processed: Social Work, CHW, Care Manager		referral tracking and follow-up documentation		Shared Care Plan
Outside Patient Specific Encounter	Case Management	follow-up referral, interventions and incorporate into patient shared care plan			shared Care Plan



Future state high-risk patient workflow
EPIC
Case manager
Hospitalists
Homecare
PCP
Patient
Hospital specialists[a]
Start
Upon admission, patient is identified as 'high risk'
CM checks that the patient is high risk and notifies homecare and PCP if patient is high risk
Receives risk assessment score
Receives risk assessment score
CM and social worker discuss readmission
(If patient is readmitted) Social worker called to discuss readmission
Develop comprehensive care plan
CM coordinates ongoing care
Rank phone numbers in patient's file / check accuracy
CM contacts someone in patient's home to get information
Call HC to inform them that patient has gone home
Discharge patient before 12 pm, at latest 5 pm (note: on Fridays, must be discharged by 10 am) Update EPIC red banner
HC consult generated and DC summary faxed to HC. Notification sent to PCP by hospitalist
Informed that patient has gone home by CM
Receives consult, medical documents and DC summary
Informed that patient has gone home by CM
Receives notification of DC and schedules appointment within 24–48 hours maximum within 7 days
Sees patient
Patient returns home
Schedules appointment with PCP within 24–48 hours maximum within 7 days
Seen by HC Visits PCP



Planned Care Visit (PCV)
Criteria:
A1C: >7.0
LDL>100
BP>130/80
Identify potential candidates on the PCP's diabetes roster
Review patient list with PCP
Print out phone script and complete bottom section
Document any overdue diabetes related HM items
Foot & eye exams
Immunizations
Labs
PAMFOnline enrollment
End
NO
Call patient and review planned care visit
Schedule Appointment
YES
Schedule appt for +7 days and mark with red dot in E-HR
Alert patient to complete any labs prior to PCV
Pend orders and assign diagnosis code
Prepare packet and mail to patient
In the E-HR
Under "New Msg"
Click - Pt Call Back
NO
Call patient - remind them to complete labs, goal sheet and verify appt date/time
Send yourself a Patient Callback message for 2 days prior to PCV
When you receive Pt Call Back Msg check to see if labs have been completed
YES
Print out updated ABC letter
Blank goal sheet
Foot exam form
Foot Care Tips handout
PCV:
Room patient
Take vitals
Review med list, ABC letter, labs and goal sheet. Offer pt PAMFOnline if not already enrolled.
Enter diagnosis code 000.35 in problem list and annotate goal from goal sheet
Enter dot phrase .dmaction in patient instructions
Perform foot exam and annotate form
Enter foot exam dot phrase (.foot) in charting section.
Enter "no charge foot exam in orders section.
Patient visits with PCP
Print AVS and give to patient. PAMFOnline patients can view in PAMFOnline
Determine time, date and method for follow-up on action plan.
End

SDOH Outcome-based Measures

- Percent of patients screened for SDOH
- Percent of patients with specific SDOH
- Percent of patients with positive screen being referred to community-based resources
- Percent of patients that receive follow up
- Percent of patients that have successfully addressed an identified SDOH challenge

Upstream QI Workflow for Mr. M	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Food insecurity	Upstream QI committee	Project Team oversees & tracks PDSAs	"Upstream Project Canvas"	# QI team participation # PDSAs
Screen	Medical Assistant	Ask during vitals of diabetics	2-item food insecurity screener	% screened
Triage	Medical Assistant	Flag in EMR	Triage Protocol	% positive % flagged
Exam	PCP	Adjust / create treatment plan	EMR care plan	% plans updated
Chart/Code	Medical Assistant	Scribe, standing order to refer to SW	EMR	% internal referrals
Refer	Social Worker or RN	Assess / Food bank referral	Resource database (e.g. Healthify)	% referred
Follow-up	Social Worker or RN	Q1month or more check-in based on risk	EMR CRM (e.g. Healthify)	% decrease in food insecurity & utilization

HealthBegins

People

Processes

Technology

Building Capacity to Respond to Data

Organizational Resources

Create Services In-House

People: Develop staffing models to respond to SDOH
Process: Develop resources to support staff in addressing SDOH needs at point of care
Tech: Develop ways to track non-clinical services provided

Form Coalitions w/ Community Partners & Advocates for Policy & Enviro Change

People: Build and staff a resource desk and community resource guides
Process: Build and sustain effective community partnerships
Tech: Track referrals to non-clinical services and measure intervention impact

Raise Awareness to Strengthen Staff, Patient, and Partner Knowledge of SDOH

People: Deliver skills training on how to discuss SDOH
Process: Create opportunities for staff & leaders to know the value of addressing SDOH
Tech: Begin collecting data on SDOH in EHR

Partner w/ Community-based Organizations & Leaders

People: Set up volunteer programs for community volunteers
Process: Focus public health/grant funds to support partnership development
Tech: Develop an electronic referral system or resource guide

Local Community Resources

EveryONE Project Toolkit

Practice Leadership for Health Equity

- Focuses on enabling medical practices to create an organizational cultures that values health equity
- Develops team-based approaches for addressing patients' SDOH

Assessment and Action

- Offers tools to help with screening and referral processes

Community Collaboration and Advocacy

- Provides information and resources to help providers engage with their community
- Advocates policies that have been shown to reduce health inequities

https://www.aafp.org/family-physician/patient-care/the-everyone-project.html

Delaware Valley Community Health, Inc.

Kimberly Allen, MSN RN CPHQ FACHE

Chief Quality & Innovation Officer

Delaware Valley Community Health, Inc.

Janine Gibbons, RN

Director of Care Coordination

Delaware Valley Community Health, Inc.

Delaware Valley Community Health, Inc.

Self-Monitored Blood Pressure (SMBP) & Remote Patient Monitoring (RPM)

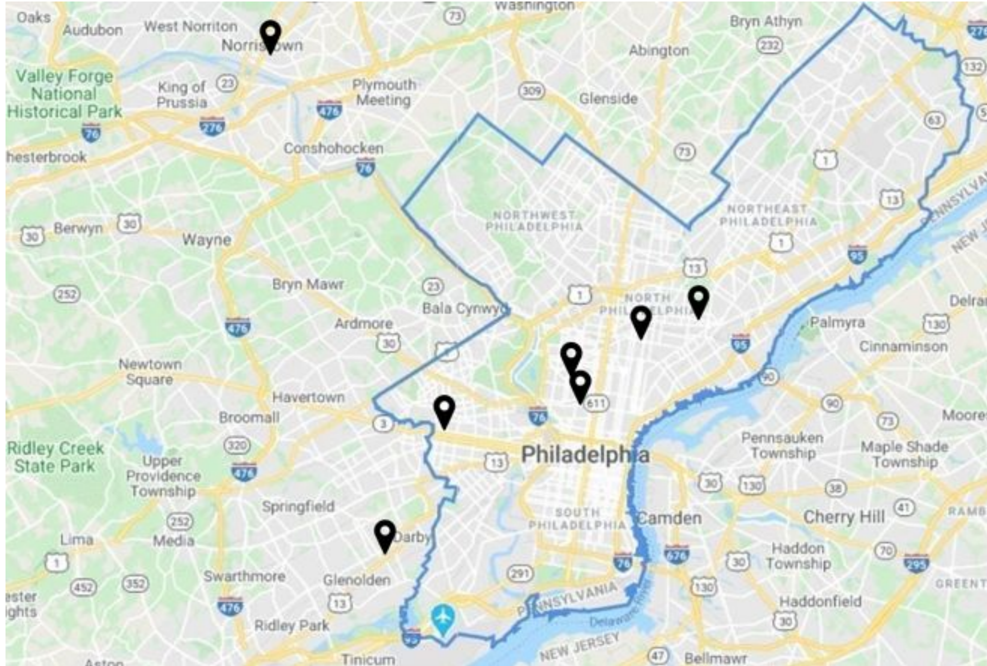
- Kimberly Allen, RN FACHE CPHQ (Chief Quality & Innovation Officer)
- Janine Gibbons, RN (Director of Care Coordination)

OUR MISSION

Delaware Valley Community Health (DVCH) is a community-focused health care organization providing affordable, accessible, primary medical, dental and behavioral health care and preventive services to the uninsured and underinsured patients in its service area. Services are provided in a fiscally responsible manner to all patients regardless of their ability to pay.

Delaware Valley Community Health, Inc.

DelawareCare Valley Community Health, Inc.



Services

- ✔ Adult Medicine
- ✔ Behavioral Health
- ✔ Care Coordination
- ✔ Dental
- ✔ Gynecology
- ✔ Health Education
- ✔ Health Insurance Enrollment
- ✔ Hepatitis C Care
- ✔ HIV Care
- ✔ Legal
- ✔ Medication Dispensary
- ✔ Optometry
- ✔ Pediatrics
- ✔ Prenatal Care/Obstetrics
- ✔ Podiatry
- ✔ Social Services

Community-Focused Healthcare

Delaware Valley Community Health, Inc. (DVCH) is a private, non-profit healthcare organization that provides quality **medical, dental, and behavioral health services** to patients, **regardless of their ability to pay**.

- Operates **9 Federally Qualified Health Centers (FQHCs)** in Southeastern Pennsylvania Services
- **Operating over 50 years** as the safety net provider for all
- Provided access to care to **47k+ patients**

ROAD TO CONTROLLED HYPERTENSION: 2021-2023

Program Overview

- **Self-measured blood pressure (SMBP)** is the monitoring of blood pressure by the patient outside the clinical setting.
- When combined with clinical support, it is an evidence-based way to improve BP control.
- SMBP employs a medical home and team-based approach.
- **Grant funding for 3 years**

ROAD TO CONTROLLED HYPERTENSION: 2021-2023

The "How"

Interdisciplinary Team

Utilizing Tech

Grounded in Equity

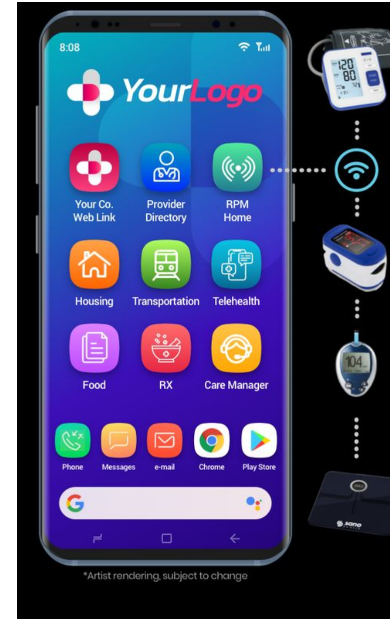
Replicated Easily

Delaware Valley Community Health SMBP Care Team

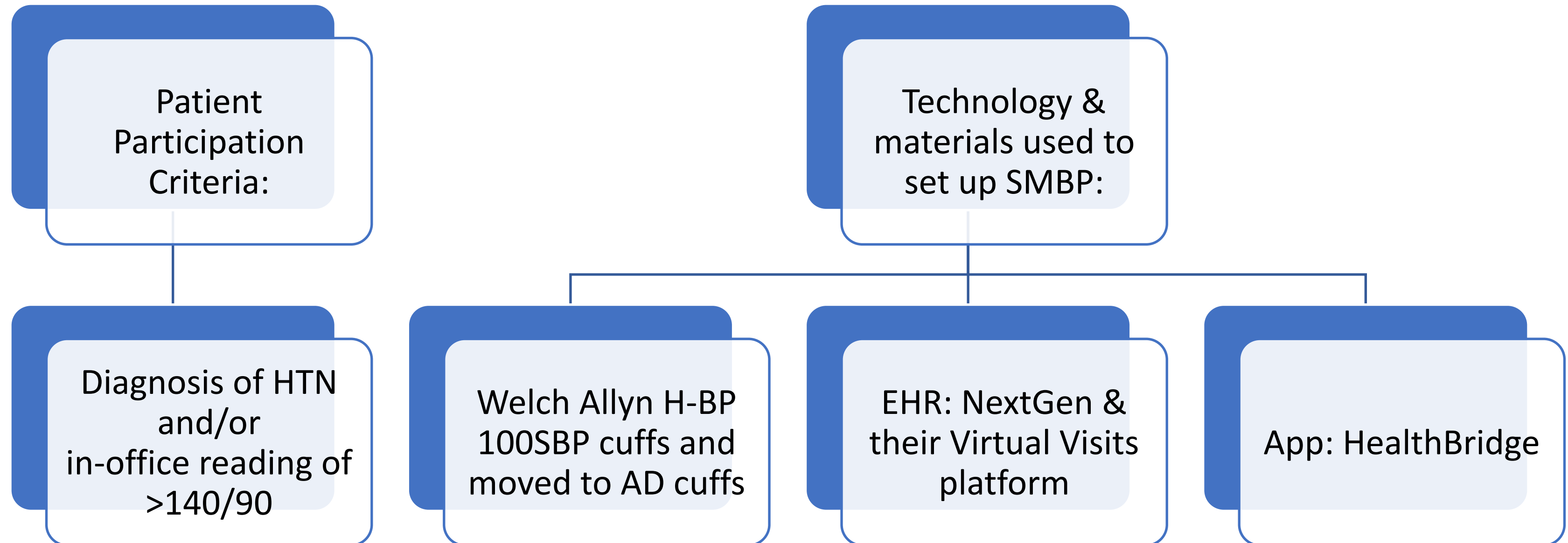
The SMBP Care Team and Community Partnerships

- **The Food Trust:** FBRx produce prescriptions are distributed to patients by their healthcare providers.

- **Sano Health:** They provide devices and mobile connectivity, backed by live customer support.



Million Hearts/Chronic Disease Collaborative via Health Federation of Philadelphia



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Delaware Valley Community Health, Inc.

Action Items

- Identify proper personnel for screening administration
- Conduct process mapping exercise
- Identify outcome measures for your SDOH screening program

Wrap Up & Evaluation

Please help us measure our impact with this session by filling out the evaluation survey that will pop up on your screen as you exit Zoom.

You must complete the survey to be redirected to the CE link.

Module 3: Wednesday, February 1, 2023 from 2:00-3:00 pm ET

- Recordings, presentation slides, and resources from Session 2 will be added to the Google Site shortly.

Nurse-Led Forum for Vaccine Confidence

Nurse Well-being and Burnout: 2-Part Learning Collaborative Series

February 9th & February 23rd at 1:00 PM EST

- 1.5 CE credits offered per session
- Register here: https://nurseledcare.phmc.org/training/item/1365-nurse-wellbeing-and-burnout-2-part-learning-collaborative-series.html