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ROOTS Program

Optimizing the Flow of Information and Work for Social Needs Webinar

December 14, 2017

CENTER FOR CARE INNOVATIONS

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Webinar Reminders

1. Everyone is muted.
   - Press *6 to **mute** yourself and *7 to **unmute**.

2. Remember to chat in questions!

3. Webinar is being recorded and will be posted and sent out via email.

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Agenda

1. Welcome and Introductions
2. Program Reminders
3. Presentation: **Sara Badar and Dr. Rishi Manchanda from Health Begins**
   - How to map your current information and workflows
   - How to identify opportunities for work and information flow improvement
   - Hayward Wellness: how they improved the flow of information and work in order to integrate food insecurity screening
4. Questions & Answers

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Upcoming Events

Event	Where	What	Date
Program Webinar	Virtual	Focused on program updates, including evaluation metrics and site visits. Also focus on brainstorming partnership content.	January 10, 2018 at 11am
ROOTS Clinic Site Visit	Oakland, CA	Highlighting partnerships, addressing community development and food insecurity	January 31, 2018
Idea Sharing Webinar	Virtual	TBD	February 1, 2018
KKV Site Visit	Kalihi Valley, HI	Highlighting approaches/solutions addressing homelessness, formally incarcerated populations, and unemployment	February 22, 2018
In-Person Convening #2	Los Angeles, CA	Focused on partnerships.	March 8, 2018

Optimizing the flow of information and work for social needs

RISHI MANCHANDA MD MPH
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DECEMBER 14, 2017

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Learning Objectives

By the end of this webinar, learners will be able to:

- Describe how Hayward Wellness' improved the flow of information and work to integrate food insecurity screening
- Map current information and workflows
- Identify opportunities for work and information flow improvement

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Using Health IT Strategies to Screen and Address Food Insecurity: Hayward Wellness Case Study

Documenting Food Insecurity Screening in NextGen

1. MA documents at bottom of Screening Summary
2. Positive screens auto populate Assessment with Z59.14 ICD10 code and Patient Plan with Produce Rx given and Help Desk Rx give

1.	Assessment	Food insecurity (Z59.4).
	Patient Plan	1. Produce prescription given to patient to redeem at Food Farmacy in Hayward Wellness lobby. 2. Help Desk prescription given to patient to redeem at Health Advocate Help Desk in Hayward Wellness lobby. 3. Patient can also call the Help Desk line 510-437-4400.

Food Insecurity Screening:

For each of the following two statements, please tell me whether the statement was: often true, sometimes true, or never true.

Within the past 12 months, we were worried whether our food would run out before we got money to buy more. (•) Often ( ) Sometimes ( ) Never

Within the past 12 months, the food we bought just didn't last and we didn't have the money to buy more. ( ) Often (•) Sometimes ( ) Never

Save & Close | Cancel

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ASSESS and REFER: Documenting in NextGen

1. Z59.4 code will be auto-populated in Assessment section
2. PCP to use auto-populated prompts to fill out low, medium, high level of food insecurity in Provider Details and modify treatment plan for food-related relevant medical conditions (e.g. diabetes)
3. Plan details to be autopopulated: Produce Rx, Help Desk Rx. However, must manually refer to Healthy Lifestyle/Food Insecurity group or Clinical Pharmacist

Plan Details

Previous Patient Details (Curr Prov) | Previous Patient Details (All)

Previous Patient Details — Sort By: Summary Phrase

Patient Details: Exclusions | My Phrases | Common Phrases | Manage My Phrases

1. Produce prescription given to patient to redeem at Food Farmacy in Hayward Wellness lobby. 2. Help Desk prescription given to patient to redeem at Health Advocate Help Desk in Hayward Wellness lobby. 3. Patient can also call the Help Desk line 510-437-4400.

Today's Orders:

Assessment/Plan

Assessments
My Plan
A/P Details
Labs
Diagnostics
Referrals
Office Procedures
Review/Cosign Orders
View Immunizations
Office Diagnostics
Physical Therapy Orders
Health Promotion Plan
Follow Up

1.	Assessment	Food insecurity (Z59.4).
	Patient Plan	1. Produce prescription given to patient to redeem at Food Farmacy in Hayward Wellness lobby. 2. Help Desk prescription given to patient to redeem at Health Advocate Help Desk in Hayward Wellness lobby. 3. Patient can also call the Help Desk line 510-437-4400.
	Provider Plan	ASK the following 2 questions: 1. Has anyone in your patient's household experienced hunger because food just ran out or didn't last long enough? Adults, children, or both 2. What kind of food does your household eat? Healthy, nutrient poor, or severe lack of nutrition THEN, select the level of Household Food Insecurity: 1. Low severity = No hunger in household, concerns about budget lead to change in buying and managing food 2. Medium severity = Adults report hunger, while children are shielded, diets poor in nutrients 3. High severity = Adults and children experience hunger due to severe cuts in food intake, severe lack of nutrition FINALLY, adjust your plan accordingly.

Add or Update Assessment

Assessments | My Plan | A/P Details | Labs | Diagnostics | Referrals | Office Procedures | Cosign Orders

Today's Assessments: (Select an assessment and enter the details below)

#	Description	Code	Status	Chronic
1	Food insecurity	Z59.4		N

Selected Assessment: Food insecurity

Impression/Comments: Sort By: Summary Phrase My Phrases | Manage My Phrases

Differential Diagnosis: Sort By: Summary Phrase My Phrases | Manage My Phrases

(Only the first 215 characters will be displayed in the Diagnosis Module)

Plan Details

Previous Patient Details — Patient Details: Exclusions | My Phrases | Common Phrases | Manage My Phrases

1. Produce prescription given to patient to redeem at Food Farmacy in Hayward Wellness lobby.
2. Help Desk prescription given to patient to redeem at Health Advocate Help Desk in Hayward Wellness lobby.
3. Patient can also call the Help Desk line 510-437-4400.

Previous Provider Details — Provider Details:

ASK the following 2 questions:
1. Has anyone in your patient's household experienced hunger because food just ran out or didn't last long enough? Adults, children, or both
2. What kind of food does your household eat? Healthy, nutrient poor, or severe lack of nutrition
THEN, select the level of Household Food Insecurity:

(Provider details will not print on the patient plan.)

Today's Orders:

Comments to MA/RN: (These comments will appear on the checkout template)

Follow Up | Counseling Details | Tobacco Cessation Information | Tobacco cessation discussed: | Quick Task | Save & Close | Cancel

1 2 3

HaywardWellness

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Creating information and workflows for upstream interventions

Step 1: For your health-related social need, do you have a well-defined performance target?

- For example: 80% of eligible patients will be screened for food insecurity using the Hunger Vital Sign.

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Creating information and workflows for upstream interventions

Step 2: What is a process in your clinic where your current information and work flows are really good?

- For example: Has your clinic done well in screening for HTN, depression or tobacco?

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Step 2:

What is a process in your clinic where your current information and work flows are really good?

Example: **Let's look at how Clinic X has managed flow to help 80% of their HTN patients keep BP within target range.**

Patient-specific activities	Current information flow for blood pressure control at Clinic X
Pre-Visit*	We connect eligible to ambulatory BP monitoring equipment. RN CMs call high-risk patients 1 week before scheduled visits to check on home BP measurements and support pre-visit planning and med rec.
Team Huddle	The MAs do chart prep to pre-assemble data to assist provider decision-making and, during pre-session huddles, the teamlet reviews data and needed interventions for patients scheduled to be seen that day.
Check-In*	The front desk updates flags in the patient chart to update disease registries at check-in.
Vitals*	The MAs check BP per protocol, enter data into EMR, and flag high BPs that need urgent attention.
Triage*	MAs contact provider "on-call" with any elevated BPs that are above a threshold level or are associated with symptoms and follow a standing order to check EKG.
Examination*	Providers use EMR templates to document key HTN-data,
Chart/Code	Based on MA data entry at Vitals, EMR auto-documents and updates problem list with ICD-10 code.
Refer	Providers use EMR to place medication orders and referrals to specialists as needed
Check-out	MAs review orders with patients, conducts med rec, rechecks BP and triggers protocol if BP markedly elevated.
Post-Visit	Our RN CM reviews a disease registry of HTN patients once a week, follows up with patients and care teams as needed, monitor progress towards our performance target

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Creating information and workflows for upstream interventions

Step 3: What are the opportunities to enhance your current workflow for traditional clinical conditions in order to incorporate social needs screening and referrals?

Example: Let's look at how Clinic X brainstormed ways to build on their BP flow to address food insecurity.

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Patient-specific activities	Current information flow for blood pressure control at Clinic X	Opportunities to address food insecurity
Pre-Visit*	We connect eligible to ambulatory BP monitoring equipment. RN CMs call high-risk patients 1 week before scheduled visits to check on home BP measurements and support pre-visit planning and med rec.	During RN CM calls with high-risk patients, RN CM administers two-item Hunger Vital Sign.
Team Huddle	The MAs do chart prep to pre-assemble data to assist provider decision-making and, during pre-session huddles, the teamlet reviews data and needed interventions for patients scheduled to be seen that day.	During chart prep, MA identifies patients who had previously screened positive for food insecurity. During huddle, updates provider. Teamlet reviews needed interventions.
Check-In*	The front desk updates flags in the patient chart to update disease registries at check-in.	Front-desk provides patients with paper or iPad –based screening social needs questionnaire to complete while waiting
Vitals*	The MAs check BP per protocol, enter data into EMR, and flag high BPs that need urgent attention.	MA collects screening questionnaire. If incomplete, MA asks Hunger Vital Sign. Information entered in EMR.
Triage*	MAs contact provider "on-call" with any elevated BPs that are above a threshold level or are associated with symptoms and follow a standing order to check EKG.	Positive screens entered in EMR auto-populate problem list and trigger standing order referral to social service partner
Examination*	Providers use EMR templates to document key HTN-data,	Provider reviews Food Insecurity with patient, adjusts treatment plan as needed
Chart/Code	Based on MA data entry at Vitals, EMR auto-documents and updates problem list with ICD-10 code.	Providers review and update EMR problem list, care plan, and referral to food bank or social service partner
Refer	Providers use EMR to place medication orders and referrals to specialists as needed	SW reviews standing order referrals to food bank. does brief assessment of level of food insecurity, refers patient as needed
Check-out	MAs review orders with patients, conducts med rec, rechecks BP and triggers protocol if BP markedly elevated.	MA reviews orders with patient, including food rx
Post-Visit	Our RN CM reviews a disease registry of HTN patients once a week, follows up with patients and care teams as needed, monitor progress towards our performance target	RN CM reviews disease registry including food insecurity registry.

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Creating information and workflows for upstream interventions

Step 4: Now, identify a few initial opportunities to build your new ‘upstream’ workflow

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Patient-specific activities	Current information flow for blood pressure control at Clinic X	Opportunities to address food insecurity
Pre-Visit*	We connect eligible to ambulatory BP monitoring equipment. RN CMs call high-risk patients 1 week before scheduled visits to check on home BP measurements and support pre-visit planning and med rec.	During RN CM calls with high-risk patients, RN CM administers two-item Hunger Vital Sign.
Team Huddle	The MAs do chart prep to pre-assemble data to assist provider decision-making and, during pre-session huddles, the teamlet reviews data and needed interventions for patients scheduled to be seen that day.	During chart prep, MA identifies patients who had previously screened positive for food insecurity. During huddle, updates provider. Teamlet reviews needed interventions.
Check-In*	The front desk updates flags in the patient chart to update disease registries at check-in.	Front-desk provides patients with paper or iPad –based screening social needs questionnaire to complete while waiting
Vitals*	The MAs check BP per protocol, enter data into EMR, and flag high BPs that need urgent attention.	MA collects screening questionnaire. If incomplete, MA asks Hunger Vital Sign. Information entered in EMR.
Triage*	MAs contact provider "on-call" with any elevated BPs that are above a threshold level or are associated with symptoms and follow a standing order to check EKG.	Positive screens entered in EMR auto-populate problem list and trigger standing order referral to social service partner
Examination*	Provider	Provider reviews Food Insecurity with patient, adjusts treatment plan as needed
Chart/Code	Based o ... em list with ICD-10 c	Providers review and update EMR problem list, care plan, and referral to food bank or social service partner
Refer	Provider ... needed	SW reviews standing order referrals to food bank. does brief assessment of level of food insecurity, refers patient as needed
Check-out	MAs rev ... rs protocol if BP markedly elevated.	MA reviews orders with patient, including food rx
Post-Visit	Our RN CM reviews a disease registry of HTN patients once a week, follows up with patients and care teams as needed, monitor progress towards our performance target	RN CM reviews disease registry including food insecurity registry.

Initial opportunities to enhance current BP flow to address food insecurity at Clinic X

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Creating information and workflows for upstream interventions

Step 5: Based on the opportunities you identified, refine the roles and tools that you'll need to integrate health-related social needs

Use the **Upstream Medicine Workflow Canvas™**

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Upstream Medicine Workflow Canvas™ Target SDOH:	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Pre-visit*				
Huddle				
Check-in*				
Vitals/ Rooming*				
Triage				
Exam*				
Chart/Code				
Refer				
Check-out				
Post-visit				

Typical visit workflow

*= Opportunities to screen

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Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Pre-visit*				
Huddle				
Check-in*				
Vitals/ Rooming*				
Triage				
Exam*				
Chart/Code				
Refer				
Check-out				
Post-visit				

Who has responsibility for this step currently?

*= Opportunities to screen

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Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Pre-visit*				
Huddle				
Check-in*				
Vitals/ Rooming*				
Triage				
Exam*				
Chart/Code				
Refer				
Check-out				
Post-visit				

Outline the process or role that this team members performs

*= Opportunities to screen

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Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Pre-visit*				
Huddle				
Check-in*				
Vitals/ Rooming*				
Triage				
Exam*				
Chart/Code				
Refer				
Check-out				
Post-visit				

What tools are available to support this step and where is this data pulled from?

*= Opportunities to screen

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Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Pre-visit*				
Huddle				
Check-in*				
Vitals/ Rooming*				
Triage				
Exam*				
Chart/Code				
Refer				
Check-out				
Post-visit				

What metrics could you track to measure effectiveness?

*= Opportunities to screen

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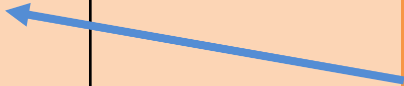
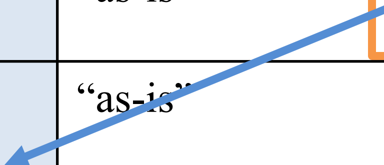
Upstream Medicine Workflow Canvas™ Target SDOH: Food Insecurity at Clinic X	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Pre-visit*	Clinic X chose to keep what works from their BP workflow. This stays “as-is”			
Huddle	“as-is”			
Check-in*	“as-is”			
Vitals*				
Triage				
Exam*	“as-is”			
Chart/Code	“as-is”			
Refer				
Check-out				
Post-visit	“as-is”			

Initial opportunities to enhance current BP flow to assess food insecurity at Clinic X





*= Opportunities to screen

Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
SDOH: Food Insecurity	Upstream QI committee	Project Team oversees & tracks PDSAs	"Upstream Project Canvas"	# QI team participation # PDSAs
Pre-visit	Patient	Patients receive automated info on food resources	Automated SMS (e.g. via CareMessage)	# Message open rate
Vitals	Medical Assistant	Ask during vitals of all diabetics and HTN pts	2-item food insecurity screener (HVS)	% screened
Triage				
Exam				
Chart/Code				
Refer				
Post-visit				

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Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
SDOH: Food Insecurity	Upstream QI committee	Project Team oversees & tracks PDSAs	"Upstream Project Canvas"	# QI team participation # PDSAs
Pre-visit	Patient	Patients receive automated info on food resources	Automated SMS (e.g. via CareMessage)	# Message open rate
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				
Chart/Code				
Refer				
Post-visit				

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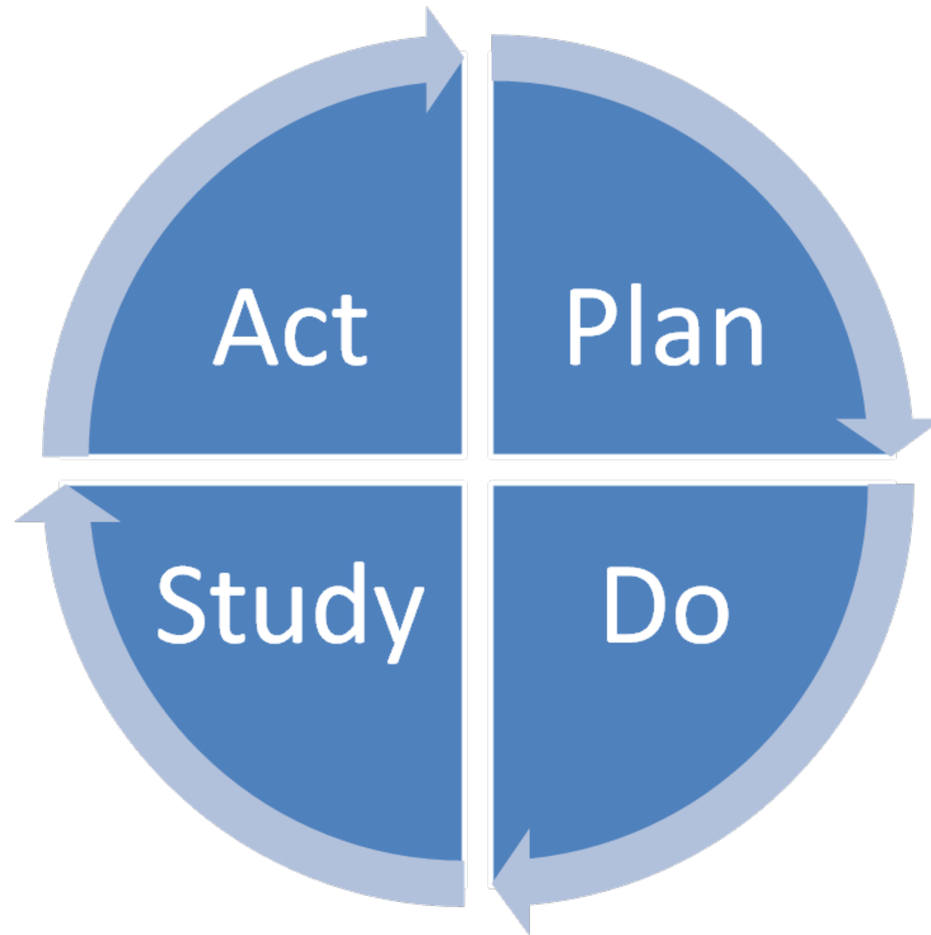
Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
SDOH: Food Insecurity	Upstream QI committee	Project Team oversees & tracks PDSAs	"Upstream Project Canvas"	# QI team participation # PDSAs
Pre-visit	Patient	Patients receive automated info on food resources	Automated SMS (e.g. via CareMessage)	# Message open rate
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	Review / Adjust treatment plan if food insecure	EMR autopopulates Problem List	% plans updated
Chart/Code	Medical Assistant	MA entry of positive screen at vitals stage auto-populates EMR problem list	EMR problem list (Z59.4)	% internal referrals
Refer				
Post-visit				

Upstream Medicine Workflow Canvas™	Care Team Member	Role/ Process	Tools/ Data Source	Metric
SDOH: Food Insecurity	Upstream QI committee	Project Team oversees & tracks PDSAs	"Upstream Project Canvas"	# QI team participation # PDSAs
Pre-visit	Patient	Patients receive automated info on food resources	Automated SMS (e.g. via CareMessage)	# Message open rate
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	Review / Adjust treatment plan if food insecure	EMR autopopulates Problem List	% plans updated
Chart/Code	Medical Assistant	Scribe, standing order to refer to SW	EMR	% internal referrals
Refer	RN CM	MA entry at vitals auto-populates referral to RN CM, who refers to food bank	1) EMR referrals to RN 2) Online resource database (e.g. Healthify, One Degree)	% referred to RN % referred via online resource database
Post-visit				

Upstream Medicine Workflow Canvas™ *v1.0 Food Insecurity @Clinic X*	Care Team Member	Role/ Process	Tools/ Data Source	Metric
Pre-visit	Patient	As – is (per BP workflow)	As - is	As - is
Team huddle	Teamlet	As - is	As - is	As - is
Check-in	Front-desk	As - is	As - is	As - is
Vitals	Medical Assistant	Ask during vitals of diabetics	2-item food insecurity screener	% screened
Triage	Medical Assistant	Positive screens entered as flag in EMR	Automated 'Triage Protocol'	% positive % flagged
Exam	PCP	As - is	As - is	As - is
Chart/Code	Medical Assistant	MA entry of positive screen at vitals stage auto-populates EMR problem list	EMR	% internal referrals
Refer	RN CM	Auto-populates referral to RN CM, who refers to food bank	Online Resource database (e.g. Healthify, One Degree)	% referred
Check-out	MA	As - is	As - is	As - is
Post-visit	RN CM	As - is	As - is	As - is

Now… test!



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"Food" for thought…

- What opportunities have you identified for improvement to your current information and workflow to incorporate social needs?

- How could you incorporate social needs screening into your existing workflow?

- "What can you do by next Tuesday" to test an idea on a small scale?

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Thank you!

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Q & A

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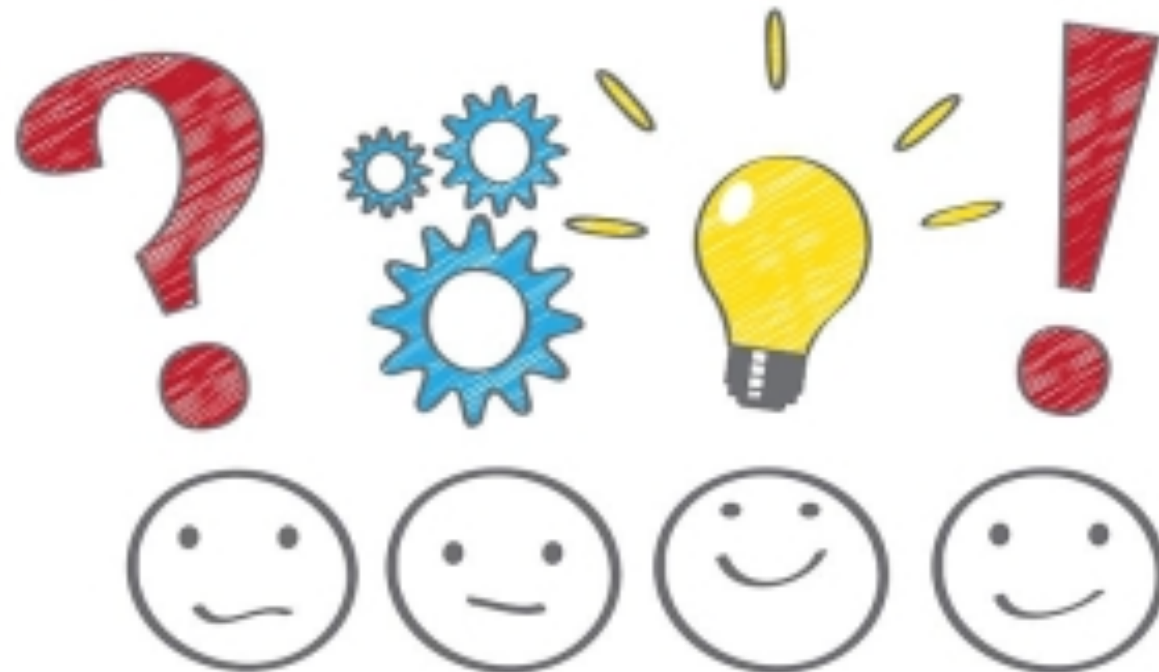

Thank you!

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