Subcommittee: HIE Stakeholder Engagement

Co-chairs: Dr. Yavar Moghimi and Dr. Mary Awuonda

Date: April 27, 2023

Status: Draft

District of Columbia Health Information Exchange Policy Board

Recommendation to Approve the Use of Educational Materials Regarding DC HIE Tools for Health-Related Social Needs Screening and Referral

I. SUMMARY

The HIE Policy Board Stakeholder Engagement subcommittee proposes the approval of an educational handout to encourage provider education and use of these HIE tools. These workflows are intended to illustrate how providers in different care settings can use CRISP DC tools to capture, view, and track social needs screening and referral data. The handout aims to further the use of HIE tools to screen and document social needs, search for community-based organizations (CBOs), and send e-Referrals, all within the CRISP environment. The handout also includes an example step-by-step breakdown of how users can incorporate the use of these tools within their workflow and offers additional reference materials. The handout was collaboratively developed with the HIE Community Resource Inventory (CRI) subcommittee.

II. PROBLEM STATEMENT

As outlined in the 2022 State Medicaid Health IT Plan (SMHP) update, Recommendation #6 outlines the need to improve education and communication efforts in order to increase awareness and use of the DC HIE and its tools. In response, the Stakeholder Engagement subcommittee reviewed the DC Community Resource Information and Exchange (CoRIE) Initiative – an interoperable system within the DC HIE that allows for social needs data sharing between different stakeholders across the health care continuum. This includes three major functions – (1) Sharing of Health-Related Social Needs (HRSN) screening data; (2) Resource lookups through a centralized directory within the HIE; and (3) Electronic referrals to CBOs and other support services. As such, these tools enable a user to view social needs screening and assessment information in the HIE, derived from multiple sources including electronic health records (EHRs). The referral tool also facilitates digital connections with CBOs and other support service providers to address unmet social need, while also allowing users to review referral status and referral history. Various subcommittee members also underscored that the use of CRISP tools is a new addition to existing workflows at health care facilities. To address this, the Stakeholder Engagement subcommittee developed a workflow that outlines screening to referral pathways that are supported by these tools and promotes the value of utilizing DC HIE tools.

III. SUBCOMMITTEE GOAL AND ACTIVITY

This activity can be added under Goal #1 under the subcommittee's workplan – *Identify and inform ways to improve stakeholder engagement in the District's HIE initiatives and to promote the value of health information exchange and of advancing along the SMHP HIT Framework to District stakeholders.*

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IV. DISCUSSION

The Stakeholder Engagement subcommittee proposes an educational handout for providers that highlights the various HRSN tools within the CRISP environment. This handout is located in **Appendix 1** of this document. To inform the development of materials, the subcommittee hosted various representatives from the Designated HIE entity, CRISP DC, and reviewed all three functions and tools available within the CRISP environment. In addition, the subcommittee held robust discussions on the utilizing and notating Z-codes within EHRs. The subcommittee considered perspectives from the DC Primary Care Association (DCPCA) and the DC Hospital Association (DCHA) and their respective pilot initiatives to increase social needs screenings and documentation of Z-codes for identified social needs. The subcommittee also worked with representatives from the HIE CRI subcommittee for additional feedback on the resources available in the DC CRI and assisted CRISP DC partners in the development of a priority list of CBOs for outreach and onboarding to the HIE. Finally, the subcommittee reviewed how users access the HIE (either by logging into the CRISP web portal or via Single Sign On) to ensure that workflow language was responsive to the needs of users. To ensure that this handout remains updated, the subcommittee will periodically review and update the workflow as necessary. This review will include any updates to existing HIE tools, inclusion of any new HIE tools, and additional reference materials (if appropriate).

V. RECOMMENDATION(S) FOR BOARD ACTION:

The Stakeholder Engagement subcommittee proposes that the DC HIE Policy Board approve the use of this handout to educate providers on using social needs tools on the DC HIE.

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***Committee Members*:** Dr. Yavar Moghimi**;** Dr. Mary Awuonda; Dr. Eric Marshall; Mr. Mark LeVota; Mr. Ronald Emeni; Mr. Luigi Leblanc; Ms. Stephanie Brown; Ms. Linda Nguyen; Ms. Eden Cunningham; Ms. Donna Ramos-Johnson; Ms. Corrine Jimenez; Ms. Nancy Ware; Mr. David Poms; Ms. Luizilda de Oliveira; Ms. Adaobi Anyiwo; Ms. Joan Kim; Ms. Jamie Gittelman; Ms. Aida Semere; Ms. Jacquiese Unonu; Ms. Rachel Harbut; Mx. Deniz Soyer, Mr. Nathaniel Curry; Ms. Eduarda Koch; Ms. Maava Khan; Ms. Asfiya Mariam

Appendix 1: Educational Materials for HRSN Tools on the DC HIE

Workflow 1 – For Providers who are familiar with CRISP DC HIE

CLOSING THE LOOP ON UNMET SOCIAL NEED

Using DC HIE tools to screen patients, view previous Z-codes, and refer them to community-based resources

Encounter Patient A is an individual who is food insecure

STEP 1 – Encounter Location

CRISP-connected facilities can be provisioned to access HRSN tools on CRISP

- Health Centers and FQHCs
- Hospitals and Emergency Departments
- Payers/ MCOs
- CBOs

STEP 2 – HRSN Screening

Any member of the care team can collect and document screening data

- Custom Screening Tool
- Standardized Screening Tool
- General Questions/ No Screening Tool
- Self-Identified Need

Conducting HRSN Screenings on the DC HIE

Direct Entry Screening Tool

Providers can screen patients using a questionnaire of their choice. Responses are directly recorded and maintained within the CRISP environment and shared with other members of the patient's care team

Assessments and Conditions Subtabs

Providers can view all screening data for the patient here, including data captured from EHRs, (such as Z-codes), direct entry screening tools, and from third-party platforms like FindHelp. This is viewable both via the CRISP web portal and their SSO.

STEP 2 – HRSN Screening

The provider uses the InContext App to view previous screening and referral data, including previous Z-codes. The provider then logs into the CRISP web portal to conduct a screening for Patient A using the Direct Entry Screening Tool

Sending Electronic Referrals to CBOs

Community Resource Inventory

Providers can access a list of community-based resources, categorized by various social needs domains. Providers can use CRISP to access the CRI and send electronic referrals to these organizations

Referral History

Documented referrals will be displayed here. Providers can use this tab to view previous referrals, review referral status, and to follow-up with patient to determine if their need was met

STEP 3 – Refer to CBO and View Referral Status

Within the CRISP Web Portal, the provider uses the CRI to find a food bank and send an electronic referral. The CBO that receives the referral can update the status of the referral. This status is viewable to all members of the care team under the CRISP Referral history tab.

CBO – Community-Based Organization
CRISP – The District's Designated HIE Entity
DHCF – Department of Health Care Finance
EHR – Electronic Health Record
FQHC – Federally Qualified Health Center
HIE – Health Information Exchange
HRSN – Health Related Social Needs
MCO – Managed Care Organization
InContext App/ SSO – Single Sign On

Workflow 2 – For Providers new to the CRISP DC HIE

CLOSING THE LOOP ON UNMET SOCIAL NEED

Enhance existing workflows by using the DC HIE to screen patients, view old Z-codes, and send electronic referrals to social care services

☑ Improved Workflow using the DC HIE

STEP 1 – Encounter Location
A provider at a CRISP-connected facility uses the DC HIE to view previous screening and referral data, including previous Z-codes

STEP 2 – HRSN Screening
The provider (or a member of the care team) logs into the CRISP web portal to conduct a screening for Patient A using the Direct Entry Screening Tool

STEP 3 – Refer to CBO
The care team uses the DC CRI to find a food bank. The care team uses the CRISP eReferral tool within the Web Portal to send an electronic referral to a food bank

STEP 4 – Tracking Data
CBOs that receive the referral can update the status of the referral. This is viewable to all members of the care team under the CRISP Referral history tab

Encounter Patient A is an individual who is food insecure

CRISP Social Needs and Referral Tools

Direct Entry Screening Tool
Providers can screen patients using a questionnaire of their choice. Responses are directly recorded, maintained, and shared within CRISP. Viewable via the CRISP web portal.

Assessments and Conditions Subtabs
Providers can view all screening data for the patient here, such as data from EHRs (Z-codes), direct entry screening tools, and from third-party platforms like FindHelp. Viewable via the CRISP web portal and SSO.

Community Resource Inventory and eReferrals
Providers can use CRISP to send electronic referrals to a CBO listed within the DC CRI. CBOs that receive referrals can use CRISP to update referral status. Viewable via the CRISP web portal.

Referral History Tab
Providers can use this tab to view documented referrals, previous referrals for the patient, and review referral status. Viewable via the CRISP web portal and SSO.

☒ Existing Workflow

STEP 1 – Encounter Location
A provider can only view screening and referral data for the patient from their organization, not at other locations

STEP 2 – HRSN Screening
The provider (or care team member) conducts a screening, which may be notated in the EHR using free text and/ or structured data

STEP 3 – Refer to CBO
The care team member may assist the patient in contacting the CBO via phone and may track the referral in the EHR

STEP 4 – Tracking Data
The care team may or may not track referrals. Referral status can only be tracked at the next patient encounter

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DC HIE Social Needs Tools

Enhancing data collection to address unmet social needs

CRISP DC and DHCF have partnered with District stakeholders to offer a cohesive solution to conduct screenings, capture data on social needs, and enhance closed-loop electronic referrals. These workflows are intended to illustrate how providers in different care settings can use CRISP DC HIE tools to capture, view, and track social needs screening and referral data. Below are the general steps that providers can take to use CRISP tools:

Step 1
Individual is screened at a screening location

Step 2
Review CRISP's Social Needs Tab to check for previous screenings

- If the individual was not previously screened, utilize the Direct Entry Screening Tool to conduct a screening.
- If the tab displays previous screenings for the inidviudal, refer to the CRISP Referral History tab to determine the status of a referral.

Step 3
Send a referral to a Community–Based Organization (CBO)

- Utilize the CRISP Referral tool to send an electronic referral to a CBO to address unmet social need.
- Providers can utilize the DC CRI within the CRISP environment to identify resources.

Description of DC HIE Social Needs Tools

- **Screening**: The DC HIE enhances existing social needs screening workflows by consolidating screening data from current and previous patient encounters.
  - Assessments and Conditions Subtab: Updated real time, this tab pulls information from EHRs, ADTs, and from screening results submitted from other entities such as MCOs. Together, the subtabs offer a comprehensive view of the patient's screening history. This tab also displays screening data from third-party referral platforms (e.g., FindHelp, Mahmee).
  - Direct Entry Screening tool: This tool allows for providers or organizations to choose from a variety of pre-populated evidence-based standardized screening tools (e.g., PRAPARE, AHC), allowing credentialled users to directly input social needs data into CRISP. Health care settings that do not currently have a mechanism for screening and assessment can document and track the social needs of their patients.

- **Community Resource Inventory (CRI)**: The DC CRI is a publicly available directory of community-based organizations that offer various services to address unmet social need. Providers can utilize the CRI to access this directory directly within the CRISP environment.

- **Referrals**: The DC HIE augments referrals pathways by slowing providers to both conduct and track referrals to various organizations, while also consolidating referral history for a patient. The CRISP Referral Tool allows for closed-loop electronic referrals such that providers can send and track a referral to a community-based organization (CBO) all within the CRISP environment. CRISP-connected CBOs can receive these referrals and close the loop and can send referrals to other CBOs to address any additional needs.

You can review more information on the DC HIE Social Needs tools on the CRISP DC website at crispdc.org.

Additional Resources and Reference Materials

- *CRISP DC Webpages: Screening, Referral, DC CRI*
- *CMS; Infographic on Using Z-codes*
- *CMS, August 2022; A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool*
- *HIMSS SDOH Guide: Workflow Considerations*
- *Health Leads; Social Health Data Toolkit*
- *NACHC; PRAPARE Implementation Toolkit*