MISSOURI HOSPITAL ASSOCIATION

Aligning Zcodes with Closed Loop Referral Process Two Part Webinar Series

Jackie Gatz, Senior Vice President of Quality, Safety and Research

June 3, 2025, 10-11:30 a.m.

Session 1: Social Risk Factor Screening, Coding and Utilizing Closed Loop Referral Network to Address Care Gaps

Overview

This session will highlight the practical use of social risk factors by care teams including community health workers, pharmacy technicians and providers. The audience will have an opportunity to learn about how social risk factors are documented in different settings of care, such as community health centers, rural pharmacies, and hospitals/health systems. Presenters will share innovative best practice strategies that have been deployed in Missouri to improve health outcomes, reduce health disparities and reduce costs.

Pre- Poll Questions

Presenters

Annie Eisenbeis, Pharm D, MBA,
Director of Practice
Development
Missouri Pharmacy Association

Latisha, 'Tish' Bryant, B.S.
Community Integration
Coordinator
Missouri Primary Care Association

Objectives

- highlight the important role of CHWs and pharmacy technicians in addressing social risk factors
- review the process of coding social risk factors into their claims data
- review social risk factor screening tools and coding processes in rural pharmacies
- review social risk factor screening tools and processes in community health centers
- receive an overview of the Community Pharmacy Enhanced Services Network program in Missouri from the Missouri Pharmacy Association
- receive an overview of the gravity interventions project from the Missouri Primary Care Association

Why Pharmacy?

Not all community pharmacies are the same.

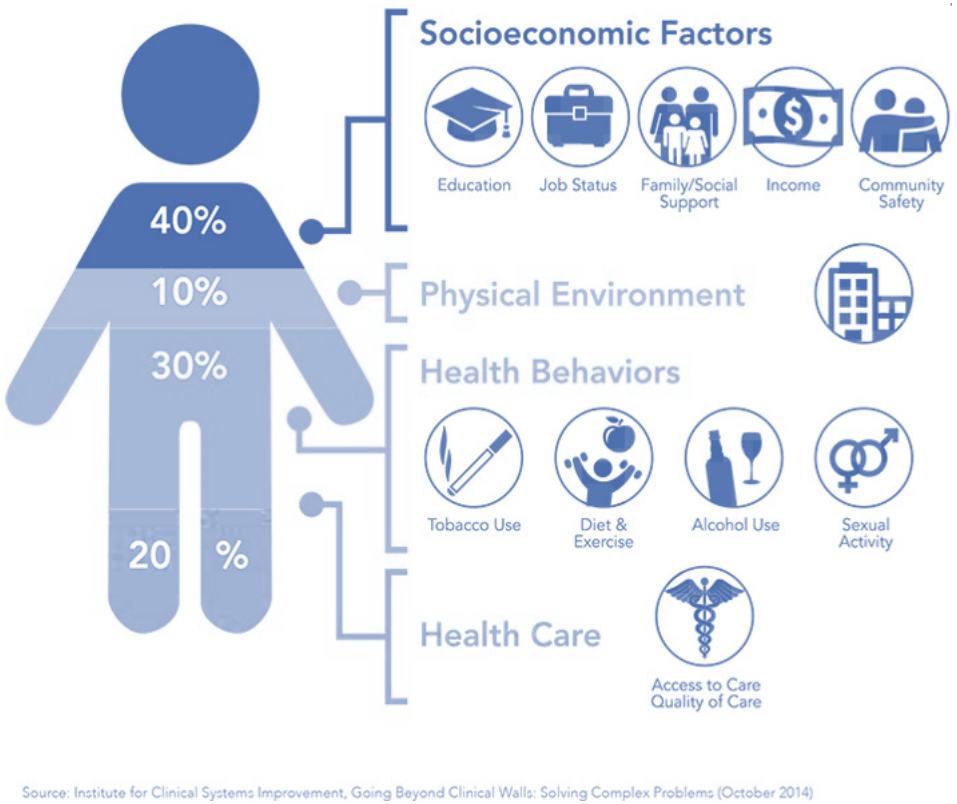
Why Pharmacy?

Slide courtesy of CPESN USA. Reference available at www.cpesn.com

Why CPESN?
Not all community pharmacies are the same.

- Clinically integrated network of local pharmacies
  - Sustainability pathway for future opportunities with payers & partners
- Minimum services provided by CPESN pharmacies:
  - Comprehensive Medication Review process
  - Medication Synchronization (Med sync) program
  - Immunizations
  - Personal Medication Record
  - Face-to-face access
- CPESN pharmacies are built on local roots, local relationships, and local engagement.

Not all Patients with the Same Care Gaps Have the Same Needs



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Up to **20 percent** of a person's health and well-being is driven by access to care and quality of services provided

80 percent of a person's health and well-being is related to the physical environment and driven by social and behavioral factors

Training Pharmacy Technicians as CHWs

- L&S Pharmacy pilot in SEMO
- State-approved curriculum for pharmacy personnel
- CEimpact approved in all 50 states + 4 US territories to date
- Missouri has trained over 400 pharmacy technicians as CHWs
- We meet “Network Adequacy” with pharmacy tech/CHWs to provide health equity services to the majority of Missourians

Differentiating CHWs and Technicians

Task	Pharmacy Technician	Community Health Worker	Pharmacy Technician / CHW
Prepare medications, include sterile products	x		x
Perform calculations on medication preparation	x		x
Interview patients to collect information, including medication histories	x		x
Adjudicate third party billing claims	x		x
Support compliance with regulatory needs	x		x
Care Coordination		x	x
Referrals		x	x
Home Assessments		x	x
SDOH Risk Assessments		x	x

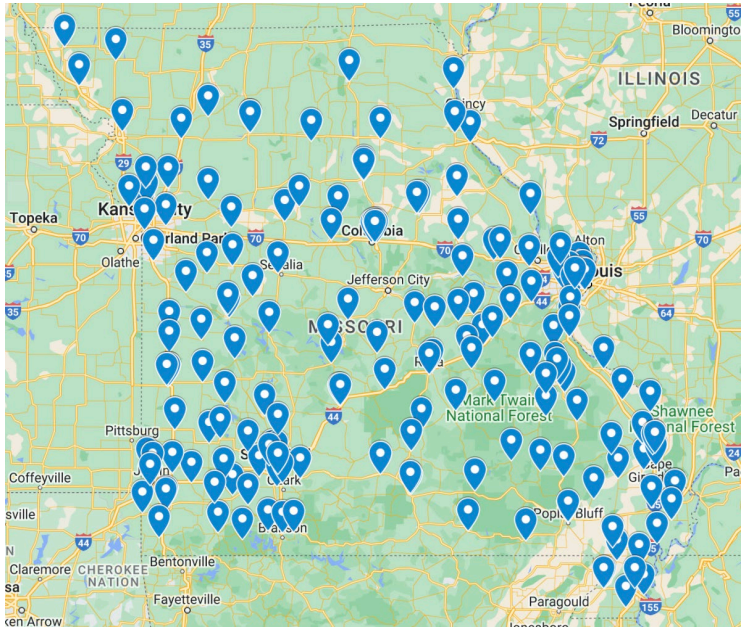
Why it works:

- Sustainable position: No $ needed to support the position, just the work.
- Tying the clinical aspect of care with the social and community aspect
  - Pharmacist: Patient, Tech/CHW: Person
- Broad access for patients to reach a CHW/tech in a pharmacy
  - No appointment necessary
  - Already have substantial opportunity for touchpoints (at least monthly)
  - Home visit options with pharmacy delivery drivers

What is CPESN?

About CPESN Missouri (www.CPESNMo.com)

- Local network under CPESN USA
- Currently have 180+ community pharmacies in the MO network
  - We have more pharmacies in the state than Walmart and CVS
- Special Purpose Networks: CPESN Health Equity



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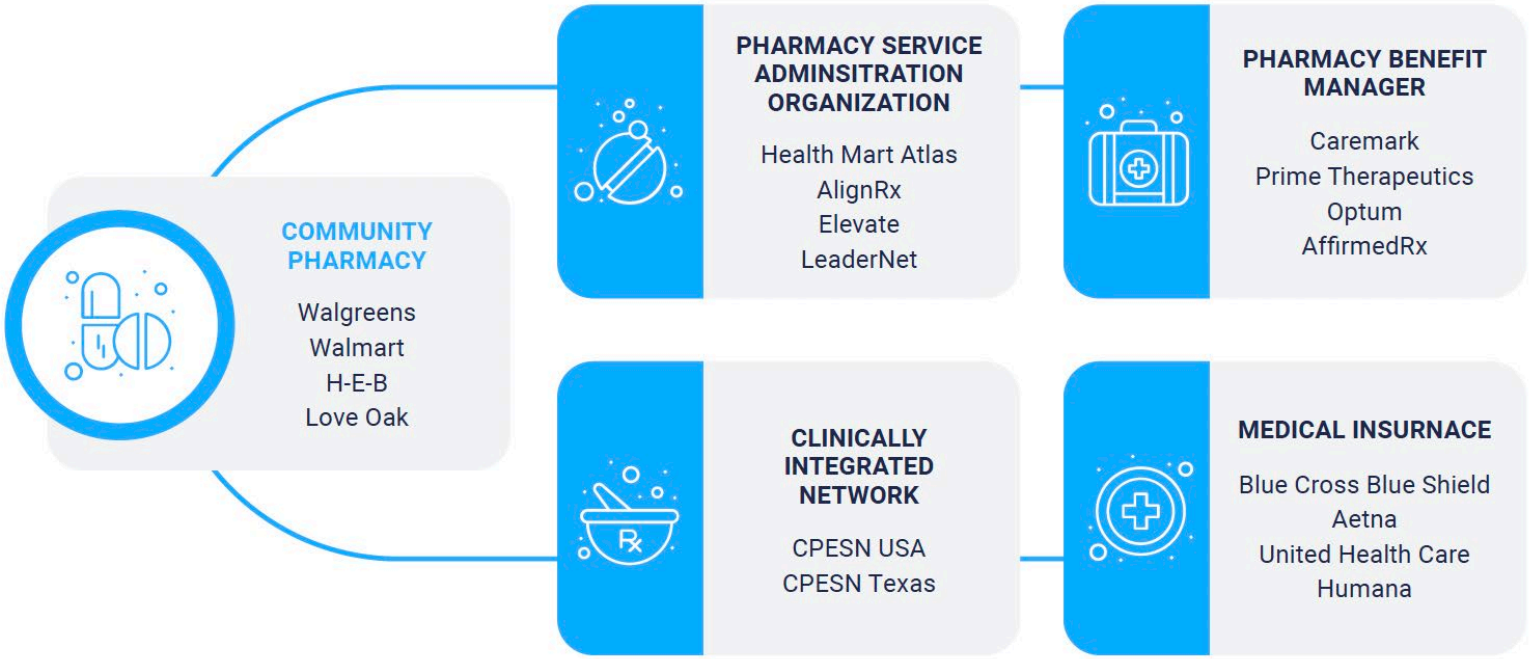
Current Landscape

The Pharmacy Data Silo

Contracting Infrastructure: Pharmacy or Medical?



KEY: Community pharmacies have two primary mechanisms for contracting – either with pharmacy benefit managers for product (medication) distribution or with medical insurance for clinical services. Pharmacy service administration organizations and clinically integrated networks are the mechanisms for independently owned pharmacy providers to aggregate under a single contract. Many of the chain pharmacies do not contract with a PSAO or CIN but are effectively acting as one.

Data Interoperability or Lack Thereof

- Pharmacy Management System + Point-of-Sale
- Pharmacy Claims Data to Payer (PBM)
- eCare Plan Documentation
- Multitude of other Portals (likely have separate logins and documentation systems → double/triple/quadruple data entry is common)

Pharmacy [Vaccine] Gap Closure Program

[Insert any preventive or primary care gap.]

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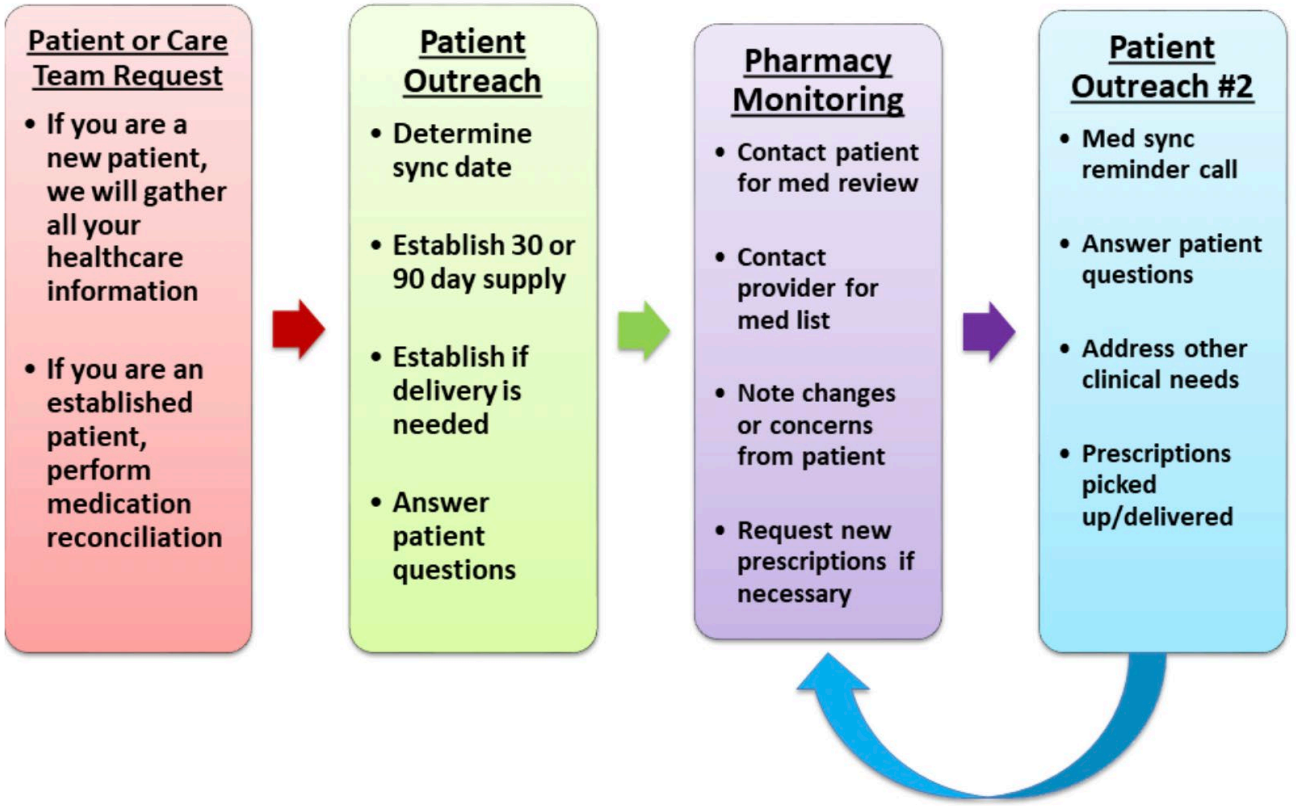
In 9 months:

- Vaccine Hesitancy and Education Interventions (G0310): **80,000+**
- Over 500 providers enrolled in the program, including pharmacists and CHW/technicians
- Over 12,000 vaccine gaps closed in August and September community care vaccine clinics alone
- 132 October health-equity focused vaccine clinic requests
  - Anticipated number of uninsured patient vaccine gaps closed: 6,300+

In-Pharmacy Operations: Phase 1 & 2

- Phase 1: Med Sync Patients
- Phase 2: Longitudinal Care Process (using Med Sync as template) for all pharmacy patients, whether enrolled in Med Sync program or not

Pharmacy Med Sync Process



https://www.advcr.com/services/pharmacy-services/medication-synchronization

Service Outline: G0310

1. Eligible patients are screened by the pharmacist for all vaccinations prior to monthly care call.
2. Patients are counseled initially on appropriate vaccinations by the pharmacist during their medication synchronization monthly care call or in-person during their monthly pick-up date. Initial standardized patient intake form competed including SDoH screening, allergy update, address, race, ethnicity, etc. data collected.
3. Pharmacy tech trained as Community Health Worker (CHW) in the pharmacy connects with patients through additional outreach who initially refuse the appropriate vaccine to address hesitancy or access issues (especially those related to SDoH) during medication synchronization monthly care calls. CHW will also refer to pharmacist for additional vaccine counseling, as needed.

G0310
Initial & follow-up

Documentation Form

Basic Patient Information

Name:_____ **DOB:** ____/____/_____ **Patient Zip-Code:** _____ **Patient Phone Number:** _____

Initial Assessment

Demographics:

Gender at Birth: M / F **Identify:** M / F / Transgender / Non-Binary / Unknown/ Prefer Not to Answer

Sexual Orientation: Heterosexual / Homosexual / Bisexual / Asexual / Unknown / Prefer not to Answer

Race: White / Black / Asian / Pacific Islander /American Indian or Alaskan Native / Hawaiian /Unknown/ Other: _____

Ethnicity: Hispanic/Latino *OR* Not Hispanic/Latino

Preferred Language: English / Spanish / Other *(list):* _____

Did the patient identify as having a disability? YES / NO *(I.e. hearing / vision/ cognitive / self-care difficulty / independent living difficulty)*

If YES, please list: _____

Health Conditions: *(Please mark any health conditions the patient has)*

[ ] Alzheimer's Disease [ ] Depression [ ] Liver Disease
[ ] Anxiety [ ] Falls in Elderly [ ] Multiple Sclerosis
[ ] Asthma [ ] GERD [ ] Obesity
[ ] Cancer [ ] Heart Failure [ ] Organ Transplant
[ ] COPD [ ] HIV [ ] Osteoporosis
[ ] Diabetes [ ] Hypertension [ ] Stroke
[ ] Other:_____

Insurance Type:

[ ] Medicaid Only
[ ] Medicare Only
[ ] Commercial
[ ] Self-Pay
[ ] Dual Eligible
[ ] Uninsured
[ ] Unknown
[ ] Other: _____

Health-Related Social Needs:

[ ]Access to Care
[ ]Financial Insecurity
[ ] Inadequate Housing
[ ] Lack of Adequate Food
[ ] Problems Associated with Health Literacy
[ ] Problems related to health literacy
[ ] Transportation Insecurity
[ ] Other: _____

Other: *(if applicable)*

Allergies: YES / NO *if **YES,** describe:* _____

Is the patient pregnant? YES / NO *if **YES**, list trimester:* _____

Weight: _____lbs.

Intervention:

Date of Intervention: ___/_____/_____

Start Time: _____:_____ **End Time:** _____:_____

Place of Service: _____

RPh Signature: _____

Immunization Intervention:

The patient is eligible for the following: *(RPh Only):*

	Dose 1	Dose 2	Dose 3	N/A	Contraindicated
Influenza					
COVID-19					
PCV15/PCV20					
RSV					
Td/DTap					
Hep B					
Shingles					
HPV					

Assessment: *(Please enter the provider's assessment of the vaccine hesitancy conversation using SOAP format (i.e. subjective, objective, assessment, plan)*

Plan & Follow-Up : (*Please enter the provider's plan, follow-up and recommendations based on the conversation)*

CPESN MO | CPESN HE. Vaccine Gap Program Phase 1 and 2.

Why it works:

- Current workflow model already exists, uses the entire team, and current pharmacy software supports
- Already have established relationship and rapport with patients
- Patients *answer the phone* when the pharmacy calls!
- Additional touchpoints: monthly call + pick-up/delivery of medications

Community Reach: Phase 3 & 4

- Phase 3: Education and Vaccination Community Clinics
  - Community Care Clinic – defined as outside of pharmacy business walls or normal operation hours
    - Should answer “yes” to this question: Does this expand access to vaccine education and vaccinations?
- Phase 4: Vaccine Gap Closures through coordination and verification (includes patients who do not utilize your pharmacy)
  - Pharmacy tech/CHW interventions ONLY

Phase 3: Community Care Clinics
Service Outline

Services can include:

- Patient Screening and Eligibility
- Vaccine Hesitancy Counseling (similar to Phase 1 & 2, but not longitudinal)
- Vaccine Gap Closure Verification
  - +/- Health Equity Incentive (if patient is identified as socially vulnerable in SDOH assessment/screening; includes uninsured and underinsured patients)

Phase 3
Community Clinic

Documentation Form

Clinic Name: _____ **Date:** ___/____/____ **Address:** _____ **City/Zip:** _____

Type: Home / Nursing Home / Community Center / Place of Worship / Pharmacy / Other: _____

Basic Patient Information

Name:_____ **DOB:** ___/___/_____ **Patient Zip-Code:**_____ **Patient Phone Number:**_____

Assessment

Demographics:

Gender at Birth: M / F **Identify:** M / F / Transgender / Non-Binary / Unknown/ Prefer Not to Answer

Sexual Orientation: Heterosexual / Homosexual / Bisexual / Asexual / Unknown / Prefer not to Answer

Race: White / Black / Asian / Pacific Islander /American Indian or Alaskan Native / Hawaiian / More than 1 Race / Prefer not to Answer

Ethnicity: Hispanic/Latino *OR* Not Hispanic/Latino *OR* Prefer not to Answer

Preferred Language: English / Spanish / Other *(list):* _____

Did the patient identify as having a disability? YES / NO (*i.e. hearing / vision/ cognitive / self-care difficulty / independent living difficulty)*

If YES, please list: _____

Other: *(if applicable)*

Allergies: YES / NO *if **YES,** describe:* _____

Is the patient pregnant? YES / NO *if **YES,** list trimester:* _____

Weight: _____lbs.

Health Conditions: *(Please mark any health conditions the patient has)*

[ ] Alzheimer's Disease
[ ] Anxiety
[ ] Asthma
[ ] Cancer
[ ] COPD
[ ] Diabetes
[ ] Depression
[ ] Falls in Elderly
[ ] GERD
[ ] Heart Failure
[ ] HIV
[ ] Hyperlipidemia
[ ] Hypertension
[ ] Kidney Disease
[ ] Liver Disease
[ ] Multiple Sclerosis
[ ] Obesity
[ ] Organ Transplant
[ ] Osteoporosis
[ ] Stroke
[ ] Other:_____

Insurance Type:

[ ] Medicaid Only
[ ] Medicare Only
[ ] Commercial
[ ] Self-Pay
[ ] Dual Eligible
[ ] Medicare + Supp
[ ] Uninsured
[ ] Unknown

Health-Related Social Needs:

[ ] Transporation insecurity
[ ] Access to care
[ ] Financial insecurity
[ ] Problems related to health literacy
[ ] Lack of adequate food
[ ] Inadequate housing
[ ] Problems associated with living alone
[ ] Lack of insurance, un/underinsured
[ ] Other:

Immunization Intervention(s):

	Not Eligible or CI (RPh Only)	Up to Date (RPh Only)	Eligible (RPh Only)	Counseled on Hesitancy	Vaccine Administered	Referred for Follow-Up
Influenza						
COVID-19						
Pneumococcal						
RSV						
Td/TDap						
Hep A						
Hep B						
Shingles						
HPV						
MMR						
Meningococcal						

Assessment: *(Please enter the provider's assessment of the vaccine hesitancy conversation)*

Plan & Follow-Up: (*Please enter the provider's plan, follow-up and recommendations based on the conversation)*

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Phase 4: Care Coordination Services
Service Outline (Tech/CHWs ONLY)

1. Call patients as follow-up from referral(s) or clinics
2. Vaccine Hesitancy Counseling (similar to Phase 1 and 2)
3. Vaccine Coordination (unlimited number of attempts)
4. Vaccine Gap Closure Verification (when administered off site)
   - ► +/- Health Equity Incentive - if identified as socially vulnerable AND administered at the pharmacy

Phase 4 Coordination & Verification

Documentation Form

Basic Patient Information

Name:_____ **DOB:** ____/____/_____ **Patient Zip-Code:**_____ **Patient Phone Number:** _____

Assessment

Demographics:
Gender at Birth: M / F **Identify:** M / F / Transgender / Non-Binary / Unknown/ Prefer Not to Answer
Sexual Orientation: Heterosexual / Homosexual / Bisexual / Asexual / Unknown / Prefer not to Answer
Race: White / Black / Asian / Pacific Islander /American Indian or Alaskan Native / Hawaiian / More than 1 Race / Prefer not to Answer
Ethnicity: Hispanic/Latino *OR* Not Hispanic/Latino *OR* Prefer not to Answer
Preferred Language: English / Spanish / Other *(list)*: _____
Did the patient identify as having a disability? YES / NO (*i.e. hearing / vision/ cognitive / self-care difficulty / independent living difficulty)*
If YES, please list: _____
Other: *(if applicable)*

Allergies: YES / NO *if **YES**, describe:* _____

Is the patient pregnant? YES / NO *if **YES**, list trimester:* _____

Weight: _____lbs.

Health Conditions: *(Please mark any health conditions the patient has)*

[ ] Alzheimer's Disease	[ ] Falls in Elderly	[ ] Liver Disease
[ ] Anxiety	[ ] GERD	[ ] Multiple Sclerosis
[ ] Asthma	[ ] Heart Failure	[ ] Obesity
[ ] Cancer	[ ] HIV	[ ] Organ Transplant
[ ] COPD	[ ] Hyperlipidemia	[ ] Osteoporosis
[ ] Diabetes	[ ] Hypertension	[ ] Stroke
[ ] Depression	[ ] Kidney Disease	
[ ] Other:_____		

Insurance Type:
[ ] Medicaid Only
[ ] Medicare Only
[ ] Commercial
[ ] Self-Pay
[ ] Dual Eligible
[ ] Medicare + Supp
[ ] Uninsured
[ ] Unknown

Health-Related Social Needs:
[ ] Transporation insecurity
[ ] Access to care
[ ] Financial insecurity
[ ] Problems related to health literacy
[ ] Lack of adequate food
[ ] Inadequate housing
[ ] Problems associated with living alone
[ ] Lack of insurance, un/underinsured
[ ] Other: _____

Vaccine Coordination:

Date: ___/_____/_____ **Referral:** Pharmacy-led Community Care Clinic / Local Resource:_____
Attempt #:_____ **Reason (Attempt 2+):**_____
Resources and support provided to coordinate care:
[ ] Scheduled Appointment [ ] Scheduled transportation to clinic [ ] Scheduled transportiation of vaccine to patient
[ ] Found payment services [ ] Other: _____

Vaccine(s):

[ ] Influenza	[ ] Pneumococcal	[ ] Td/Tdap	[ ] Hep B	[ ] HPV	[ ] Meningococcal
[ ] COVID-19	[ ] RSV	[ ] Hep A	[ ] Shingles	[ ] MMR	

Vaccine Gap Closure Verification:

Appointment Date: ___/_____/_____ **Apppointment Location**: _____
Verified Vaccine Received: YES / NO
*if **YES**, select verification method and location administered:*
Verification Method:
[ ] Administered at pharmacy (same NCPDP as CHW) [ ] ShowMeVax [ ] Provider (Spoke with: _____ at _____: _____ AM / PM)
Administration Location:
[ ] Pharmacy (same NCPDP as CHW) [ ] Health Department
[ ] Different Pharmacy [ ] Provider's Office (PCP, FQHC, VA)

Assessment: *(Please enter the provider's assessment of the vaccine hesitancy conversation)*

Plan & Follow-Up: *(Please enter the provider's plan, follow-up and recommendations based on the conversation)*

Community Care Clinic Examples

- Visit a homebound patient to provide education and eligible vaccine(s)
- LTC facility clinic to educate residents and/or staff (education-only clinic)
- County fair booth to provide education to fair participants (education-only clinic)
- Weekend clinic at the pharmacy to provide education and eligible vaccine(s) when normally closed (outside normal business hours)
- Pharmacy clinic to provide education and eligible vaccine(s) to patients unable to attend a clinic during normal work hours (outside normal business hours)

Why it works:

- Previously might’ve thought that enrollment or documentation would be barriers for pharmacy – not the case!
- Step-by-step approach
- Pharmacy teams are ready and engaged and wanting to support their community care needs
- Activation of this incredibly strong pharmacy network can happen for any care gaps NOW

Recap

SDOH Assessment in Community Pharmacy

SDOH Assessment & Follow-Up/Referral

- Looks different in a community pharmacy setting
- NOT a standardized survey questionnaire
- Longitudinal, multi-touchpoint assessment and follow-up
- Local CHW/tech has local community resources + always 6 ft away from clinician (pharmacist) for clinical resource hub too!

Opportunities to scale and close [*significantly more*] care gaps.

Questions?

Reach out for further discussions

Email: aeisenbeis@cpesn.com

MISSOURI PRIMARY CARE ASSOCIATION

Screening and Addressing Identified Risks, Barriers and Needs

LaTisha Bryant, Community Integration Coordinator

Objectives

Review drivers of health risk factor screening tools and processes in community health centers.

Receive an overview of the gravity interventions project from the Missouri Primary Care Association.

Missouri Primary Care Association (MPCA)

Founded in November 1984, as a non-profit organization dedicated to improving access to high quality, community-based and affordable primary care, behavioral health, and oral health across the state. MPCA is the recognized voice of Missouri's Community Health Centers also known as Federally Qualified Health Centers (FQHCs).

https://mo-pca.org/

Five Essential elements of Community Health Centers (CHCs/FQHCs)

Located in high-need area.

Provide comprehensive health and related (especially “enabling services”).

Open to all people, regardless of ability to pay, with sliding scale fee charges based on income.

Governed by community boards, to assure responsiveness to local needs.

Follow performance and accountability requirements regarding their administrative, clinical and financial operations.

Federally Qualified Health Centers in Missouri

REGION 1

- **Northwest Health Services**
  NwHealth-Services.org | 816.271.8261

REGION 2

- **Clarity Healthcare**
  Clarity-Healthcare.org | 573.603.1460
- **Northeast Missouri Health Council**
  NemoHealthCouncil.com | 660.627.5757

REGION 3

- **HCC Network**
  HccNetwork.org | 660.259.2440
- **KC CARE Health Center**
  KcCare.org | 816.753.5144
- **Katy Trail Community Health**
  KatyTrailCommunityHealth.org | 877.733.5824
- **Samuel U. Rodgers Health Center**
  RodgersHealth.org | 816.474.4920
- **Swope Health Services**
  SwopeHealth.org | 816.271.8261
- **Compass Health**
  See Region 6
- **Hope Family Care Center (Look-Alike)**
  HfccKc.org | 816.861.6500

REGION 4

- **Arthur Center Community Health**
  ArthurCenter.org | 573.582.1234
- **Central Ozarks Medical Center**
  Central Ozarks.org | 573.765.5141
- **Community Health Center of Central Missouri**
  CHCMO.org | 573.632.2777
- **Compass Health**
  See Region 6

REGION 5

- **Affinia Healthcare**
  AffiniaHealthCare.org | 314.814.8700
- **Betty Jean Kerr People's Health Center**
  PhCenters.org | 314.367.7848
- **CareSTL Health**
  CareSTLHealth.org | 314.633.6363
- **Compass Health**
  See Region 6
- **Family Care Health Centers**
  FamilyCareHealthCenters.org | 314.353.5190
- **Great Mines Health Center**
  GmhCenter.org | 573.438.9355

REGION 6

- **Access Family Care**
  AccessFamilyCare.org | 417.451.9450
- **Compass Health**
  CompassHealthNetwork.org | 844.853.8937
- **Fordland Clinic**
  FordlandClinic.org | 417.767.2273
- **Jordan Valley Community Health Center**
  JordanValley.org | 417.831.0150
- **Ozarks Community Health Center**
  OzarksCHC.com | 417.745.2121

Aids Project of the Ozarks (Look-Alike)
APO-Ozarks.org | 800.743-5767

REGION 7

Cross Trails Medical Center
CrossTrails.us | 573.332.0808

- **Missouri Highlands Health Care**
  MoHigh.org | 573.663.2313
- **Missouri Ozarks Community Health**
  Mo-Ozarks.org | 417.683.5739
- **Southeast Missouri Health Network**
  SemoHealthNetwork.org | 573.313.2501
- **Southern Missouri Community Health Center**
  SMCHC.org | 471.255.8464

Please note:
The locations listed are for main offices only, Community Health Centers often have multiple locations. To locate the center nearest you, please visit mo-pca.org/find-a-health-center

★ FQHCs with CHWs

Overview

Screening and Addressing Identified Risks, Barriers and Needs

Screening and Addressing Identified Risks, Barriers and Needs

FQHCs are utilizing Protocol for Responding to & Assessing Patients' Assets, Risks & Experience (PRAPARE) as the standardized screening tool across all health centers in Missouri.

PRAPARE

Structured documentation of PRAPARE in EHR to allow mapping to population health management system.

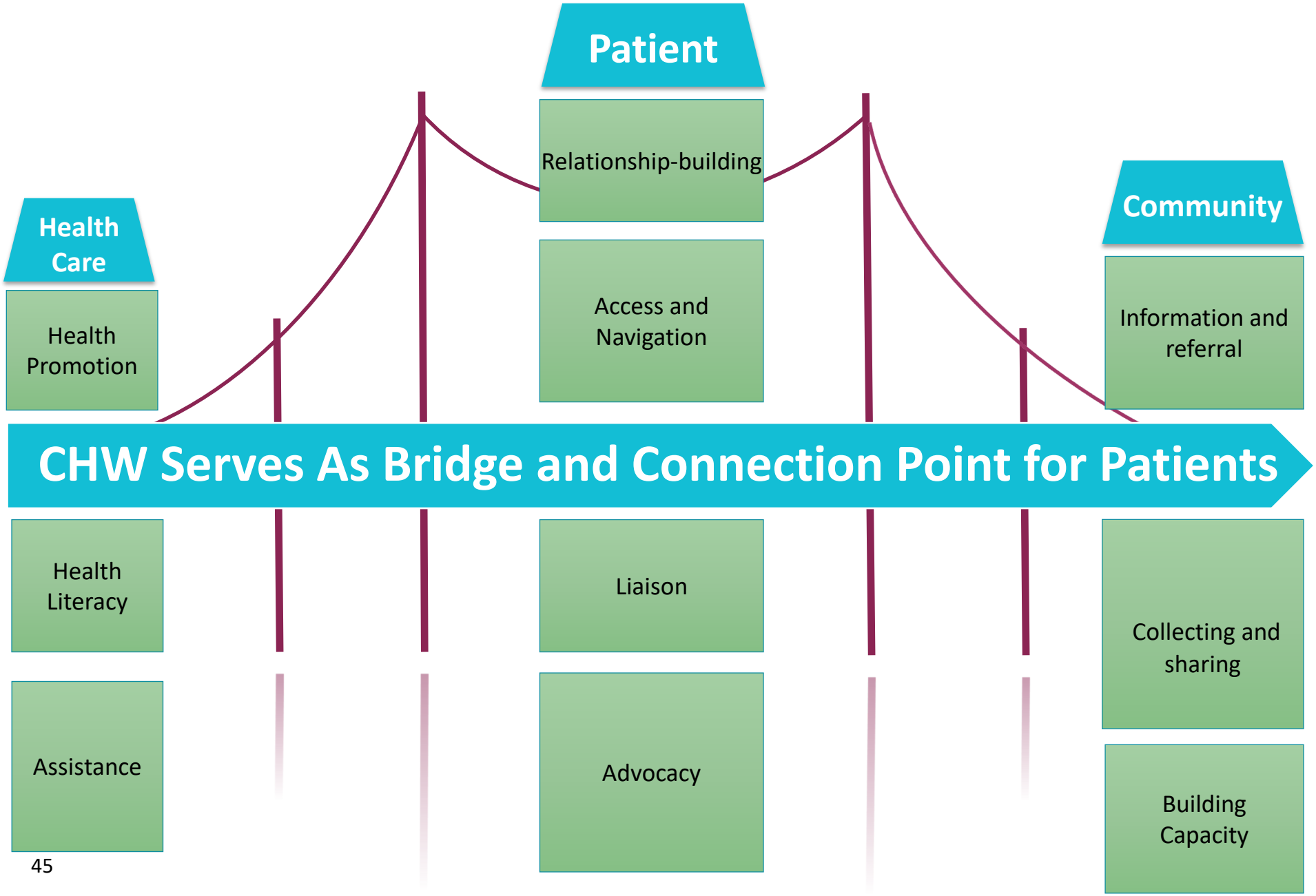
Screening information from PRAPARE is available in Azara DRVS the population health management system used in Missouri in registries, dashboards, pre-visit planning tool/alerts, and ability to apply drivers of health to various quality metrics.

Screening and Addressing Identified Risks, Barriers and Needs

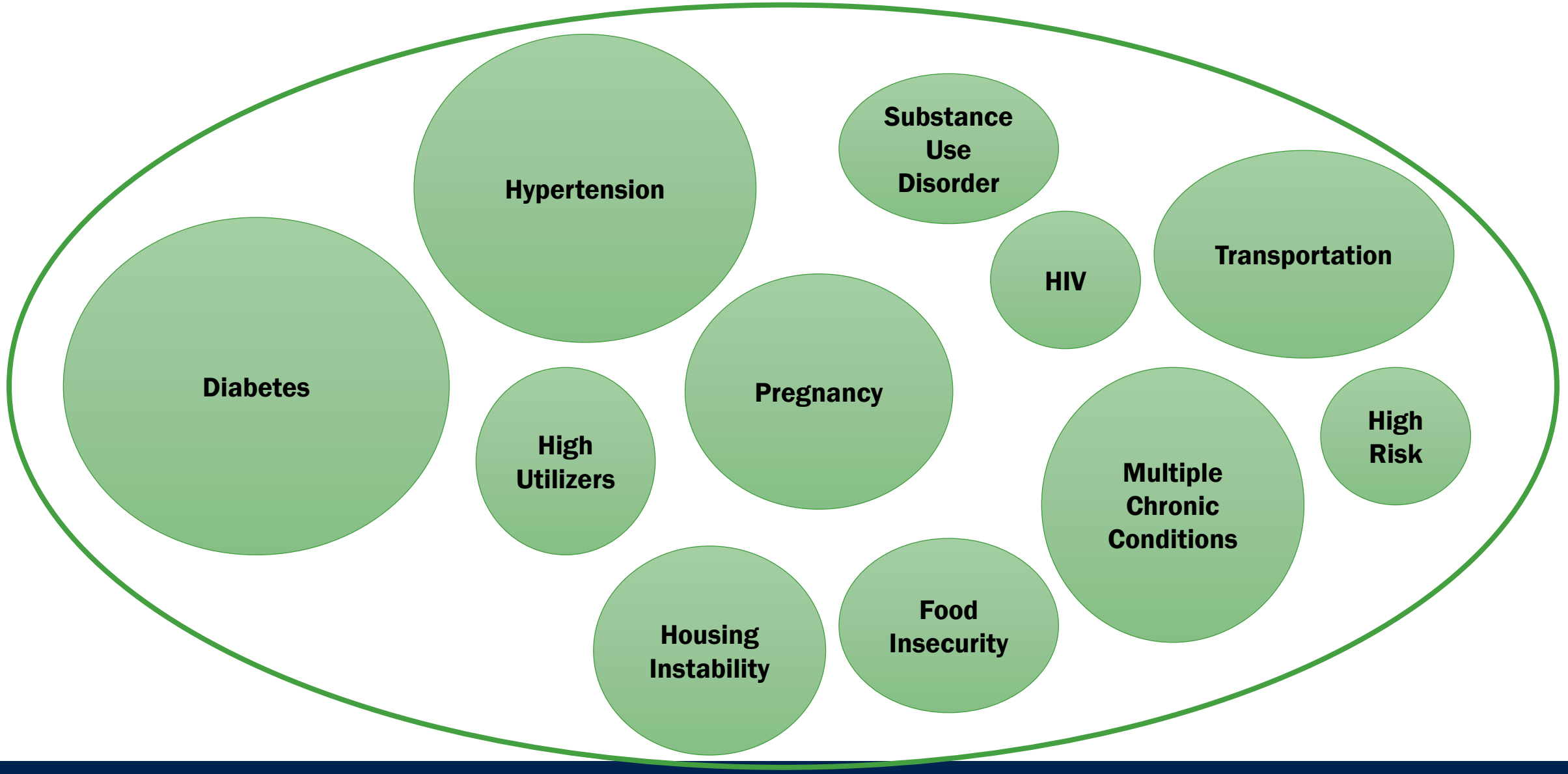
Drivers of health screening is not enough, need a workforce to assist patients with navigating resources to meet needs identified by screening.

Movement towards community referrals being tracked and treated the same as referrals to clinical specialties.

FQHCs are exploring IT solutions for community-based organization drivers of health referrals including UniteUs, Find Help, and/or local referral networks/platforms


Patient
Relationship-building
Health Care
Health Promotion
Access and Navigation
Community
Information and referral
CHW Serves As Bridge and Connection Point for Patients
Health Literacy
Liaison
Collecting and sharing
Assistance
Advocacy
Building Capacity

Population: By Condition or Factor



Why Screen for non-health related needs/risk/barriers?

There is growing consensus that screening information improves whole person care and lowers cost. Unmet needs negatively impact health outcomes.

- **Food insecurity correlates to higher levels of diabetes, hypertension, and heart failure.**

Food insecurity and cardiovascular disease risk factors among U.S. adults

- **Housing instability factors into lower treatment adherence.**

Meeting the Health and Social Needs of America's Unhoused and Housing-Unstable Populations: A Position Paper From the American College of Physicians

- **Transportation barriers result in missed appointments, delayed care, and more difficulty with self-management of chronic diseases.**

Transportation Barriers to Health Care in the United States

- **Overview:** National public collaborative that develops consensus-based data standards to improve how we use and share information on social determinants of health (SDOH).

- **Mission:** The Gravity Project exists to serve as the open public collaborative advancing health and social data standardization for health equity.

- **Goal:** Build and promulgate consensus driven social determinants of health (SDOH) data standards for health and social care interoperability and use among multi-stakeholders.

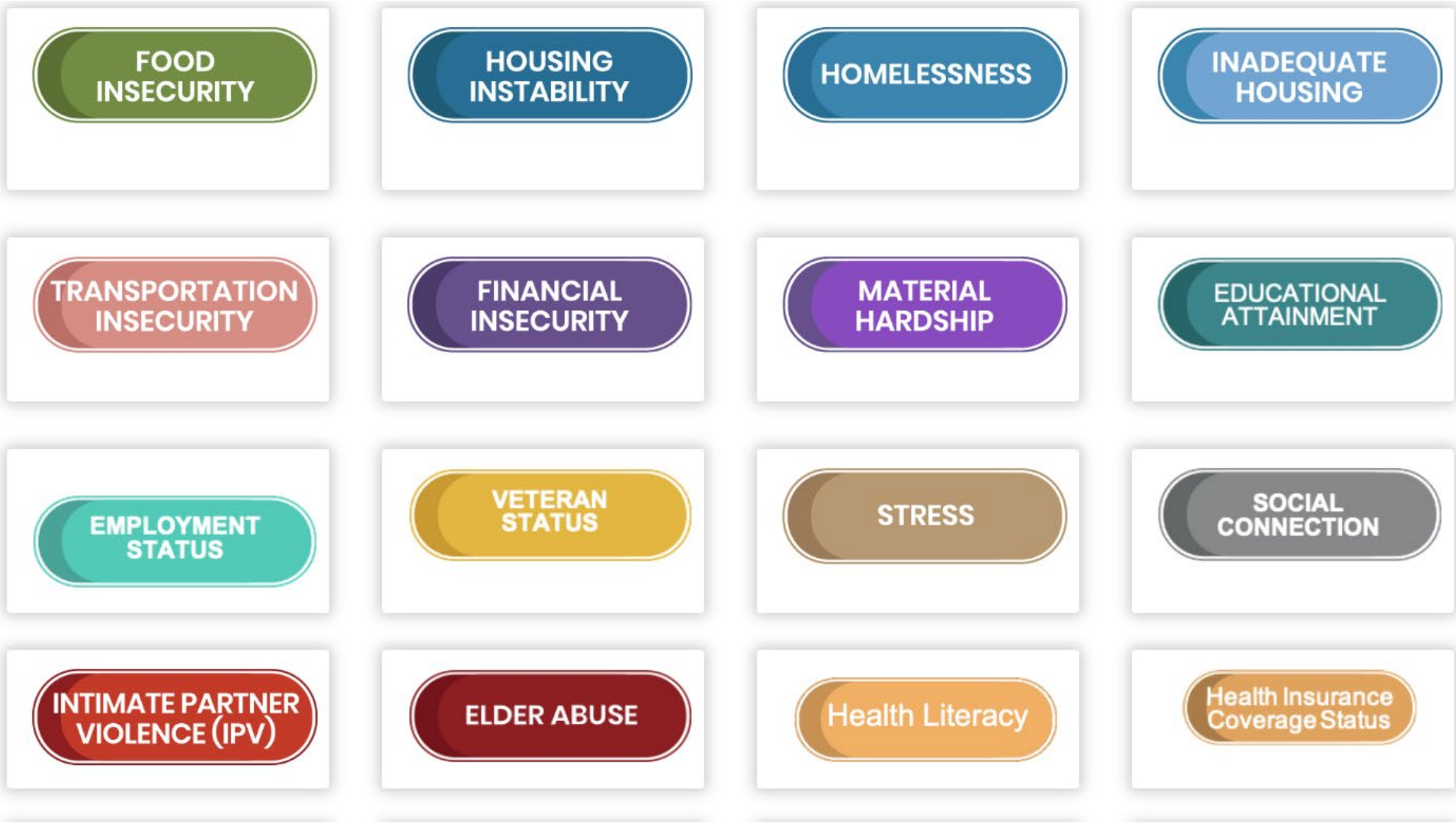
Gravity

Gravity Project Data Principles Overview

- Improving Personal Health Outcomes
- Improving Population Health
- Ensuring Personal Control
- Designing Appropriate Solutions
- Ensuring Accountability
- Preventing, Reducing, and Remediating Harm

Gravity Data Principles - Gravity Project - Confluence

Where to find Published Gravity Data Sets?



Terminology Workstream - Gravity Project - Confluence

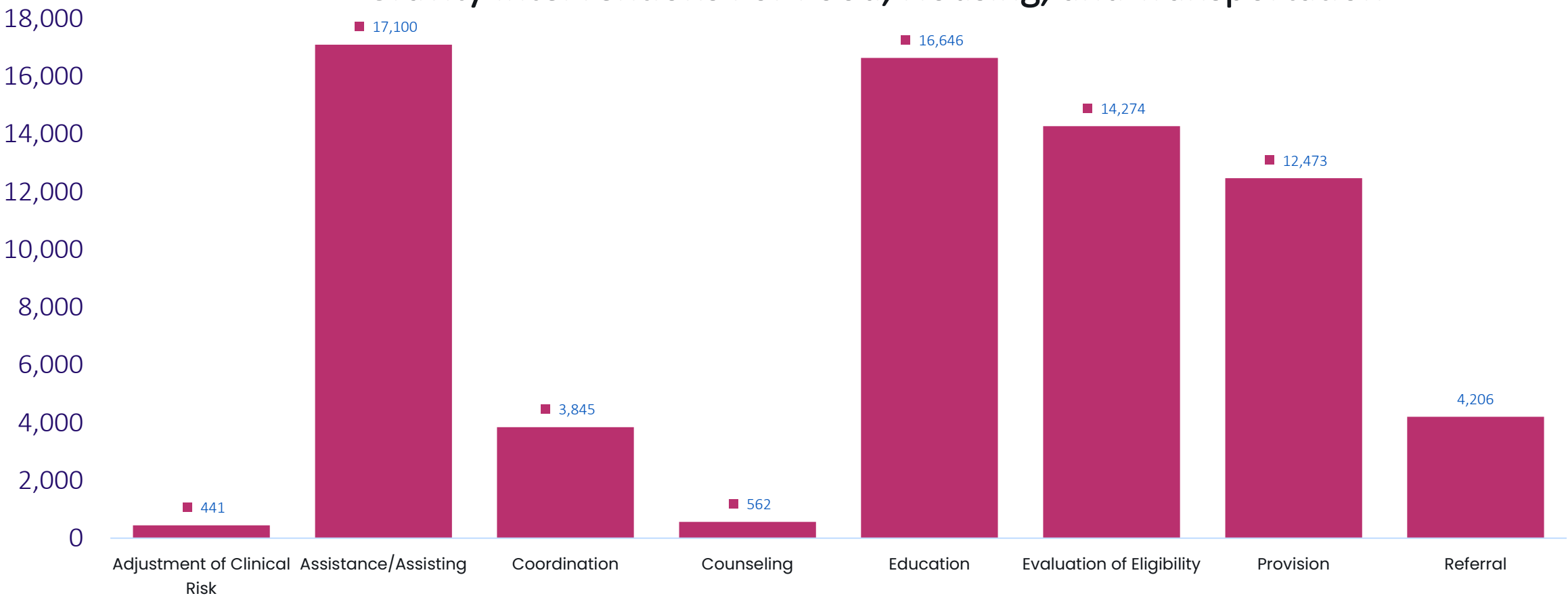
Gravity Project Intervention Types and Definitions

Intervention Type	Definition
Adjustment	Adjust clinical plan to accommodate social risk
Assistance/Assisting	To give support or aid to, help
Coordination	Process of deliberately organizing activities and sharing information to achieve safer and more effective care aligned with patient preferences.
Counseling	Psychosocial procedure that involves listening, reflecting, etc., top facilitate recognition of course of action/ solution
Education	Procedure that is synonymous with those activities such as teaching, demonstration, instruction, explanation, and advice that aim to increase knowledge and skills, change behaviors, assist coping and increase adherence to treatment.
Evaluation of Eligibility	Process of determining eligibility by evaluating evidence.
Evaluation/Assessment	Determination of a value, conclusion, or inference by evaluation evidence.
Provision	To supply/make available for use.
Referral	The act of directing someone to a different place or person for information, help, action.

Total number of CHW Encounters
July 1, 2024-March 31, 2025: 60,750

Total Number of PRAPRARE Screenings:
July 1, 2024-March 31, 2025: 97,644

Gravity Interventions For Food, Housing, and Transportation



Number of Interventions by type for Positive PRAPARE Screenings within 30 days for patients with Food, Housing and Transportation Risks Needs/Barriers since July 1, 2024 for all health centers.

Social Risk Coding and Gravity

The Gravity Project and the American Medical Association (AMA) have taken a significant step towards clarifying the coding process for social risk.

CM and SNOMED CT codes in this resource are for AHC HRSN Screening Tool questions that relate to the domains of Housing Instability, Homelessness, Inadequate Housing, Food Insecurity, Transportation Insecurity, and Utility Insecurity.

The suggestions are not necessarily an exhaustive list. They are based on Gravity's analysis and build in each SDOH domain.

Resources for Social Risk Coding in Care Settings - Gravity Project – Confluence

Resources for Social Risk Coding in Care Settings

Resources for Implementation

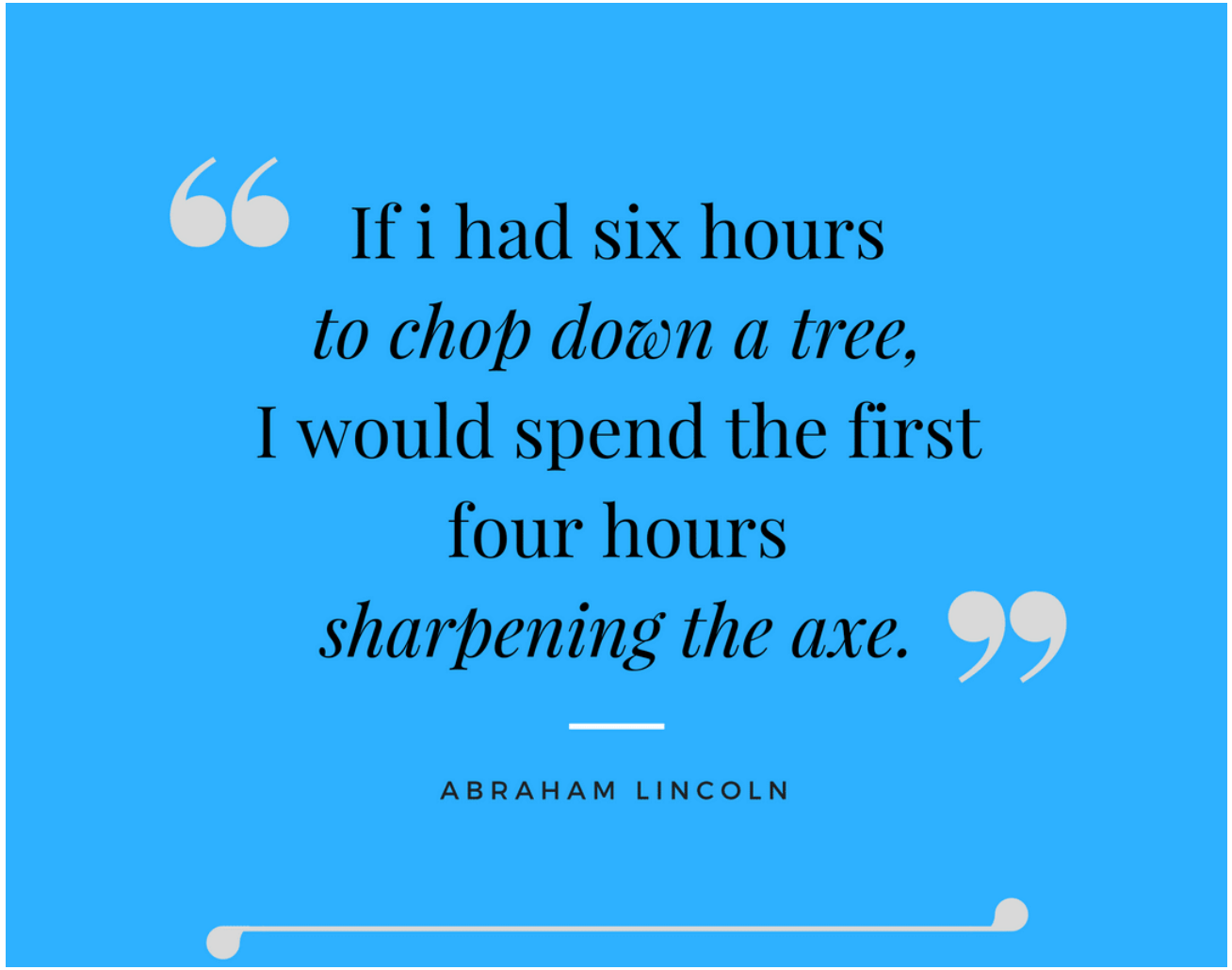
Join the Gravity Project!
https://45021617.hs-sites.com/join-the-gravity-project

Overview

Community Health Center’s CHW Initiatives

CHW return on investment (ROI) in VBC:

Every $1.00 invested in CHW intervention returns $2.47 to Medicaid



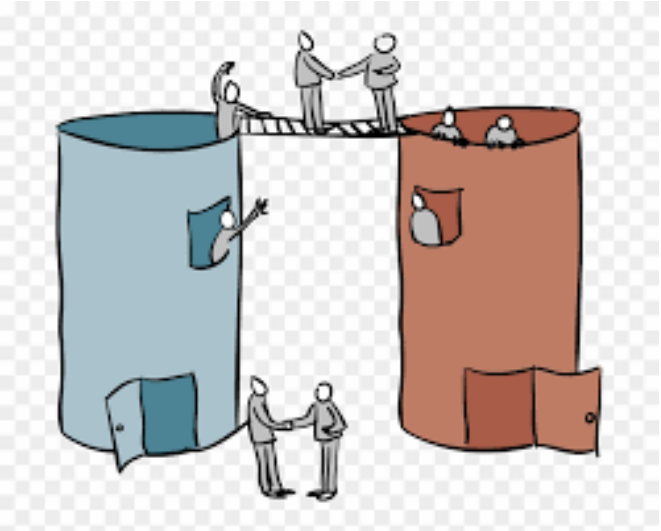
Health Affairs CHW ROI Study

What happens when patients understand?

- VBC Goal: Increased inclusion and encouragement of the patient as an active participant in their own healthcare
- Patients with a greater awareness and understanding of their illnesses, treatment options, healthcare needs, and entitlements are:
  - Be able to self-manage their condition(s)
  - More open to change
  - More likely to take charge of their health
  - More likely to be their own catalysts in making positive lifestyle changes

How do CHWs benefit patients and health center?

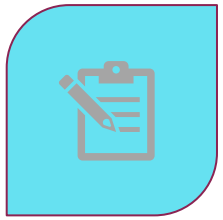
- Engagement
  - CHWs know the community and the resources available
  - Identify/address social risk factors & health needs
  - Link between internal and external care & services (social support)
  - Promoting preventive care
  - Reducing costly and unnecessary hospital interventions
- Outreach
  - Proactive outreach to patients needing appointments scheduled
    - Wellness visits, high utilizers, hospital follow-ups
  - Reconciliation/auditing of patient reports
  - Enrollment and assignment processes
- Collaboration & Integration
  - Pre-visit planning and in huddles
  - PCHH, care teams, scheduling staff, enrollment staff
  - *Spend the time to sharpen the axe; no more silos!!*



Screening Workflow Barriers

STAFFING

ELECTRONIC HEALTH RECORD DOCUMENTATION



TRAILING OF SCREENING TOOLS

BILLING, CPT CODES, Z-CODES

- Patient Hesitancy and Confidentiality
- Unintended negative consequences of screening
- Time Constraints
- Resource Limitations
- EHR Integration Challenges
- Offending the patient
- Risk of judgement
- Overemphasis on deficits
- Closing the loop

Arvin, G., Boynton-Jarrett, R., Dworkin, P. Avoiding the Unintended Consequences of Screening for Social Determinants of Health. *JAMA.* 2016;316(8):813-814. doi:10.1001/jama.2016.9282 https://jamanetwork.com/journals/jama/article-abstract/2531579 Accessed June 1, 2023

MPCA CHW Training and Technical Assistance

- FQHC CHW Peer Network Meetings
- FQHC CHW Supervisor Peer Network Meeting
- In-Person FQHC CHW Regional Meetings across state (West, East, Central, SE, and SW)
- Statewide In-Person and Virtual Training Opportunities for CHWs and health centers
- CHW Monthly Newsletter
- 1:1 CHW Supervisor and Health center meetings at the health center request
- EHR User Groups-SDOH/CHW Best Practices
- 1:1 assistance with CHW Program Reporting
- Community Partnerships/Training opportunities
- PRAPARE Mapping Project
- Support and training on referral loop closure

Our Work in Progress

Patient and Family →	Timely, meaningful, whole-person care and treatment based on patient preferences, clinical and non health related needs and barriers.
Care Team Members →	Patient preferences and non health related needs and barriers guide care and treatment, ensuring appropriate care for each patient. Foster trusting, communicative relationships among care team members.
Health Center →	Enhance care teams and services based on patient voice and patient data.
Community/Local Health System →	Identify community level health and wellbeing priorities using community and patient voice along with community needs data. Create whole-person care continuum through cross-sector partnerships.
Payment →	Value based payment models that invest in interventions/ enabling services for patients. Community funding opportunities to strengthen the network of programs and expertise of each partner.
State and National →	Leverage community voice and risk needs data to address barriers for whole-person care.

Questions

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Post – Poll Questions

SAVE THE DATE:

Session 2: Aligning Zcodes with Closed Loop Referral Process

Payer and Provider Perspective of Zcodes and Closed Loop Referral Network, June 26, 10-11:30 a.m.

This session will highlight the payer and provider perspective of screening for Z codes and how they influence cost and patient outcomes. The integration of these approaches from both the payer and provider perspective can contribute to closing identified gaps and reducing health care disparities. This session will highlight the crucial role of payers and providers with a focus on the impact of policies and programming.

Community and Hospital Social Worker Resource

Missouri Resource Guide

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