Title: How People, Processes, and Technologies Hindered a Universal Screening Effort to Address Patients' Non-Medical Needs + Finding Solutions to Move Forward

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Agenda

- Describe technical, operational, and resource barriers encountered when launching universal screening effort for patients' non-medical needs
- Discuss strategies to overcome these barriers
- Highlight the complexities associated with coding, billing, and reporting these patient needs to the Medicaid Managed Care Organizations (MCOs)

Social Drivers of Health (SDOH):

The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

SDOH refers to community-level factors. They are sometimes called "social determinants of health" or "non-medical needs".

Adapted from CDC Healthy People 2030)

SDOH can be grouped into 5 domains:

Health-Related Social Needs (HRSN):

Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use.

HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation. (Adapted from HHS)

SDOH and HRSN can coincide and overlap in the case of a household with income below the federal poverty line (an individual-level HRSN) in an area with poor economic conditions (a community-level SDOH).

Health providers can take steps to address HRSN by understanding the needs of their patients and referring them to community-based services.

- Implement a person-centered assessment to screen (PRAPARE) for HRSN and referring to community resources and other social services to address individual patient needs
- Focus on addressing HRSN in specific areas of care, such as maternal, behavioral, or geriatric health
- Provide patients access to care managers, social workers, health coaches and peer support specialists who can connect patients with resources to meet their HRSN

PRAPARE

Jun 26, 2024

Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE®)

Protocol for Responding to & Assessing Patients' Assets, Risks & Experience (PRAPARE) is a national standardized patient risk assessment tool designed to engage patients in assessing & addressing social drivers of health (SDOH). PRAPARE is evidence-based, designed through stakeholder engagement, paired with an Implementation and Action Toolkit, and standardized across ICD-10, LOINC, and SNOMED. PRAPARE is available in over 25 languages.

NACHC collaborated with the Association of Asian Pacific Health Organizations (AAPCHO) and Oregon Primary Care Association (OPCA) to develop PRAPARE®.

Learn more by visiting the **PRAPARE® Website**, or view the **PRAPRE® Screening Tool**.

Question on PRAPARE®? Email prapare@nachc.org

So why has the uptake been so slow?

- Technical barriers
  - EHRs slow to embed the screeners
    - Licensing
    - Competing priorities given Meaningful Use, MIPS, clinical quality measures, etc
    - Limited financial incentives
    - Customer demand
    - Complex data mapping
      - Placement within the EHR (social hx versus screeners)
      - Redundancies with fields collected in registration and social hx
      - Score logic
    - Limited integrations with 3rd parties (for screening and/or referral tracking)

Why has uptake been so slow?

- Operational barriers
  - **Workflow Disruption**
    - Time-consuming screener (~3 min – 12 mins on average)
    - Clinics must decide *when*, *where*, and *by whom* the screener is administered (e.g., during check-in, rooming, or post-visit)
    - Lack of alignment with existing visit workflows
  - **Staff training** and capacity constraints
  - Technology and data capture limitations
    - PRAPARE data may not auto-populate or flow easily into clinical dashboards or referral systems and often require custom builds or third-party tools to fully integrate PRAPARE responses (Epion tablets aka Kyruus)
  - **Patient/staff discomfort or literacy issues**
  - **Leadership buy-in** across teams and/or departments

Why has uptake been so slow?

- Resource Barriers
  - Limited staff availability (dedicated staff vs existing staff)
  - Insufficient funds or incentives to support infrastructure needed (e.g. EHR customization, tablets or apps for self-screening, interface setups, or data analytics tools)
  - Inadequate referral tracking to Community-Based Organizations
    - CBO’s vary across geographic regions (may belong to findhelp or unite us or not)
  - No clear reimbursement model
    - Each MCO (or other payor) utilizes different CPT and/or Z codes which makes automation and/or documentation and workflow protocols nearly impossible!

AHL's experience

Pilot

- 1st pilot: time study with PRAPARE on tablets and set up orders for nursing staff and providers to follow

- 2nd pilot: focused on placement of PRAPARE (social hx or screener section)

Findings:

- Push back on literacy levels to complete screener; while staff queue'd up orders, providers missed adding the Z codes onto the claims

- One spot allowed for Z codes; other spot allowed for CPT codes – not both; too many different order sets – staff needed cheat sheets for Z codes

Wishlist:

- As EHRs advanced (and Azara), we needed to weigh options on EHR placement for screener
  - Needed to be able to be automated with order sets with appropriate billing codes
- **Simplify** order sets and Z codes (but this was challenged since each payor only recognized different Z codes for reimbursement)
- **Remove** work from staff plates before we could add on!
- **Integration** into our EHR
- Needed to ensure that non-medical needs surfaced to care team (e.g. Azara and/or Care Plans)

Access and Launch Findhelp.org from the Athena EMR

athenaOne Calendar Patients Claims Financials Reports Quality Apps Support

340270 cgauthreaux2 Log out

Zz TEST
32yo F 08-31-1990 #340270

Document ▾ Sign-off

Ready For Provider | Not Online | Bh Case Management 30 | Isiah Paige, CM

Find
Allergies
Problems
Meds
Vaccines
Vitals
Results
Visits
History
Quality
Care

Active Problems Historical (0)

Move Multiple Settings

Chronic 1 Other Diagnosis | 0 problems

No chronic problems documented.

Acute 0 problems

No acute problems documented.

Not Categorized 10 problems

attention deficit hyperactivity disorder, predominantly inattentive type

benign essential hypertension

body mass index 25-29 - overweight

Reason for Visit REASON

ICCM Community Navigation

Newly referred patient, patient being referred back or new patient

NOTE

Appointment note Community Navigation

Assessment & Plan DIAGNOSES & ORDERS

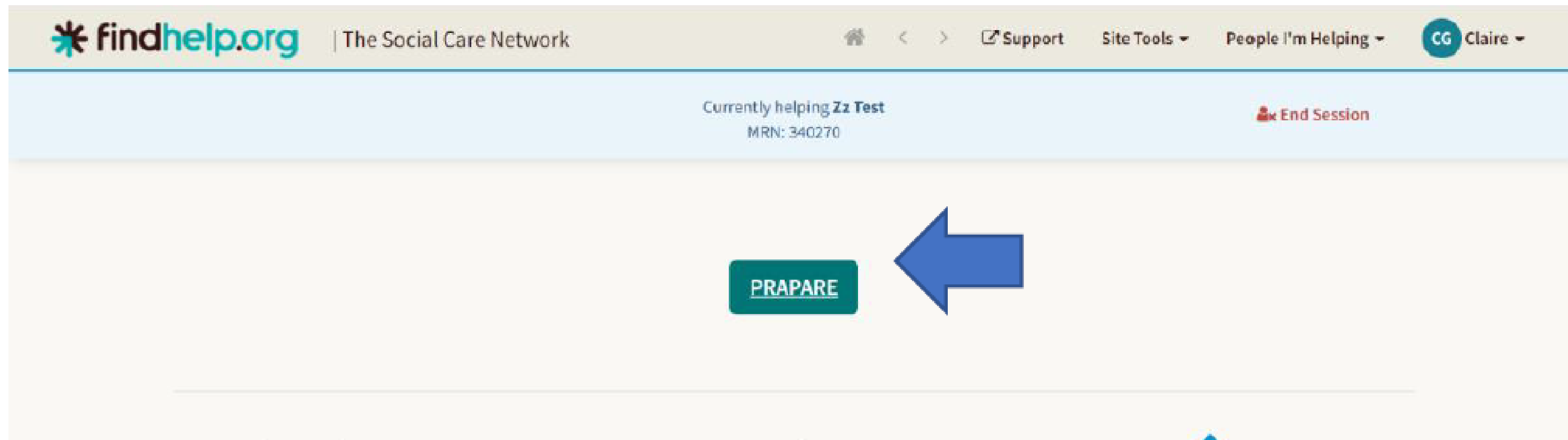
View Telehealth call length

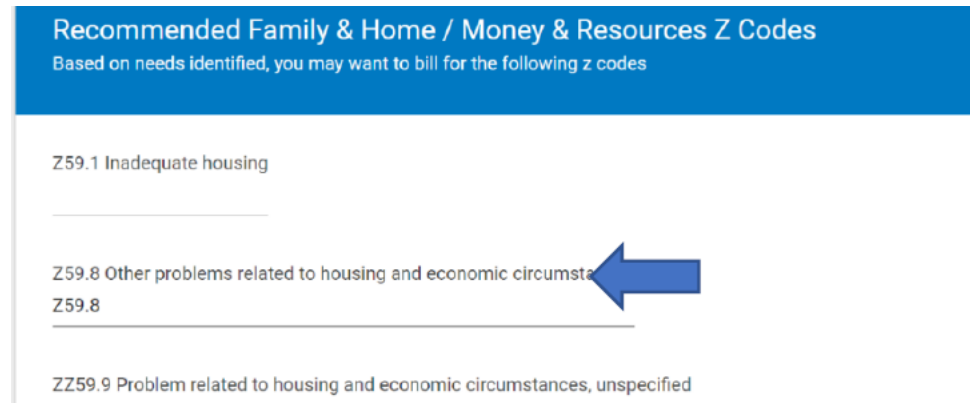
1 potential diagnosis has not been added to a claim this year. Risk score 0.241

screening procedure
Z13.9 Encounter for screening, unspecified

- Quickview
- Start OB episode
- Create patient case
- Create order group
- Print chart sections
- Print forms
- Add document
- Chart export
- Third party applications
- Audit history

Launch PRAPARE assessment in Findhelp.org





Identify Resources in Findhelp.org

Map
Satellite
New Orleans

Notice out-of-date information or see a program you work for? Click Suggest to share an update or claim your program listing to get access to free tools and data.

Best Matches
These programs contain **all of the word(s) you searched** in the provider name, program name, or description and are likely to be the most relevant matches.

General Assistance
by Society of St. Vincent de Paul, Archdiocesan Council of New Orleans
Reviewed on: 03/05/2023

St. Vincent de Paul of New Orleans is a Catholic organization that provides an array of services such as training, education, spiritual formation, and financial support in order meet a wide range...
Main Services: disaster response, food pantry, clothing, financial assistance, navigating the system, home visiting, spiritual support
Serving: anyone in need, all ages

Next Steps:
Call 504-351-1500 (your nearest location) or call 504-827-5842.
4.08 miles (serves your local area)
535 Deerfield Road, Terrytown, LA 70056
Open Now: 8:00 AM - 5:00 PM CST

MORE INFO | SAVE | SHARE | NOTES | SUGGEST | SEE NEXT STEPS

Save a Favorite!
CREATE A NEW FOLDER | BELLE CHASSEE, LA | SAVE

Find programs you've added in **"Saved Favorites"** from the link in the top navigation.
TIP: From Saved Favorites, you can **email folders** or programs and **share with your team.**

CANCEL

FIND HELP FREE RESOURCES TO HELP YOU!

SCAN CODE FOR HELP

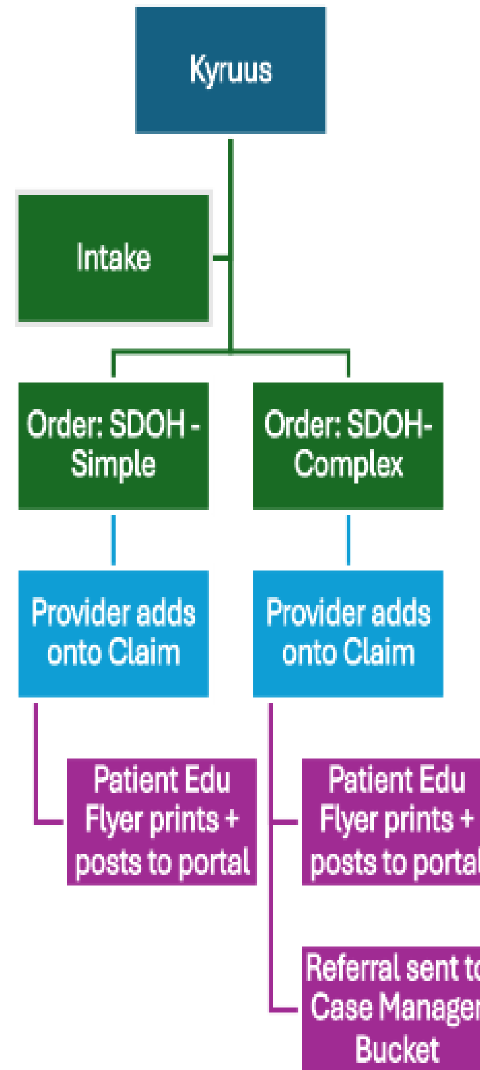
YOU CAN RECEIVE HELP WITH...

TRANSPORTATION
CLOTHING
FOOD PANTRY/MEAL DELIVERY
JOB TRAINING
EDUCATION
LEGAL ASSISTANCE/AID
DISABILITY BENEFITS ASSISTANCE
UTILITIES
HOUSING
DOMESTIC VIOLENCE SHELTERS
PRESCRIPTION ASSISTANCE
HEALTH/WELLNESS
GOVERNMENT ASSISTANCE
VETERANS BENEFITS

UNABLE TO ACCESS THESE RESOURCES ON YOUR OWN?
Schedule an appointment with one of our skilled case managers.

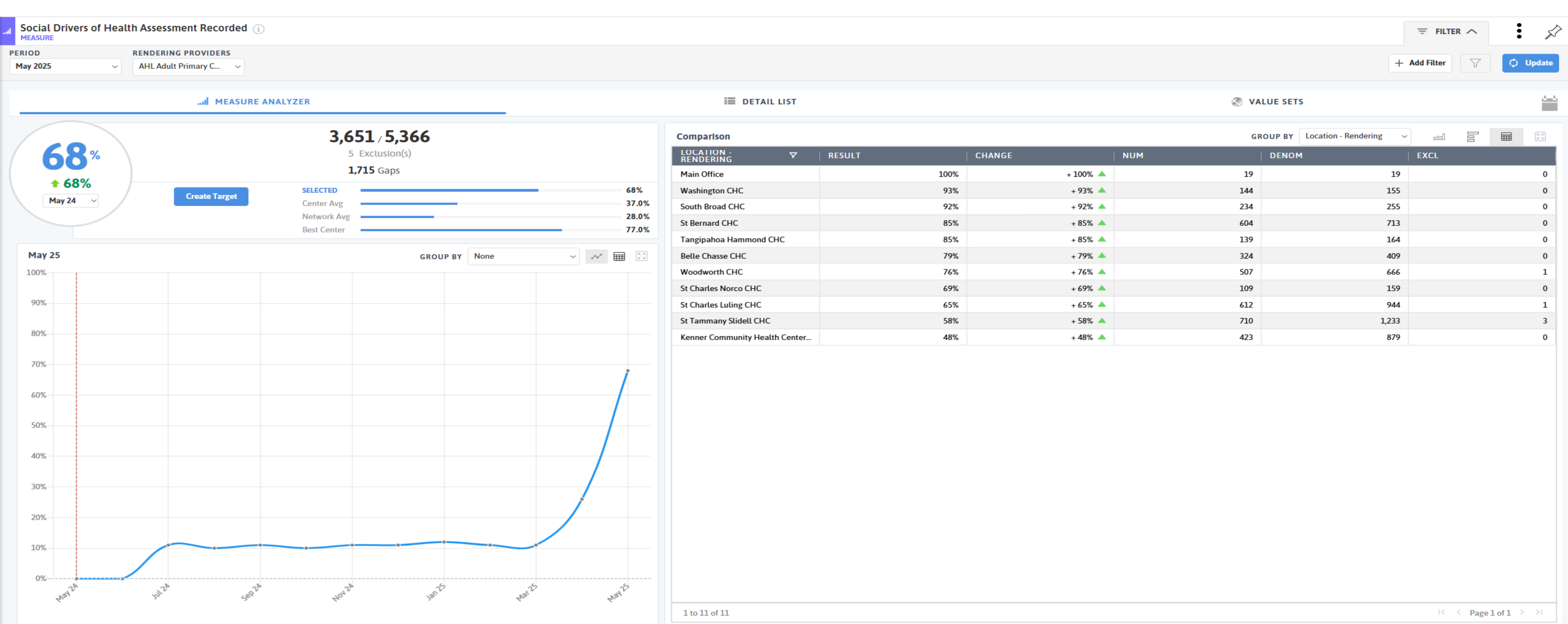
If you have insurance (Medicaid Managed Care, Medicare Advantage, Private Insurance or Insurance through your employer) your insurance plan will offer additional resources and/or assistance with your social needs.

WWW.ACCESSHEALTHLA.ORG | 1-866-530-6111



Simple	Complex
Transportation	Health/ Wellness
Job Assistance	Social Isolation
Education	Domestic Violence
Clothing	Utilities
Food	Housing
Childcare	

The Medical Assistant should print the patient education material (showing QR code to our AHL find help page of resources to self-help) and hand it to the patient before discharge.



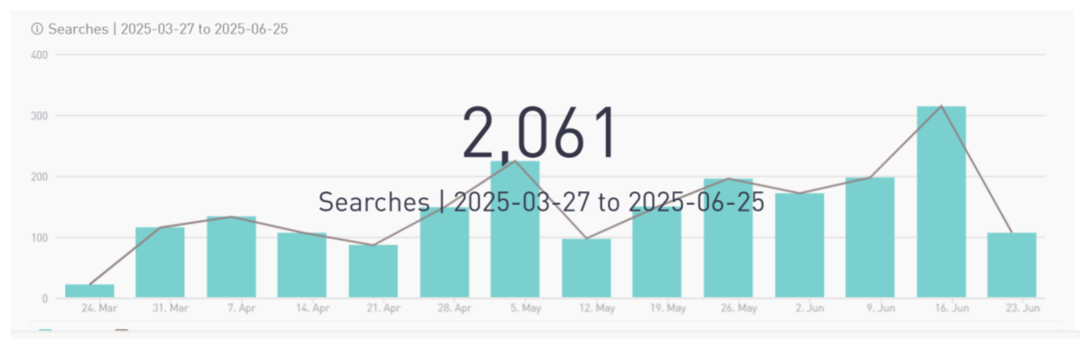
LOCATION - RENDERING	RESULT	CHANGE	NUM	DENOM	EXCL
Main Office	100%	+ 100%	19	19	0
Washington CHC	93%	+ 93%	144	155	0
South Broad CHC	92%	+ 92%	234	255	0
St Bernard CHC	85%	+ 85%	604	713	0
Tangipahoa Hammond CHC	85%	+ 85%	139	164	0
Belle Chasse CHC	79%	+ 79%	324	409	0
Woodworth CHC	76%	+ 76%	507	666	1
St Charles Norco CHC	69%	+ 69%	109	159	0
St Charles Luling CHC	65%	+ 65%	612	944	1
St Tammany Slidell CHC	58%	+ 58%	710	1,233	3
Kenner Community Health Center...	48%	+ 48%	423	879	0

SDOH Screening

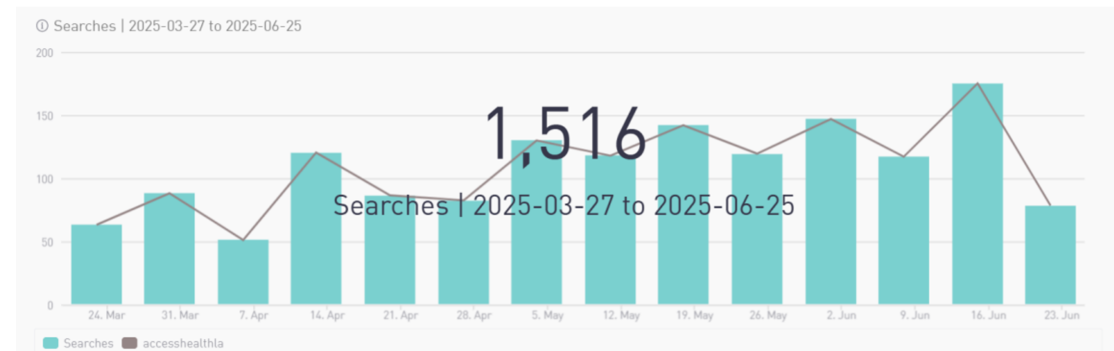
- Workflow change to add step for MA to confirm SDOH Case Manager referral with patients who screen positive for complex need(s). Recommendation to add a consent question for patients to confirm they would like to speak with a case manager.
- 3,651 patients screened (68%) (Azara SDOH Assessment Recorded Measure, May 2025, AHL Primary Care Providers)
- 233 patients were referred for complex SDOH in May 2025 (Azara Referrals Report, May 2025, AHL Primary Care Providers)

Search Traffic on findhelp

AHL Staff

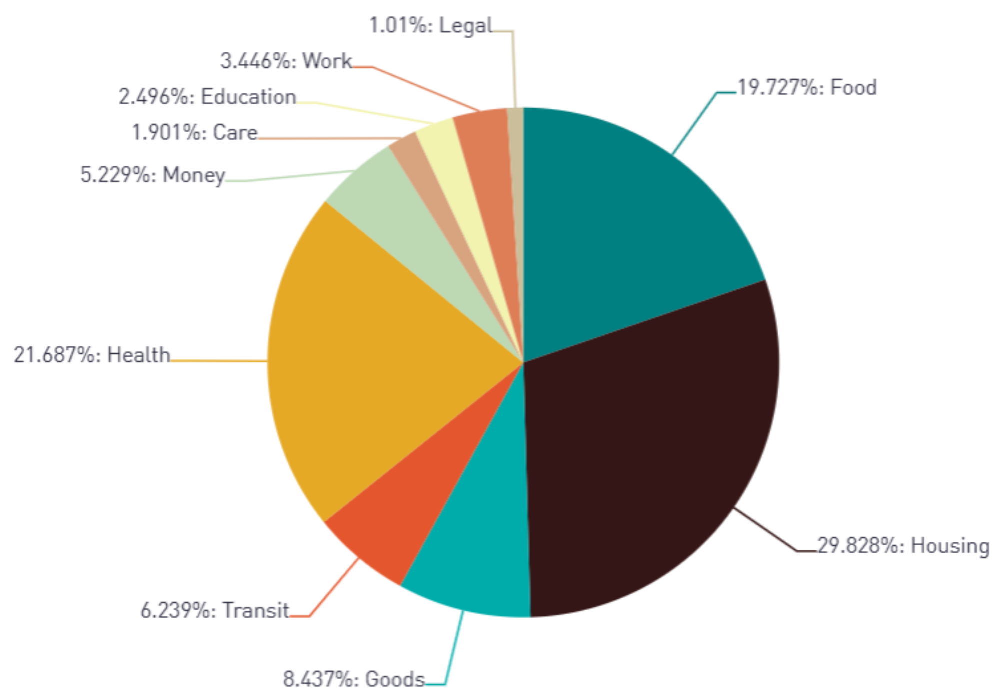


accesshealthla.org



- Searches were increasing since launch of universal screening workflow
- Appears that more searches occur with guidance from ahl staff than patients taking initiative to search web themselves
- AHL staff navigation: resulted in 97% having interactions with findhelp (e.g. screener, hours/addresses, etc) and 73% received a referral in findhelp
- Self help resulted in only 54% having interactions, and just 12% made a connection with a program

Searches by Category | 2025-03-27 to 2025-06-25



Most Common Search Terms | 2025-03-27 to 2025-06-25

TERM	DOMAIN	SEARCHES
help pay for utilities	housing	91
help pay for housing	housing	82
clothing	goods	68
food pantry	food	60
help find housing	housing	50
emergency food	food	49
food delivery	food	47
help pay for healthcare	health	34
financial assistance	money	34
housing vouchers	housing	31
government food benefits	food	27
help pay for internet		26
transportation for healthcare	transit	24
help pay for food	food	22
meals	food	22

Takeaways:

- Best practice to **integrate with 3rd party**: findhelp and Azara
- Implement a **tiered screening** and referral model
  - Low Acuity - self help
  - High Acuity, willing – case manager, CHW, or health coach
  - High Acuity, not-willing – documented without referral
- Use Order Sets to **automate codes** onto billing claims
- **Track** and report performance feedback (internally and with plans)
- **Surface** non-medical needs to the care team

Now you've done all this work, how are you gonna get paid?

Medicaid Payers	SDOH CPT Code	ICD-10 Z-Codes	Reimbursement	Frequency
Aetna Better Health	G0136	Z55, Z56, Z57, Z58, Z59,Z60,Z62, Z63, Z64, Z65	$30	PRAPARE must be performed and have positive findings to pay and can be billed once a year per unique patient
AmeriHealth Caritas	Not required	Any Z-code on a claim	$5	Once a year per unique patient
Healthy Blue	PRAPARE T1015 and Z-codes	Excludes: Z59.6 Low income, Z00.129 and Z13.9	$20	PRAPARE Assessment performed per unique patient per quarter
Humana Healthy Horizons	N/A	N/A	N/A	N/A
LA Healthcare Connections	96160	CPT/Diagnosis combination; CPT Codes = 96160 Diagnosis Codes = Z55, Z59, Z65, Z590, Z591, Z594, Z598, Z139	$5	PRAPARE Assessment required and paid once a year per unique patient
United Healthcare Community Plan	96160	96160 AND at least one specified SDOH Z Code: Z59.0, Z59.1, Z59.8, Z59.4, Z59.6	$50	PRAPARE Assessment required and paid once per year per unique patient