Peds PCP Quality Improvement Collaborative Session #4: 4/7/26

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Arizona State University

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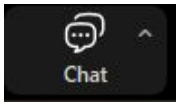
Agenda

Time	Topic	Presenter
12:00 PM to 12:05 PM	Opening & Updates	Matthew Martin, PhD
12:05 PM to 12:30 PM	Non-Medical Drivers of Health (NMDOH) • Network Status & Performance Implications • Dashboard	Taylor Vaughan, MPH
12:30 to 12:35 PM	NMDOH Polling	Matthew Martin, PhD
12:35 PM to 12:45 PM	Provider Spotlight Presentation on NMDOH	Karen Eynon, RN, Arbor Medical Partners
12:45 PM to 12:58 PM	Q&A	Matthew Martin, PhD
12:58 PM to 1:00 PM	Closing	Kailey Love, MBA, MS

Learning Objectives

1. Describe strategies to facilitate population health management improvement.
2. Critically analyze the application of improvement methods and techniques to improve HEDIS quality metrics.
3. Evaluate strategies to identify and address upstream drivers of health for high risk populations
4. Explore process improvement strategies for population health management

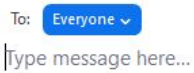
Guidelines



Do not enter your name or organization in the Chat. Zoom will automatically record your attendance. Please only use the chat for questions and comments.

Participants will automatically be muted and videos off as they join.

When interested in participating in the discussion, please raise your hand and unmute yourself.



Please drop your questions into the Chat. If we do not have time to address your question, we will compile all questions into a FAQ document and distribute post-event.

Disclosure

This is a CME activity

Acknowledgment: This CME event is not supported by any commercial entity.

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Credit Statement: Arizona State University designates this live activity for a maximum of 1-credit from the following:

- ***AMA PRA Category 1 Credit™ – CME – 1 credit hour per session***
- ***Nursing Continuing Professional Development – NCPD – 1 credit hour per session***
- ***Psychology – CEP – 1 credit hour per session***
- ***Social Work – ACE – 1 credit hour per session***
- ***Interprofessional Continuing Education – IPCE – 1 credit hour per session***

**Providers should only claim credit commensurate with the extent of their participation in the activity.*

Updates & Reminders

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AHCCCS Office Hours Reminders

- AHCCCS-Led Office Hours are general meetings hosted by AHCCCS to address concerns, questions and comments regarding TI 2.0.
- Upcoming General Office Hours:
  - Friday, April 10, 2026 at 11 AM (Arizona Time) - **Register Here**
  - Monday, April 20, 2026 at 12 PM (Arizona Time) - **Register Here**

For meeting information including meeting materials, contact the TI Team at the following email: targetedinvestments@azahcccs.gov

ASU TIPQIC Reminders

- ASU TIPQIC is upgrading to MY HEDIS® 2025 measure specifications for Year 4 performance measure calculations
  - Please visit tipqic.org/measures to see the measure detail guides and health plan billing guidance
- Want to know who is in your numerator and denominator? Complete **data harmonization** with ASU TIPQIC!
  - Email tipqic@asu.edu and following the naming instructions listed on the “Data Harmonization” section under tipqic.org/perfimp

Table 1 Targeted Investments (TI) 2.0 Year 4 Milestones and Incentive Percentages			
MILESTONES	**PEDS PCP** **INCENTIVE % OF ANNUAL PAYMENT**		
M1. Performance Measures	**50**		
	W30 - Part 1	W30-Part 2	WCV
	15	20	15
M2. Screening and Referral Systems for Nonmedical Drivers of Health	25		
M3. Closed Loop Referral System (CLRS)	15		
M4. Quality Improvement Collaboratives (QICs)	10		

Network Performance Snapshot

- TI 2.0 Peds PCP providers are performing higher than their non-TI counterparts on the W30 Part 2 and WCV measures
  - Also outperforming the WCV national average
- W30 Part 1 remains a focus area

Measure	AOC Performance	Non-TI Performance
W30 Pt 1	56%	57.9%
W30 Pt 2	66%	64.5%
WCV	54.1%	48%

HEDIS MY 2023 performance for the report period ending October 31, 2025 is calculated with claims/encounter data adjudicated through January 31, 2026.

Network Performance Snapshot

- Among the 43 unique TINs participating in the Peds PCP AOC,
  - W30 Part 1:
    - 8 are currently exceeding their target
    - 6 are within 5% of meeting their target
    - 5 are within 10% of meeting their target
  - W30 Part 2:
    - 11 are currently exceeding their target
    - 8 are within 5% of meeting their target
    - 3 are within 10% of meeting their target
  - WCV:
    - 13 are currently exceeding their target
    - 10 are within 5% of their target
    - 6 are within 10% of meeting their target

HEDIS MY 2023 performance for the report period ending October 31, 2025 is calculated with claims/encounter data adjudicated through January 31, 2026.

Non-Medical Drivers of Health (NMDOH)

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Importance of NMDOH

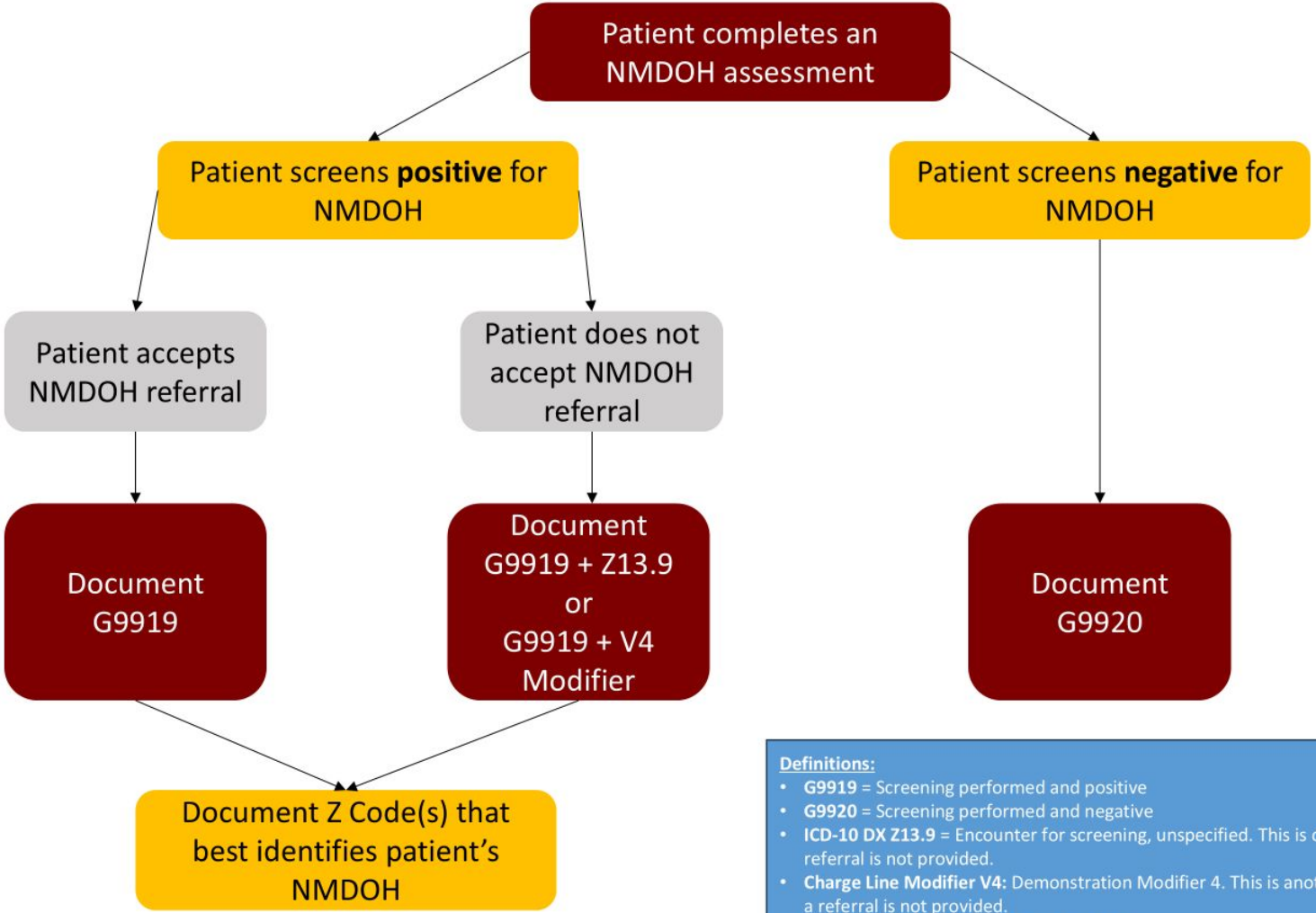
- Addressing NMDOH, along with clinical care, is important to improving HEDIS measure performance
- Unmet social needs contribute to:
  - Missed or delayed appointments
  - Gaps in continuity of care
  - Lower medication adherence
  - Reduced access to preventive services
- Integrating screening, referral, and follow-up for social needs can help:
  - Close care gaps
  - Improve engagement
  - Support sustained health outcomes

Addressing NMDOHs in the TI 2.0 Program

M2A – ATTEST to screening members annually using an evidence based, standardized screening tool that includes (at least) for all eight required domains: (Housing instability, Utility assistance, Food insecurity, Transportation needs, Interpersonal safety, Social isolation/support, Employment, and Justice involvement).

M2B - ATTEST to documenting nonmedical drivers of health screening and referral results via consistent submission of claims using G procedure codes (G9919 and G9920), V4 modifier, and Z diagnosis codes as appropriate.

Year 4 Milestone Requirements



Definitions:

- **G9919** = Screening performed and positive
- **G9920** = Screening performed and negative
- **ICD-10 DX Z13.9** = Encounter for screening, unspecified. This is one option to use when referral is not provided.
- **Charge Line Modifier V4:** Demonstration Modifier 4. This is another option to use when a referral is not provided.
- **NMDOH ICD-10 DX Z codes:** Z55x – Z65x.

Billing Reminders

- An NMDOH Z code (Z55x-Z65x) should always be reported with G9919
  - Only **30.6%** of positive screenings submitted by Peds PCP providers follow this guideline.
- If a patient screens positive but declines a referral, do not submit G9919 + V4 modifier + Z139. **Choose either G9919 + V4 OR G9919 + Z139.** Submitting both will result in an error.
- See the “NMDOH* Screening & Referral Guides” section on the TIPQIC website at https://tipqic.org/measures.html

NMDOH G/Z code results were calculated using claims and MCO supplemental claim files submitted between November 1, 2024, and October 31, 2025. This analysis is limited to G code claims submitted by Peds PCP providers for patients under 21 years old.

NMDOH Data & System Status

- A total of 22,969 NMDOH screenings were completed for 20,345 unique pediatric patients by 31 Peds PCP providers between November 1, 2024, and October 31, 2025.
  - **11 Peds PCP TINs have not yet submitted a G code for a pediatric patient.**
- Most screenings were negative (79.6%; N = 17,605), while 20.4% (N = 4,533) identified at least one NMDOH need.
- Among screenings with an identified need, 75.3% (N = 3,523) resulted in a referral.

NMDOH G/Z code results were calculated using claims and MCO supplemental claim files submitted between November 1, 2024, and October 31, 2025. This analysis is limited to G code claims submitted by Peds PCP providers for patients under 21 years old.

NMDOH Data & System Status

Domain	Count
Housing	**582**
Utility Assistance	**326**
Food Insecurity	**243**
Social Isolation	242
Employment	236

NMDOH G/Z code results were calculated using claims and MCO supplemental claim files submitted between November 1, 2024, and October 31, 2025. This analysis is limited to G code claims submitted by Peds PCP providers for patients under 21 years old.

HEDIS Performance and G Codes

- Screening and age impact Peds PCP performance
- Screening efforts show to be more effective over older pediatric population
  - W30 Pt 1 - 5% higher performance for screened group
  - W30 Pt 2 - 9% higher performance for screened group
  - WCV - 25% higher performance for screened group
- Among screened patients, the most frequent needs identified include:
  - W30 Pt 1, W30 Pt2 - housing and food insecurity, transportation, utility assistance, and food insecurity
  - WCV - housing, isolation, utility assistance, and food insecurity

NMDOH G/Z code results were calculated using claims and MCO supplemental claim files submitted between November 1, 2024, and October 31, 2025. This analysis is limited to G code claims submitted by Peds PCP providers for patients under 21 years old. HEDIS MY 2023 performance for the report period ending October 31, 2025 is calculated with claims/encounter data adjudicated through January 31, 2026.

TI 2.0 NMDOH Dashboard

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Provider NMDOH Dashboard Overview

- Available now at: data.tipqic.org
- Newly developed dashboard displaying your provider organization's use of NMDOH G/Z codes
  - Claims are received monthly from the six ACC/ACC-RBHA health plans
- Dashboard features
  - Each time period reflects G/Z codes submitted for that month
  - The main bar chart displays total G codes submitted per month, color-coded by whether an NMDOH need was identified
  - Among positive screens, identified NMDOH needs in your patient population are shown, stratified by referral status
- Dashboard instructions are available at https://tipqic.org/dashboard.html

TIPQIC NMDOH Coding Dashboard

TIP QIC Targeted Investments Program Quality Improvement Collaborative

Definitions

Screening Results:

- NMDOH Need Identified: G9919, G9919 + V4 modifier, or G9919 + Z139
- No Needs Identified: G9920

NMDOH Need Identified	Z Codes
Education	Z55, Z550, Z551, Z552, Z553, Z554, Z555, Z556, Z558, Z559
Employment	Z560, Z561, Z562, Z563, Z564, Z565, Z566, Z5681, Z5682, Z5689, Z569, Z570, Z571, Z572, Z5731, Z5739, Z574, Z575, Z576, Z577, Z578, Z579
Food Insecurity	Z594, Z5941, Z5948
Housing & Shelter	Z5901, Z5902, Z5910, Z5911, Z5912, Z5919, Z592, Z593, Z59811, Z59812, Z59819
Interpersonal Safety	Z630, Z631, Z6372, Z638, Z639
Justice & Legal	Z650, Z651, Z652, Z653, Z654, Z655
Social Isolation	Z600, Z602, Z603, Z604, Z605, Z608, Z609, Z6379
Transportation	Z5982, Z758
Utility Assistance	Z5881, Z5889, Z5911, Z5912, Z599
Larger Economic Conditions	Z595, Z596, Z597, Z5986, Z5987, Z5989
Larger Social Conditions	Z620, Z621, Z6221, Z6222, Z6223, Z6224, Z6229, Z623, Z626, Z62810, Z62811, Z62812, Z62813, Z62814, Z62815, Z62819, Z62820, Z62821, Z62822, Z62823, Z62831, Z62832, Z62833, Z62890, Z62891, Z62892, Z62898, Z629, Z6331, Z6332, Z634, Z635, Z636, Z6371, Z640, Z641, Z644, Z658, Z659, Z733

Please contact us at tipqic@asu.edu with questions, feedback, or ideas about this dashboard.

TIPQIC NMDOH Coding Dashboard

TIP QIC Targeted Investments Program Quality Improvement Collaborative

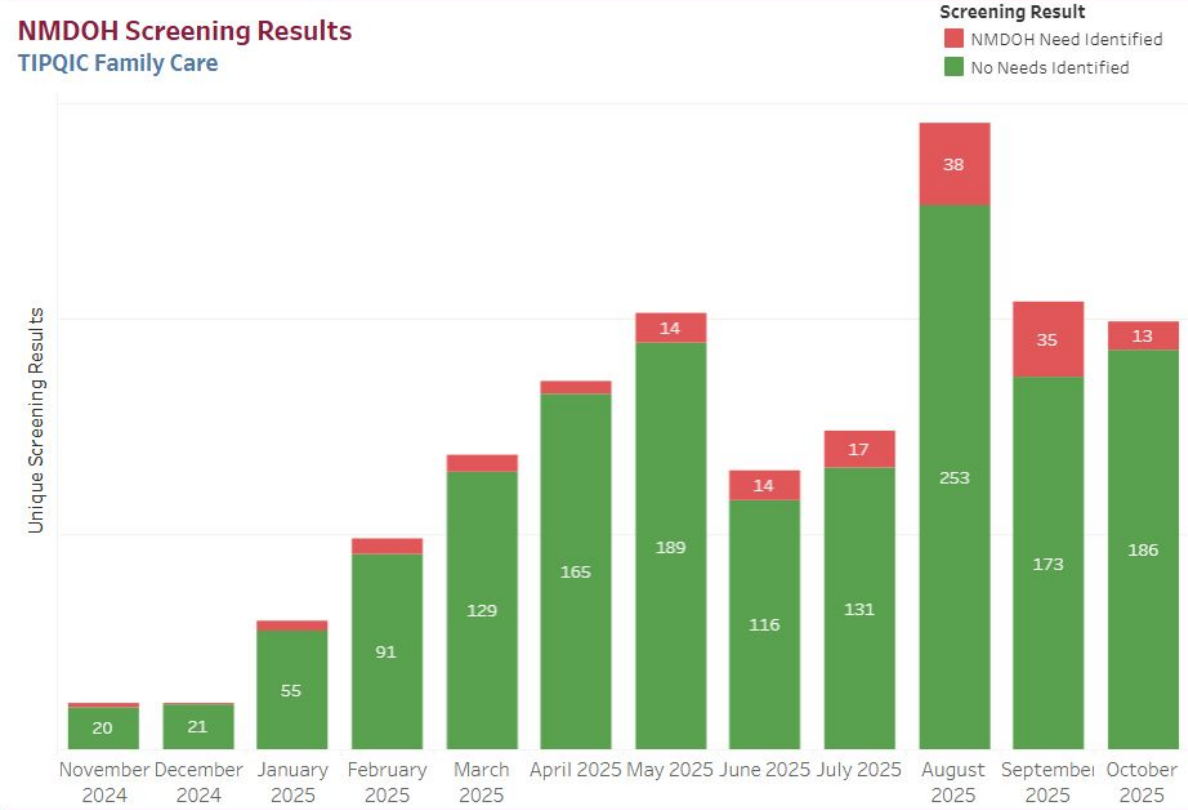
Provider Name: TIPQIC Family Care

Month: (All)

Total NMDOH Needs Identified by Provider Organization: 88

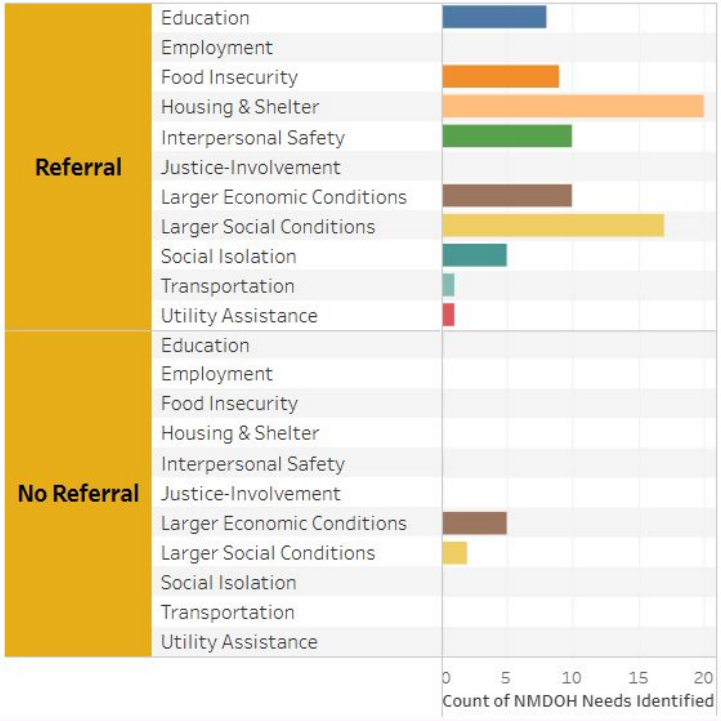
NMDOH Screening Results

TIPQIC Family Care



NMDOH Needs Identified by Referral Status

TIPQIC Family Care



Dashboard last updated **March 4, 2026**. Analysis performed with claims and MCO supplemental file data adjudicated through **January 31, 2026**. Counts less than 10 are suppressed (*).

Please contact us at tipqic@asu.edu with questions, feedback, or ideas about this dashboard.

TIPQIC NMDOH Coding Dashboard

TIP QIC Targeted Investments Program Quality Improvement Collaborative

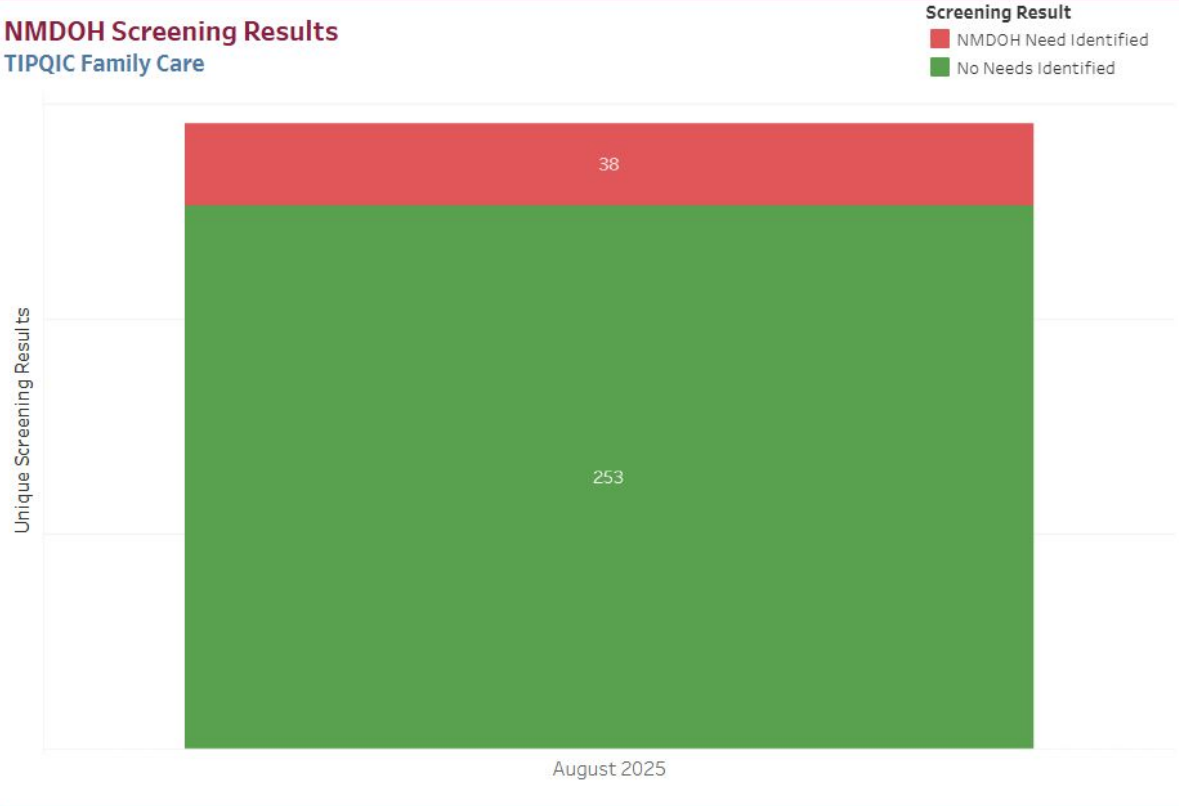
Provider Name: TIPQIC Family Care

Month: August 2025

Total NMDOH Needs Identified by Provider Organization: 23

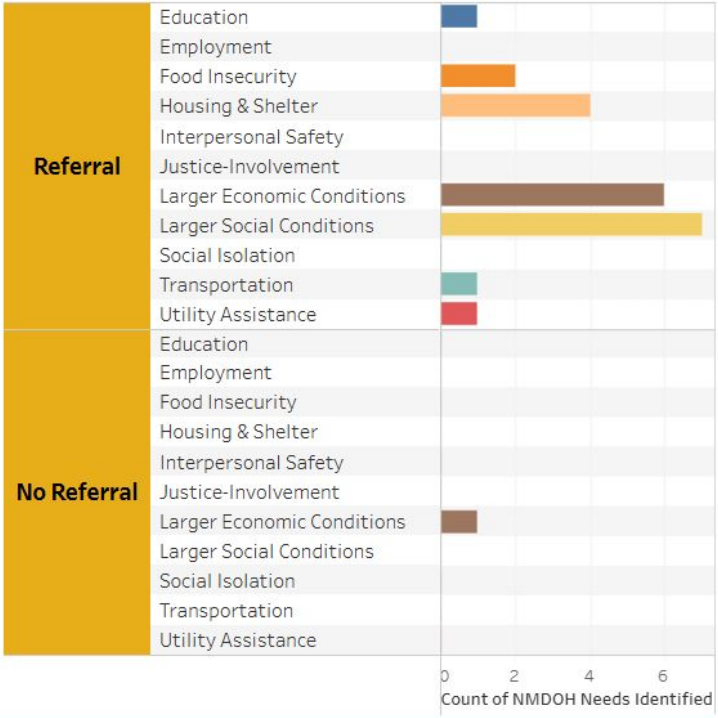
NMDOH Screening Results

TIPQIC Family Care



NMDOH Needs Identified by Referral Status

TIPQIC Family Care



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NMDOH Polling

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NMDOH Polling Questions

- Do you currently screen all patients for NMDOH at least once per year?
  - Yes / No / Only high-risk patients
- Does your team have a system to track closed-loop referrals for social needs?
  - Yes / No / Partially
- How confident are you that your current NMDOH screening and referral process impacts HEDIS performance?
  - Very confident / Somewhat confident / Not confident
- Which NMDOH domain most affects your AOC's HEDIS measures?
  - Transportation, Housing & Shelter, Food Insecurity, Employment, Other
- Are your staff consistently documenting NMDOH screenings in the EHR?
  - Always / Sometimes / Rarely / Never

Provider Spotlight

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Improving SDOH/HRSN Screening and Referral in Pediatric Primary Care: Arbor Medical Partners (now Arbor Pediatrics

Enhancing screening and referral processes for better pediatric health outcomes

Karen Eynon RN MSN CPNP MATS (Director, Clinician Practice Enablement, Pediatric Associates – Arbor Pediatrics
Lisa Engel, MD, Senior Regional Medical Director
Arlene Deluera, Regional Practice Administrator

SDOH Screening & Referral Workflow

SDOH Screening Procedure

Prapare slightly adapted for more structure data to ease electronic reporting

Added end question for consent:

Screening tool:
Prapare

Delivery: Electronically to phone, ipad, computer

Frequency: 1mo, 6mo, 12mo, 18mo, annually from 2yo and up

Screening initiated in August 2024

Inconsistent completion	• Screening not sent out consistently • <50% completion rate • Patient reluctance to complete or declined certain questions
Referrals not made timely	• Lack of staff to complete referrals • Hesitancy on clinicians part/ unsure what to do • Communication not consistent regarding referrals
Referral declined	• Patient declined resources • More than 70% of community connections declined services due either incorrect referral or lack of resources

Screening and Referral Initiation

Positive SDOH screens trigger referrals - entered into Unite Us, with documentation in EHR systems.

Initial results:

- 20% patients screened positive
- Only ~2% connected to services
- Need improved referral workflow

Quality project due to low results

Positive SDOH screen with consent triggers referral with EHR by program coordinator

Positive screen triggers automatic data send to care coordinator

Care Coordinator Engagement / PCCN connection

Care coordinators review referrals, contact families up to three times, and assess needs via interviews and tools.

Community Resource Referral and Follow-up

Coordinators refer families to community resources, follow up on progress, and document all actions in dashboards.

Monitoring and Outcome Review

SDOH staff monitor referral progress and update charts; monthly reviews ensure accountability and improved outcomes.

Improvement Strategies & Outcomes

Key Improvements Implemented

- Goal metrics set at
- 85% screening completion
- 90% successful referral rate
- 45% of positives and consented families connected with community resources

STANDARDIZE WORKFLOW ACROSS ALL OFFICES: AUTOMATE VIA ELECTRONIC SEND DURING PRE-REG

CONNECTED WITH PCCN CARE COORDINATORS:

ENSURE CARE COORDINATORS HAVE EXTENSIVE KNOWLEDGE OF COMMUNITY RESOURCES

CONSISTENT USE OF REFERRAL PROCESS

PCCN Care Coordination

1. 3 outreach attempts
2. Assess needs
3. Connect to community resources
4. Follow-up and document

Closed loop process:

*Referral made through EHR

*Soon an automated process

*Care Coordinators makes contact

*Secured email sent back to project coordinator and uploaded into chart documents section

Clinician Role & Take-Home Points

What Clinicians Need to Do

Screening and Family Discussion

Clinicians review SDOH screening results and normalize discussions to support families effectively.

Streamlined Documentation

Templates simplify documentation, coding, and treatment plans, reducing clinician workload.

Referral and Collaboration

Clinicians support referrals, collaborate with care coordinators, and ensure closed-loop communication.

Improving Health Outcomes

Routine SDOH screening in pediatric care reduces disparities and enhances patient health outcomes.

Take-Home Points

Standardized SDOH Screening

Screening for social determinants of health is integrated into pediatric care to improve patient outcomes.

Closed-Loop Referral System

The referral system ensures follow-up and connection with community resources, reducing disparities.

Clinician and Community Partnership

Collaboration with PCCN supports whole-child health through coordinated care and resource access.

Continuous Quality Improvement

Ongoing monitoring and quality improvement sustain progress in addressing social health needs.

Q&A

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Closing

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Closing & Next Steps

- For those interested in CME, an evaluation survey will be distributed following this event and CME certificates will be distributed to those who complete this survey at the end of the month.
- Register for the upcoming Optional QIC session(s)

Questions?

AHCCCS Questions: targetedinvestments@azahcccs.gov
ASU TIPQIC General Inquiries: TIPQIC@asu.edu
Support Tickets: support@TIPQIC.org

Relevant Websites:

- AHCCCS TI: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/
- ASU TIPQIC: tipqic.org
- Dashboards: data.tipqic.org

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