Peds BH Quality Improvement Collaborative Session #4: 4/9/26

Arizona State University

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

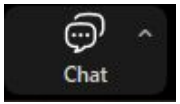
Agenda

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	Brian Rosenstein, MBA, and Megan Lipman, Jewish Family & Children's Services
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

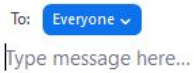
Guidelines



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.

Disclosure: There are no relevant financial relationships, sponsorships, or other disclosures from anyone in control of content associated with this activity. This program is designed to provide educational information and does not involve the promotion of any specific product or service.

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

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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 BH** **INCENTIVE % OF ANNUAL PAYMENT**		
M1. Performance Measures	**50**		
	FUH7	FUH30	APM
	20	20	10
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 BH providers are outperforming their non-TI counterparts on all Year 4 measures
  - Also outperforming the FUH7/FUH30 national average
- APM remains a focus area
  - Only 0.9% from the APM national average

Measure	AOC Performance	Non-TI Performance
APM	37.5%	31.8%
FUH7	84.9%	47.9%
FUH30	94.3%	70.6%

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 40 unique TINs participating in the Peds BH AOC,
  - APM:
    - 13 are currently exceeding their target
    - 7 are within 5% of meeting their target
    - 3 are within 10% of meeting their target
  - FUH7:
    - 20 are currently exceeding their target
    - 7are within 5% of meeting their target
    - 4 are within 10% of meeting their target
  - FUH30:
    - 26 are currently exceeding their target
    - 6 are within 5% of their target
    - 2 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

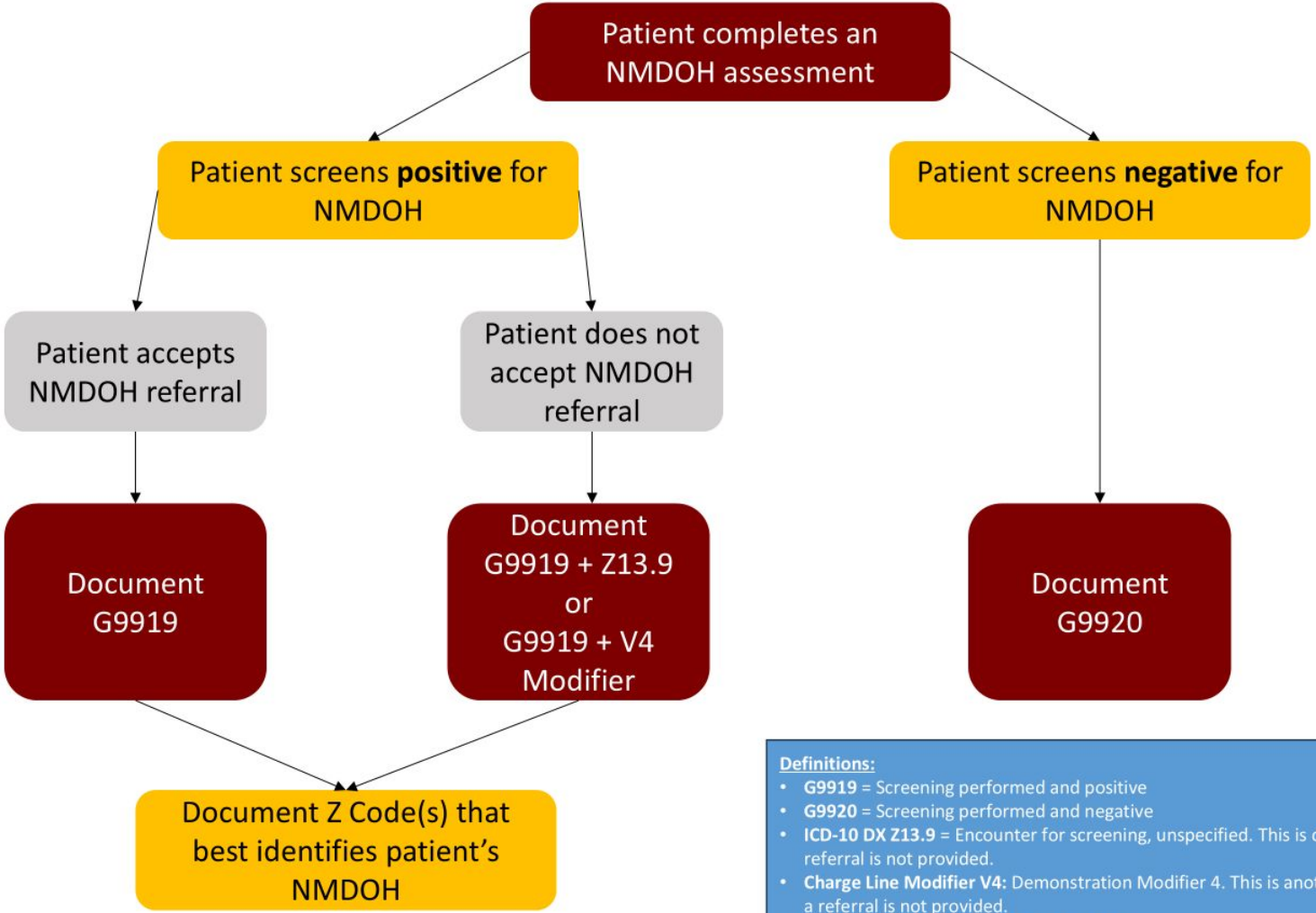
- Addressing NMDOH, along with clinical care, is important to improving HEDIS measure performance
- Unmet social needs contribute to:
  - Missed or delayed appointments
  - Gaps in continuity of care
  - Lower medication adherence
  - Reduced access to preventive services
- Integrating screening, referral, 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 **29.2%** of positive screenings submitted by Peds BH 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 BH providers for patients under 18 years old.

NMDOH Data & System Status

- A total of 6,687 NMDOH screenings were completed for 5,569 unique pediatric patients by 27 Peds BH providers between November 1, 2024, and October 31, 2025.
  - **13 Peds BH TINs have not yet submitted a G code for a pediatric patient.**
- Most screenings were negative (70.3%; N = 4,704), while 29.7% (N = 1,983) identified at least one NMDOH need.
- Among screenings with an identified need, 72% (N = 1,428) 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 BH providers for patients under 18 years old.

NMDOH Data & System Status

Domain	Count
Larger Social Conditions	**333**
Larger Economic Conditions	**139**
Interpersonal Safety	89
Social Isolation	87
Education	**77**

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 BH providers for patients under 18 years old.

HEDIS Performance and G Codes

- Screening impacts performance, particularly for chronic measures.
  - APM performance is approximately 9% higher among screened individuals
  - FUH7 and FUH30 performance is similar between screened and non-screened patients.
- Among screened patients, the most frequently identified needs include:
  - APM - social isolation and larger economic conditions
  - FUH7 and FUH30 - social isolation, interpersonal safety, and larger economic conidtions

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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

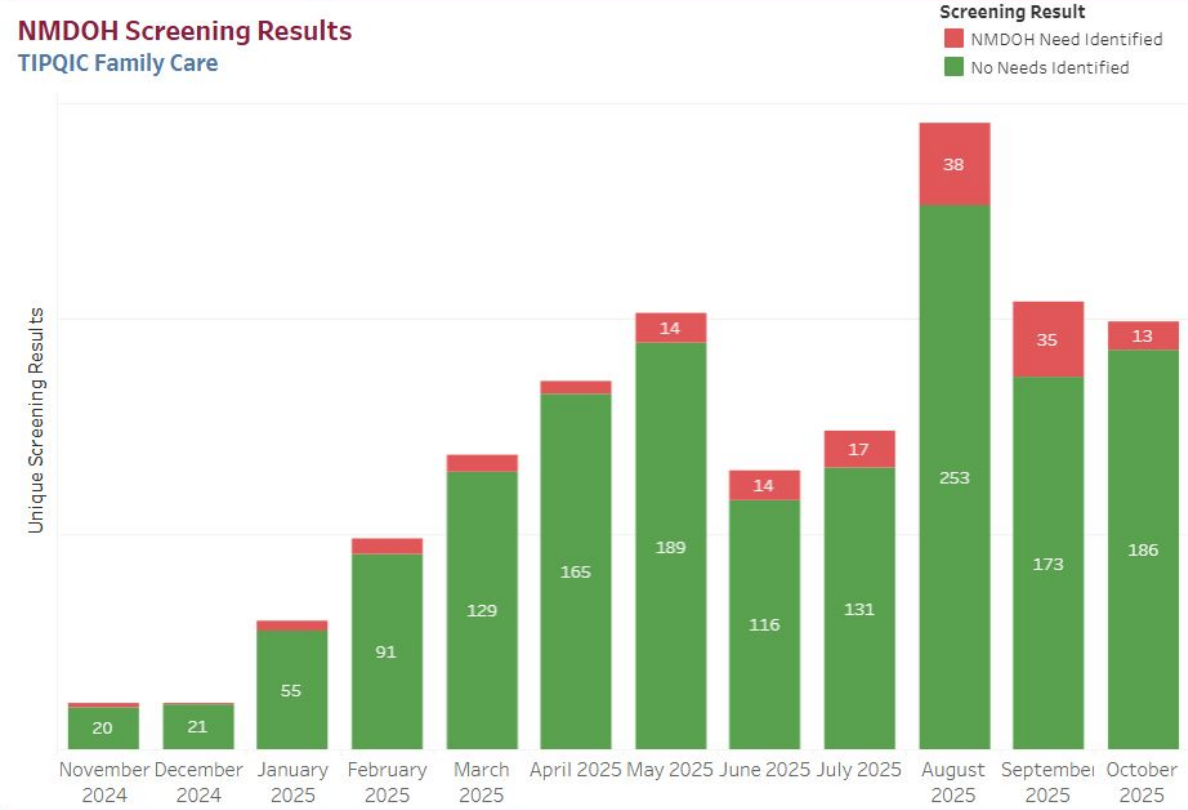
Provider Name: TIPQIC Family Care

Month: (All)

Total NMDOH Needs Identified by Provider Organization: 88

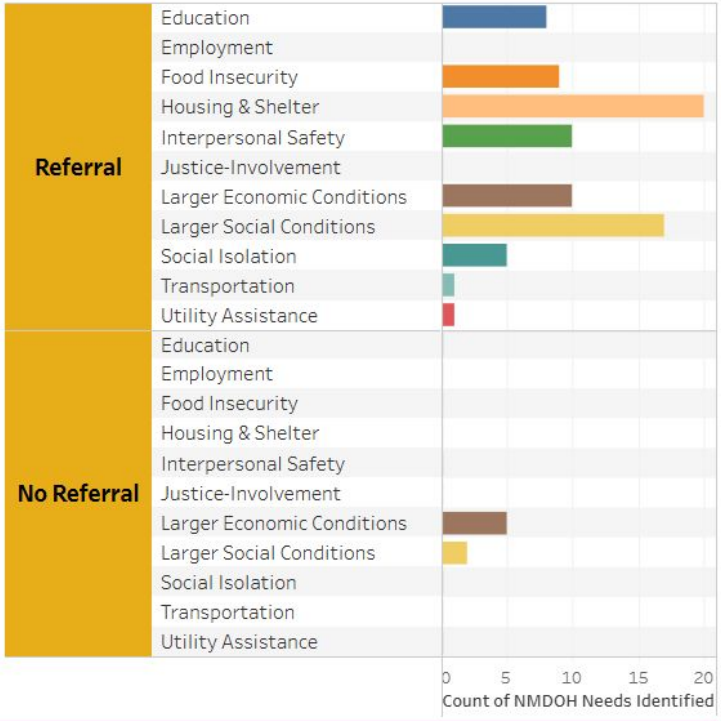
NMDOH Screening Results

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

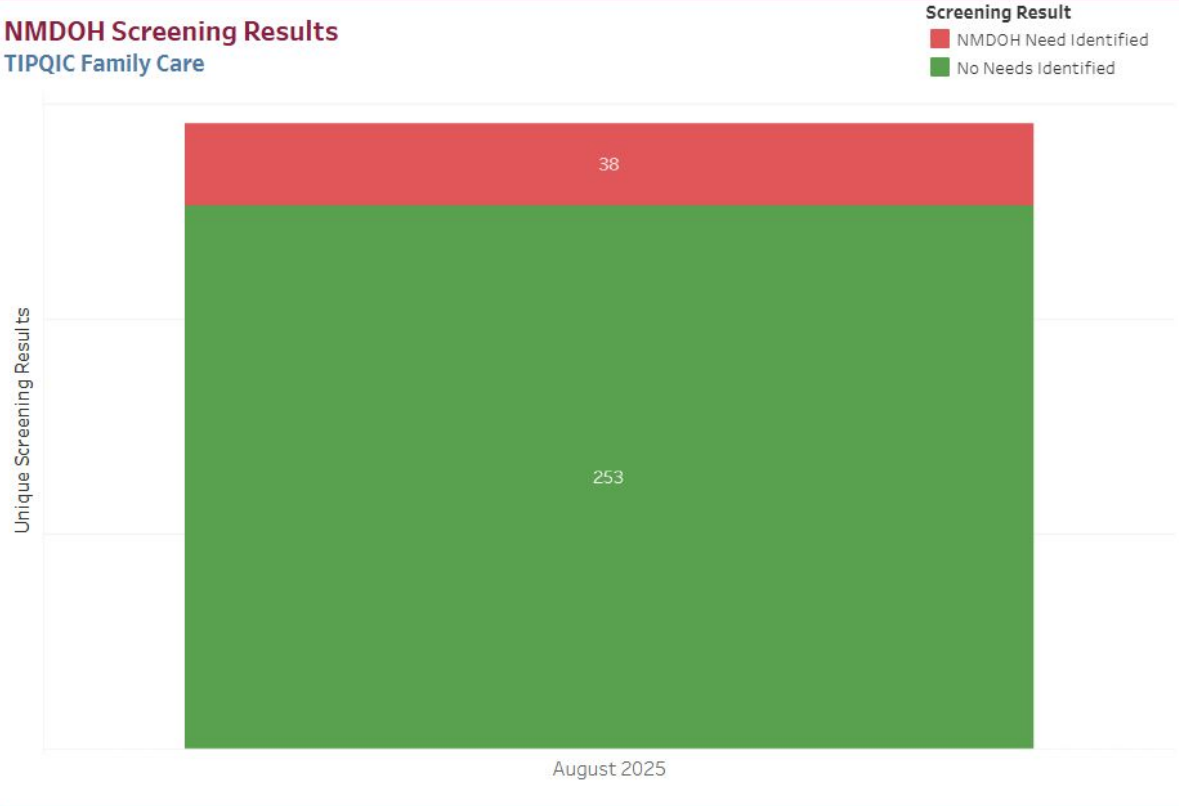
Provider Name: TIPQIC Family Care

Month: August 2025

Total NMDOH Needs Identified by Provider Organization: 23

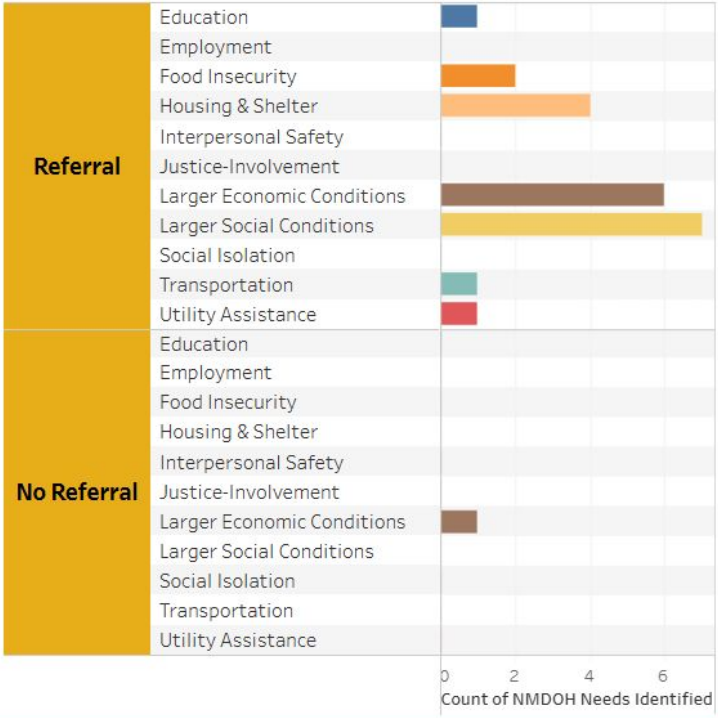
NMDOH Screening Results

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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Bridging the Gap: From SDOH Screening to Actionable Support

Addressing Non-Medical Drivers of Health Through Integrated Workflows

Summary:

- Why NMDOH matters — and what we're doing about it
- How we turned screening data into a closed-loop referral system

About JFCS

Jewish Family & Children's Service (JFCS) is a non-profit, non-sectarian 501(c)(3) organization dedicated to strengthening the community by providing behavioral health, healthcare and social services to all ages, faiths and backgrounds. JFCS was founded in 1935 and has been providing services to the community for 90 years.

JFCS programs and services include:

- Primary care
- Counseling
- Mental health assessment and treatment
- Support for victims of domestic violence
- Substance abuse services
- Workforce readiness
- High school equivalency exams for teens in foster care
- High-needs case management and
- Services for those with Serious Mental Illness (SMI)

The Visibility Challenge

If It Isn't Tracked, It Isn't Visible

- **The Data Shadow:** Our teams do a great job screening for needs — but NextGen lacked a reliable way to track what happened after a referral was made.
- **Fragmented Documentation**: Referral outcomes often lived in free-text notes instead of discrete data fields, and inconsistent Z-code use made it nearly impossible to report on which social needs were actually being addressed.
- **Disconnected Follow-up:** Without a standardized workflow, the loop stayed "open" in our records — even when members were actively being helped.
- **The Goal:** Move from knowing a need exists to seeing the solution reflected in our data.

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Our Multi-Layered Screening Approach

Creating a 360-Degree View of Member Needs

- **Beyond the SCRA:** The Social Needs Screening Tool is our foundation — but no single tool captures all 7 SDOH domains on its own.
- **The Layered Strategy:** We close that gap by integrating data from three sources:
  - SCRA (Primary Tool)
  - Comprehensive Assessment
  - Health Risk Assessment (HRA)
- **Shared Across Teams:** These tools aren't role-limited, enabling staff to identify and address needs at every touchpoint.
- **The Result:** A complete, accurate picture of social needs captured across every member touchpoint.

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Engineering Visibility into the EHR

- **Data Mapping:** We identified every relevant data element and assessment question in NextGen and mapped each one to the 7 SDOH domains.
- **Clinical Coding:** Z-codes were integrated alongside assessment data to embed social needs directly into the formal clinical record.
- **New EHR Functionality:** Drop-down menus were added to track whether resources were provided and whether the connection was successful.
- **The Result:** A clean, actionable report that gives staff a closed-loop view of member needs — built for daily operations, not just leadership dashboards.

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The Closed-Loop Workflow (NextGen)

Building a JFCS Referral System

- **Step 1 — Resource Delivery:** Staff use a ‘pick list’ in the contact note when a resource is provided.
- **Step 2 — Coding the Need:** Z-codes are used to document the specific social need being addressed.
- **Step 3 — The Follow-Up:** A second contact note item confirms if the member actually received the help.

The Cycle: The report refreshes to show who is "pending" vs. "closed," creating an internal tracking system.

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Driving Adoption: Training & Accountability

Empowering the Frontline

- **Clear Roles:** Every team member — Manager, MAs, and Care Coordinators — knows exactly what action they own.
- **Simplicity First:** One-on-one training and quick job aids replace complex manuals and lengthy onboarding.
- **Member Education**: Members receive plain-language materials and resources at the point of care, ensuring they understand the support available to them and how to access it.

Launching the Workflow

- **Guided Launch:** Rather than handing staff a report and expecting immediate adoption, Population Health ran the report biweekly and delivered curated member lists — showing exactly who to reach out to and why.
- **Building Ownership:** By acting as a guide through the early stages, we helped staff internalize the process until they could own it themselves — the goal was never dependency, but confidence.
- **The Result**: Over time, tracking becomes routine — just part of the job, not an added burden.

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Tools for Our Staff

Empowering the Frontline

- **Internal Resource Guide:** A curated, continuously updated directory of trusted community partners and local services.
- **Unite Us Integration:** Our primary platform for electronic social care coordination and external referrals.
- **Clinic-Specific Resource Lists:** Neighborhood-level resources maintained by each clinic location to reflect the community they serve.
- **The Workflow Link:** These tools supply the what — the right resource — while the EHR handles the how — the tracking and follow-up.

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Outcomes: What the Data Tells Us

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G – Code Compliance Rates for SCRA Completion since June 2025

	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	25-Dec	26-Jan	26-Feb	Mar-26
Compliance Rate per Month	33%	34%	41%	69%	64%	71%	73%	73%	72%	76%

SDOH Needs: Member Distribution by Domain

SDOH data is derived from our comprehensive SDOH reporting system, which analyzes member needs based on their most recent assessments (Comprehensive, HRA, and SCRA) and any current open Z-codes in the medical record. This data represents our current SDOH needs.

Distribution of JFCS Members with Identified SDOH Needs by Domain	
Housing	4%
Utilities	15%
Food	7%
Transportation	19%
Interpersonal Safety	20%
Social Support	18%
Employment	6%
Justice Involvement	23%

Distribution of JFCS Members by Number of SDOH Domain Challenges	
0	47%
1	29%
2	14%
3	5%
4	3%
5	<1%
6	<1%
7	<1%

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Challenges & Lessons Learned

The Reality of the Implementation

Roles: Defining clear actions for Front Desk, MAs, Case Managers, and Care Coordinators.

- **Screening ≠ Connecting:** Getting a positive screen is only half the battle — actually closing the loop on the referral remains our biggest conceptual and operational hurdle.
- **Culture Shift Takes Time:** Z-code compliance and process adoption require ongoing reinforcement, not a one-time training.
- **Working Within EHR Limitations:** Success required a deep understanding of how NextGen stores and structures data — knowing exactly where to pull from and how to connect the right fields to surface what we needed.
- **Client Engagement**: Not every member who screens positive is ready or willing to accept support. Meeting clients where they are — and respecting their autonomy — is an ongoing challenge that data alone can't solve.
- **The Golden Rule:** Keep it simple enough that staff *want* to use it.

Built to Last: Embedded Workflows

- **Workflow Integration:** This isn't a "pilot project"—it's now how we use our EHR.

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Questions?


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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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