Adult PCP Quality Improvement Collaborative Session #4: 4/21/26

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Arizona State University

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

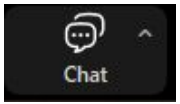
Agenda

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	Lori Wellman, MBA, MC, Banner University Medical Group
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

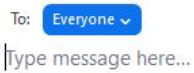
Guidelines



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

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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	**ADULT PCP** **INCENTIVE % OF ANNUAL PAYMENT**		
M1. Performance Measures	**50**		
	CCS	**PPC**	**AAP**
	20	**15**	**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 Adult PCP providers are performing higher than their non-TI counterparts on the PPC-First Trimester and CCS measures
  - Also outperforming the national average on the CCS and AAP measures

Measure	AOC Performance	Non-TI Performance
PPC	61.2%	59%
CCS	43.7%	42.8%
AAP	75.6%	75.9%

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 50 unique TINs participating in the Adult PCP AOC,
  - PPC:
    - 11 are currently exceeding their target
    - 17 are exceeding or within 5% of meeting their target
    - 27 are exceeding or within 10% of meeting their target
  - CCS:
    - 7 are currently exceeding their target
    - 27 are exceeding or within 5% of meeting their target
    - 40 are exceeding or within 10% of meeting their target
  - AAP:
    - 24 are currently exceeding their target
    - 36 are exceeding or within 5% of their target
    - 41 are exceeding or 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

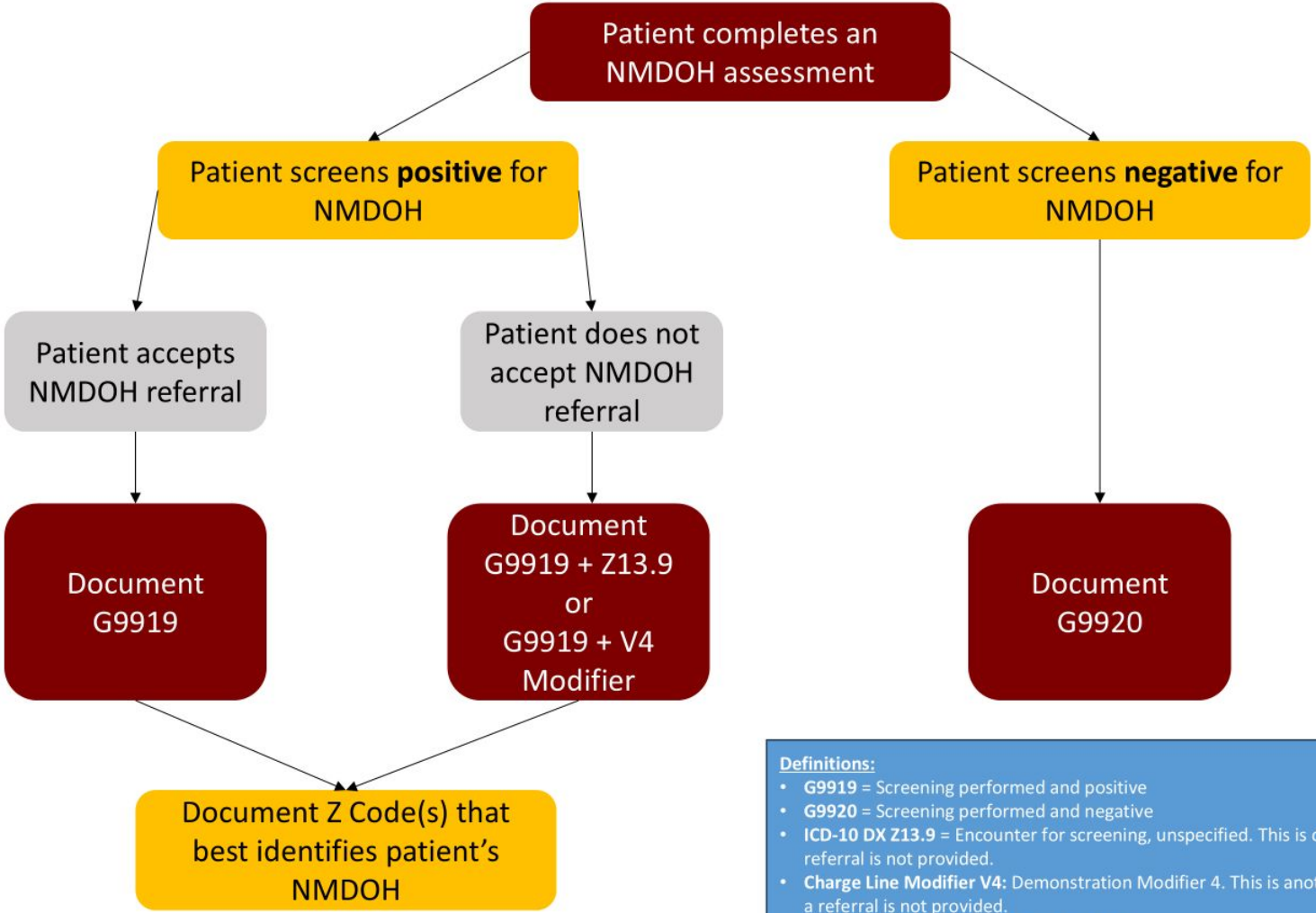
- Addressing NMDOH, along with clinical care, is important to improving HEDIS measure performance
- Unmet social needs contribute to:
  - Missed or delayed appointments
  - Gaps in continuity of care
  - Lower medication adherence
  - Reduced access to preventive services
- Integrating screening, referral, 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 **36.3%** of positive screenings submitted by Adult 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 Adult PCP providers for patients over 18 years old.

NMDOH Data & System Status

- A total of 13,476 NMDOH screenings were completed for 11,212 unique adult patients by 28 Adult PCP providers between November 1, 2024, and October 31, 2025.
  - **20 Adult PCP TINs have not yet submitted a G code for an adult patient.**
- Most screenings were negative (53.6%; N = 7,219), while 46.4% (N = 6,257) identified at least one NMDOH need.
- Among screenings with an identified need, 63% (N = 3,939) 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 Adult PCP providers for patients over 18 years old.

NMDOH Data & System Status

Domain	Count
Larger Economic Conditions	**880**
Employment	**771**
Larger Social Conditions	540
Housing	**471**
Interpersonal Safety	289

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 Adult PCP providers for patients over 18 years old.

HEDIS Performance and G Codes

- Screening positively impacts performance for CCS and AAP measures, scare among PPC qualifying patients.
  - AAP - 20% higher performance for screened group
  - CCS - 5% higher performance for screened group
  - PPC - not sufficient screening/referrals
- Among screened patients for the CCS and AAP measures, the most frequently identified needs include employment, housing and larger economic conditions

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 Adult PCP providers for patients over 18 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

Patient Population
- **Pediatric:** Under 18 years old
- **Adult:** 18 years old and older
- **Justice:** Justice-involved patient referred to a TI 2.0 Justice provider

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

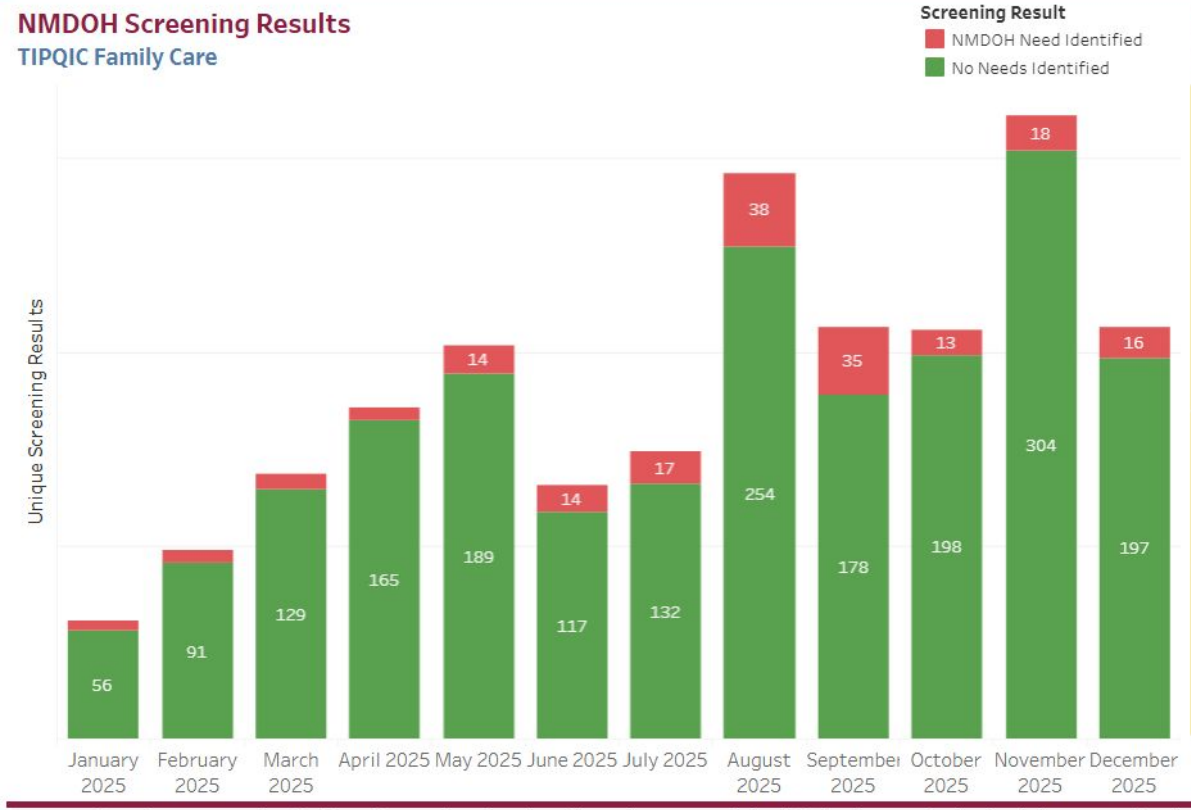
Month: (All)

Patient Population: Pediatric

Total NMDOH Needs Identified by Provider Organization: 105

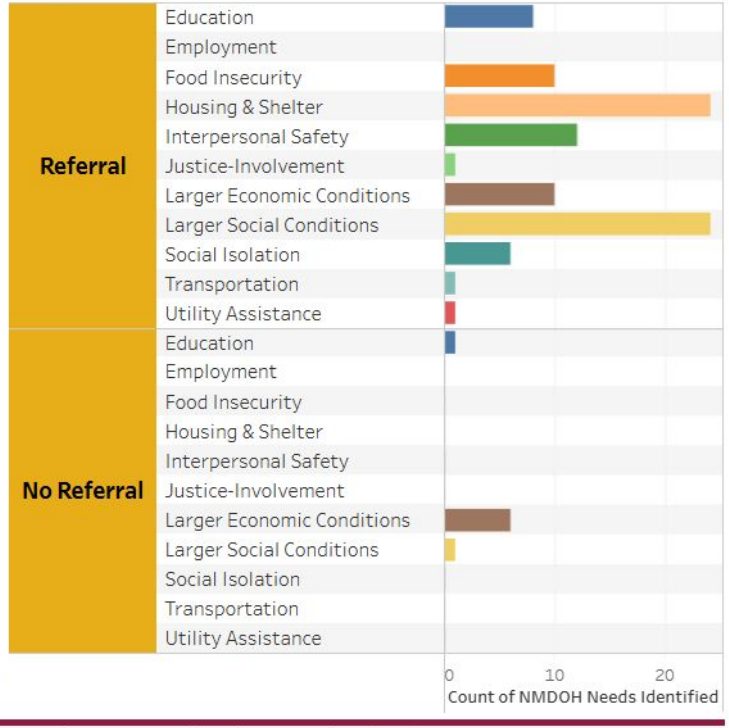
NMDOH Screening Results

TIPQIC Family Care



NMDOH Needs Identified by Referral Status

TIPQIC Family Care



The information in this dashboard is privileged and confidential. It is intended solely for the use of individuals designated by the named organization for informational and quality improvement purposes.

Dashboard last updated **April 17, 2026**. Analysis performed with claims and MCO supplemental file data adjudicated through **March 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: September 2025

Patient Population: Pediatric

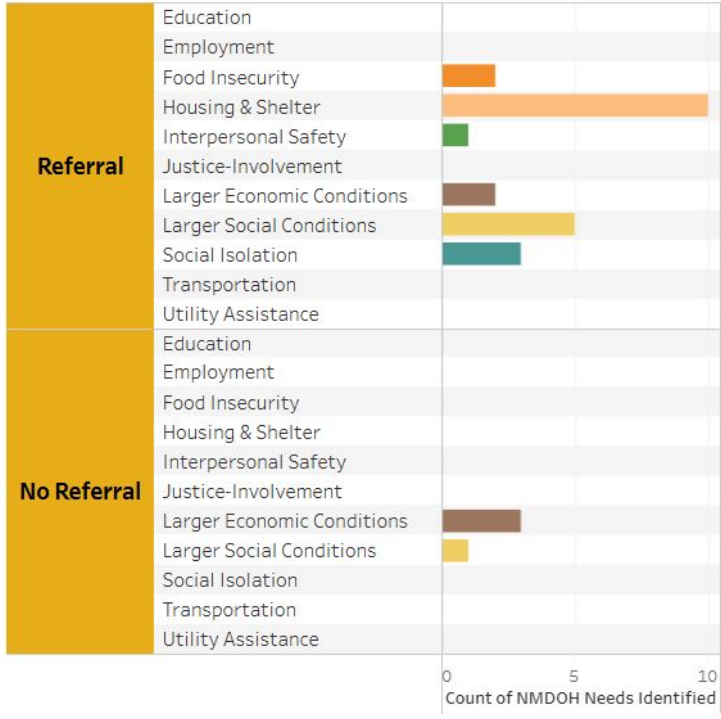
Total NMDOH Needs Identified by Provider Organization: 27

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

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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BUMG Tucson Non-Medical Drivers of Health (NMDOH) Screening and Referrals

Lori Wellman

Associate Director, Integrated Care Team

Agenda

1. Implementation
2. Roles and responsibilities
3. Screening and documentation
4. Data documentation and tracking
5. Referrals and UniteUs
6. Internal Dashboard Tracking and Trending
7. How NMDOH efforts have impacted HEDIS performance
8. Challenges encountered
9. Key sustainability strategies

Implementation

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Reason For Implementation

Sofia (a patient that represents the people we serve) engages a Banner team member while she is *in pain and scared*. Struggling to manage *housing and food costs*, Sofia knows that the prescriptions and directions given by the provider will not be followed. While Sofia is worried that the pain will return after the visit, Sofia's family - Mikey & Miya - need food for the night.

That means that Sofia has a choice to make, either fill her prescription or find food & housing.

NMDOH Implementation for BUMG Tucson Primary Care Clinics

What:

- Universal screening for NMDOH

When:

- Screening must be completed at least annually and when new barriers are identified
  - Rolled out August 2024 in Ambulatory space

Who/Where:

- All patients seen at BUMG Tucson Primary Care clinics

How:

- PRAPARE Screening
- NMDOH Dashboard
- UniteUs Referral System

Roles

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BUMG Tucson Primary Care Roles & Responsibilities

Front Desk

- Hands laminated **PRAPARE** form to Sofia to complete as part of the check-in process

MA

- Reviews and transcribes in **Electronic Health Record** "Social Determinants (PRAPARE)" form.
- For any positives, MA confirms if patient would like a referral or not; checks appropriate box on form
- "Yes" referrals are automatically added to **Internal Dashboard** for follow-up. Patient is informed they will receive follow up phone call

Provider

- Is aware of screening and referral process
- Communicates with MA regarding positive/yes results and communicates with patients as needed

TIP/Integrated Care Team

- Pull referral follow-up list from **Internal Dashboard**
- Team member outreaches patient
- Enters referral in **Electronic Health Record UniteUs Platform**, selecting appropriate CBOs in UniteUs
- If no CBO is available, team members provide alt. resources if available to patient

CBOs

- Outreach patient to connect with resource

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Screening
&
Electronic Health Record Documentation

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Completed by patient or MA/RN

Banner Health

SOCIAL DETERMINANTS OF HEALTH SCREENING

Patient Name _____
Date of Birth: _____
Best Contact Number: _____

Patients often have needs beyond just medical, for example, housing, food or transportation challenges. While we may not be able to help with those directly, we do have partners in the community who may be able to help. We would like to put you in touch with them. The following are a few questions to see if there are resources that may help you.

Personal Characteristics

1. At any point in the past 2 years, has seasonal or migrant farm work been you or your family's main source of income?
   __ Yes __ No __ I choose not to answer this question

2. Have you been discharged from the armed forces of the United States?
   __ Yes __ No __ I choose not to answer this question

Family and Home

3. What is your housing situation today?
   __ I have housing __ I do not have housing __ I choose not to answer this question

4. Are you worried about losing your housing?
   __ Yes __ No __ I choose not to answer this question

5. How many family members, including yourself, do you currently live with? _____

Money & Resources

6. What is the highest level of school you have
   __ Less than high school __ High school or GED
   __ More than high school (**circle one:** some college, university degree(s), post graduate degree(s))
   __ I choose not to answer this question

7. What is your current work situation?
   __ Full time work __ Part time or Temporary work __ Unemployed and seeking work
   __ Unemployed, not seeking work __ Retired __ Student __ Other
   __ I choose not to answer this question

8. During the past year, what was the total combined income for you and the family members living with you? $ _____ __ I choose not to answer this question

[redacted]

9999-0212 (05/2023)

Banner Health

SOCIAL DETERMINANTS OF HEALTH SCREENING

9. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?
   __ Child care __ Utilities (**circle one:** heat/cooling, water, electricity) __ Clothing __ Food
   __ Medicine or any health care __ Phone __ Other (what?) __ None
   __ I choose not to answer this question

10. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
    __ Yes, kept from getting to medical appt/getting medications
    __ Yes, kept from non-medical meetings, work, or necessities
    __ No __ Other _____ __ I choose not to answer this question

Social & Emotional Health

11. How often do you see or talk to people you care about and feel close to? (for example, talking to friends on the phone or visiting friends or family, going to church or club meeting)
    __ Less than once a week __ 1 or 2 times a week __ 3 to 5 times a week
    __ More than 5 times a week __ I choose not to answer this question

12. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?
    __ Not at all __ A little bit __ Somewhat __ Quite a bit __ Very much
    __ I choose not to answer this question

13. Do you feel physically and emotionally safe where you currently live?
    __ Yes __ No __ Unsure __ I choose not to answer this question

14. In the past year, have you been afraid of your partner or ex-partner?
    __ Yes __ No __ Unsure __ I have not had a partner in the past year
    __ I choose not to answer this question

15. Are you a refugee?
    __ Yes __ No __ I choose not to answer this question

16. In the past year have you spent more than 2 nights in a row in jail, prison, detention center, or juvenile correctional facility?
    __ Yes (what was your release date? _____) __ No __ I choose not to answer this question

17. There may be community-based organizations available to help you. Would you like a referral for those services? If so, we will share your information with them.
    __ Yes, I want a referral __ No, I don't want a referral

[redacted]

9999-0212 (05/2023)

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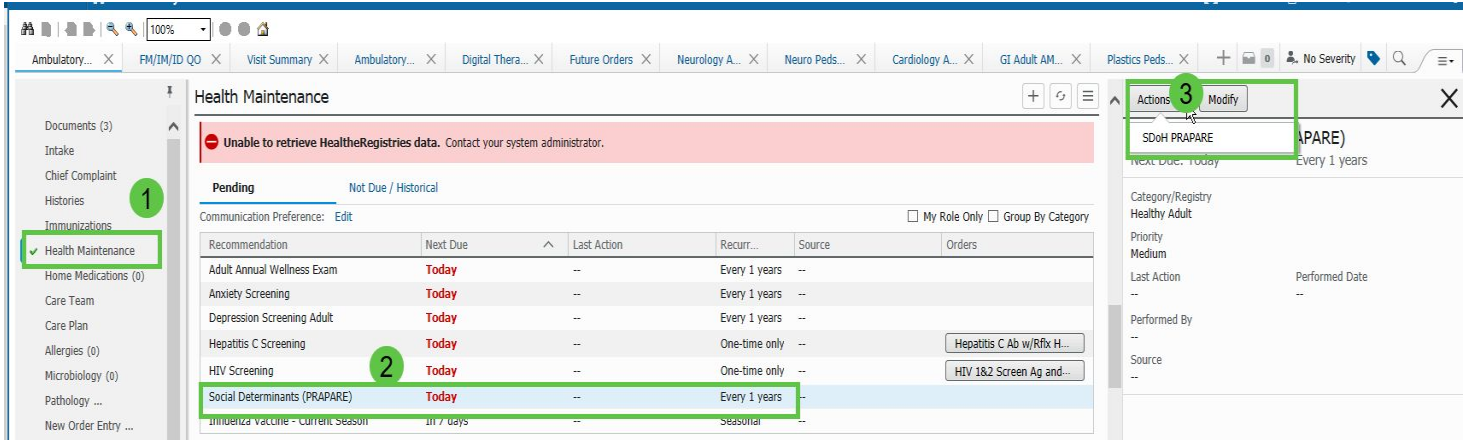
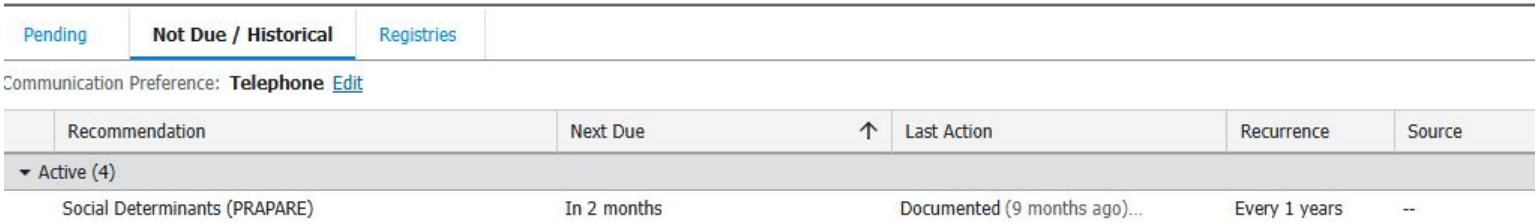
Electronic Health Record
Health Maintenance
How to Determine if Screening is Due or Not



Screening Due



Screening Not Due

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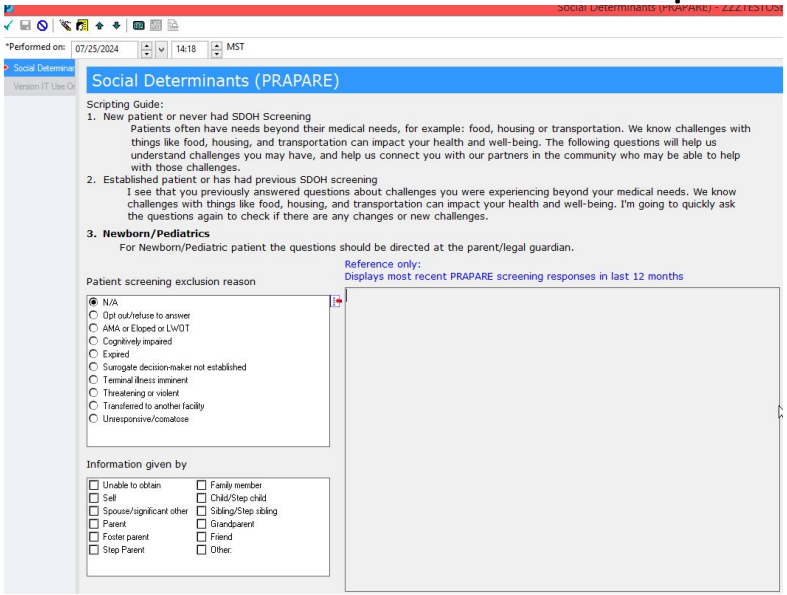
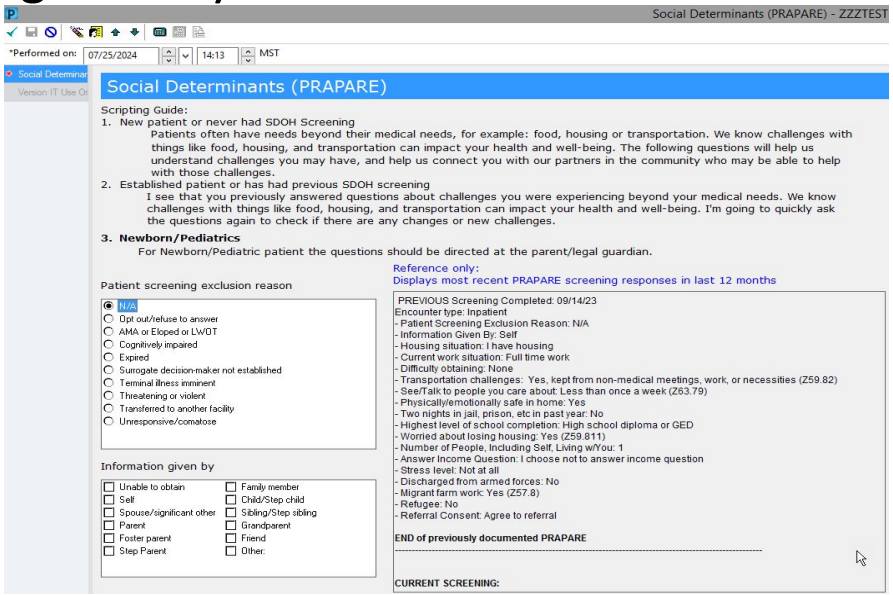
Electronic Health Record Documentation

- When PRAPARE is opened, form will display most recent screening responses from the last 12 months
- MA/RN reviews and transcribes responses onto the PRAPARE form in Electronic Health Record prior to being seen by PCP





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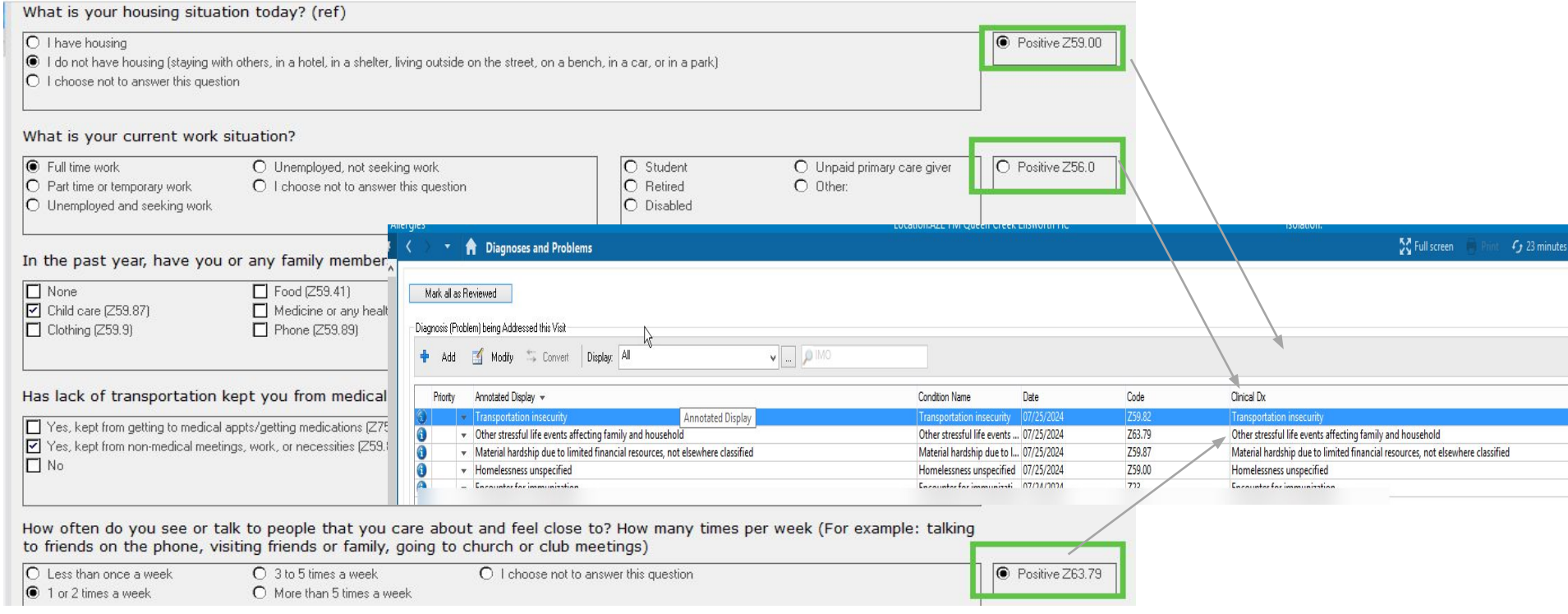
Electronic Health Record Coding

Embedded Z (and G) codes auto populate



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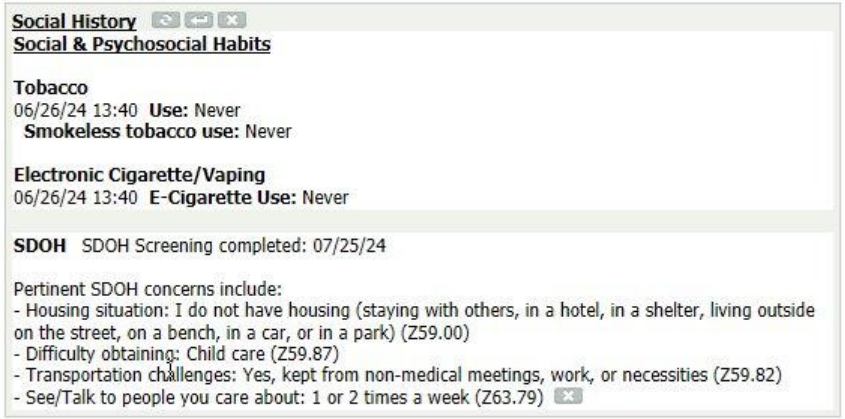
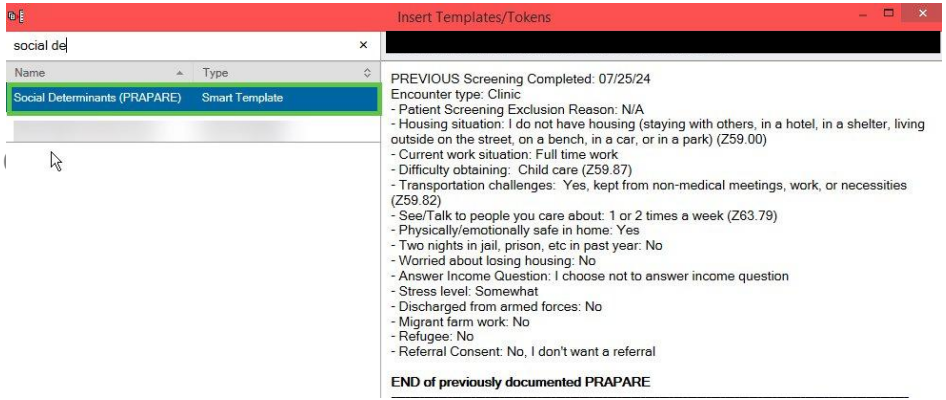
NMDOH Screening-PCP

1. Office Clinic Template
   - Built into Social History
   - Built in Codified Diagnosis



2. Can be built into PCPs autotext documentation
   - Shows date of last screening and z-cod
   - Shows pertinent positive results from screening



NMDOH Referrals and UniteUs

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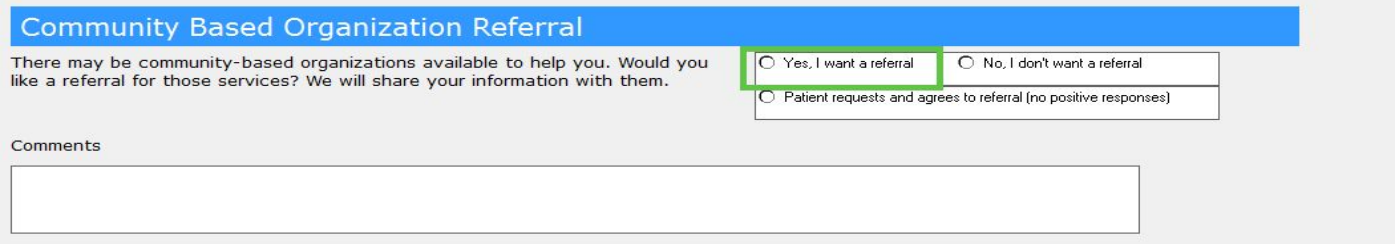
Referrals and Next Steps

- Any “yes/positive” responses from the form along with “Yes, I want a referral” will be sent to an internal dashboard for designated team members to access/review



- Team member will submit referrals into Unite Us
- Unite Us will connect patient to Community Based organizations (CBO)

Referrals and additional supports

- Available in Electronic Health Record
  - UniteUs
  - Adhoc form
- Team maintains available resource lists
- Banner Intranet includes:
  - PRAPARE screening and referral workflow
  - UniteUs tip sheets and videos
  - Access to our internal dashboards

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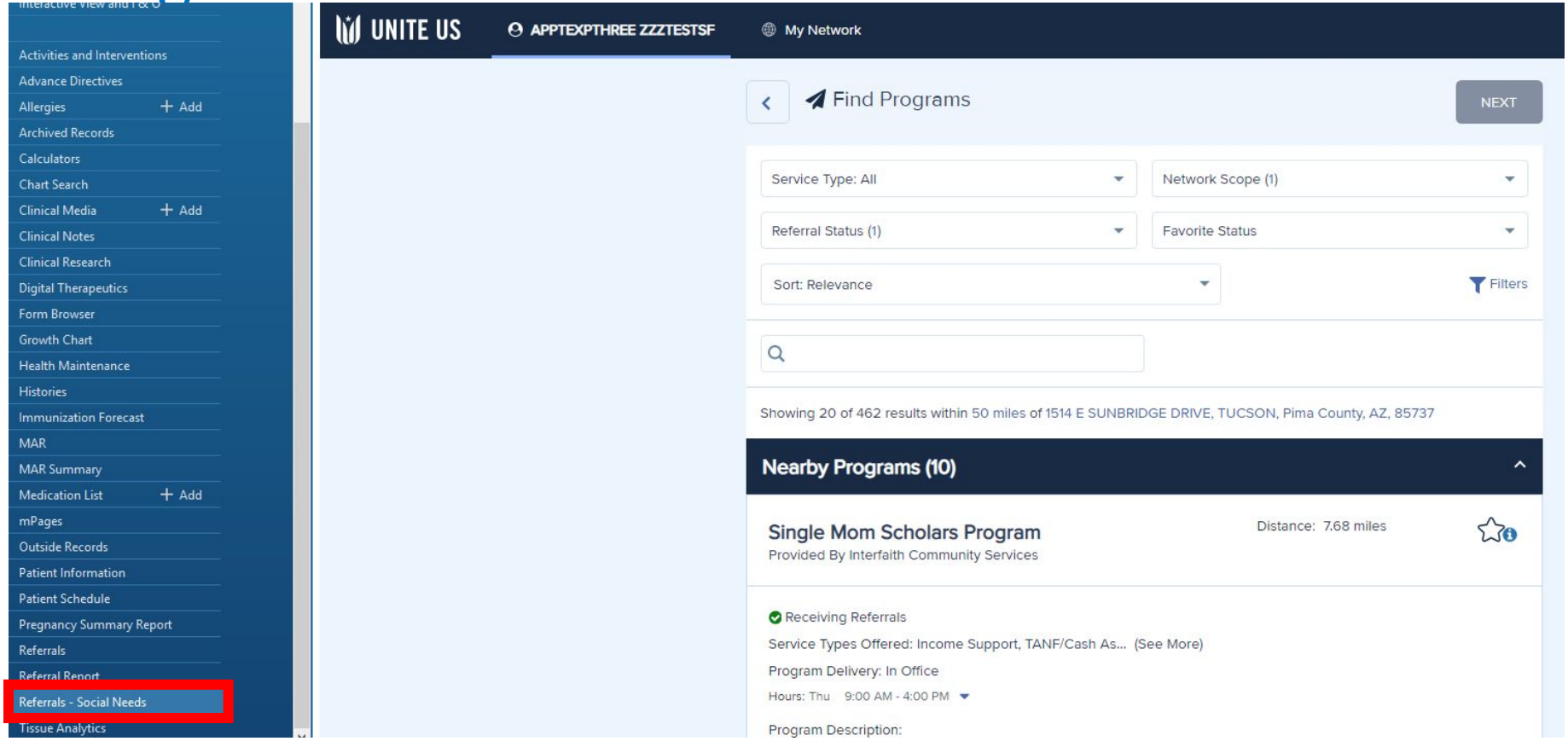
Integrated UniteUs Platform in Cerner



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Internal Dashboard Tracking and Trending

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NMDOH Internal Dashboard-PRAPARE Responses

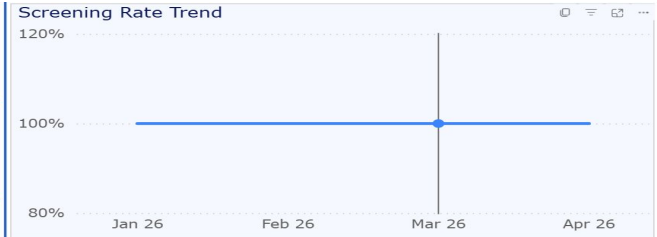
Encounters
7,709

Patients
7,662

Screening Rate
100.00%
Screening: 7,662

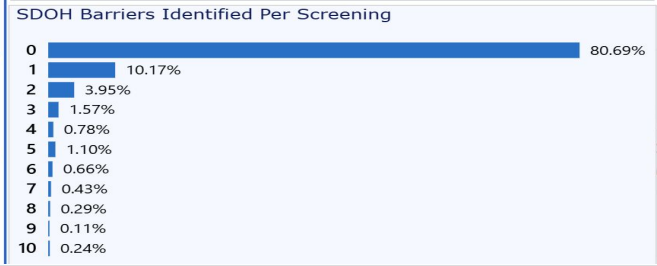
Barrier Rate
14.13%
Barriers: 1,083

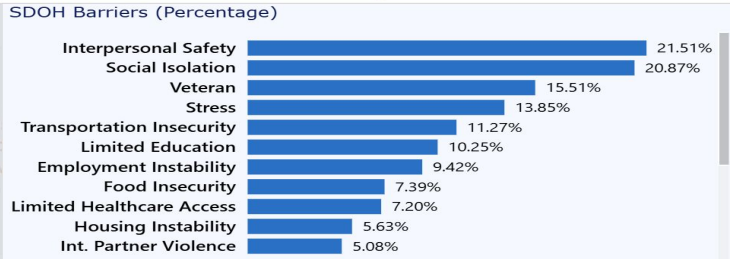
Patients Desiring Referral
18.84%
Referrals: 204

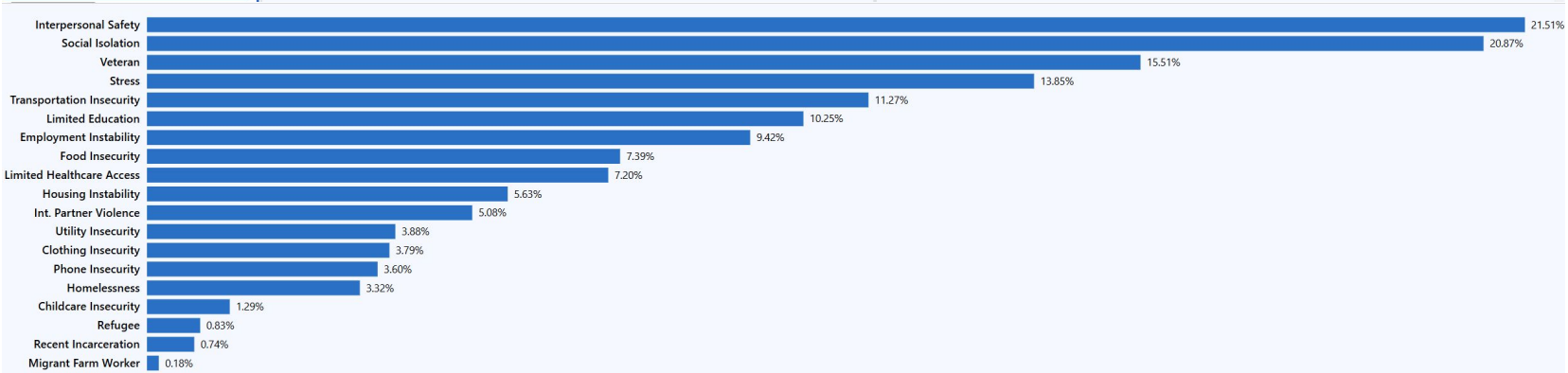


Screening Exclusion Reason	Count	% of Population
N/A	5,582	73.03%
Opt out/refuse to answer	2,074	26.88%
Cognitively impaired	6	0.08%
Unresponsive/coma tose	1	0.01%
Total	**7,662**	**100.00%**

Info Given By	Count	% of Population
N/A	5,300	68.95%
Self	2,156	28.12%
Parent	205	2.62%
Multiple	8	0.10%
Unable to obtain	5	0.06%
Grandparent	4	0.05%
Child/Step child	2	0.03%
Family member	2	0.03%
Total	**7,662**	**100.00%**







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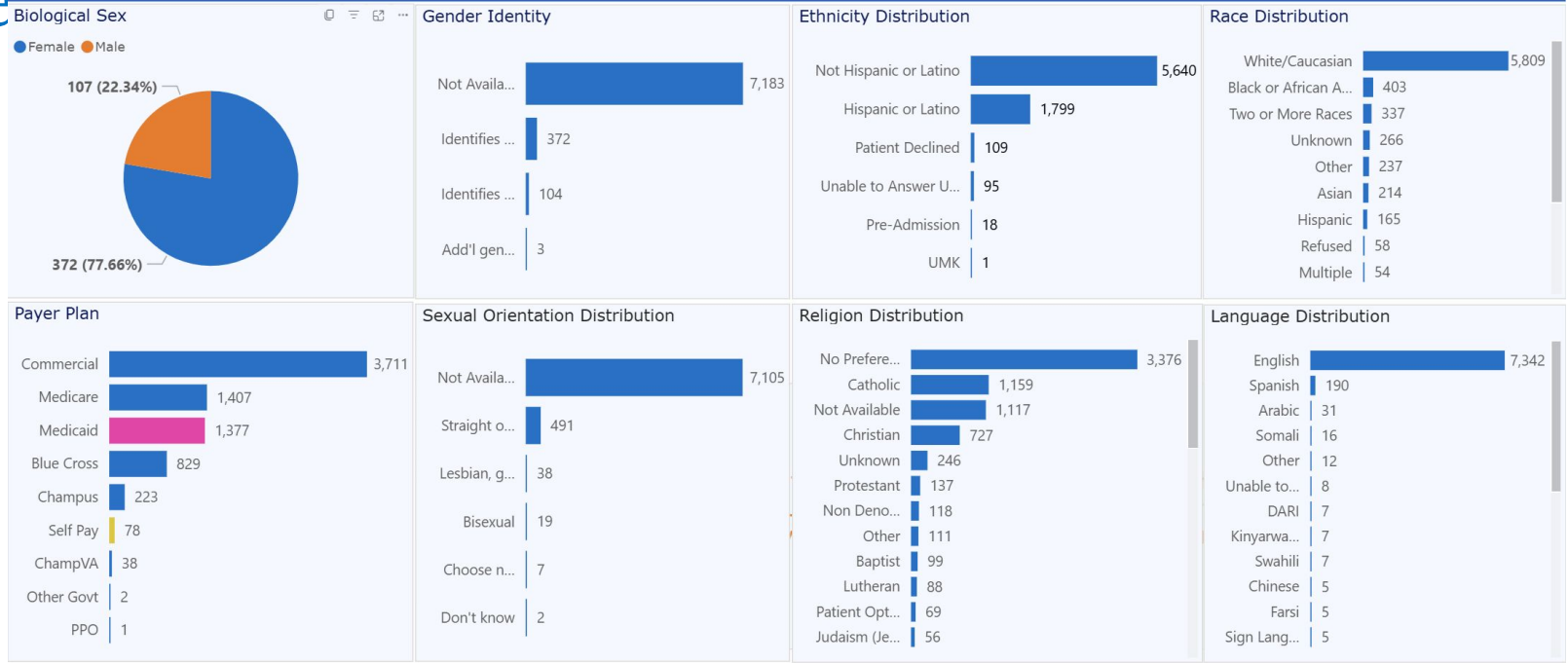
NMDOH Internal Dashboard-Patient Demographics



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NMDOH Internal Dashboard-Clinic Level Detail

Screening Numerator	Screening Denominator	Overall Screening Rate	Barrier Identified	Veteran Status	Childcare Insecurity Barrier	Clothing Insecurity Barrier	Employment Instability Barrier	Food Insecurity Barrier	Homelessness Barrier
743	743	100.00%	181	67			8	3	2
1,204	1,204	100.00%	295	49		2	14	9	12
645	645	100.00%	169	34	2	5	6	10	1
967	967	100.00%	125	6	3	8	18	14	10
373	373	100.00%	55	5	2	5	6	3	
848	848	100.00%	47	4	1	4	9	3	4
812	812	100.00%	93	3	3	3	15	5	1
1,034	1,034	100.00%	95		2	11	25	21	2
1,037	1,037	100.00%	23		1	3	1	12	4
7,662	**7,662**	**100.00%**	**1,083**	**168**	**14**	**41**	**102**	**80**	**36**

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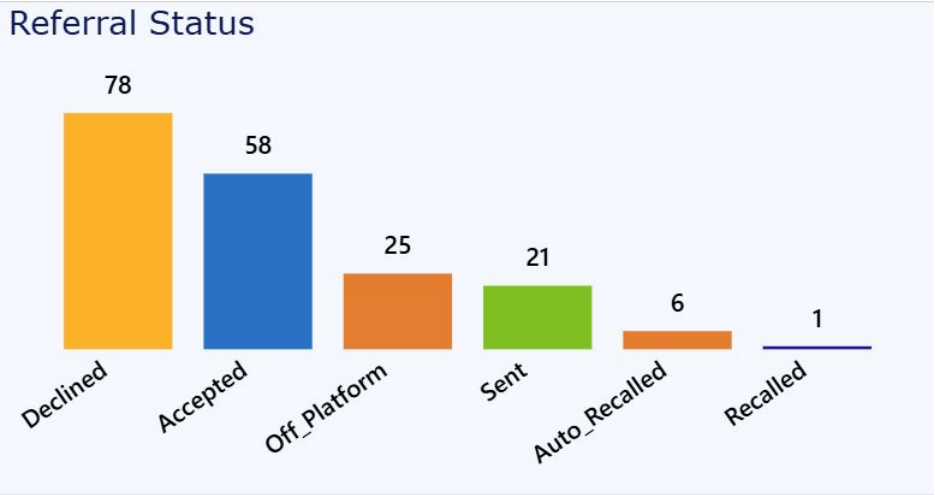
NMDOH Internal Dashboard-Electronic Referrals

Encounters	7,709
Patients	7,662
Percentage Desiring Referral	18.84%
UniteUS Referral Rate	38.24%
UniteUS Referral Count	189



CBO Category (within UniteUs)

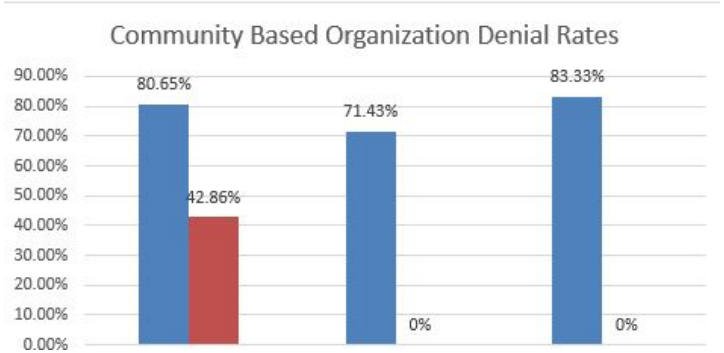
Top Referral Outcome by CBO

NMDOH Team Master Tracker

- The Integrated Care Team exports data from the Internal Dashboard to track our patient engagement via spreadsheet
- In addition to tracking barrier identified, we track:
  - Name
  - DOB
  - Location
  - Visit Date
  - Screening Date
  - Referral Create Date
  - Referral Created By
  - CBO Name
  - If referral was submitted through UniteUs
  - Referral Status (used to close the loop)
  - If the patient engaged and by what means (phone, in person, email)

NMDOH Efforts
&
Impact on HEDIS Performance

- TI Online Project (Closing The Loop)
  - Based on analysis from internal dashboard, we identified 3 CBOs with high decline rates and prioritized grassroots engagement.
    - 2 of the three CBOs decline rate went down to 0% over 3 months
    - 1 reduced decline rate by 50%



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Impact on HEDIS Performance

- Efforts to reduce barriers
  - Personalize care to improve the quality of life for patient
  - Improve likelihood for follow-up care
  - Impact on health and well-being
  - Identified barrier is often just the tip of the iceberg
    - We will schedule for AWV, CCS and more in addition to provide resources and support for identified barrier
  - Increase on-going engagement with CBOs to increase education on services offered in the community, increase connecting patients with needed supports.

Challenges

- Not all community-based organizations are loaded onto UniteUs.
  - Integrated Care Team worked closely to identify our most important partners in the community.
  - Banner has developed an AdHoc form to use to document CBO referrals provided not in UniteUs.
- High no response rate from Team members outreach efforts.
- Individual clinics adjusted workflow to accommodate unique needs
  - Resulted in challenges with incomplete PRAPARE forms, minimal discussion with patients regarding identified barriers and awareness of follow up from Integrated Care Team member.

Key Sustainability Strategies

- Internal committee to review data, challenges and needs to ensure NMDOH continues to be top of mind with patient care
- C-Suite involvement in community investment to address top barriers identified through out the system
- Workgroups development with end users to modify barriers in workflow
- Electronic Health Record modifications as needed to address barriers and continue compliance
- Internal Dashboard reviewed routinely
  - Add components as needed
  - Remove components not needed

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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