Exploring the use of z-codes For Social Needs Documentation

Learnings from the Cambia Social Data Sharing Collaborative

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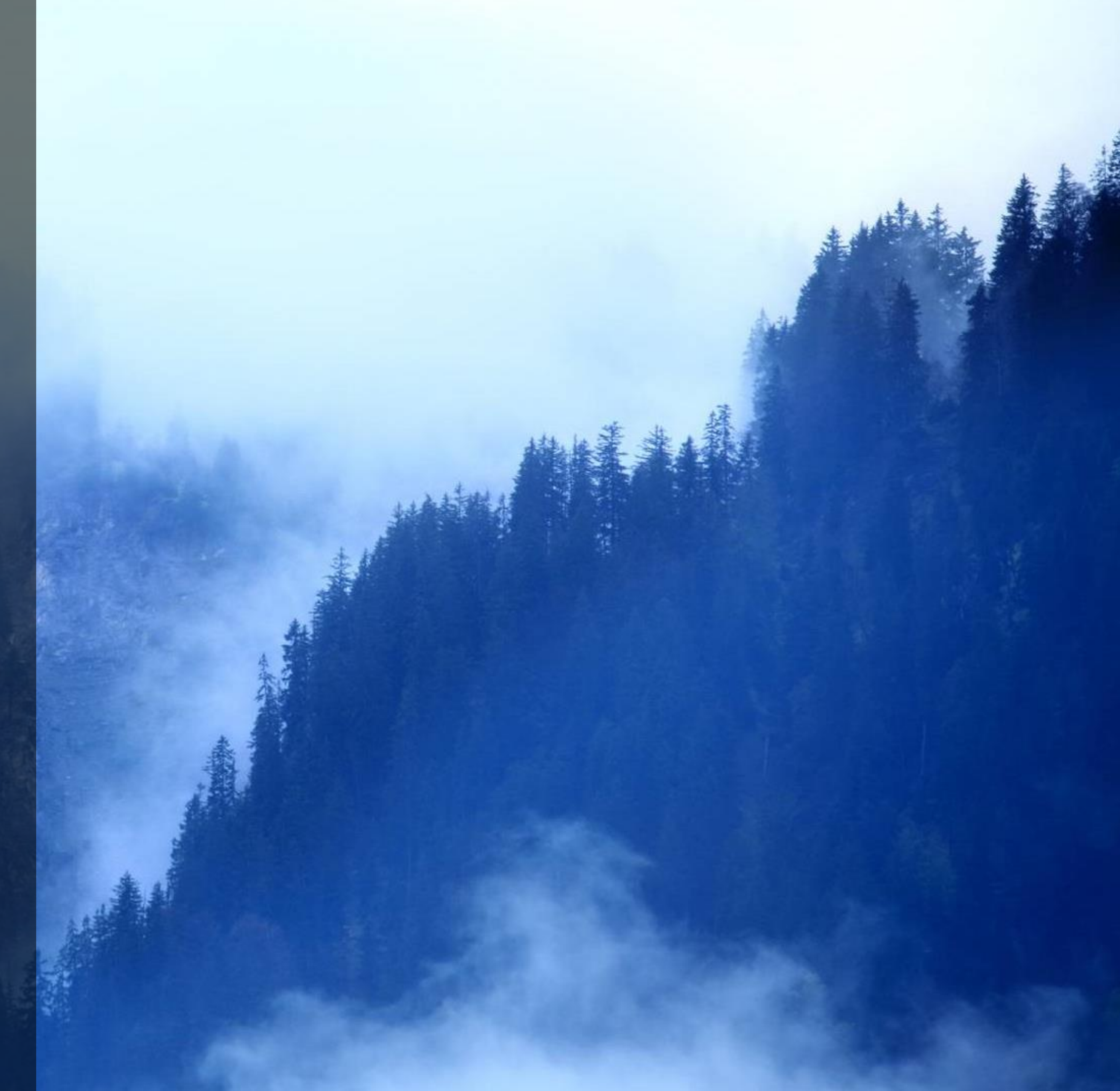

Aim Statement

By October 31, 2020, establish a shared understanding of whole-person health and the role of social health and related work that supports system change by addressing needs at the individual and community level, incorporating equity lens

Objectives

Development of a draft script and workflow for SDoH screening that has been reviewed by the Rinehart Patient Advisory Council and CPCCO CAC

Adoption of a set of Z-codes to be screened for for the purpose of the pilot

Development of shared process for documenting z-code screening results and standards for follow-up and closing the referral loop

Development of standard process for CCO monitoring and review of Z-codes via claims - creation of a standard report

Measures of Success

Implementation of new SDoH screening workflow with clinic MA team	CCO receipt of Z-codes via claims	CCO process for integrating z-code data into data framework & strategy informing and development	Confirmation of closed loop referral process within clinic using a "test patient“	Successful SDoH screening process in a telehealth visit setting	Complete trauma informed training for all staff who engage with patients
• Increased awareness of resources by patient(s) • Increase in number of patients receiving SDoH screening	• Pilot claims report and evaluating data • Share results with CHC partner	• Preliminary work will happen over next 3-6 months/Q1-Q2 2021 • Assessing how data from Unite Us will enhance/streamline data exchange • Determine implications of OHA SDoH metric WG decision	• Once confirmed, it will become an official clinic process	• Pilot workflow and optimize in January 2021, include PAC in process • Explore role of front office staff in the workflow/process	• Assess impact on patients' social needs screening responses (high # of negative screens - curious if related to perceived comfort, trust, safety) • mini test of theory of change with small patient sample

Workflow and Process Pilot

Step #1

Care Team MAs will do pre-screening questionnaire, if need is identified the MA connects patient to appropriate staff person to address (process confirmed in upcoming meeting with MA team)

Step #2

MA will drop z-code and PCP will confirm or adjust code as appropriate

Step #3

Claim is submitted and will include z-code

Step #4

a) CCO will receive claim with z-code(s) and can run reports
b) clinic is working to develop a process for running a report with z-codes - partnering with OCHIN to learn about opportunities and another OCHIN Epic clinic to learn about their process

Step #5

a) Positive screenings, if possible, will be connected to the outreach specialist for community resource at time of visit, if unavailable, staff message will be sent for follow up
b) CCO will run claims report capture z-code data, analyze, and report back to CHC

3-5 Z Codes

- Z59.4 - Lack of adequate food and safe drinking water
- Z59.7 - Insufficient social insurance and welfare support
- Z59.9 Problem related to housing and economic circumstances, unspecified
- Z59.5 Extreme poverty (100% FPL or below)
- Z59.6 Low income (200% FPL or below)

Data Sharing Process Pilot

CHC

Social Data is captured via z-code as part of office visit and included on visit claim, data is only included if patient provides consent

CCO

We have not tested the data process since the z-codes began being included in the claim

Plan to run a claims report to assess volume of z-codes received and share with CHC

CHC

- ability to connect patients to immediate needs to support optimal health
- identify what resources can be provided as part of healthcare and develop workflows to external resources
- ability to quantify specific social domain needs and establish staffing proposals to support needs

PAC and CAC Advisement

Clinic Patient Advisory Council

- Presented proposed pre-screen process and asked how they would feel about the information living in their medical record
- Concern about having social health information as part of the individual health record
- Consensus that there was value in asking questions about social needs and offering solutions/resources
- How questions are posed/asked to the patients matters
  - Action: MA lead developed training for MA team on doing trauma informed and patient-centered social screening
  - Brought training back to PAC for review and input

Community Advisory Council

- CHC staff presented at meeting, similar to what was presented at CAC
- Concern about ensuring patient lived experience is taken into consideration during the screening process and follow-up
  - Ex. tobacco cessation counseling being delivered from someone who has quit smoking themselves

SDoH Cheat Sheet

	Outreach Worker
	LCSW or RN Care Coordinator

Patient Support Pre-Questionnaire

Patient MRN: ____________________ **Date of Service:** ____________________

Many things impact your health. The more we know about you, the better health care we can provide.

Please circle the areas you would like assistance with. We cannot guarantee assistance in all areas, but we will do our best to respond to your priorities.

- **I have no needs at this time.**
- **I am having a hard time getting access to and/or paying for (please circle items below):**

Housing	**Utilities (electricity, phone, heat)**	**Food**	**Physical Safety**	**Counseling**
Transportation	**Health Insurance**	**Addictions** (Recovery)	**Legal Assistance**	**Material Goods (clothing, furniture, school supplies, etc.)**
Health Supplies (medical equipment, glasses, medicine, etc.)	**Education**	**Child Care**	**Social Support**	**Employment**

Can we record your answers in your health record? Yes No

Would you like to be contacted by a member of our health care team about this survey? Yes No

If yes, please share the best way to contact you (phone number, email or address).

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Workflow and Process Updates

- All Medical Assistants are involved in the SDOH pre-screening as part of Annuals, New Patients, F/U Hospital Visits
- Any positives are then expanded to the PREPARE screening tool
- Worked with Ochin to have Pre-Screen populate in Storyboard (icons)
- Pre-Screen asks patient if they want this as part of the Medical Record
- If yes--MA's enter Z-codes, PCP accepts when signing visit
- Z59.4, Z59.7, Z59.9, **Z56.9, Z91.89**
  - Based off of feedback from the MA/RN team, we added **unemployment & transportation codes**

Data Sharing

Utilizing smartphrases in Ochin Epic:

- **249** patients who have been screened for social needs since August 2020
- **3** staff documenting z-codes
- **40** social needs positive screens have been referred to community resources
- CCO and Rinehart Clinic data sharing and analyzing stalled by COVID-19 response and vaccine support

Nov 2, 2020 – May 3, 2021	408
Lack of adequate food and safe drinking wat...	2
DV	0
Safety	5
Incarceration	0
Mental Wellness/Stress	0
Military deployment status(ICD-10-CM: Z56....	0
Illiteracy and low-level literacy(ICD-10-CM: Z...	0
Income	0
Insufficient social insurance and welfare su...	7
Housing	13
Education	0
Employment	3
Patient's intentional underdosing of medicat...	0

CPCCO Claims Report
Data below is 1/1/2020 - 1/5/2021

	A	B	C	D	E
	paytoprovider	icdDiagPriCd	icdDiagPriDesc	numofdistinctMembers	numclaims
7	RINEHART CLINIC	Z55.3	UNDERACHIEVEMENT IN SCHOOL	1	1
8	RINEHART CLINIC	Z59.0	HOMELESSNESS	2	5
9	RINEHART CLINIC	Z63.9	PROBLEM RELATED PRIMARY SUPPORT GROUP UNS	1	2
0	RINEHART CLINIC	Z91.410	PERSONAL HISTORY ADULT PHYSICAL & SEXUAL ABUSE	1	1
3					

Measures of Success

Measure	Status	Comments
Implementation of new SDoH screening workflow with clinic MA team	✓	• workflow presented to, modified, and approved by PAC • Input by CCO CAC incorporated
CCO receipt of Z-codes via claims	✓	• Tested and verified process
CCO process for integrating z-code data into data framework and strategy informing and development	Not Started	• preliminary work will happen over next 3-6 months/Q1-Q2 2021 • assessing how data from Unite Us will enhance/streamline data exchange
Confirmation of closed loop referral process within clinic using a "test patient“	Not Completed	• Paused due to COVID response
Increased awareness of resources by patient(s)	✓	• Positive feedback from patients reinforcing increased awareness
Increase in number of patients receiving SDoH screening	✓	• 126 pre-screens completed as of Dec 11, 2020 (estimate 80% increase!)
Successful SDoH screening process in a telehealth visit setting	Not Started	• Pilot workflow and optimize in January 2021, include PAC in process

Updated Measures of Success

Measure	What we wanted to learn
CCO receipt of Z-codes via claims	• Inform theory around one method of closed loop data exchange for social needs
CCO process for integrating z-code data into data framework and strategy informing and development	• Determine how to efficiently use data on a macro level (ex. gaps in care, service delivery, grant funding) • Identify opportunities/gaps/similarities between different data streams/sources • Claims data vs. Unite Us data vs. excel tracking aggregate report
Confirmation of closed loop referral process within clinic using a "test patient“	• Assess if patients are accessing resources provided once they leave the clinic and if able to get needs met (i.e., do they qualify?)
Successful SDoH screening process in a telehealth visit setting	• Learn how to expand access to social needs screening for all patients regardless of visit type
Complete trauma informed training for all staff who engage with patients	• Assess impact on patients' social needs screening responses (high # of negative screens - curious if related to perceived comfort, trust, safety)

Where We Ended – May 2021

Next Steps

- Developing CCO process for integrating z-code data into data framework and strategy informing and development
- Confirmation of closed loop referral process within clinic using a "test patient“
- Pilot successful SDoH screening process in a telehealth visit setting
- Complete trauma informed training for all staff who engage with patients
- Explore the low positive social needs screening rate
  - Are the right questions being asked, setting, person screening, etc.
  - Do patients feel like primary care should be asking these questions/it is their role?
- Set dates for clinical team check-ins as well as CCO-Clinic data reviews

A Year Later…What is Happening Now (June 2022)

- New MAs and providers are being trained on SDoH screening workflow
- We’ve switched from a list flowsheet to the (634) Prescreening Tool For SDH in OCHIN Epic
- PREPARE questions
- Top social needs have changed

Special Thanks to our OPCA Learning Collaborative Team Members

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Questions and Discussion