



# MEDICAID PAYMENT AND DELIVERY SYSTEM SOCIAL DATA SHARING COLLABORATIVE

JULY 2021 FINAL REPORT

## WHAT

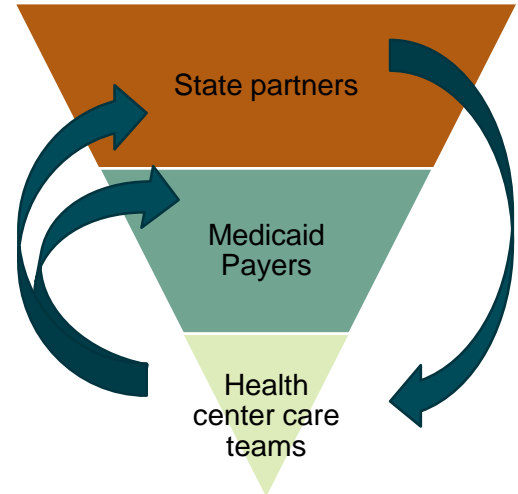
Payers and health care organizations recognize the importance of social factors for their impact on patient outcomes, as well as cost and utilization of health care services.

Community health centers (CHCs), whose roots are in the social justice movement, have been working steadily for decades to improve the health and social risks of families and communities experiencing poverty.

Despite their recognized value, incorporating social data in medical records, care plans, and in communication with health system partners and payers is not standardized. Both primary care clinicians and Coordinated Care Organizations (CCOs) play a critical role in identifying and addressing social needs for their patients and members to improve health and the structural barriers to health.

## WHY

### Social needs information sharing across Oregon's Medicaid system



With funding from Cambia Health Foundation, OPCA led an innovative, 12 month **learning collaborative** for Oregon's Medicaid payment and delivery systems to come together and explore documentation and data sharing as it relates to social needs and social determinants of health (SDoH).

## COLLABORATIVE OBJECTIVES

This collaborative created a space to innovatively explore a new kind of data sharing across health system partners, with the goal of improving patient experience and whole person care. Specifically, this 12-month opportunity had the following objectives:

- 1) Create a resourced space for pilot sites to explore existing and alternative options for social data documentation and sharing using z codes between CCO and clinical partners;
- 2) Develop a core set of replicable questions to consider and key partners to engage when embarking on data sharing efforts between payers and clinics; and
- 3) Improve standardized documentation and social data sharing across the health system, including opportunity for integration with state or regional level health information exchange (HIE) efforts.



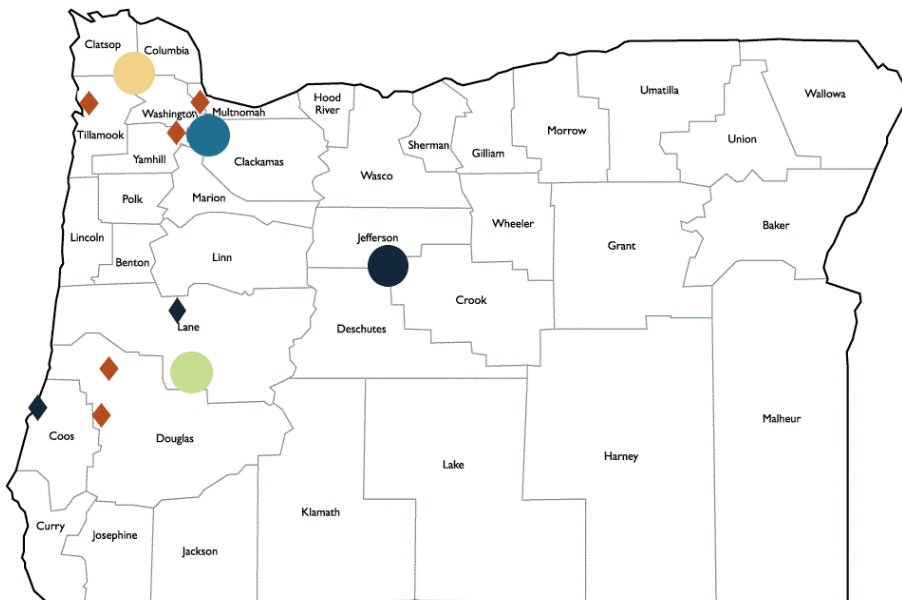
## 2020 - 2021 TIMEFRAME AND CONTENT:

	2020							2021						
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Webinars														
Workshops														
CCO/CHC Calls														
Advisory Calls														

HEALTH CENTER BENEFIT	CCO BENEFIT
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| <ul style="list-style-type: none"> <li>➤ Develop/expand partnership with the local CCO on a concrete and ongoing project;</li> <li>➤ Increase opportunity to share social data on patient assignment;</li> <li>➤ Refine clinical workflows and documentation of social needs with technical assistance;</li> <li>➤ Develop aggregate reporting for identified social needs to demonstrate value;</li> <li>➤ Contribute to state and national best practices related to z code usage; and</li> <li>➤ Opportunity to inform larger state health information exchange conversations.</li> </ul> | <ul style="list-style-type: none"> <li>➤ Develop/expand partnership with local health center(s) on a concrete and ongoing project;</li> <li>➤ Begin to aggregate social information on membership for population health efforts;</li> <li>➤ Create better care coordination and payment alignment for members;</li> <li>➤ Opportunity to inform larger state health information exchange conversations.</li> </ul> |
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## LEARNING COLLABORATIVE REACH



### Participating Organizations

- CareOregon
- ◆ Virginia Garcia Memorial Health Center
- ◆ Wallace Medical Concern
- Columbia Pacific CCO
- ◆ Rinehart Clinic
- Umpqua Health Alliance
- ◆ Aviva Health
- ◆ Adapt Integrated Health Care

### Participating Ad Hoc

- ◆ Waterfall Community Health Center
- ◆ Community Health Centers of Lane County
- Pacific Source CCO



## PRE AND POST-COLLABORATIVE SURVEY DATA

One survey was administered to each participating organization before the Collaborative and again after the Collaborative. The results below do not include responses from organizations who participated ad hoc.

	Pre Collaborative Survey Collected 6/25/2020 – 7/20/2020		Post Collaborative Survey Collected 5/20/2021	
	FQHCs N = 5	CCOs N = 3	FQHCs N = 5	CCOs N = 3
Are you currently gathering standardized social needs information on your members/patients?	Yes = 5 No = 0	Yes = 1 No = 2	Yes = 5 No = 0	Yes = 2 No = 1
If yes, how?	PRAPARE = 3 AHC = 1 My clinic designed a tool = 2	OHA Dashboard = 1	PRAPARE = 4 AHC = 1 My clinic designed a tool = 1	Mostly z codes from claims = 1 Care coordination = 1
Do you have this information for all members/ patients?	Yes = 3 Subpopulation = 2	Yes = 0 No = 3	Yes = 3 Subpopulation = 2	Yes = 0 No = 3
If a subpopulation, how do you define it?	New patients = 1 Self-referral = 1		4 provider panels = 1 Self-identify = 1	
What are the top 3 social needs identified for your member/patient population?	Food = 5 Housing = 4 Transportation = 2 Utilities = 2 Social Isolation = 1 Unsure = 1	Food = 3 Housing = 3 Education = 1 Social Isolation = 1 Unsure = 1	Food = 5 Housing = 5 Transportation = 2 Utilities = 2 Income = 1	Food = 3 Housing = 3 Employment = 1 Income = 1 BH access = 1
Are you using z codes?	Yes = 2 N = 3	Yes = 0 No = 3	Yes = 4 No = 1	Yes = 2 No = 1
I have a good understanding of my partner and what they do in the region (avg.)	4.2	4	4.2	4.7
I would rank my overall relationship with our CCO/CHC partner (avg.)	4.4	4.3	4.4	5



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## Are you using z codes? Why or why not?

### At baseline CCOs wrote:

- No; Limited data
- No; We can't use them, being a health plan
- No; We don't receive them regularly

### At baseline FQHCs wrote:

- Yes; some associated with PRAPARE
- Yes; no answer
- No; staff hasn't had training
- No; inconsistent use
- No; inconsistent use

### After the Collaborative CCOs wrote:

- Yes; to understand social needs of our members to provide whole person care and direct community investments to be more responsive
- Yes; we are incentivizing clinics to screen and add z codes to claims
- No; We are a CCO, we don't use codes. We receive them.

### After the Collaborative FQHCs wrote:

- Yes; to standardize SDoH data and contribute to risk stratification models
- Yes; to partner with the CCO, to understand regional needs and future partnership needs
- Yes; z codes are useful, reportable data
- Yes; for data analysis and identifying SDoH
- No; have not implemented but plan/hope to

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## (CCO) The top way my partner clinic could support my organization in social data sharing is...

### At baseline CCOs wrote:

- By joining the Health Information Exchange
- By streamlining protocol and standardization of z codes (focus on high level or granular), understanding screening and identification process for clinics using codes, understanding ethical concerns, and sharing thoughts on Unite Us and how that might be a better platform.
- By developing a standardized workflow to collect and share the data with the CCO, but it should be a bidirectional relationship where we integrate the data in larger strategy development and report outs; creation of a dashboard

### After the Collaborative CCOs wrote:

- Agreements/payment in place
- Set up a scheduled data drop, e.g. monthly using the excel format.
- By continuing to be the amazing partner(s) that they already are! Our ability to be transparent, our shared values around putting patients/members at the center of our thinking, and our shared growth mindset has us really well positioned in this work together.

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## (FQHC) The top way my partner CCO could support my organization in social data sharing is...

### At baseline FQHCs wrote:

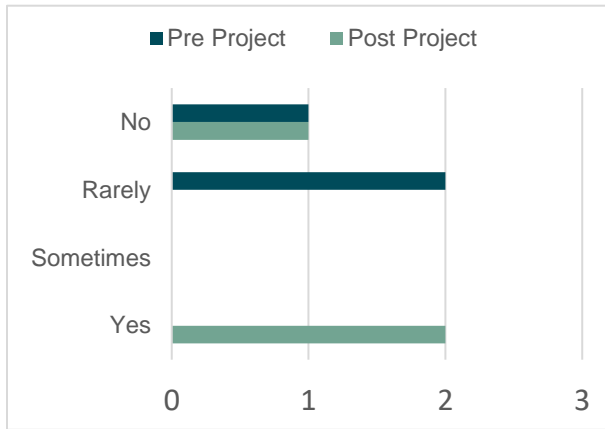
- Supply any data they are tracking on SDoH for our patient panel
- Not sure
- Provide advice/direction on how to incorporate best practices regarding SDoH data collection
- Funding, training, partnership
- Data to identify top areas of concern and resources to help in those areas

### After the Collaborative FQHCs wrote:

- Their internal requirements for receiving patient level data on SDoH
- Funding, incentives, training support, implementation support
- Funding, resources, and education.
- Voicing that this is a priority area. We look to our CCO not only as a partner but also as a leader to help define priority areas and if the CCO indicates a desire to focus on SDH that will help the health center prioritize standardizing screening.
- They could provide CHW courses to the community



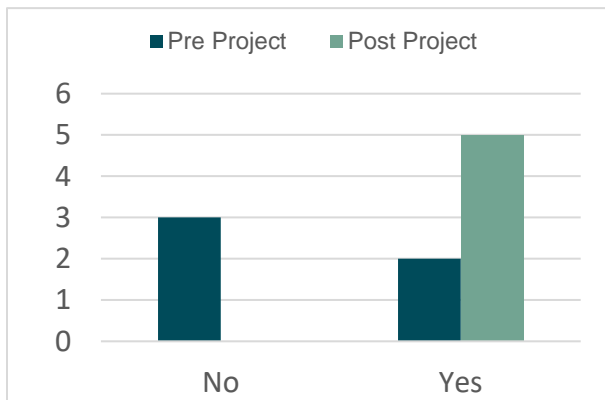
### My CCO is currently receiving social data on our members from the FQHC(s):



At baseline, two CCOs stated they received social data from the FQHC(s) rarely: one rarely because it is not standardized and one rarely through claims. The third CCO stated they received no social data from the FQHC(s) due to lack of regional HIE.

After the Collaborative, two CCOs stated they receive social data from their FQHC(s): one receives PRAPARE data via excel and adds z codes to claims, the other runs a claims report for z codes documented by the clinic. One CCO does not receive social data from their FQHC(s) because they are currently working to establish an EHR feed for social data.

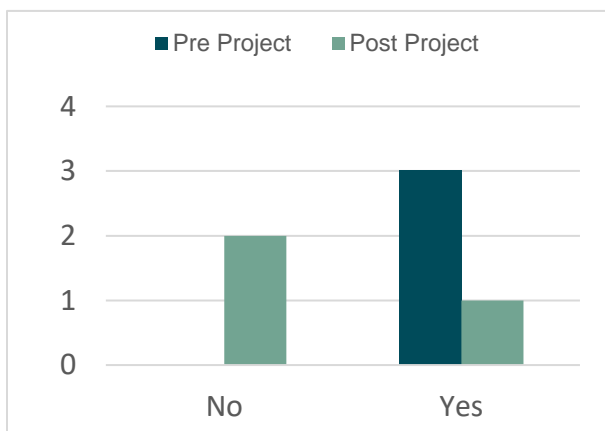
### As a FQHC, we are receiving patient and population health data from our CCO:



At baseline, two FQHCs stated they received patient and population health data from their CCO: one received patient lists for health screenings outreach and one received weekly updates on OHA quality metrics. Three FQHCs stated they did not receive patient and population health data from their CCO.

After the Collaborative, all five FQHCs receive patient and population health data from their CCO: one receives lists to conduct patient outreach, one receives regional data in excel, and three receive quality metric related data.

### (CCO) Are you using your Community Advisory Council (CAC) to define priorities for social needs data collection and response interventions?



At baseline, all CCOs stated they were using their CACs to define priorities for social needs data collection and response through co-creation of Community Health Improvement Plans or Rural Health Improvement Plans.

After the Collaborative, two CCOs stated they are not using their CAC: one because it is out of department scope and one because the planned meeting for CAC feedback has not yet occurred. One CCO stated they are using their CAC to shape clinic workflows and to identify concerns related to integrating social care into the health setting; In addition, the FQHC Collaborative partner will be represented in this CAC moving forward.

Though yes and no responses show a decrease in CAC engagement over time, the open-ended survey responses indicate a change in perspective regarding meaningful CAC engagement for social needs data collection and that additional efforts are underway.



## TOPICS COVERED BY LEARNING COLLABORATIVE SESSION

This learning collaborative created a space to explore a new kind of data sharing for health system partners across three workshops each comprised of three virtual sessions. Each clinic-payer team presented to the Collaborative twice in each workshop.

### Workshop 1

July - August 2020

- Team formation, workplan, objectives, measures of success
- Select three to five z codes
- Select pilot patient population
- Determine data sharing mechanisms

### Workshop 2

December 2020

- Oregon social data sharing landscape and upcoming opportunities
- Clinic and data sharing workflows
- Common challenges
- Revised objectives and measures of success
- How can CCOs support this work?

### Workshop 3

May 2021

- Project data, reporting templates, workflow updates
- Key collaborative learning questions and system recommendations
- Best practices
- Greatest barriers
- Will you continue using z codes?

## CLINIC WORKFLOWS AND DATA SHARING MECHANISMS

Z CODES SELECTED	
<b>Housing</b>	Z59.0-1 Z59.8-9
<b>Income</b>	Z56.0 Z59.5-9
<b>Food</b>	Z59.4
<b>Material Security</b>	Z91.12
<b>Transportation</b>	Z91.89
<b>Employment</b>	Z56.9
<b>IPV (*removed)</b>	Z63.9

**Clinic Workflows:** The most common z codes domains selected were housing, food, and income. Transportation and employment were later added. Although initially selected, interpersonal violence was removed due to patient safety concerns and need to determine best practices in EHRs.

A variety of staff roles were selected to document z codes, including Community Service Coordinator, Patient Navigator, AmeriCorps Patient Navigator, and Medical Assistant. Some clinics plan to expand capacity for this work by including students and medical residents.

Three clinics documented z codes in the problem list: one using an integrated screening tool, one using smartphrases, and the third manually. One clinic developed an order system for social needs and associates groups of z codes by domain, allowing staff to then deselect the granular codes that do not apply. Two clinics are integrating Unite Us into workflows for referrals and tracking.

One clinic planned for social work interns to document z codes in the problem list but paused z code documentation due to staff capacity, tension around problem list ownership, and competing priorities including COVID-19. They plan to pilot z codes soon.



**Data Sharing Mechanisms:** Collaborative participants utilized three different data sharing workflows throughout the Collaborative, distinct to each CCO.

In the first data sharing workflow, the clinic shares an EHR report containing z codes with their CCO partner during monthly check-ins. The CCO uses this information to understand population health and is still determining which social data to return to the clinic. This team is working to establish an EHR claims feed that includes z codes and are aligning risk stratification models and goals.

In the second data sharing workflow, the clinic includes z codes on visit claims. The CCO runs a claims report and assesses the volume of z codes captured. This clinic and payer are working to identify the most common social needs and expand staff capacity to target them.

In the third data sharing workflow, an EHR report that includes PRAPARE data and z codes is pulled by the clinic and sent to the CCO in an encrypted excel sheet. The CCO adds z codes to claims and uploads to OHA. The CCO adds the captured social data to regional data sets using Tableau and returns regional population health data to the clinic, as well as any additional available resources for addressing needs.

CLINIC PROJECT DATA since July 2020	CHC 1	CHC 2	CHC 3	CHC 4	CHC 5
Patients screened	34%	474	249	36% (1535)	4145
Staff documenting codes	3	19	3	3	0
Referrals submitted	1.5%	157	40	416	unknown
Z codes	335 food 114 housing 10 material security	38 poverty 36 food 31 housing	CCO analytics on hold due to vaccination efforts	247 food 341 housing	774 food 601 housing *# of positive screens, no codes yet

## BEST PRACTICES

After a year of piloting social needs data sharing using z codes, Collaborative participants were asked to determine best practices. They stated:

- Attach z codes to the screening questions in the EHR.
- Provide z code reference sheets to staff for quick look-up.
- Explain the importance of including, attaching, and documenting z codes to all staff to avoid non-pilot staff removing z codes from problem lists.
- Build an EHR workflow to capture patient consent to document and share their social needs screening results.
- Consider a hybrid paper and electronic screening approach. Patient-self screening can result in more positive social needs in some cases and electronic is only utilized by patients with ability to perform pre-check in on their personal device. Ultimately, electronic screening that is accessible by all patients would be ideal.
- Include key stakeholders in workflow development, such as direct care staff and data analysts. Involve team members completing the screenings in all stages of implementation. Consider monthly check-ins with relevant staff.



- Identify support from operations to avoid complications related to repurposing or expanding roles and also to help identify roles to document the z code during patient visits.
- Select only a few z codes to start and consider accessible resources, accuracy of data, and highest patient needs.
- Have a screening foundation and detailed instruction documents for staff. Expand routes for social needs screening, schedule trainings for all relevant staff, and create policy and procedure documents for screening early.
- Celebrate small successes and anticipate slow progress with competing public health demands.
- If utilizing orders in the EHR for z code entry, create an order system that groups z codes based on the sections of the social needs questionnaire. This allows for medical staff to deselect codes that do not apply, rather than memorize or utilize a reference sheet of all z codes.

## ADDITIONAL BEST PRACTICES FROM OPCA

The Social Data Sharing Collaborative began with 6 FQHCs and 4 CCOs, as well as others participating ad hoc. During the first quarter of their pilot projects, one clinic-payer team and one clinic reconsidered their participation due to limited buy in from clinic staff and leadership, high burden of reporting requirements outside of the Collaborative, competing strategies for social needs programming, and existing investment in other SDoH efforts. The clinic-payer team ended their participation. The second clinic identified financial support from their CCO partner and remained in the Collaborative. Based on these discussions, we recommend the following when embarking on social data sharing efforts between clinics and payers:

- Align organizational priorities early and consider parallel reporting requirements, social needs programming, and other data sharing mechanisms that could be in tension.
- Consider internal incentives for social needs data collection, even if not available statewide.
- Engage key stakeholders at the payer level that may be able to streamline decision making, identify funding, and incorporate social needs into existing payment models.

## BARRIERS

After a year of piloting social needs data sharing using z codes, Collaborative participants were asked to determine their greatest barriers. They stated:

- Education
- Clinic and staff buy in
- Determining the appropriate staff roles for applying z codes
- Considerable time was spent retrofitting existing systems to work around existing technology not originally intended or built for social care workflows.
- Lower than anticipated positive rate for social needs that resulted in limited data collection and the need to re-evaluate screening questions, screening setting, staff roles, trauma informed care practices, and other potential influences.
- The COVID-19 pandemic and vaccination efforts, including:
  - Inability to devote workforce to social needs data collection and sharing
  - Delayed higher level decision making
  - Adapting workflows too quickly to a virtual setting
  - Reduced ability to perform “warm hand off” to Patient Navigators





- Reduced ability to conduct screenings in person
- Staff overwhelmed with many competing priorities
- Like projects in the social needs realm limit staff bandwidth and create challenges at the organizational level.
- Transitioning to a new EHR

## WILL PARTICIPANTS CONTINUE USING Z-CODES?

Of the five clinic-payer teams participating in the Social Data Sharing Collaborative, four teams stated they **will continue** using z codes because:

- CHC-CCO Team 1: Z codes help capture the true picture of a patient and can identify areas that require additional resources from clinics and staff. Payers are looking for the additional information z codes can identify for risk stratification.
- CHC-CCO Team 2: Z codes offer useful and reportable data that we can use to build our SDoH program and improve the care of our patients.
- CHC-CCO Team 3: We are only beginning this important work due to COVID-19 and vaccination focuses at both the clinic and CCO.
- CHC-CCO Team 4: Z codes can help standardization of SDoH data and contribute to risk stratification models. We believe use of z codes will help promote the normalization and de-stigmatization of the impact that social factors have on health outcomes, promote billable services by CHWs and Patient Navigators, and promote regularity of SDoH screeners (similar to other medical screeners such as PHQ9 and SBIRT).

One team has **not yet determined** whether they will continue to use z codes:

- CHC-CCO Team 5 **pros**: Z codes align with our goals regarding patient segmentation, are visible to the PCP, help to prepare for metrics and potential future incentives, offer ease in running reports, and support data aggregation.
- CHC-CCO Team 5 **cons**: There is a responsibility for “resolving” z codes that no longer apply, frequency to review, tension around problem list ownership, and overall documentation burden that also includes a SDoH flowsheet and Unite Us.

## KEY LEARNING COLLABORATIVE QUESTIONS

Collaborative participants were divided into three workgroups to make system recommendations for social needs data sharing: Group A focused on CCOs and payment, Group B focused on data standardization and quality improvement, and Group C focused on clinic implementation and patient centered care.

**Methods:** Collaborative participants selected their workgroup based on topic area interest and were asked to answer from a perspective most concerned with the relevant topic area. Most participants chose the workgroup that closely aligned with their individual role or specialty.

Workgroup answers were submitted with full consensus from all individuals in the workgroup. Any answer detail without workgroup consensus has been included in the tables below as “additional considerations”. Additional considerations are relevant to social data strategy but are not necessarily applicable system wide.



**1. Given that Oregon Health Authority (OHA) is encouraging collection of social needs information for care coordination and risk modeling,**

**a) what social needs should be screened for?**

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>Housing, food access, utilities, transportation, broadband/internet, employment, and social isolation. Intimate partner violence should not be screened unless there are statewide, Violence Against Women Act complaint processes and reporting guidelines to protect survivors.</p> <p><u>Additional considerations:</u> How should we consider Adverse Childhood Experiences (ACEs) in screenings?</p>	<p>Food, transportation, housing, and domestic violence, safety. Other needs should be considered when resources could be provided when identified.</p> <p>Clinics should be able to determine what they need to screen for in their populations and each community will likely have SDoH screening needs unique to their area served.</p> <p>Needs might change seasonally.</p>	<p>Housing, food security, transportation, utilities.</p> <p>Financial difficulties, such as managing and prioritizing bills, should be more clearly defined and comes up often.</p> <p><u>Additional considerations:</u> access to affordable health care.</p>

**b) what type(s) of screening tool(s) should be used?**

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>OHA should approve a list of several standardized screening questionnaires (eg. PRAPARE).</p> <p>Multiple translations and culturally appropriate questions are essential.</p> <p><u>Additional considerations:</u> The tool does not matter as much as how the screening is done and the questions that are asked.</p> <p>Have domains and z codes standardized but allow each clinic to determine when to drop a z code.</p>	<p>PRAPARE, or pre-screen tool that is followed by PRAPARE.</p>	<p>PRAPARE. Have the social needs screener in the EHR and a tool that can be self-administered by the patient (for a higher screening rate).</p> <p>A spectrum of screening is needed to meet patient needs and a hybrid approach can be successful (ex. icon pre-screen followed by full screen).</p> <p><u>Additional considerations:</u> paper copy of easy-to-follow questionnaire with icons for patients who have low literacy.</p>

**c) who should be screened?**

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>All patients, equity-based screening. 15+ is the age of consent for health in Oregon.</p>	<p>All patients engaged in care during the year should be screened annually.</p> <p>If social needs are identified, providers could drive more frequent screening but no more than once per year should be required.</p>	<p>All patients annually. There is still the question of how to conduct social needs screening for the pediatric population.</p> <p><u>Additional considerations:</u> All patients, at least annually, with goal to follow up if needs are identified. Consider consent age for screening or have guardian complete for minors.</p>



**d) how should social needs information be documented and reported?**

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>A menu of feasible options. It will be unlikely to find a “one size fits all” process for documenting and reporting. Options should be patient driven.</p> <p>Data can be aggregated at CCO level without PHI. Patient level data can be connected to z codes between CHC and CCO.</p> <p><u>Additional considerations:</u> Document in the EHR, but don’t include social needs in the after visit summary without patient consent.</p> <p>Document in the EHR, visible in MyChart or other patient viewing platforms.</p>	<p>Ideally, from a data perspective, it should be documented in the EHR in the patient chart, but in a way that is only accessible by the PCP and can be excluded when sharing patient records with specialists. This would ensure that the PCP has access to the information and that it can be reported but would prevent sensitive information from being shared with unnecessary parties.</p> <p>Community Information Exchange (CIE) should also be included but avoid separate tracking mechanisms.</p> <p>Build confidence by asking for patient consent to document in the EHR.</p>	<p>Information should be recorded in the EHR with patient consent, if not, just in excel or another private tracking document.</p> <p><u>Additional considerations:</u> Utilize the EHR and excel to compare accuracy of EHR reports.</p> <p>CIE, when possible. A workflow to get the appropriate staff to follow up is needed.</p>

**2. Who within the system should screen for social needs? What are the strengths of each entity in screening?**

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>THWs or staff trained in trauma informed care, motivational interviewing, or Empathic Inquiry. The who of screening matters less than training, skills, resources, and time to screen.</p> <p><u>Additional considerations:</u> Community Benefit Organizations (CBOs) in regions with Connect Oregon or similar.</p> <p>Traditional Health Workers (THWs), Case Managers, MAs, Clinicians, Behavioral Health, or members can self-screen. However, it matters less who screens than who responds to completed screens.</p>	<p>No wrong door, and it doesn’t need to be the same person recording and asking questions. Whoever the patient feels comfortable with.</p> <p>Medical Assistants (MAs): have first contact with patients, usually have a relationship, have experience with screening tools, and have broad patient reach. They often need more time to complete screenings in an empathetic manner (require trauma informed and Empathic Inquiry training). Depending on MA capacity, screening should be done by Patient Navigators or an Intake Specialist.</p> <p>Community Health Workers (CHWs) often understand barriers best but do not work with as many patients.</p> <p>Patients may feel more comfortable filling out the screening on their own and self-screening can be completed through electronic check-in.</p>	<p>Medical Assistant, RN, or other clinical support have opportunity to screen during rooming, after which the PCP can review and submit referral as needed. These staff can connect social needs to health goals and outcomes.</p> <p>Patients can also self-administer via MyChart or during rooming, offering privacy and autonomy.</p> <p>CHW focus on navigation, as opposed to screening, would support teams working at the top of their scope and can help with scaling work.</p> <p><u>Additional considerations:</u> Patients typically trust MAs and they serve as bridges between the patient and PCP.</p> <p>CHWs create trusting relationships with patients and can help connect patients to external resources.</p>



### 3. What are the barriers to implementation for z coding (including existing mechanisms such as the problem list, EHR, claims)? Should new mechanisms be created?

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>Z codes alone do not fully capture all social needs information, but we should consider the utility of z codes. If for data purposes to get aggregate counts in subpopulations, having a standard taxonomy would work. There needs to be established workflows and processes around patient consent to share info in the EHR and where it is documented.</p> <p>Avoiding duplication of screening and being trauma informed, genuine and driven by patient need, is key.</p> <p>Intimate Partner Violence or Domestic Violence should not be a part of overall social needs screening nor documented in the EHR for safety purposes and should be an entirely different process, procedure, and policy.</p> <p><u>Additional considerations:</u> Payment.</p>	<p>Patient trust and education, staff engagement and turnover, billing criteria, and lack of reporting and tracking tools within the EHR.</p> <p>Make z codes reportable without being too easily accessible by care providers outside of the PCP or relevant CBO (Z codes could be documented without being added to the problem list).</p> <p>CHW encounters are not billable and z codes entered into their encounters are not sent to CCOs unless a report is pulled and sent outside of claims.</p> <p>Requiring staff, such as Medical Assistants, to know all z codes is a barrier.</p>	<p>Ownership over the problem list, including who is allowed to document, is a barrier.</p> <p>Knowing when to resolve the z code.</p> <p>Ideally, z codes could connect to the screener or flowsheet responses and auto populate, as opposed to manual entry.</p> <p>Lack of time due to staff being more involved in vaccination efforts or other urgent community needs.</p> <p><u>Additional considerations:</u> create new mechanisms for tracking z codes within social needs workflows, such as an order system within the EHR to auto populate groups of z codes based on the sections of the PRAPARE screen (after which staff can delete z codes that do not apply).</p>

### 4. How should partners determine how to measure and monitor progress?

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>A collaborative decision through a social needs screening advisory body or integrate decision making into an already existing body. This could include Community Advisory Council, Patient Advisory Council, or CNAB, but account for regional differences.</p> <p>Partnership should include those conducting screening, patients who complete screenings, and those who receive the results and follow up on them.</p>	<p>Keep the patient at the center.</p> <p>Consider measuring the number of patients screened, then trend the positive screens and identify community resources and gaps in care. Start small and start with screening goals, then add the z code portion of the workflow.</p> <p>Reporting and tracking should be EHR based and then analyzed for quality improvement.</p> <p>State specific data should be the basis for decision making and policy.</p> <p>Very specific instructions and documented workflows have helped staff understand how documentation impacts reporting and data analysis.</p>	<p>Screening numbers, z code usage, and closed loop community resource referral tracking.</p> <p>The number of screens completed should be calculated as percentage of patient population.</p> <p>The number of patients provided resource information is a factor, as not all patients require navigation and can access resources independently.</p> <p>Clinics know what we are doing but are unclear on measurement strategy because we need to know the relevant partners their feedback. We strongly urge the need to proactively engage CBOs to do this work well.</p>



**5. What infrastructure and investments are needed to support this work? How can payment models, state investment, and leadership support this?**

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>Clear guidance from OHA on how to integrate social health into payment models.</p> <p>Better infrastructure and guidance on CBO payments.</p> <p>Standards that consider rate parity for social care.</p> <p>More state investment on workforce development in rural areas where new capacity is needed to sustain this work.</p> <p>Some standardization is needed at the state level because every system conducting social needs screening differently would be difficult to monitor.</p>	<p>Greatest need for investment is workforce: dedicated social needs staffing in both care and data, dedicated staff for response and tracking of referrals. As data requirements increase for clinics, we need more data staff and infrastructure to support this work.</p> <p>Technology is needed to track screenings and referrals, referring members to organizations, tracking or monitoring progress on referrals, and housing.</p> <p>Implementation of a robust value based care model to focus on all around patient care and payment model for care team transformation.</p> <p>Community collaboration and awareness of resources.</p>	<p>Ongoing investment in workforce as needs are identified, including CHWs and MSWs.</p> <p>State investment in social services that CHCs may not offer, such as CBOs. Programs for undocumented Oregonians are especially needed.</p> <p>Expand access to shared tools including Unite Us, EHR enhancements to modify screening tools, and statewide CIE (and require CCOs and build in initiatives for CBOs to participate).</p> <p>Ensure language accessibility and plain language screening questions.</p> <p>Add pressure and make a statement on the urgency of this work to push payers to adopt change.</p> <p><u>Additional considerations:</u> Funding for workers to become certified CHWs and bill for services. Invest in trainings and materials for staff doing the work.</p>

**6. How can CCO Community Advisory Councils (CACs) be engaged to define priorities for this work?**

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>All policies and procedures should be brought to CACs for review, input, feedback, and approval. Ideally, CACs should have input before processes are “on paper” and their experiences and concerns should be considered beyond simple approval or disapproval.</p>	<p>Engage CCO and clinic advisory councils in developing workflows, data, promoting screenings, and communication efforts. Continually adjust workflows based on member feedback.</p> <p>Listen to clinic needs to reduce barriers to SDoH data and continue to advocate for FQHCs’ need for resources, funding, education, technology, and staff for screenings.</p> <p>Help destigmatize and promote the credibility of CHWs, Patient Navigators, and community support staff because these positions are imperative and prove the value of team care models.</p>	<p>CACs can identify and define problem areas. They should be involved in the review process for workflows.</p> <p><u>Additional considerations:</u> Monthly updates.</p> <p>Engage CACs to provide feedback on standardized tools.</p>



## 7. How should providers or CCOs connect beneficiaries to community resources? Are there particular tools or methods the system should focus on?

Group A: CCOs and payment	Group B: data standardization and quality improvement	Group C: clinic implementation and patient centered care
<p>Connect Oregon (Unite Us): focus on getting more CBOs on the Unite Us platform and provide best practices for the human side of the process and tool.</p> <p>Traditional Health Workers (THWs).</p>	<p>CHWs will be critical and referral navigators are needed to track community referrals and assist with barriers.</p> <p>Providers can work with CCOs to identify gaps in community resources.</p> <p>Unite Us will benefit all once staffing can be committed and organizations are supported in using the platform and enable sharing actionable information. Ideally, referrals could be submitted and tracked within the EHR but there is no solution or tool that is fully integrated. In addition to separate interfaces, currently Unite Us and EHR reporting is not integrated due to 3 month reporting maximum and lack of medical record numbers in Unite Us.</p> <p>Support organizations to use CIE.</p>	<p>Unified CIE platform. Use platforms that allow patient self-determination and autonomy, such as Unite Us.</p> <p>Always ask patient consent and establish patient desire to connect with staff about resources prior to sending referrals or requesting support.</p> <p><u>Additional considerations:</u> Offer to sit with the patient when calling and offer to connect (call or in person) with resource agencies to ensure referrals were received.</p>

[Group A Worksheet](#), [Group B Worksheet](#), [Group C Worksheet](#).

## LEARNING METHODS

Participants were provided with the following tools and templates:

- [Social Domains to Z Code Crosswalk](#)
- [Project Planning Toolkit](#)
- Workshop 1: [Team Presentation 1 Template](#), [Team Presentation 2 Template](#)
- Workshop 2: [Team Presentation 1 Template](#), [Team Presentation 2 Template](#)
- Workshop 3: [Team Presentation 1 Template](#), [Team Presentation 2 Template](#)
- [Key Learning Collaborative Questions Mural Worksheet](#)

## WEBINAR SERIES

Throughout the Collaborative, participants heard from partners in Pennsylvania, Rhode Island, and Washington on their statewide incentives for collection of z code data within Medicaid.

**October 2020:** “Social Needs Data Collection and Coding: Pennsylvania’s Experience” by Suzanne Cohen, Senior Director of Population Health at the Health Federation of Philadelphia, and Valerie McEvoy, Manager of Practice Quality Optimization at Health Partners Plans.



**April 2021:** “Counting Things that Count: Finding Value in Z-codes...and Beyond” by Dr. Andrew Saal, Chief Medical Officer of the Providence Community Health Centers and Dr. Jonathan Gates, Chief Medical Officer for Accountable Care at Providence Community Health Centers.



**June 2021:** “Social Determinants of Health and Risk Adjustment” by David DiGiuseppe, Vice President of Healthcare Economics at Community Health Plan of Washington.

## ADVISORY COMMITTEE

The Advisory Committee for the Social Data Sharing Collaborative is a volunteer group of content area experts formed to advise OPCA staff in identifying opportunities for alignment and collaboration, to guide on experience, and to help consider next steps. The Advisory Committee met quarterly throughout the Collaborative to give input, react to ideas, make suggestions for improvement or expansion, offer strategic connections to other related projects, and suggest additional advisors as needed.

**Advisory Committee Members:** *Celia Higuera, Unite Us Community Engagement Manager; Erika Cottrell, OCHIN Investigator/Researcher; Chris DeMars, OHA Transformation Center Director; Anna King, ORPRN AHC Director; Lynn Knox, Oregon Food Bank Health Care Liaison; Katrina Lonberg, OHA CQMR Program Manager; Ned Mossman, OCHIN Social Determinants of Health and Value Based Payment Manager; Amana Peden, OHA Transformation Center Analyst; Catherine Potter, Kaiser Permanente Safety Net Manager; Samantha Shepherd, CCO Oregon Executive Director; Jonathan Weedman, CareOregon Vice President of Population Health; Elizabeth Whitworth, HIT Commons Community Information Exchange Lead.*

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