ORPRN
Oregon Rural Practice-Based Research Network

OHSU

OREGON HEALTH AUTHORITY

January 21, 2025

CCO Community of Practice: Deep Dive on EHR, Chart Review & Claims-Related Data

Social Determinants of Health (SDOH) Social Needs Screening & Referral Measure Learning Collaborative

Zoom Meeting Tips

This event is being **recorded**

- It will be shared on the **OHA Transformation Center Webpage** after the event

For **live captioning**

- Click the **"cc"** button located at the bottom of your screen

For **zoom troubleshooting**

- Chat **Kristina Giordano**

Welcome & Introductions

In the Zoom chat, please introduce yourself with the following:

- Your name & pronouns
- CCO
- What is the main question or issue you would like to discuss today related to our topic?

★ **Please include your CCO or organization affiliation in your Zoom name**

Today's Objectives

- Discuss EHR, claims-related data (coding) and chart review as data sources that help with accuracy and completeness of SDOH data collection in clinical settings.
- Share strategies to integrate claims-related and chart review data into a unified framework for SDOH screening and referral data collection within the CCO service area.

★ **Participation is key! Please have your cameras on when speaking, especially in group discussion.**

Today's Agenda

- Component 2 Metric Specifications
- Guest Presenter: James McCormack PhD, Oregon Rural Practice-based Research Network (ORPRN)
- Q&A with James McCormack PhD
- Breakout Group Discussion: Strategies to Capture Claims-Related and Chart Data for Component 2 Reporting
- Next Steps & Upcoming Technical Assistance Opportunities

SDOH Social Needs Screening & Referral Metric

Component 2

- Intended to measure the percentage of CCO members screened and referred to social needs resources.
- Beginning in 2025 CCOs will report on a sample of 1067 members who met continuous enrollment criteria.
- Hybrid model - multiple sources of data can be used including;
  - ✓ Medicaid Management Information System (MMIS)/Decision Support and Surveillance Utilization Review System (DSSURS)
  - ✓ Electronic Health Records (EHR)
  - ✓ Community information exchange (CIE)
  - ✓ Health information exchange (HIE)
  - ✓ Other data sources

SDOH Social Needs Screening & Referral Metric

Component 2 Scoring

Rate 1: % who were screened

Numerator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Denominator: All members who meet continuous enrollment criteria except those who decline to be screened in all 3 domains

Rate 2: % who screened positive

Numerator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

Denominator: Members who were screened once during the screening period for all three required domains using an OHA-approved or exempted screening tool

Rate 3: % who screened positive and received a referral

Numerator: Members who received a referral within 15 calendar days for each domain in which they screened positive.

Denominator: Members who screen positive for one or more needs in the required domains during screenings for the 3 domains

What data do you need for each member in the sample?

- Did the member interact with a screening and referral partner during measure year?
- Was member eligible for screening?
- What approved or exempted screening tool was used?
- Did the patient decline screening?
- Were food, housing, and transportation assessed?
- What were the results for all 3 domains?
- Were needs identified in any domain?
- For each identified domain, was a referral made?
- Did the patient decline referral?

Oregon Health Authority

Appendix 1: Template for Component 2 Reporting

Field	Valid Input Value	Definition	Sample Reporting[4]
Coordinated Care Organization name		Corresponds to Health Analytics reporting CCO Name	OHA
Date loaded	YYYYMMDD	Date OHA pulled the sample data	OHA, Sample Only
Member ID	Member's Medicaid ID		OHA
Member name	Last Name, First Name MI		OHA
Member date of birth	YYYYMMDD		OHA
Match flag	Yes, No	This field is to be reported by the CCO and only for hybrid reporting. CCOs must report 'Match Flag' (Yes/No) field for all visits sampled by OHA. 'Yes' – was a member of the CCO for 180 consecutive days or more. 'No' – was not a member of the CCO for 180 or more consecutive days.	CCO, Required, Sample Only (If match flag = no, CCOs do not have to complete Screened for Social Needs question and the Housing, Food, and Transportation domains.)
Screened for	Yes,	Yes – a social needs screening occurred	CCO, Required,

Reporting template found beginning on page 16 of 2025 Measure Specifications: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2025%20specs%20SDOH%202024.12.31.pdf

James McCormack, PhD (he/him)
Senior Research Associate
Oregon Rural Practice-based Research Network (ORPRN)
OHSU Department of Biomedical Informatics

Deep dive: Using electronic health record (EHR), chart review and claims data for SDOH screening and referral data

Takeaways from previous TA sessions

- Measure overview and background
- Coding options, North Carolina model
- CIE features and data capabilities by Unite Us and findhelp
- OCHIN and Gravity Project presentations
- CCOs shared strategy, challenges, and plans for collecting metric data

https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

Today will focus on two data sources CCOs might use to capture SDOH screening and referrals in clinical settings: Medical claims and clinical data from EHRs

Medical Claims from EHRs

- Clinical encounter history
- Procedure codes (CPT, HPCS)
- Diagnosis codes (ICD)
- Code modifiers

Clinical Data from EHRs (queries, chart audits)

- Problem lists and encounter codes
- Structured social history
- Discrete capture of screener details, Q&A
- "Back-end" data coding (LOINC, SNOMED)
- Free-text notes with needs and follow-up
- Structured data in notes
- Orders and referrals for social services

★ Previous learning sessions discussed **Community Information Exchange (CIE)** and **Health Information Exchange (HIE)** features and reporting capabilities.

https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

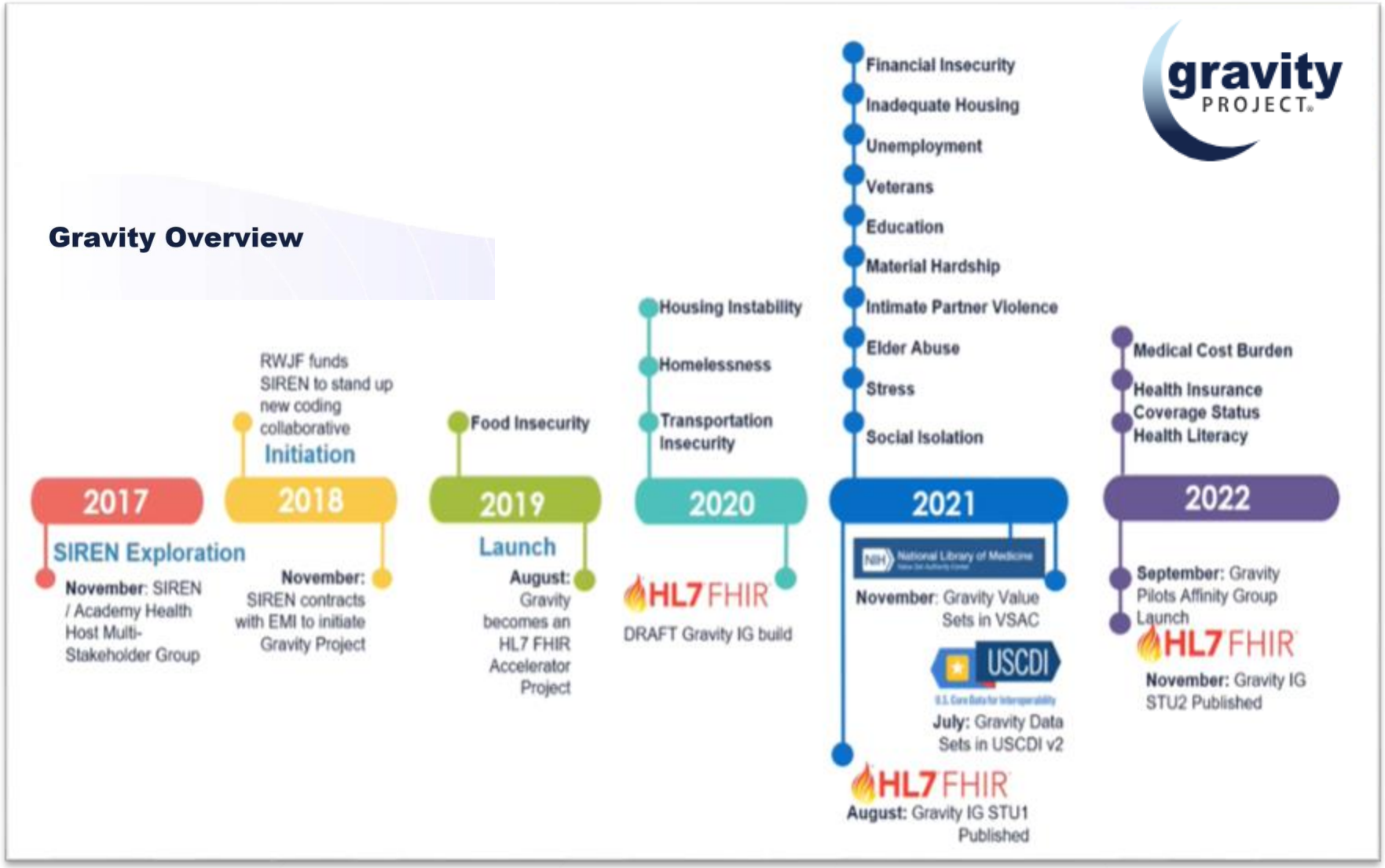
Coding and interoperability standards for SDOH are evolving rapidly

Controlled Vocabularies:

- Diagnosis: ICD (Z codes)
- Procedure: CPT, HCPCS
- Observation: SNOMED
- Assessment: LOINC

Resources:

- Gravity Project
- USCDI
- FHIR/HL7
- Value Set Authority (VSAC)

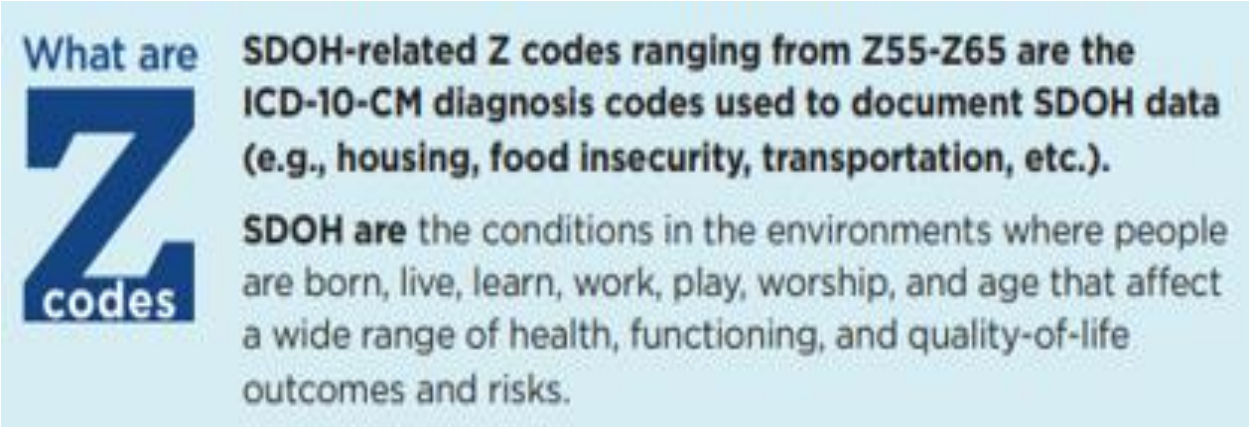


★ A previous learning collaborative included a presentation on the Gravity Project.

https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

Considerations when using ICD Z codes on claims and in EHR

- Coding guides and tip sheets are available for using Z codes for SDOH
- Z codes have been mapped to the common SDOH screeners (e.g. PRAPARE)
- Z codes usually represent the **presence** of a need and not the ***absence***
- Clinic workflows for adding Z codes to claims or EHR records may be cumbersome
- Some EHRs may be able to add or prompt for codes based on screening responses
- Z codes could be recorded in patient problem lists, encounter codes, and/or claims



https://www.cms.gov/files/document/zcodes-infographic.pdf

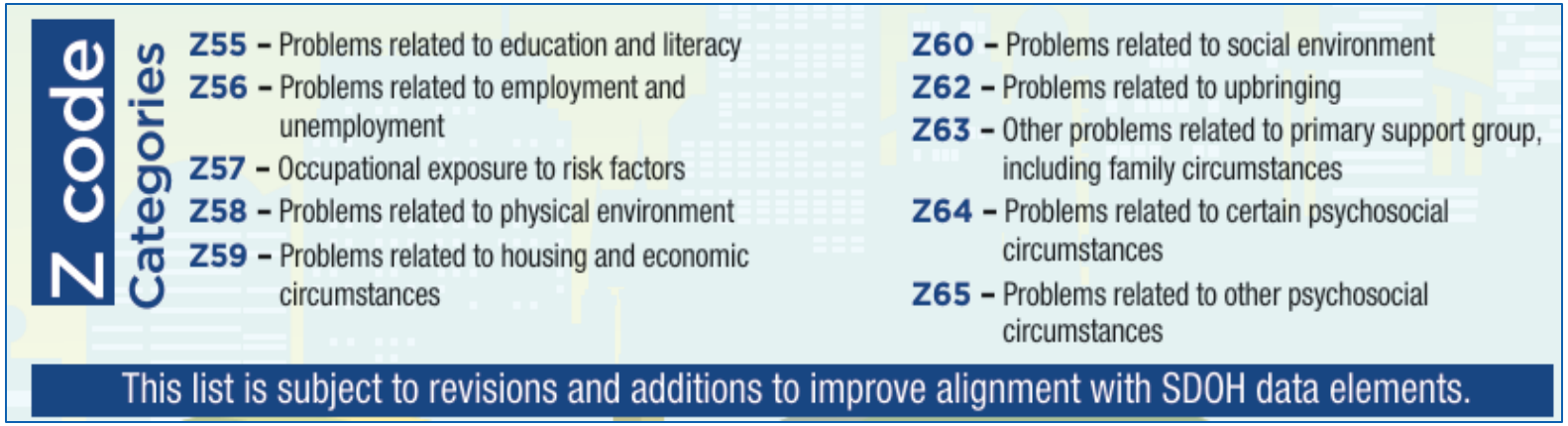
★ PacificSource presented a prototype “crosswalk” document to help guide clinics in using Z codes in a previous learning collaborative.

https://www.oregon.gov/oha/hpa/dsi-tc/pages/sdoh-metric.aspx

Using ICD Z codes to document the presence of social needs

CMS.gov

https://www.cms.gov/files/document/zcodes-infographic.pdf



Considerations for clinics and CCOs using different coding approaches

Does the proposed coding approach:

- Require new clinician or back-office workflows to populate claims?
- Require additional supporting documentation (screening vs. assessment)?
- Conflict with rules for other payers and programs (e.g., Medicare)?
- Capture delivery of both negative **and** positive screens?
- Capture which tool was used to assess food, transportation, housing?
- Capture SDOH domain-specific findings?
- Pass through to CCOs with OHA claims data?

EHR capabilities for SDOH screening vary widely by vendor and implementation

Screening for SDOH

- Most commonly used EHRs now offer built-in SDOH screeners, mostly PRAPARE
- Options to customize built-in screeners and reports are limited
- Mixing and matching domain questions requires EHR customization
- Older EHRs may allow creation of social history to capture SDOH screens
- Vendor-provided mapping to LOINC, SNOMED is rare and inconsistent
- EHR integration options vary by vendor and may involve additional cost

Referral tracking for social services

- EHR tools and workflows are designed for tracking medical referrals
- Use of the CIE may split referral workflows across platforms
- Tracking “closed loop” referrals is already a challenge for clinics

Epic OCHIN eClinicalWorks "Improving Healthcare Together" athenahealth

Considerations for EHR capabilities for SDOH screening and referral

Does the EHR vendor offer some or all of the following?

- Built-in [OHA approved] screeners for SDOH?
- Allow practices to create or customize SDOH screeners to meet OHA requirements?
- Permit “mixing and matching” of questions and responses for food, transportation, and housing?
- Capture detailed screening responses as structured data (e.g. flowsheets, social history)?
- Provide internal code mapping of screening delivery and outcomes to ICD, LOINC, and/or SNOMED?
- Provide options to send or receive screening forms and outcomes electronically?
- Provide EHR referral tools and workflows suited to community service providers?
- Duplicate data entry and reporting when using a CIE for screening and referral?
- Allow tracking of “closed loop” referrals for social services?
- Provide tools to report or query individual and population-level data on screening and referrals?
- Clinical decision support tools to identify eligible patients and prompt for screening?

Data quality considerations for claims and EHR sourced SDOH data

Recommendations for assessing SDOH data quality before use:

- Data should reflect ALL SDOH screens performed in (or outside) of the clinic
- EHR must capture tool (or combination of tools) used for screening
- There must be a consistent process for capturing negative AND declined screening events
- Consider if screening and referral data are fragmented (EHR + CIE) or duplicated
- Codes identifying housing, food, or transportation must be correct and used consistently
- Different clinic workflows and coding requirements may be needed for different payers

Data Quality = Completeness **+** Correctness **+** Concordance **+** Currency **+** Plausibility

Extracting EHR data can be done through reports, custom queries, or manual chart audits

Pros

EHR reports and queries

- “Canned reports” might already exist
- Custom queries provide needed data

Manual chart audits

- Low tech option
- Allows extraction of non-structured and scanned SDOH data
- Provides only the data required
- Can be combined with EHR queries for to semi-automate abstraction

Cons

- Dependent on vendor capabilities
- Tools and expertise may not be available
- Workflow variation limits vendor reports
- Unable to access data in notes and documents

- Requires extensive time and effort
- Requires direct access to local clinic EHRs and patient records
- Not feasible for full population measure

Lessons from ORPRN's SDOH-HE program

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Social Determinants of Health and Health Equity Population Approaches to Chronic Disease Prevention (SDOH-HE) is an ORPRN project funded by the Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention Section to support clinics and healthcare organizations in developing or improving their social needs screening and resource referral process and targeting health interventions for patients with chronic conditions.

- 4th year of the program (July 2021 - Present)
- Quality improvement and technical assistance, not research
- Currently working with 7 clinics across Oregon
- Providing EHR workflow and data support for Epic, Athena, and eClinicalWorks

Lessons from ORPRN's SDOH-HE program

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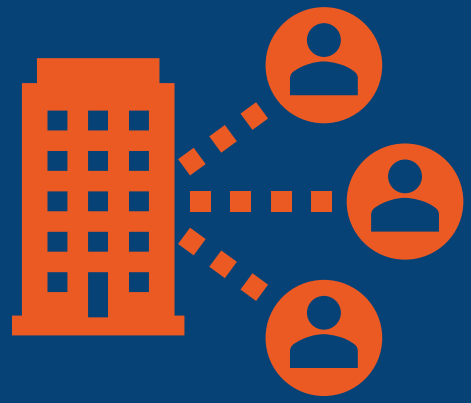
- Clinics are just beginning to rollout universal SDOH screening
- Paper screening is still prevalent and many struggle to choose the best screener to align with OHA and other programs
- Several clinics are using a brief pre-screener and doing a full screening if positive
- EHR workflows for CHW handoff and external referrals are challenging
- All clinics, regardless of EHR, have reported data challenges identifying patients who were screened
- While varied by region, adoption of the CIE for screening and referral is very low

Reflections from year one of the program can be found here: https://www.ohsu.edu/oregon-rural-practice-based-research-network/takeaways-sdoh-he-program

Q&A

James McCormack, PhD (he/him)
Senior Research Associate
Oregon Rural Practice-based Research Network (ORPRN)
OHSU Department of Biomedical Informatics



Break-out Discussion:
Strategies to Capture Claims-Based and Chart Data for Component 2 Reporting

Breakout Discussion

Questions:

- How has your CCO worked with providers on use of specific codes for the social needs screening metric?
- What methods is your CCO considering for claims-related data, EHR data, and/or manual chart review for overall SDOH data collection?
- Do your clinics have the necessary EHR capabilities and resources to provide high-quality screening and referral data to support Component 2?

Next Steps

- ★ New FAQ Responses in the January FAQ Release
- ★ Final 2025 Measure Specifications Released

Upcoming Metric TA Opportunities

- Upcoming TA Event Announcements coming January 29th!
- For 1:1 technical assistance inquiries, reach out to **Claire Londagin at londagin@ohsu.edu**

Measure Contacts

Technical Assistance Team

- Kate Wells, MPH (she/her)

katemcwells@gmail.com

- Claire Londagin, MPH (she/her)

londagin@ohsu.edu

- Kristina Giordano (she/her)

giordank@ohsu.edu

Oregon Health Authority Team

- Rachel Burdon, MPH (she/her)

Rachel.E.Burdon@oha.oregon.gov

- Katie Howard, MPH (she/they)

Katie.Howard@oha.oregon.gov