WEBVTT

1
00:00:08.010 --> 00:00:17.639
Katie Garfield / Center For Health Law and Policy Innovation: Hello, and welcome to our Webinar on back to basic medical coding. We're just letting everyone filter in and we'll get started in just a minute or two,

2
00:00:59.630 --> 00:01:24.440
Katie Garfield / Center For Health Law and Policy Innovation: hey? I think we're going to go ahead and get started, as everyone else continues to filter in. My name is Katy Garfield. I am the director of whole personal care for the center for health law and policy innovation of Harvard Law School, where my work focuses on the integration of social determinants of the world, health care system. And so I am so thrilled to be a part of this back to basic

3
00:01:24.450 --> 00:01:33.790
Katie Garfield / Center For Health Law and Policy Innovation: medical coding for food-based prevention, Webinar held by Spurs digital discourse platform.

4
00:01:33.800 --> 00:01:38.120
Katie Garfield / Center For Health Law and Policy Innovation: So i'll go ahead and get us started. I'm: going to share my screen.

5
00:01:40.630 --> 00:01:43.210
Katie Garfield / Center For Health Law and Policy Innovation: Okay, Are we all able to see that

6
00:01:45.430 --> 00:01:46.649
Katie Garfield / Center For Health Law and Policy Innovation: excellent.

7
00:01:46.660 --> 00:02:04.830
Katie Garfield / Center For Health Law and Policy Innovation: So again I am so thrilled to be participating on today's Webinar, in which we're going to examine a key question in the field of food and health. How do we code for food-based interventions? And before we jump into that, I want to briefly step back and consider why we're here.

8
00:02:04.840 --> 00:02:24.799
Katie Garfield / Center For Health Law and Policy Innovation: What is it about this moment that makes a question of medical coding for food-based intervention. An urgent issue. First and

foremost, we know the diet is the number one risk factor for death in the United States. It's also a critical driver of negative health outcomes, healthcare utilization and health care costs.

9
00:02:24.930 --> 00:02:40.490
Katie Garfield / Center For Health Law and Policy Innovation: As a result, we're seeing some really amazing innovation across the country to develop and grow programs that really respond to that connection between health And I'll note those programs are sometimes described as food as medicine,

10
00:02:40.500 --> 00:02:54.260
Katie Garfield / Center For Health Law and Policy Innovation: medically supported food and nutrition services, or even food and health, and they include a wide spectrum of services ranging from medically tailored meals and groceries to produce prescriptions to food pharmacies, and more.

11
00:02:54.270 --> 00:03:02.480
Katie Garfield / Center For Health Law and Policy Innovation: And as evidence for this program grows, we're seeing increasing interest in embedding them in the Us. Health care system

12
00:03:04.670 --> 00:03:11.790
Katie Garfield / Center For Health Law and Policy Innovation: at the State level. We're seeing states like North Carolina, Massachusetts, Oregon, California, New Jersey Washington,

13
00:03:11.800 --> 00:03:21.980
Katie Garfield / Center For Health Law and Policy Innovation: New York, and others experiment with building food-based interventions into their medicaid programs to better meet the needs of low-income individuals in those States.

14
00:03:22.450 --> 00:03:24.590
Katie Garfield / Center For Health Law and Policy Innovation: Similarly, at the federal level the

15
00:03:24.600 --> 00:03:33.790
Katie Garfield / Center For Health Law and Policy Innovation: we're seeing policymakers use regulations appropriations and legislation to test the impact of food-based interventions to programs such as Medicare,

16
00:03:33.800 --> 00:03:37.400

Katie Garfield / Center For Health Law and Policy Innovation: Indian Health Service and Veterans health administration.

17
00:03:37.410 --> 00:03:52.019
Katie Garfield / Center For Health Law and Policy Innovation: And I think it probably goes without saying. But just this week the Biden Harris Administration held a historic event at this White House Conference to launch their national strategy on hunger, nutrition, and health,

18
00:03:52.030 --> 00:04:03.950
Katie Garfield / Center For Health Law and Policy Innovation: and that document specifically highlights expanding access to food as medicine interventions and moving towards universal screening for food and security as policy priorities.

19
00:04:06.460 --> 00:04:12.890
Katie Garfield / Center For Health Law and Policy Innovation: So where does medical coding fit into this broader movement to embed food into our health care system

20
00:04:12.900 --> 00:04:25.809
Katie Garfield / Center For Health Law and Policy Innovation: Honestly, everywhere. Medical coding for the use of specific alpha numeric codes. To describe patient care is a foundational part of how we deliver health care in the United States.

21
00:04:25.890 --> 00:04:32.960
Katie Garfield / Center For Health Law and Policy Innovation: It's foundational to have health care. Providers communicate with one another about what care a patient needs, and why

22
00:04:34.060 --> 00:04:37.629
Katie Garfield / Center For Health Law and Policy Innovation: to how health care payers pay for services,

23
00:04:37.860 --> 00:04:48.439
Katie Garfield / Center For Health Law and Policy Innovation: and how we, as researchers, advocates, and policymakers, develop the data needed to identify broader trends or failings in our health care system.

24
00:04:50.170 --> 00:05:01.789

Katie Garfield / Center For Health Law and Policy Innovation: And so, as these broader policy efforts in the forward, we need to be able to explain how food fits into our coding systems, which brings us really to the meat of today's Webinar.

25
00:05:01.800 --> 00:05:09.489
Katie Garfield / Center For Health Law and Policy Innovation: Today we'll be examining a few fundamental questions that will help us navigate the landscape of coding for food-based interventions.

26
00:05:09.500 --> 00:05:19.389
Katie Garfield / Center For Health Law and Policy Innovation: These include questions like, What is medical quoting and how does it work? Where are we on coding for food-based interventions, and Where do we need to go?

27
00:05:20.930 --> 00:05:40.310
Katie Garfield / Center For Health Law and Policy Innovation: But I will be the first to admit that while I know coding is foundational, I also find it extremely mysterious. Ah! Which is why I am so thrilled to welcome Sarah and facility to the Webinar today to help us really go back to basic and demystify medical coding for food-based intervention.

28
00:05:40.320 --> 00:06:09.100
Katie Garfield / Center For Health Law and Policy Innovation: Sarah Balances practice as a rural family nurse practitioner with advocacy for addressing the social determinants of health in clinical and community practice her area focus is developing the terminology to capture the process of caring for patient's, social needs, and over the last decade she's collaborated with colleagues at children's health loss the Food Research and Action Center and siren on the Medical and Social care, integration and interoperability projects.

29
00:06:09.220 --> 00:06:34.169
Katie Garfield / Center For Health Law and Policy Innovation: Her work has now evolved into the gravity project, the national consensus initiative to develop criminology, to address social needs. She serves as the terminology director, helping to lead the practice of social care. Community based approaches and the literature of social risks into healthcare terminology. So without further ado, please join me in welcoming Sarah, Sarah, I'll let you figure it from here

30
00:06:35.110 --> 00:06:43.829
Sarah DeSilvey / Northwestern Medical Center: all right. So i'm going to share my screen first, and then once it gets settled, I will um introduce myself. I'm going to go back a slide. Here.

31

00:06:43.840 --> 00:06:59.029
Sarah DeSilvey / Northwestern Medical Center: It is such my honor to be here today. What Kenny did not mention, is it? It may have been obvious, as my origin story is addressing the work, because there are some food in security and clinical practice, and I am surrounded by very long-standing friends

32
00:06:59.040 --> 00:07:09.329
Sarah DeSilvey / Northwestern Medical Center: on this call today and the work. You see that I will be talking about specifically regarding food and security leveraged the wisdom of many of the organizers of this event.

33
00:07:09.340 --> 00:07:32.280
Sarah DeSilvey / Northwestern Medical Center: So, um! I've changed the name a little bit, because the name I am a terminologist. My job is to name things and define things, and the word coding can trigger a little bit of confusion in the in the health record world. So i'm just going to be talking about data in a sense of these. Um, Because the activity of coding and the healthcare space is the work of coding a visit. So i'm going to be using the word data as we go forward.

34
00:07:32.390 --> 00:07:36.179
Sarah DeSilvey / Northwestern Medical Center: So I've renamed it food security data, necessities, the basics.

35
00:07:36.320 --> 00:08:06.040
Sarah DeSilvey / Northwestern Medical Center: Um. So I have a very packed agenda which will be a ton of time for questions, because my aim in this presentation is to help everyone get a basic understanding, I believe, ahead of the visit. Um! You were sent an overview of of of health, of food and security, terminology and healthcare settings existing and emerging opportunities, which is a breeze by rope with the Csx siren, Children's health watch and the food research and action um center in two thousand and eighteen. It's due to be updated. But you'll see a lot of his games from

36
00:08:06.050 --> 00:08:24.740
Sarah DeSilvey / Northwestern Medical Center: that brief here. So we're going to talk about Why, data documentation is important. I want to briefly interview the gravity, Introduce the Gravity project. I'll be going into what types of health and care and social care data are there out there. I'm going to be talking about. Why, what kinds of claims data are there?

37
00:08:24.750 --> 00:08:49.189
Sarah DeSilvey / Northwestern Medical Center: I'll be talking about. Why, documenting and claims is so important. And really, what are the opportunities for food security experts such as

you to be language makers? I want to close with a conversation on Allies right. So I long before I was a terminologist long before I was a nurse practitioner, I worked in community action, and can you organizing as a farmer. So um, knowing your allies and ecosystems is really important, and i'll try to close with that

38
00:08:50.410 --> 00:09:07.330
Sarah DeSilvey / Northwestern Medical Center: Why, is that about documentation important so in an ever-increasingly data-oriented world. That of documentation is a way to make things visible. And the world. Of addressing inequity is making social concerns and social labor visible is really best framed as a matter of social justice,

39
00:09:07.480 --> 00:09:21.350
Sarah DeSilvey / Northwestern Medical Center: and their risk of being visible. We acknowledge those right risk of being put in harm's, way, risks of bias. But we're really going to be talking about addressing the injustice of being invisible in our aim to create better data.

40
00:09:22.360 --> 00:09:35.080
Sarah DeSilvey / Northwestern Medical Center: The heart is addressing the risk of invisibility by clearly telling the story of people's, concerns, and the labor and actions of the community aims to help them. It's key to care, research, resource, allocation,

41
00:09:35.090 --> 00:09:52.589
Sarah DeSilvey / Northwestern Medical Center: and equitable structural solutions, because, as we talk about in a social justice world, we can identify things as a person level. But solutions are always structural at the policy level at the community level. So we want to make sure that we have the right data to identify those solutions and direct interventions where they need to be.

42
00:09:53.810 --> 00:10:08.940
Sarah DeSilvey / Northwestern Medical Center: Oh, here I figure out my buttons. So the gravity project. It was launched in two thousand and nineteen. It's the National Consensus initiative that has a charter to develop the data and data standards, to address the social, tremendous of health,

43
00:10:08.990 --> 00:10:21.550
Sarah DeSilvey / Northwestern Medical Center: the mission to its advance and promote equitable health and social care by leading the development and validations of consensus-driven interoperability. Interoperability standards for the social determinism of

44
00:10:21.560 --> 00:10:32.919

Sarah DeSilvey / Northwestern Medical Center: I ordered the story in the gravity project was just as a food and security subject matter expert. I came in with the knowledge and terminology for food and security, and then I evolved into the director of the terminology division over time.

45
00:10:33.980 --> 00:10:46.450
Sarah DeSilvey / Northwestern Medical Center: The graphic products deliverables are data standards to represent and exchange patient-level social risk data across four clinical activities screening and assessment basically like screening tools,

46
00:10:46.460 --> 00:10:56.559
Sarah DeSilvey / Northwestern Medical Center: diagnoses your problem, statements, patient-centered goal setting and treatment interventions. That last treatment interventions element is the one we'll be talking about. The most

47
00:10:57.080 --> 00:11:14.680
Sarah DeSilvey / Northwestern Medical Center: our use cases are non-funding specific. So this is patient care, care, coordination, human service, sectors, population, health, public health, value-based payment, and clinical research over the course of our last three years we have addressed seventeen domains student security. In one of them

48
00:11:15.100 --> 00:11:18.799
Sarah DeSilvey / Northwestern Medical Center: all of our data is open and curated in public.

49
00:11:18.810 --> 00:11:31.049
Sarah DeSilvey / Northwestern Medical Center: All of our data is coated in groups of data called value sets that sit at the National Library of Medicine. These value sets for screening diagnosis, goal setting, and interventions

50
00:11:31.060 --> 00:11:41.249
Sarah DeSilvey / Northwestern Medical Center: are the references for many of the quality measures that are coming out in the ecosystem, and they are the guidelines and guardrails for utilizing food and security terminology in us health care.

51
00:11:43.320 --> 00:11:50.980
Sarah DeSilvey / Northwestern Medical Center: So these are core health care data types. So this is where we get to like like terminology data, one hundred and one

52
00:11:51.290 --> 00:11:52.720

Sarah DeSilvey / Northwestern Medical Center: green

53
00:11:52.840 --> 00:12:01.879
Sarah DeSilvey / Northwestern Medical Center: identified by existing in claims. So I tried to make it seem crazy. So there's terminology called like

54
00:12:02.270 --> 00:12:09.540
Sarah DeSilvey / Northwestern Medical Center: loin, is the terminology of questions and their answers. So you can imagine being a lab and the result

55
00:12:09.970 --> 00:12:14.370
Sarah DeSilvey / Northwestern Medical Center: like glucose, What glucose? One hundred and forty, two.

56
00:12:14.590 --> 00:12:21.360
Sarah DeSilvey / Northwestern Medical Center: But it's also the terminology of screening instrument questions and answers like the hunger vital sign,

57
00:12:22.370 --> 00:12:30.120
Sarah DeSilvey / Northwestern Medical Center: A. C. Tencm. Is the terminology that's a Us. Extension of the World Health Organization, Icd. Ten.

58
00:12:30.270 --> 00:12:39.189
Sarah DeSilvey / Northwestern Medical Center: It's a us-focused adaptation to address further diagnostic granularity and specifically a diagnostic terminology that transfers in clients

59
00:12:39.200 --> 00:12:59.369
Sarah DeSilvey / Northwestern Medical Center: right. So when a clinician assesses a problem, they diagnose it it drops into the claim as an Ic. Tencm. And then travels, whether it be to population, health registries, whether it be to the payer, whether it be to the next clinician. So this Ic. Ten Cm. And its fluidity and claims, and its existence in claims

60
00:12:59.390 --> 00:13:10.940
Sarah DeSilvey / Northwestern Medical Center: specifically, as we think about like Center for Medicaid and Medicare services, getting all of the Ic. Ten data that we have. So that's a critical diagnostic terminology that's available in clients.

61

00:13:11.600 --> 00:13:16.949
Sarah DeSilvey / Northwestern Medical Center: I'll. I'll define what claims is in just a second. I'm going to define it on the next slide.

62
00:13:17.280 --> 00:13:32.580
Sarah DeSilvey / Northwestern Medical Center: Snowman. Dt. Is an international terminology that defines almost everything gets even health care. So, as a clinician. If i'm documenting that a patient has a history of a surgery. If i'm documenting that a person's a person's mother had a certain condition

63
00:13:32.590 --> 00:13:37.799
Sarah DeSilvey / Northwestern Medical Center: from documenting and curating a problem list for a patient of concerns. I want to monitor over time.

64
00:13:37.840 --> 00:13:41.750
Sarah DeSilvey / Northwestern Medical Center: I'm documenting an intervention or a patient-centered goal.

65
00:13:41.760 --> 00:13:45.069
Sarah DeSilvey / Northwestern Medical Center: All of those elements are contained within Snow and Ct.

66
00:13:45.220 --> 00:14:01.719
Sarah DeSilvey / Northwestern Medical Center: So many t is exchanged in many ways, but it doesn't commonly transferring plans. It transfers by a different pathways of data exchange that happen every single time I send a referral or any time I send messages directly from one side to another, but it doesn't go in Place

67
00:14:02.490 --> 00:14:12.530
Sarah DeSilvey / Northwestern Medical Center: Cpt, which is a registered trademark of the a product of the American Medical Association, is also known as Kickpics Level One

68
00:14:13.800 --> 00:14:31.930
Sarah DeSilvey / Northwestern Medical Center: Um. It is a uniform language that really exists for coding, and I put this in close medical services and procedures, and it because it's the American Medical Association. They use the word medical here, but it's really coast things that track billing and events that happen in clinical settings. One needs to have a license for this.

69

00:14:31.940 --> 00:14:52.959
Sarah DeSilvey / Northwestern Medical Center: So caution with using it in social care settings, which is why we're going to be talking a fair bit about kick picks. But this is this is what drives reimbursement for immunizations. It's what drives reimbursement for a splint that I might use with a patient. It would drive reimbursement from my own time as a clinician I work in rural family medicine. So cpt is level, one

70
00:14:52.970 --> 00:14:54.260
Sarah DeSilvey / Northwestern Medical Center: hectics,

71
00:14:54.300 --> 00:14:58.859
Sarah DeSilvey / Northwestern Medical Center: and it's the language for coding medical services and procedures.

72
00:14:59.500 --> 00:15:01.500
Sarah DeSilvey / Northwestern Medical Center: H. Picks level two

73
00:15:01.630 --> 00:15:06.490
Sarah DeSilvey / Northwestern Medical Center: basically covers all services and procedures that are captured in Cpt.

74
00:15:06.500 --> 00:15:23.430
Sarah DeSilvey / Northwestern Medical Center: Right, and this is owned and and curated by the center for Medicaid and Medicare and Medicaid services. And this is where we're going to be talking a fair bit today because it is federally owned It's more accessible and available for developing terminology for social care settings.

75
00:15:23.440 --> 00:15:43.329
Sarah DeSilvey / Northwestern Medical Center: And there's a lot of opportunities here, and we'll talk about existing pick terminology in a second. But really this is where the opportunity lies. So again you have loin for questions and answers as you ten Cm. Primarily for diagnosis, the traveling claims some Nct. For almost everything, but it does not travel in claims,

76
00:15:43.340 --> 00:15:57.299
Sarah DeSilvey / Northwestern Medical Center: Cpt. For medical services and procedures, and then pick picks everything the Cpt Doesn't cover. So izd tencm. Cpt. And hiccups level. Two are all claims based data

77

00:15:58.620 --> 00:16:26.490
Sarah DeSilvey / Northwestern Medical Center: um. I wanted to focus just because it's very, very important. I don't want to admit to talk about our social care data types in our work of the gravity project, we reference and mirror and map to the two of them on a late taxonomy, because we know how critical it is for indexing human services and resources. So every terminology that we create in that intervention set in gravity is mapped to a mirror compared to, and commonly defined with, two, one, one L. A. Terms

78
00:16:26.500 --> 00:16:44.530
Sarah DeSilvey / Northwestern Medical Center: really at high level, because those of you who work in the two in one space know how granular it can be. Um, but really at a high level. We make sure that we have alignment because in the work of medical and social care integration, it's really important to make sure that we're staying up in target and align with our social care friends.

79
00:16:46.190 --> 00:17:10.369
Sarah DeSilvey / Northwestern Medical Center: So how do we tell people's stories in healthcare data? So I just talk about the types of terminology I've really touched on claims, and i'll go more into that in a bit. I talked about the work of the gravity project. We're creating terminology process four activities, and I touched on two and one away. I'm. Now going to go a bit deeper and try to make the case for the work that needs to be done, But clearly, you understand, needs to be done. Um. So we can go further.

80
00:17:11.390 --> 00:17:22.339
Sarah DeSilvey / Northwestern Medical Center: So this is an example of a terminology that the graphic project has built over the course of the last three years for food and security, Food and security was our first social risk domain.

81
00:17:22.349 --> 00:17:37.870
Sarah DeSilvey / Northwestern Medical Center: Again. I'm going to nod to the fact that the wise individuals of the Buddhist Medicine Coalition Um and Sophie. And you know food, Research and Action Center and children's health watch. We're all really critical in developing the terminology that you see here.

82
00:17:37.880 --> 00:17:49.639
Sarah DeSilvey / Northwestern Medical Center: So you can see what I mentioned about those loin questions and answers Right on the in that big purple box is the terminology that represents the hunger vital sign in code.

83
00:17:49.650 --> 00:17:59.160

Sarah DeSilvey / Northwestern Medical Center: So the question within the past twelve months we worried about whether our food went out before we had money to but get more is eight, one, two, two, seven,

84
00:17:59.570 --> 00:18:09.160
Sarah DeSilvey / Northwestern Medical Center: it's answered, often true, sometimes never true, or Don't know refused is in a panel called Ll. Four, seven, three, zero, nine,

85
00:18:09.170 --> 00:18:27.240
Sarah DeSilvey / Northwestern Medical Center: and it goes on so in the Snowman, ct. And in the and I, c. Ten of the diagnosis realm. We have a food and Security Snowman, Ct. Code that a person could put on a patient's problem list, and We also have a new last year Food and security. Ic. Ten code.

86
00:18:27.250 --> 00:18:36.310
Sarah DeSilvey / Northwestern Medical Center: It's fifty, nine point four, one. So gravity built this. It came out last year, and this means a person. Me can diagnose food and security for a patient.

87
00:18:36.320 --> 00:18:51.659
Sarah DeSilvey / Northwestern Medical Center: Put it into the plan of care, and, as a claims-based term it'll travel to the payer. It'll travel to Cms. It can travel wherever that claim goes.

88
00:18:52.140 --> 00:19:08.870
Sarah DeSilvey / Northwestern Medical Center: You can see food and security goals, and so we have a food security statement. And so Mit, and we have an upcoming fields. Food and tape. Quantity is adequate for males. All of our work on food and security terminology was also shaped by our wise colleagues of the American Academy of Magician and Dynamics.

89
00:19:09.040 --> 00:19:13.290
Sarah DeSilvey / Northwestern Medical Center: But over here we have Snowman, Tt. And Cpt. And Hypics.

90
00:19:13.300 --> 00:19:22.609
Sarah DeSilvey / Northwestern Medical Center: Right? So for procedures. We have things like referrals referral to critical roles, referral to community healthcare

91
00:19:22.930 --> 00:19:28.290

Sarah DeSilvey / Northwestern Medical Center: procedures. We all have also have things. We give provision of food voucher the

92
00:19:28.300 --> 00:19:31.990
Sarah DeSilvey / Northwestern Medical Center: or medically tailored meals or vegetable prescription.

93
00:19:32.000 --> 00:19:46.789
Sarah DeSilvey / Northwestern Medical Center: Right? There's a lot of real estate here in these blue boxes that's not visualized. If one wanted to the set of complete interventions for food and security is about two hundred and fifty terms wide. This is just an example,

94
00:19:46.800 --> 00:20:07.519
Sarah DeSilvey / Northwestern Medical Center: and then you can. So we have two terms. And so, my Tt. And then we also have a term. This and Kit picks right. We have that ever so famous, ever so implemented and utilized, but vastly um insufficient home delivered meals, including preparation per meal s five, one hundred and seven zero. This is a hiccup code that's been blazing in my mind

95
00:20:07.530 --> 00:20:11.089
Sarah DeSilvey / Northwestern Medical Center: for about twelve years.

96
00:20:11.100 --> 00:20:33.500
Sarah DeSilvey / Northwestern Medical Center: So there's many waivers, and you know, statewide projects that aim to leverage this to represent the complexity of other different food sources, and like such a set of material meals. But it's the definitions don't alive so. But this is an example of a hypothesis code that will be in the gravy interventions that that would be passing in claims. So in interventions most known as Cct. Terms are not going on the claims.

97
00:20:33.510 --> 00:20:36.009
Sarah DeSilvey / Northwestern Medical Center: But that s five, one hundred and seven zero can.

98
00:20:39.210 --> 00:20:41.589
Sarah DeSilvey / Northwestern Medical Center: Um. So i'm going to tell a story now

99
00:20:41.630 --> 00:20:48.530

Sarah DeSilvey / Northwestern Medical Center: and then. Hopefully. Soon we can get to questions and answers, and we're going to have plenty of time, I think, based on the fact that I'm almost done

100
00:20:48.730 --> 00:20:56.689
Sarah DeSilvey / Northwestern Medical Center: so. I'm just going to tell the story of what happened on the previous slide. That was all code right. Everything bolded is data that exists.

101
00:20:56.790 --> 00:21:06.669
Sarah DeSilvey / Northwestern Medical Center: Um. So a patient with permanent disability, newly living and supported housing presents to the care, setting their screen for food and security, using the hundred vital signs. The screening was popular,

102
00:21:06.880 --> 00:21:13.909
Sarah DeSilvey / Northwestern Medical Center: but further discussion. The patient identified food security as a concern. They wanted to address Ic. Ten, Cm. Snow at Ct.

103
00:21:15.270 --> 00:21:31.410
Sarah DeSilvey / Northwestern Medical Center: It was just too hard getting by on social security alone. The care plan was crafted, and the patients say to date that having enough food would be a good enough goal, as they often go hungry. That's your patients and a goal terminology. The team member root for the patient. To a community health worker there's that referral code

104
00:21:31.420 --> 00:21:36.389
Sarah DeSilvey / Northwestern Medical Center: to help with coordination and present to the patient with a food voucher. There's that snowmet code

105
00:21:36.400 --> 00:21:43.259
Sarah DeSilvey / Northwestern Medical Center: that so much code that we have right now could eventually be a hit pick code in time because it's something that's given

106
00:21:43.710 --> 00:21:53.099
Sarah DeSilvey / Northwestern Medical Center: in coordination. It was determined that a person was eligible for home, Deliver meals because of their new supported housing, and the first deliveries arrived the following week.

107
00:21:53.110 --> 00:22:08.870

Sarah DeSilvey / Northwestern Medical Center: So there's that s five, one, seven zero. So although the previous slide was a bunch of codes, this is the story of the person that we care for, and everything in bold is that data that we talk about, and that that data is is basically part of telling the story. And you can imagine, if it wasn't there.

108
00:22:09.990 --> 00:22:22.959
Sarah DeSilvey / Northwestern Medical Center: Okay. So now i'm going to let it leverage a little bit, because I really want to set the stage where we hope the work is going to be over the course of the next few months, because the topic of this conversation is really about food and security and food-based interventions or food is medicine.

109
00:22:23.020 --> 00:22:26.789
Sarah DeSilvey / Northwestern Medical Center: So we're going to talk again about why the claims that is so significant.

110
00:22:26.800 --> 00:22:34.329
Sarah DeSilvey / Northwestern Medical Center: So first i'm going to define things again. A terminologist, a claim is a request for payment for services and benefits received

111
00:22:34.370 --> 00:22:45.879
Sarah DeSilvey / Northwestern Medical Center: claims. Data also known as administrative data is information collected on millions of clinicians, appointments, bills, insurance, and other patient provider communications

112
00:22:45.920 --> 00:23:05.300
Sarah DeSilvey / Northwestern Medical Center: directly from notes by made by the health care provider that it happens at the time that a patient sees a clinician, the electronic claim or email travels seamlessly between clinicians, payers, both public and private, and those who offer services in clinical community settings to assist patients in order to facilitate reimbursement.

113
00:23:05.310 --> 00:23:23.579
Sarah DeSilvey / Northwestern Medical Center: The flow also enables use for research and population health analysis. They used to work in accountable care organization, every data in every element of data that was available in claims we use for population, health analysis. All the definitions here come from the National libraries, medicine, finding and using health statistics.

114
00:23:25.360 --> 00:23:37.040

Sarah DeSilvey / Northwestern Medical Center: So I just want to pull out a little bit, because in our preparation we were talking about how to build Pix, and what a general term might be for those who offer services in clinical community settings.

115
00:23:37.060 --> 00:23:52.200
Sarah DeSilvey / Northwestern Medical Center: So who are they? They could be a nurse practitioner. They could be a nutritionist. They could be a social worker. They also could be a home flavor, meal, preparer, a food bank, a farmer's market, a medically thrilled meal service, a vegetable prescription prescription service, or even a farmer.

116
00:23:52.210 --> 00:24:08.449
Sarah DeSilvey / Northwestern Medical Center: So the term we were talking about and heming around, and we can throw around when we talk up and open up into Q. And A. Is basically their service providers, whether it be social care, services, clinical care services, or community-based services, it's, all providing services. And we can figure that out more as we go forward.

117
00:24:10.570 --> 00:24:15.769
Sarah DeSilvey / Northwestern Medical Center: I'm. Now going to try to pivot into opportunities in both Cpt and hiccs,

118
00:24:16.550 --> 00:24:35.170
Sarah DeSilvey / Northwestern Medical Center: and this is really the focus of just to the Lentel set, and how us focused on what work needs to be done, Because if there is real estate within terminology regarding food as medicine, it is really in this space. So gravity has built a ton of codes for screening tools, a ton of but necessary codes for diagnoses

119
00:24:35.180 --> 00:24:49.060
Sarah DeSilvey / Northwestern Medical Center: really critical protective factors and uh food and security goal statements, general terms for interventions. But we have yet to, and need your help to develop the hiccups or buildable cpt

120
00:24:49.940 --> 00:25:01.100
Sarah DeSilvey / Northwestern Medical Center: opportunities in Cbt and hit picks really fall along the following three buckets. And I've starred, too, because they're really the most important for this work for for the for the community we have here.

121
00:25:01.110 --> 00:25:18.720
Sarah DeSilvey / Northwestern Medical Center: One is to codes to simplify quality reporting, so we often use kitpicks in cpt category. Two codes, to say we screened a patient, and they were

negative, or I screened a patient, and they were positive. This is a way to simplify all the activities of the health record in one specific code that again travels and claims.

122
00:25:19.590 --> 00:25:32.949
Sarah DeSilvey / Northwestern Medical Center: But we also use hyp codes and Cbd codes. As I mentioned to document two specific things that are of value and contribute reimbursement, one to demonstrate products provided to the patient or clients,

123
00:25:32.960 --> 00:25:40.699
Sarah DeSilvey / Northwestern Medical Center: whether it be in an immunization, form a durable medical equipment, or whether it be in a home-delivered meal,

124
00:25:40.710 --> 00:25:45.889
Sarah DeSilvey / Northwestern Medical Center: or in the future vegetable prescriptions. Medical detail, like meals, et cetera

125
00:25:46.260 --> 00:25:55.279
Sarah DeSilvey / Northwestern Medical Center: we also need expanded hip-pit codes and cpt codes to demonstrate caroten labor. This work is happening in the ecosystem right now.

126
00:25:55.290 --> 00:26:08.199
Sarah DeSilvey / Northwestern Medical Center: The labor that we document in clinical and social care settings is heavily biased on the clinical person, And yet we know the work of addressing social care both of social needs and social care relies on all kinds of new

127
00:26:08.210 --> 00:26:27.560
Sarah DeSilvey / Northwestern Medical Center: about role types, right? The community health workers or key-based organizations, and their labor assistance, with applications and systems with connecting to resources So all of that labor demonstration. We're trying to figure out how to represent that, too. But really that middle one codes to demonstrate products that would provide education or clients

128
00:26:27.570 --> 00:26:35.450
Sarah DeSilvey / Northwestern Medical Center: is the critical area of expertise that everyone on this call has that we're hoping to leverage to get improved codes.

129
00:26:36.210 --> 00:26:53.129

Sarah DeSilvey / Northwestern Medical Center: So just again to pull out those last two. If we think about what we have and what we need. Um! What we have an example data to demonstrate products and services is again, that s five, one hundred and seventy zero code home delivered meals, including preparation for a meal

130
00:26:53.550 --> 00:27:07.050
Sarah DeSilvey / Northwestern Medical Center: in our data to demonstrate care team labor. I pulled out one element here and again with Cbt. We have to be careful because the it you need a license for, and it needs to be. There's very specific applications for it, but I didn't want to neglect to put it here.

131
00:27:07.060 --> 00:27:22.589
Sarah DeSilvey / Northwestern Medical Center: So this is an again nine, six, one, six, zero, which is Cpt code, which is the act and labor of screening patients. So we do know that nine, six, one, six, zero is eligible for use. And so if you are in a clinical setting that has a cpt license

132
00:27:22.600 --> 00:27:27.789
Sarah DeSilvey / Northwestern Medical Center: um. You can get reimbursed for the activity of screening by saying, nine, six, one, six, zero.

133
00:27:28.380 --> 00:27:40.920
Sarah DeSilvey / Northwestern Medical Center: What we do not have, and we need to make more robust. It's data to demonstrate products and services that are be tailored meals, vegetable prescriptions, grocery bags and boxes, pharmace, morgan vouchers, et cetera, et cetera,

134
00:27:40.930 --> 00:27:58.240
Sarah DeSilvey / Northwestern Medical Center: and as I mentioned. We also need to expand data to demonstrate protein labor, coordination, interpretation. Anything that is knitting together needs and addressing barriers that's not currently represented in labor codes that we use for primarily clinical histories in public settings.

135
00:27:59.300 --> 00:28:17.579
Sarah DeSilvey / Northwestern Medical Center: So these are the stories we're not able to consistently tell, And these are the stories we need to really figure out how to tell. Well, so of the labor community health workers and community-based organizations of the community programs that provide farm to kind of food supports of the nutritious food boxes, things to improve diabetes, management,

136
00:28:17.590 --> 00:28:21.810

Sarah DeSilvey / Northwestern Medical Center: or, if medically tailored meals that we know have an effect on health and be admission rates.

137
00:28:22.000 --> 00:28:37.050
Sarah DeSilvey / Northwestern Medical Center: So that is really the area that we need to go forward in. This is a basic primer on food and security, on ah, on Ah! Food, security, and food-based terminology and data and terminology in general, and I hope it other kicks off this network

138
00:28:37.060 --> 00:28:48.910
Sarah DeSilvey / Northwestern Medical Center: I just want to make sure that we understand considerations about crafting terms. Again, Cbt requires licensing. So usually H. Picks and Cms through Cms. Is more accessible for community partners.

139
00:28:49.300 --> 00:29:01.370
Sarah DeSilvey / Northwestern Medical Center: Um: Anything that is defined in hit picks has to be clearly delineated. So it's really critical, because we're assigning a value to it. So we know exactly what we mean when we say X

140
00:29:01.710 --> 00:29:24.460
Sarah DeSilvey / Northwestern Medical Center: right if there are different units and values that must be determined. So if there's three different kinds of of ah food prescriptions, or if there's a difference between one type of meal and another type of meal. It's important to define those of that hierarchy and that difference ahead of time, so to enable applications of fee schedules across the national setting.

141
00:29:24.590 --> 00:29:52.820
Sarah DeSilvey / Northwestern Medical Center: And then ideally, the need should align with national multi-stakeholder initiatives. That's a no-brainer right the ecosystem is desperate for these terms. The Gravity Project wants to assist in the development of these terms. We know we need them, especially as policy just drives forward, and we have increased. Um, you know. Ah, community and clinical care relationships, especially in value-based payment reform. So that last one is already a set of complete um. We also want to state that

142
00:29:52.830 --> 00:30:21.500
Sarah DeSilvey / Northwestern Medical Center: any terminology is developed in the hypnic space of an intervention would likely get brought into the gravity terminology, and then meet most of the quality measures that are being developed. Um, in the Us. Healthcare system, because quality measure developers. So far a majority of them are referencing gravity data sets and gravity value sets as complete. So it's just good to know that as we do this work as we're going to be, probably needing multiple these

143
00:30:21.510 --> 00:30:23.600
many birds with one bush. As I say,

144
00:30:24.670 --> 00:30:39.609
Sarah DeSilvey / Northwestern Medical Center: your allies in this work. Just so. We understand who they are. It's the Gravity Project. So I am the Director of Terminology. But we're easy to find on the web. So here's my email in case you want any further information you can find me on Twitter as well.

145
00:30:39.620 --> 00:30:48.909
Sarah DeSilvey / Northwestern Medical Center: A new ally that is really um is a really hopeful ally is the partnership to a mine's social care, building and coding work group, and I mentioned this group because

146
00:30:48.920 --> 00:31:10.469
Sarah DeSilvey / Northwestern Medical Center: that last bullet we had in the other slide aligned with the like critical national initiatives. I want to reiterate that the ecosystem knows these codes are important. The ecosystem wants to support community partners in documenting their labor and their products and services. We just need the terminology to do so. And so this partnership is a really critical ally in this work,

147
00:31:10.480 --> 00:31:12.050
Sarah DeSilvey / Northwestern Medical Center: and there's just so many more,

148
00:31:12.060 --> 00:31:31.849
Sarah DeSilvey / Northwestern Medical Center: and this is my anatomical heart, because i'm a sock instead. Um, but I believe now we're ready for some questions and answers, and I really try to leave time because I just covered an incredibly complex amount of information, and I want to be able to go back to slides or address any questions that you might have, and I think we have plenty of time.

149
00:31:33.010 --> 00:31:33.890
Katie Garfield / Center For Health Law and Policy Innovation: Excellent.

150
00:31:33.900 --> 00:31:44.950

Katie Garfield / Center For Health Law and Policy Innovation: Thank you so much, Sarah. Let me be the first to thank you. I can say that many of our questions coming in are simply about whether or not there is a recording, because this discussion is so helpful.

151
00:31:45.050 --> 00:32:02.139
Katie Garfield / Center For Health Law and Policy Innovation: Um! And I can link to everyone listening. Yes, there will be a recording available on the same website. Ah, where you signed up, and the link was included in the chat. Um. But if you have trouble accessing it for us reach out. Ah, so that's the first question. And then we have a couple of questions

152
00:32:02.150 --> 00:32:29.920
Katie Garfield / Center For Health Law and Policy Innovation: um about specific code that you've mentioned, and then a little bit about the process, I think, around New code. So maybe i'll go with the specific ones. First. Um, We did have a question actually. Two questions come in around the nine six, one, six go code that you mentioned um related to screening. Ah, so one person asks, Ah, would screening or nutrition risk fall under that particular Cd.

153
00:32:29.930 --> 00:32:34.690
Katie Garfield / Center For Health Law and Policy Innovation: Now you're screening for food and security. Would you use nine, six, one, six,

154
00:32:35.020 --> 00:32:51.869
Sarah DeSilvey / Northwestern Medical Center: um. So the critical element for nine, six, one, six, zero. And then there's a correlating caregiver Code of nine, six, one, six, one. And forgive me when I speak in code this is what i'd reveal, that i'm part-side work is that you're utilizing a standardized tool.

155
00:32:51.880 --> 00:33:19.759
Sarah DeSilvey / Northwestern Medical Center: So I we worked with children's health watch Um and the American Academy of Pediatrics um in two thousand and seventeen, two thousand and nineteen, when those new to New Cpt came out to verify that the hunger vital sign in Usda food security tools met the level of standardization and validation required for the application of those two codes. So um! It would have to be a standardized tool in order to meet the requirements.

156
00:33:19.800 --> 00:33:31.399
Sarah DeSilvey / Northwestern Medical Center: And again, unless you're in special arrangements with payers, with ah permission of the licensing of the American Medical Association caution with using the Cpt. In general, because it is a licensed product.

157

00:33:32.690 --> 00:33:36.490
Katie Garfield / Center For Health Law and Policy Innovation: Excellent, and that is a follow-up question.

158
00:33:36.500 --> 00:33:49.889
Katie Garfield / Center For Health Law and Policy Innovation: I also had a question about the entities that can use that code so specifically do the Cbt codes applied to Federally all by call centers, and they're asking about nine, six, one to zero.

159
00:33:49.900 --> 00:33:52.330
Katie Garfield / Center For Health Law and Policy Innovation: And can Dietitians feel for that?

160
00:33:52.680 --> 00:34:12.340
Sarah DeSilvey / Northwestern Medical Center: Um. So again I have to be careful. I'm not a coder. I'm a criminologist. So everything I say regarding using codes to get billing has to be under great massive air quotes with coffee apps, because when I, when I, when I specified at the beginning to change in the term, it's because i'm not a specialist in my business,

161
00:34:12.350 --> 00:34:15.749
Sarah DeSilvey / Northwestern Medical Center: right? So i'm going to give my best possible answer.

162
00:34:16.030 --> 00:34:18.329
Sarah DeSilvey / Northwestern Medical Center: So any clinical setting

163
00:34:19.199 --> 00:34:20.989
Sarah DeSilvey / Northwestern Medical Center: should be able

164
00:34:21.000 --> 00:34:45.300
Sarah DeSilvey / Northwestern Medical Center: to use the nine, six, one, six, zero, nine, six, one, six, one, six, one modes, F Qa. C. Is our clinical settings. There are different uh reimbursement uh strategies that Fq Hcs are dependent upon and and um because of their relationship with person, because in most settings, such as in my own setting, we get enhanced reimbursement for being an Fqhc. So you have to be really careful. So they limit you in some in some ways.

165
00:34:45.310 --> 00:34:58.109

Sarah DeSilvey / Northwestern Medical Center: Um, but it's a good question to ask your um, your building person, and whatever clinical set you're in. Um, I am going to state something that actually is really important to state if we're getting this deep into this code, though.

166
00:34:58.120 --> 00:35:17.410
Sarah DeSilvey / Northwestern Medical Center: Um, you have to universally use any Cpt. Otherwise you can't just use it in one setting, and then not give it to somebody else. If you can't just use it for somebody who has good insurance and then not use it for somebody who's under insured. And so when you're implementing anything that actually has a available service.

167
00:35:17.420 --> 00:35:19.500
Sarah DeSilvey / Northwestern Medical Center: There is an ethical question

168
00:35:20.020 --> 00:35:31.699
Sarah DeSilvey / Northwestern Medical Center: about whether it's appropriate to make people pay for screening for things that identify social needs. So this is why governance and data agreements and data principles are really important,

169
00:35:31.710 --> 00:35:58.369
Sarah DeSilvey / Northwestern Medical Center: because you want to think about the the outcomes of doing things like this right? So it's one thing to build for a service that you know the insurer is going to cover. And so you know the patient's not going to have any costs right. It's another thing, and an an ethical thing, and a governance thing to think about how to navigate um billing for things like screening where every single person might get the charge if it's universal screening, and that underinsured person might get the bill

170
00:35:58.380 --> 00:36:08.850
Sarah DeSilvey / Northwestern Medical Center: right. So I just want to make sure that we add that caveat when we're talking about Cpt. And billable services. Because again, you can't carry pick. Otherwise, you're committing fraud.

171
00:36:10.000 --> 00:36:16.099
Katie Garfield / Center For Health Law and Policy Innovation: The lawyer and me appreciate that. Answer I think

172
00:36:16.110 --> 00:36:20.690
Katie Garfield / Center For Health Law and Policy Innovation: me just really deep on that code. So I want to bring us back.

173
00:36:20.700 --> 00:36:21.590
Katie Garfield / Center For Health Law and Policy Innovation: We also have

174
00:36:21.600 --> 00:36:28.809
Katie Garfield / Center For Health Law and Policy Innovation: some very broad questions that are really important. So Aaron asks,

175
00:36:29.290 --> 00:36:32.990
Katie Garfield / Center For Health Law and Policy Innovation: How do new hiccs codes get established?

176
00:36:33.000 --> 00:36:37.650
Katie Garfield / Center For Health Law and Policy Innovation: Who approves these codes? And i'm going to tack on to this? What does the process look like?

177
00:36:39.040 --> 00:36:47.809
Sarah DeSilvey / Northwestern Medical Center: The good thing is, we have some some people who just recently tried within the Orphanage or fetus, medicine and friends, but there are application cycles,

178
00:36:47.820 --> 00:36:56.199
Sarah DeSilvey / Northwestern Medical Center: or pretty much most codes right. The net application due date or hip-it codes is in the beginning of January the twentieth twenty three.

179
00:36:56.210 --> 00:37:18.650
Sarah DeSilvey / Northwestern Medical Center: In order to submit a hectic code you have to have. You have to be a registered user in the online submission system that Cms offers for submission of pick picks. And there is are a host of different elements that a person needs to um like, fill out and navigate within that submission process. So

180
00:37:18.660 --> 00:37:28.429
Sarah DeSilvey / Northwestern Medical Center: you know, I must submit. I'm a registered user within hiccups. So um i'm able to start a submission, and you can make a team. You can have many different people who help you on the submission.

181
00:37:28.440 --> 00:37:41.169

Sarah DeSilvey / Northwestern Medical Center: Um, but i'm going to be. I'm going to say very clearly, Um, really having community. And I really the national consensus about the need for This code is really important, because it takes a lot

182
00:37:41.180 --> 00:37:49.599
Sarah DeSilvey / Northwestern Medical Center: to get new hiccup codes. Cms is very, very, but careful, because we're talking about money and reimbursement

183
00:37:49.610 --> 00:38:05.460
Sarah DeSilvey / Northwestern Medical Center: um and allocating new codes, and that's what that ally thing is really important. So if we are working on you hit the codes, you apply for them online through regular submission cycles anyone can apply. You don't have to have a fancy license or anything like that.

184
00:38:05.470 --> 00:38:12.100
Sarah DeSilvey / Northwestern Medical Center: Um, but it is fairly rigorous, and it's good to have friends and allies who can make sure that your word and message is getting through.

185
00:38:14.410 --> 00:38:16.450
Katie Garfield / Center For Health Law and Policy Innovation: Excellent! Thank you for that background.

186
00:38:16.880 --> 00:38:17.790
Katie Garfield / Center For Health Law and Policy Innovation: Ah,

187
00:38:17.800 --> 00:38:38.119
Katie Garfield / Center For Health Law and Policy Innovation: we also have a couple of questions that are getting at the fact that, as we mentioned upfront, there are states and programs that are experimenting with pay for pre-based interventions, experimenting with paying for genetically to their meals? Or is prescriptions? Spectacular groceries performs these other things.

188
00:38:38.130 --> 00:38:52.989
Katie Garfield / Center For Health Law and Policy Innovation: Um, I think they, the questions are sort of centered on. Um! Are we using codes for those? And what are we doing? I'm going to tack my own question on here, too, because I think it's important. Which is,

189
00:38:53.000 --> 00:39:01.070

Katie Garfield / Center For Health Law and Policy Innovation: Are we using codes for those, and where we don't have codes yet for payment? How are we dealing with that?

190
00:39:02.480 --> 00:39:10.450
Sarah DeSilvey / Northwestern Medical Center: That's a really good question. And i'm going to try to tack on answer to another question that I saw in the Q. And A. At the same time right so

191
00:39:10.660 --> 00:39:22.210
Sarah DeSilvey / Northwestern Medical Center: part of the work of the gravity project was to create at least some basic standardization of terminology and interventions. Even as we await the you know, the pie in the skypit code, right?

192
00:39:22.370 --> 00:39:44.600
Sarah DeSilvey / Northwestern Medical Center: So anything that can be provided. And this is a it relation to somebody asks, Are the codes on the food and security terminology code page the only codes that are out there for food and security. And the answer is No. So every single core, intervention and program available nationally, that we could possibly find for food and security is now encoded in some at Ct.

193
00:39:44.790 --> 00:39:46.630
Sarah DeSilvey / Northwestern Medical Center: So provision of

194
00:39:46.640 --> 00:40:11.480
Sarah DeSilvey / Northwestern Medical Center: um Ah! Food voucher provision of Ah! You know, farmers market voucher, you know. And then, even like Meta terms like um education about gust, shoe marker food and nutrition programs. Right? So evaluation of eligibility for snap right? You know, Referral to wic right? So every single thing we could encode we were cut in. So,

195
00:40:11.760 --> 00:40:25.209
Sarah DeSilvey / Northwestern Medical Center: prior to the gravity project really States were forced to develop, you know, homegrown solutions to this, and create internal codes because of us. Now, one could use this moment Ct. For provision of blank,

196
00:40:25.260 --> 00:40:31.690
Sarah DeSilvey / Northwestern Medical Center: a proxy, knowing that it's not in claims, but it's still they hook people to be documented in standardized ways the

197

00:40:31.700 --> 00:40:55.730
Sarah DeSilvey / Northwestern Medical Center: as we were on the the hectic codes to come. So um previously No standardization. Now, capacity for sanitization within some Ncp. And the fairly massive and comprehensive food and security set which again many of the of the organizers of this call were involved with. We had a lot of representation actually from our California food policy friends so grateful for that.

198
00:40:55.740 --> 00:41:02.830
Sarah DeSilvey / Northwestern Medical Center: And then in the future you can imagine moving from those summed Ct. Codes into hepbit codes when they're ready.

199
00:41:04.000 --> 00:41:06.189
Sarah DeSilvey / Northwestern Medical Center: It was that Kitty, Was that a good enough answer?

200
00:41:06.200 --> 00:41:21.990
Katie Garfield / Center For Health Law and Policy Innovation: I think so. The only twist I want to add to it is something that we're seeing in California is that the State has put out some guidance around coding for the nutrition intervention it's allowing under a new community support

201
00:41:22.000 --> 00:41:30.829
Katie Garfield / Center For Health Law and Policy Innovation: program which look like some of those existing hpics codes, but with modifiers. And you have A. About what that option looks like.

202
00:41:30.840 --> 00:42:00.259
Sarah DeSilvey / Northwestern Medical Center: Yeah. So the way that we have gotten around um having specific codes for specific things in the hiccup space is, we've expanded modifiers, so it's like you take a base box right? A base thing, and because you don't have a specific code for vegetable prescription, you just put a twist on it right. It's like almost like an expert. So in the hiccup space the hiccup code itself is fairly hardwired because it's connected to Cms.

203
00:42:00.360 --> 00:42:06.760
Sarah DeSilvey / Northwestern Medical Center: The modifiers can be an agreement between payers and services, Right? They can be State based.

204
00:42:06.770 --> 00:42:28.169

Sarah DeSilvey / Northwestern Medical Center: They do not have to be standardized across the whole national ecosystem. So people often use modifiers to represent. Um, you know complexity to to take that s five, one and seven zero, or deliver mere meals code and make it represent medicaid tail of meals, even though there's not a unique code for it or any other, you know, food, security, or food up for this medicine intervention.

205
00:42:28.180 --> 00:42:42.279
Sarah DeSilvey / Northwestern Medical Center: So those modifiers are still not standardized across the ecosystem, though it's the national ecosystem. But if I mention one possibility for standardization in the meantime, as snowman. The other is agreements about modifiers and what they need.

206
00:42:49.340 --> 00:43:11.119
Katie Garfield / Center For Health Law and Policy Innovation: One question about a a specific intervention that we haven't talked about yet is really um around culinary medicine, culinary nutrition. We've had a couple of questions that sort of go beyond the provision of food to talk about, sort of the um teaching of skills, and never question about how those fit into this conversation

207
00:43:11.470 --> 00:43:16.099
Katie Garfield / Center For Health Law and Policy Innovation: the the codes are, and where do they fit in?

208
00:43:16.110 --> 00:43:30.819
Sarah DeSilvey / Northwestern Medical Center: So there are some intervention codes, and I actually think they're actually in the So the Cpt family. And forgive me if i'm putting it wrong that were put into the gravity set that exists actually for teaching and food related skills because of our our relationships.

209
00:43:30.830 --> 00:43:52.430
Sarah DeSilvey / Northwestern Medical Center: Um! Ah! In gravity with the American. Ah, the Academy of Tradition and dietetics! So um the nutritionist and dietitian space is well versed in teaching food-based skills, as part of the security of food-based interventions. There's some existing terminology for those things It may not be specific enough for the purposes at hand, but there are some out there

210
00:43:55.000 --> 00:44:05.589
Katie Garfield / Center For Health Law and Policy Innovation: excellent. And then we have a question again, sort of pulling us back a little bit um, and providing us a sense of how codes are used in practice?

211
00:44:05.600 --> 00:44:20.299
Katie Garfield / Center For Health Law and Policy Innovation: Um, So one attendee asks, Could Sarah take us through a step by step, of how she codes in practice of an example. I think it would help me understand how the different roles license did not fit together in action.

212
00:44:21.540 --> 00:44:23.289
Sarah DeSilvey / Northwestern Medical Center: Certainly I can.

213
00:44:23.300 --> 00:44:34.730
Sarah DeSilvey / Northwestern Medical Center: Um, I Um. Is there? Okay? If I go back to that patient's story for a second I wanted to go back because I think it's helpful to have something to see. I'm a visual learner who here it is.

214
00:44:34.830 --> 00:44:36.970
Sarah DeSilvey / Northwestern Medical Center: Um, yet this one in this one.

215
00:44:37.110 --> 00:44:44.600
Sarah DeSilvey / Northwestern Medical Center: So the um the way I for this. I'm going to start here, and i'll go to the story in a second right. So

216
00:44:44.650 --> 00:44:56.549
Sarah DeSilvey / Northwestern Medical Center: this wheel is really meant to represent how a patient moves through visits. I didn't state that in the beginning. But if you can imagine a person comes into my clinic

217
00:44:56.560 --> 00:44:58.860
Sarah DeSilvey / Northwestern Medical Center: right, and i'm real family medicine,

218
00:44:59.420 --> 00:45:18.189
Sarah DeSilvey / Northwestern Medical Center: and in our clinic we screen every single person for good and security with a hundred vital sign, every visit right. So as i'm. Answering the as my. If the patient is using a tablet or using a piece of paper to answer the hunger bottle, sign questions the moment I put it into the health record

219
00:45:18.410 --> 00:45:30.899

Sarah DeSilvey / Northwestern Medical Center: behind the scenes. The line codes eight, eight, one, two, two, minus seven, and whatever answer in ll, four, seven, three, zero, minus nine. Drop into the data stream.

220
00:45:30.910 --> 00:45:48.480
Sarah DeSilvey / Northwestern Medical Center: So they're there. They're attached to a time. They're attached to a visit code. They're attached to the person, and they exist as answers just as I can pull up someone's sugar level or their cholesterol level. By looking at a lab answer,

221
00:45:48.490 --> 00:45:56.049
Sarah DeSilvey / Northwestern Medical Center: I can pull those same answers up from a hunger vital sign in the the exact same terminology. Right?

222
00:45:56.660 --> 00:46:09.900
Sarah DeSilvey / Northwestern Medical Center: So that's the first step. Right? Come in screen with a standardized tool that's encoded. Those codes become part of the existing like questions and answers that are part of that patient's screening section of the note on the chart,

223
00:46:09.980 --> 00:46:28.790
Sarah DeSilvey / Northwestern Medical Center: I. Then, if the if if a problem is identified. I can diagnose it as a problem. And I'm always really careful to state that we work um in patient-centered systems. So social risks or we'll be identifying screening social needs, or where the patient says Yes, I actually really want to help with students here right now,

224
00:46:28.800 --> 00:46:34.510
Sarah DeSilvey / Northwestern Medical Center: right? So I can then diagnose food and security as a problem with the patient's consent.

225
00:46:34.580 --> 00:46:53.709
Sarah DeSilvey / Northwestern Medical Center: Um! And those two codes go to different places, same thing, food and security. And again, i'm sorry if i'm getting too granular. But i'm trying to answer the question. Well, right? So food and security. The Snowmen code can can go to the patient's problem list, so I can touch base on it. Visit to visit, because problem was Don't. Go away

226
00:46:53.720 --> 00:46:57.510
Sarah DeSilvey / Northwestern Medical Center: right? They're there for me to reference every single time.

227
00:46:58.250 --> 00:47:10.909
Sarah DeSilvey / Northwestern Medical Center: Food and security can also go in claims, things and claims just go out in claims, and Don't necessarily come back. So, as a clinician I can elect to take something as a diagnosis and make it a problem, and that makes it a problem list.

228
00:47:10.920 --> 00:47:23.829
Sarah DeSilvey / Northwestern Medical Center: Um. But if I diagnose something and claims that Z. Should nine point four. One code goes off to date the State and Medicaid Agency, or it goes out to the We. It goes off to my population, Health registry,

229
00:47:23.840 --> 00:47:38.779
Sarah DeSilvey / Northwestern Medical Center: and then the next codes are early actions again internally. This is whether i'm doing this myself or i'm having a so much. The social work I work with, or my um, or the Community health worker, the documenting that role that's the way that code is demonstrated. It's sorry,

230
00:47:39.540 --> 00:47:44.800
Sarah DeSilvey / Northwestern Medical Center: then, this last way is in the interventions button. So, as a clinician,

231
00:47:44.810 --> 00:48:08.339
Sarah DeSilvey / Northwestern Medical Center: I'm. Able to order a bunch of different types of interventions, I can order. I can order goods and services in order medications I can order referrals. I can do education right. So anything in the intervention set is a doer of doing at the end of the visit, and all of that has separate codes. If I do something that's now available to hit fixed. If I say

232
00:48:08.350 --> 00:48:17.829
Sarah DeSilvey / Northwestern Medical Center: um, you know, if I was able to have a food like a food box, and I would say flood box given right order, food, box,

233
00:48:17.840 --> 00:48:28.539
Sarah DeSilvey / Northwestern Medical Center: and there was a hiccup code attached to that that would instantly go in the clean stream. If it's happening later, it's happening in an agreement between the community-based organization and the payer,

234
00:48:28.680 --> 00:48:30.989
Sarah DeSilvey / Northwestern Medical Center: it might not be happening at that moment.

235
00:48:31.240 --> 00:48:39.270
Sarah DeSilvey / Northwestern Medical Center: But all the rest of these things, every single button I touch generates data, and the data goes either in the health record or off into the same stream.

236
00:48:41.250 --> 00:48:43.069
Sarah DeSilvey / Northwestern Medical Center: Is that helpful?

237
00:48:43.250 --> 00:48:46.279
Sarah DeSilvey / Northwestern Medical Center: I think that was the answer.

238
00:48:46.840 --> 00:48:50.890
Katie Garfield / Center For Health Law and Policy Innovation: Doing answer uh for a questioner and say, Yes, I believe that was a

239
00:48:50.900 --> 00:48:53.889
Katie Garfield / Center For Health Law and Policy Innovation: Okay, that's a good explanation.

240
00:48:53.900 --> 00:48:54.950
Katie Garfield / Center For Health Law and Policy Innovation: Ah,

241
00:48:54.960 --> 00:49:13.659
Katie Garfield / Center For Health Law and Policy Innovation: we do have. I think you You've made a really good point. Um related to Cp. T. C. Codes of reinforcing the need for licensure with in an association with cpt codes. We had a couple of questions come in are regarding sort of who is considered the licensed parties. So,

242
00:49:13.670 --> 00:49:18.589
Katie Garfield / Center For Health Law and Policy Innovation: for example, we have a question saying, when you say you need a license to use Cpt.

243
00:49:18.600 --> 00:49:27.730
Katie Garfield / Center For Health Law and Policy Innovation: Who is the license party? It's not only um mps, registered nurses, nurse practitioners, or other medical licenses.

244

00:49:27.740 --> 00:49:47.699
Sarah DeSilvey / Northwestern Medical Center: Um, again, not an expert in cpt specifically, but it's usually system-based right a system a health system upon it. An. F Qa. C. A. Hospital would have the license, and those individuals who work underneath it would be able to use it. And then the the Cbt is either

245
00:49:47.710 --> 00:50:06.420
Sarah DeSilvey / Northwestern Medical Center: the way the different kinds of cpt are either meant. Some of them are bound to different types of licenses, like the kinds of codes that I use when I document how much complexity of it a visit was. Only I, a physician's assistant, or a physician, can use those codes

246
00:50:06.430 --> 00:50:14.240
Sarah DeSilvey / Northwestern Medical Center: right? But some of them are variable to anybody in the care team. So like, for instance, the nine six, one, six, zero code. Anybody can drop it in

247
00:50:14.740 --> 00:50:31.440
Sarah DeSilvey / Northwestern Medical Center: um, and I I think there are some codes like, for instance, nutrition codes, that sort of like a nutritionist or Dietitian would have to drop in. There's other codes that you would need, like a licensed social worker to drop in. So there are codes that are bound to certain types of licenses,

248
00:50:31.450 --> 00:50:38.450
Sarah DeSilvey / Northwestern Medical Center: and there's also codes that are universally available for everybody. That depends on what the thing is, what we're trying to represent.

249
00:50:39.470 --> 00:50:40.999
Excellent. Thank you.

250
00:50:41.010 --> 00:50:46.590
Katie Garfield / Center For Health Law and Policy Innovation: I think we also have some questions that are sort of aimed at next steps. In this space

251
00:50:47.370 --> 00:50:58.789
Katie Garfield / Center For Health Law and Policy Innovation: Katherine asks. It sounds like the key next step for the coalition of Buddhist medicine providers relying on intervention of definitions and design. Am I hearing that correctly?

252

00:50:58.800 --> 00:51:01.889
Katie Garfield / Center For Health Law and Policy Innovation: Contracting consensus? Is that our next step?

253
00:51:01.900 --> 00:51:04.210
Sarah DeSilvey / Northwestern Medical Center: Great It One hundred percent. No question.

254
00:51:06.700 --> 00:51:12.000
Katie Garfield / Center For Health Law and Policy Innovation: And Maybe i'm wrong, but that's my That's my impression. That's what I

255
00:51:12.010 --> 00:51:13.389
Katie Garfield / Center For Health Law and Policy Innovation: I think so, too.

256
00:51:13.400 --> 00:51:34.990
Katie Garfield / Center For Health Law and Policy Innovation: Um! And then we have a question about sort of deaths that could follow that so once created, can a pic code be modified? I'm. Hearing the importance of consensus around definition for these codes, as we learn more about the impact of different interventions, particularly in length or intensity of an intervention we wanted to change a code. Is that possible?

257
00:51:35.150 --> 00:51:52.810
Sarah DeSilvey / Northwestern Medical Center: It's actually possible to change it. But I think it's important to go back to the idea of modifiers. Right? So what's happening right now is we're modifying things. But there's a lot of real estate on income, and we're modifying them to even close. Try to closely represent what our social care experts are doing in this space.

258
00:51:52.820 --> 00:52:21.410
Sarah DeSilvey / Northwestern Medical Center: If you develop a more specific term like Melody Taylor's meals right? You could modify that with with Nuances right? So instead of modifying s five, one hundred and seventy zero to try to represent metaphysical and meals. You can modify medicine. It might be some of males to represent it sometimes where you can modify vegetable prescription to have different. Um, uh, you know, value levels, or you could. You can modify a different one to have different value levels or different nuances,

259
00:52:21.420 --> 00:52:28.839
Sarah DeSilvey / Northwestern Medical Center: So it's really um. One could change the code absolutely. Revision of existing pivot codes is something that happens all the time.

260
00:52:28.850 --> 00:52:45.270
Sarah DeSilvey / Northwestern Medical Center: But it might be more and like ah promising to imagine how we could evolve our use of modifiers from trying to represent the genre, to trying to represent specificity within the genre right? And so that's probably what I would imagine what happened instead

261
00:52:48.710 --> 00:52:57.290
Katie Garfield / Center For Health Law and Policy Innovation: excellent. So again, under underlining that idea, and let's see, we have a

262
00:52:57.300 --> 00:53:06.319
Katie Garfield / Center For Health Law and Policy Innovation: just a couple more minutes, and we still have a lot of questions, so i'm going to just see if there's any sort of broad themes we can pull out.

263
00:53:06.950 --> 00:53:08.370
I think

264
00:53:09.020 --> 00:53:14.440
Katie Garfield / Center For Health Law and Policy Innovation: there's some questions around.

265
00:53:14.490 --> 00:53:16.030
Katie Garfield / Center For Health Law and Policy Innovation: I think we

266
00:53:16.340 --> 00:53:33.089
Katie Garfield / Center For Health Law and Policy Innovation: seeing some questions early on about sort of a little bit more explanation around z codes. They fit in for this process, and and a bit of explanation around how food and security fits in into the Z.

267
00:53:34.320 --> 00:53:46.409
Katie Garfield / Center For Health Law and Policy Innovation: Can you rephrase the questions So I can understand it. So you just describe a little bit more on. What are z codes, and what sort of set they fall into, and how they get used? Absolutely.

268
00:53:46.420 --> 00:54:04.520

Sarah DeSilvey / Northwestern Medical Center: Um. So z codes are the kind of far as ranging, and one of the more critical diagnosis codes that we have, and the reason why they're critical is because they are diagnoses that are traveling claims right.

269
00:54:04.530 --> 00:54:07.280
Sarah DeSilvey / Northwestern Medical Center: So c. Fifty-nine point four, one

270
00:54:07.430 --> 00:54:10.649
Sarah DeSilvey / Northwestern Medical Center: the Z code for food and security. And

271
00:54:10.810 --> 00:54:23.609
Sarah DeSilvey / Northwestern Medical Center: there is a z code for housing instability, a z code for homelessness is the code that differentiates sheltered from unchildered homelessness. So everything i'm saying are codes that the gravity has created

272
00:54:23.620 --> 00:54:38.519
Sarah DeSilvey / Northwestern Medical Center: there's an upcoming z-code tomorrow for transportation and security. Right? So Z. Codes are a diagnostic code that was primarily made to represent with statistics in analysis,

273
00:54:38.530 --> 00:54:45.009
Sarah DeSilvey / Northwestern Medical Center: and it's used in the us health care system as the foundational diagnostic terminology for claims

274
00:54:45.020 --> 00:55:06.119
Sarah DeSilvey / Northwestern Medical Center: and for claims-based population health analysis, So that That's partly why we made the specific code for food, and security, because it was more specific than the existing code of c. Fifty-nine point four, which is lack of adequate food and safe drinking water, which has a lot of real estate underneath it, and doesn't specify the concern. So we made a more

275
00:55:10.030 --> 00:55:20.660
Katie Garfield / Center For Health Law and Policy Innovation: excellent, and then i'm going to have the last question, because we've seen this um pop up a number of times, which is, we have

276
00:55:20.670 --> 00:55:35.240

Katie Garfield / Center For Health Law and Policy Innovation: um questions about where to find um. The The The listing of codes that have been discussed on today's Webinar. Um, I think I've seen that pop up a couple of times here.

277
00:55:35.410 --> 00:55:40.079
Sarah DeSilvey / Northwestern Medical Center: Yeah. So i'm going to try to drop a hyperlink in the um in the

278
00:55:40.160 --> 00:55:45.099
Sarah DeSilvey / Northwestern Medical Center: I'm gonna stop. Can I stop sharing and then put it in the chat.

279
00:55:45.990 --> 00:55:47.360
Sarah DeSilvey / Northwestern Medical Center: Is it? Okay, Katie?

280
00:55:47.370 --> 00:55:47.990
Katie Garfield / Center For Health Law and Policy Innovation: Yeah,

281
00:55:48.760 --> 00:55:55.610
Sarah DeSilvey / Northwestern Medical Center: Because I can't get to where I need to go if i'm sharing. So i'm gonna What i'm gonna do next is I want to take you

282
00:55:55.630 --> 00:56:05.259
Sarah DeSilvey / Northwestern Medical Center: to the place where the gravity project houses all of its terminology, because it's a good link.

283
00:56:06.680 --> 00:56:16.119
Sarah DeSilvey / Northwestern Medical Center: So the best place to find the the existing and complete food and security data specifications

284
00:56:16.130 --> 00:56:24.990
Sarah DeSilvey / Northwestern Medical Center: is in the ah gravity complements or in the National Library of Medicine Valueset Authority Center.

285
00:56:25.000 --> 00:56:42.870
Sarah DeSilvey / Northwestern Medical Center: All of that sounds incredibly cryptic. But if you go to the last link I just posted there. Um! Oh, it might be available on the gravity site. We can

do a link to it in our announcements. Um i'm used to running the chat so it's it's so they can see the chat. It's exciting,

286
00:56:44.180 --> 00:56:50.700
Sarah DeSilvey / Northwestern Medical Center: but the link, I said, in there takes you to social risk a page called Social Risk Data elements and Status.

287
00:56:51.070 --> 00:56:58.809
Sarah DeSilvey / Northwestern Medical Center: That shows you all of our encoded screening tools. It also takes you to a hyperlink to something called the Value Set Authority Center,

288
00:56:58.880 --> 00:57:19.180
Sarah DeSilvey / Northwestern Medical Center: which all you need is a public login. It's super super. It's free and easy, and you can see all of our data, or you can just write me an email, and I will send you the spreadsheet like I literally, I want this to be as accessible as possible, like you guys dance from the barriers and have all the data. Be there at your fingertips, and I happen to have the gravity for the security intervention set

289
00:57:19.190 --> 00:57:22.549
Sarah DeSilvey / Northwestern Medical Center: right, but that's an envy stack on my desktop right now,

290
00:57:22.560 --> 00:57:32.669
Sarah DeSilvey / Northwestern Medical Center: but I just can't upload it so i'll. I'll send it to him ever wishes, or maybe I can send it to Katie and Katie, and then we can. We can include it as part of the after after meeting information.

291
00:57:33.900 --> 00:58:01.980
Katie Garfield / Center For Health Law and Policy Innovation: Excellent, I think that should be possible. Well, thank you again. I think this has been so helpful, really outlining the world of data in our healthcare system. I think We also have some important takeaways here about meetings built on and around codes where we don't have any yet for food based intervention, and so on, that I don't know I do want to drop um a link to a Google form in the chat

292
00:58:01.990 --> 00:58:18.680
Katie Garfield / Center For Health Law and Policy Innovation: for anyone who is sort of interested in continuing that conversation around building national agreement on food-based intervention definitions. And there's a more complete explanation in the Google Forum itself. But if that sounds interesting to you, you should go to this link.

293
00:58:18.810 --> 00:58:25.689
Katie Garfield / Center For Health Law and Policy Innovation: Well, I think we're ready to close out. Thank you again so much, Sarah, for sharing

294
00:58:25.700 --> 00:58:30.689
Katie Garfield / Center For Health Law and Policy Innovation: this has been fantastically helpful, and thank you all for joining us for this important conversation.

295
00:58:30.700 --> 00:58:32.390
Sarah DeSilvey / Northwestern Medical Center: Bye,