Indiana Hospital Association

Eliminating Health Disparities Through Z Codes

National Rural Health Center

Madeline Wilson, MSN, RN, CLSSBB
Indiana Hospital Association

February 2, 2023

IHA Work on Social Drivers of Health

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Social and Community Context
- Neighborhood and Built Environment

Our Foundation

- Healthy People 2030 features many objectives related to SDOH.
- Tracking Data to Improve Health Collaborative efforts at the federal, state, and local levels can help address health disparities.
- Healthy People offers a platform for collaboration; priority alignment, including alignment of federal strategies; and information sharing around disease prevention and health promotion priorities for the Nation.

Healthy People 2030

2022 CMS Quality Conference

Indiana Hospital Association

Advance Health Equity

Address disparities, structural racism, and injustices that underlie our health system, both within and across settings, to eliminate gaps and ensure equitable access and care for all.

- Develop standardized approach to collection of patient reported data
- Develop standardized approach to stratification for appropriate measures
- Leverage quality and value-based programs to publicly report and incentivize closing equity gaps
- Support equity through performance metrics, regulations, oversight through survey and conditions of participation, and Quality Improvement assistance

2022 CMS QUALITY CONFERENCE

Background and Methods

- Standardized tracking of social determinants of health (SDOH) elements is critical to ensuring the attainment of the highest level of health possible for all people with Medicare
  - One tool available to capture SDOH are Z codes
    - Z codes are ICD-10-CM codes used to identify broader contextual factors that strongly influence health status and contact with health services, with codes Z55-Z65 having a particular focus on hazardous social and environmental conditions
    - 2019 Medicare fee-for-service (FFS) claims and enrollment data* were used to produce:
  - Descriptive statistics for Z code utilization
    - Overall and by claims, place of service, and provider types
  - Sociodemographic, clinical, and geographic characteristics statistics for people with Medicare who are continuously enrolled

2022 CMS QUALITY CONFERENCE

Meagan Khau, MHA | meagan.khau@cms.hhs.gov
Office of Minority Health | Centers for Medicare & Medicaid Services

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Our Process

How Do We Identify Social Drivers of Health

- Z codes are a set of ICD-10-CM codes used to report social, economic, and environmental determinants known to affect health and health-related outcomes.
- Z codes comprehensively identify non-medical factors affecting health and track progress toward addressing them
- ICD-10-CM categories Z55-Z65 are a more specialized group of codes to identify social determinants of health.

ICD-10-CM SDOH Categories

Z55 – Problems related to education and literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58-- Problems related to employment and unemployment

Z59 – Problems related to housing and economic circumstances

Z60 – Problems related to social environment

Z62 – Problems related to upbringing

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstances

Z65 – Problems related to other psychosocial circumstances

ICD-10 Z Code Updates for 2023

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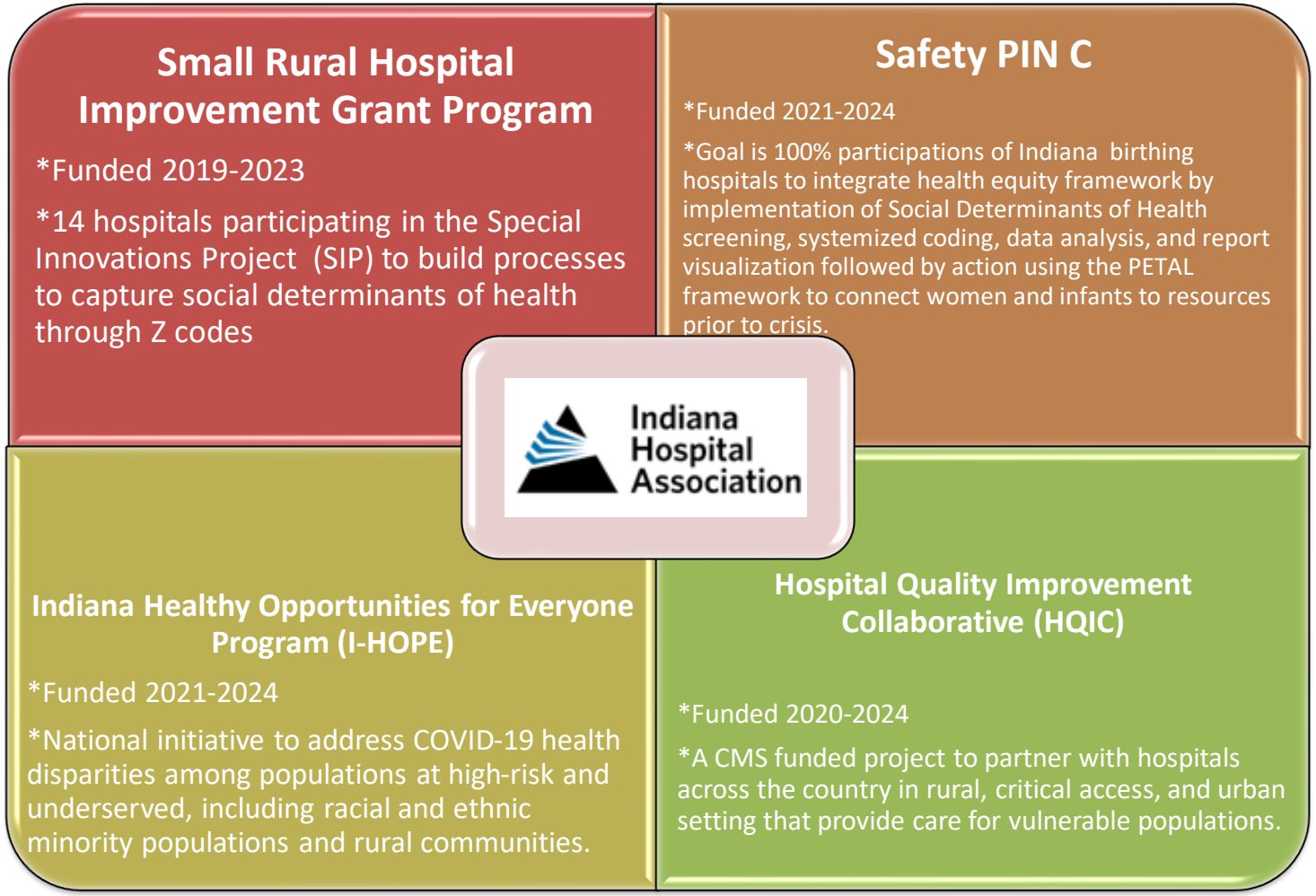
- Beginning Oct. 1, 2022, updates to Z code Z59.8 have taken effect for the fiscal year 2023. Although there is no change to Z59.8, or "other problems related to housing and economic circumstances," additional codes have been established to allow for greater specificity.

- For example, three new codes depict scenarios that may limit a patient's ability to schedule, attend and/or pay for their appointments:

    - Transportation insecurity (Z59.82) describes issues of inaccessible, inadequate, unaffordable, unsafe and unreliable transportation.
    - Financial insecurity (Z59.86) includes bankruptcy, burdensome debt and economic strain.
    - The inability to obtain adequate childcare, clothing, utilities and basic needs is covered in material hardship (Z59.87).

IHA Work on Social Determinants of Health



The Journey

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SHIP Special Innovation Project (SIP)

Small Rural Hospital Improvement Grant Program- Special Innovation Project

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- 14 Rural/Critical Access Hospitals participating in the SHIP program
- 4-year program starting in 2019 and ending in 2023
- First targeted work around social determinant or social drivers, of health with our hospitals

Starting Line

Team Building

- Hospital Leadership
- Clinical Staff
- Coders
- IT Team
- Social Workers, Navigators
- Providers
- Community Wellness Liaisons

Plan, Do, Study, Act

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PLAN

- Hospitals conducted CHNA's
- Choose focus area
- Established workgroup
- Attended multiple education sessions on SDOH screening and Z codes

DO

- Z code database was built from hospital claims data
- Used example from CMS Medicare study
- Began increased education to coders to capture Z codes

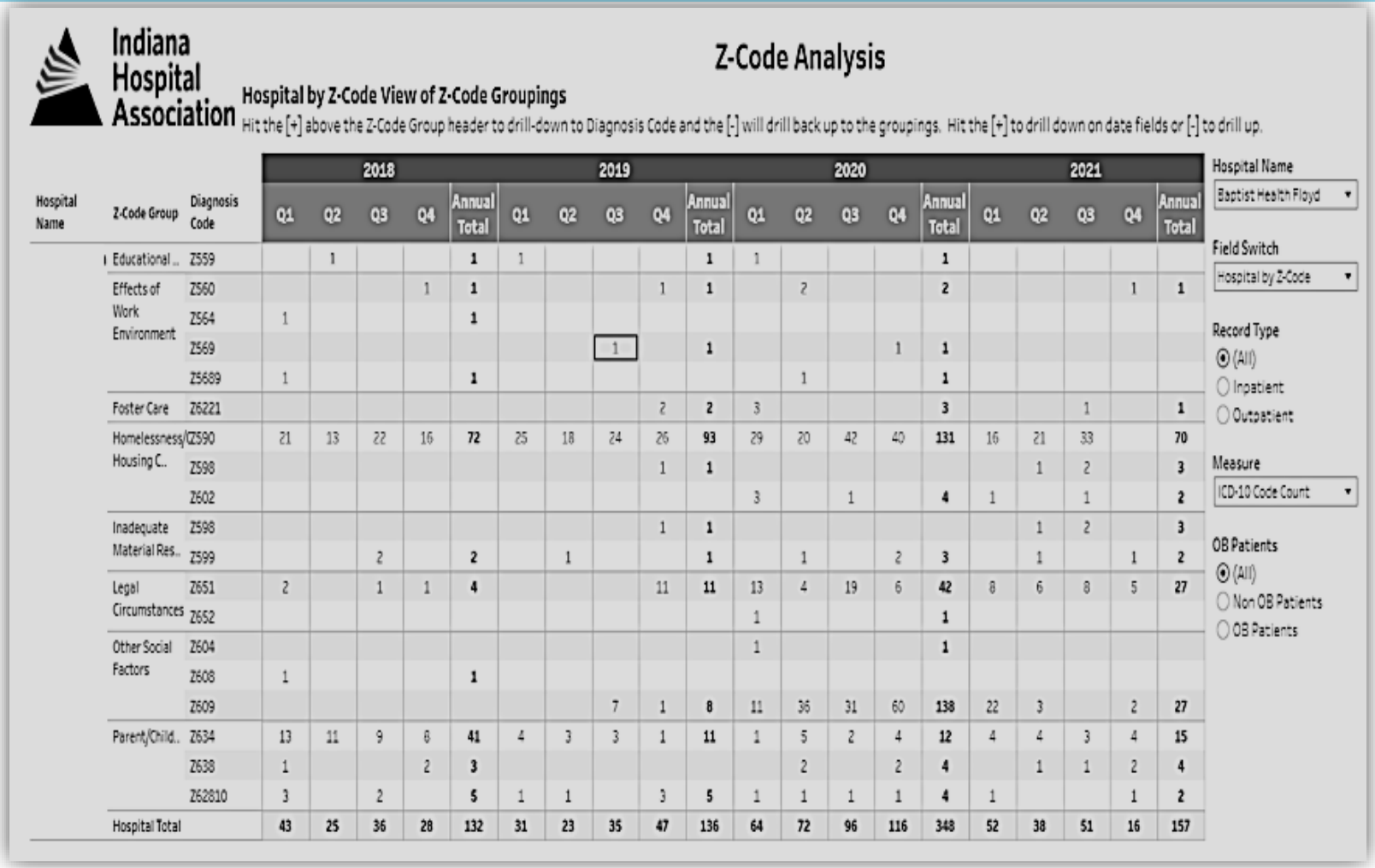
STUDY

- Teams participated in training sessions from various organizations, such as Find Help (formerly Aunt Bertha), and IN 211
- Training on changes in coding requirements
- All-hospital group sessions to discuss successes and failures
- Individual one-on-one meetings to review data and process flows

ACT

- Introduction to additional community resources for patient referral
- CHW engagement to identified resource shortage
- Enhancements to EMRs
- Staff into position to do social screenings
- Coding workflow process changes

Baseline Data



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Z-Code Analysis

Hospital by Z-Code View of Z-Code Groupings

Hit the [+] above the Z-Code Group header to drill-down to Diagnosis Code and the [-] will drill back up to the groupings. Hit the [+] to drill down on date fields or [-] to drill up.

Hospital Name	Z-Code Group	Diagnosis Code	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2018 Annual Total	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2019 Annual Total	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2020 Annual Total	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2021 Annual Total
	Educational ..	Z559		1			1	1				1	1				1					
	Effects of Work Environment	Z560				1	1				1	1		2			2				1	1
		Z564	1				1															
		Z569								1		1				1	1					
		Z5689	1				1							1			1					
	Foster Care	Z6221									2	2	3				3			1		1
	Homelessness/Housing C..	Z590	21	13	22	16	72	25	18	24	26	93	29	20	42	40	131	16	21	33		70
		Z598									1	1							1	2		3
		Z602											3		1		4	1		1		2
	Inadequate Material Res..	Z598									1	1							1	2		3
		Z599			2		2		1			1		1		2	3		1		1	2
	Legal Circumstances	Z651	2		1	1	4				11	11	13	4	19	6	42	8	6	8	5	27
		Z652											1				1					
	Other Social Factors	Z604											1				1					
		Z608	1				1															
		Z609								7	1	8	11	36	31	60	138	22	3		2	27
	Parent/Child..	Z634	13	11	9	8	41	4	3	3	1	11	1	5	2	4	12	4	4	3	4	15
		Z638	1			2	3							2		2	4		1	1	2	4
		Z62810	3		2		5	1	1		3	5	1	1	1	1	4	1			1	2
	Hospital Total		43	25	36	28	132	31	23	35	47	136	64	72	96	116	348	52	38	51	16	157

Hospital Name: Baptist Health Floyd

Field Switch: Hospital by Z-Code

Record Type: (All) / Inpatient / Outpatient

Measure: ICD-10 Code Count

OB Patients: (All) / Non OB Patients / OB Patients

DataLink

SIP Hospital Progress

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Z Code Tracking Count	Baseline	SIP YR 1	SIP YR 2*	SIP YR 3*	SIP YR 4
Hospital	2018	2019	2020	2021	2022 (3Qs)
A	86	104	232	498	410
B	9	5	6	10	11
C	31	39	191	186	345
D	5	20	19	27	9
E	106	121	104	95	75
F	85	77	40	67	300
G	3	4	5	47	278
H	50	30	25	43	43
I	75	55	44	99	137
J	10	8	10	5	2
K	53	50	25	19	17
L	14	12	18	49	52
M	4	13	23	48	19
N	8	35	27	15	33
Total	**539**	**583**	**769**	**1208**	**1731**
%improvement Year to Year		8%	32%	57%	43%
# Z Codes All Hospitals in Indiana	**44,094**	**51,973**	**48,683**	**55,361**	**37,116**
					*3Qs data

Notables

From Baseline to 2021=114% improvement

Total Number of Claims for SIP Hospitals

	2018	2019	2020	2021
INPT	16505	15829	14365	15536
OUPT	334983	342752	290905	328680
TOTAL	351488	358581	305270	344216

OUPT Claims=ED, OP OR, OP Hospital Services

What We Need to Get to The Finish Line

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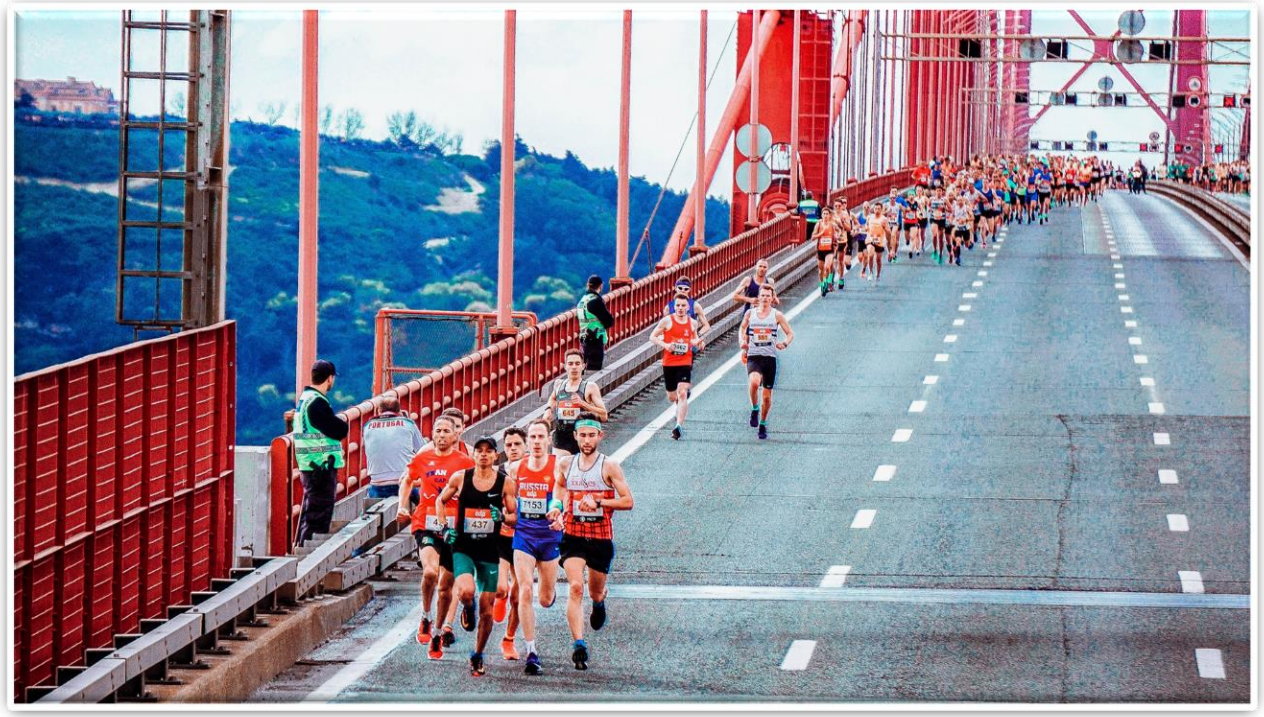
Support to Finish the Race:

- Housing
- Food Insecurity
- Transportation
- Community Wellness
- Maximizing Reimbursement
- Coding
- Motivational Interviewing Skills



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Safety PIN – Protecting Indiana's Newborns (PIN)

IN.gov

Governor Holcomb's Call to Action

2018 State of the State Address
"The Next Steps to the Next Level"
Eric Holcomb, Governor of Indiana
Delivered January 9, 2018

"Our infant mortality rate is a direct lens into the overall health of Hoosiers . . . So tonight, I'm setting a goal to become the best state in the Midwest for infant mortality rates by 2024."

The Why Behind Our Priority

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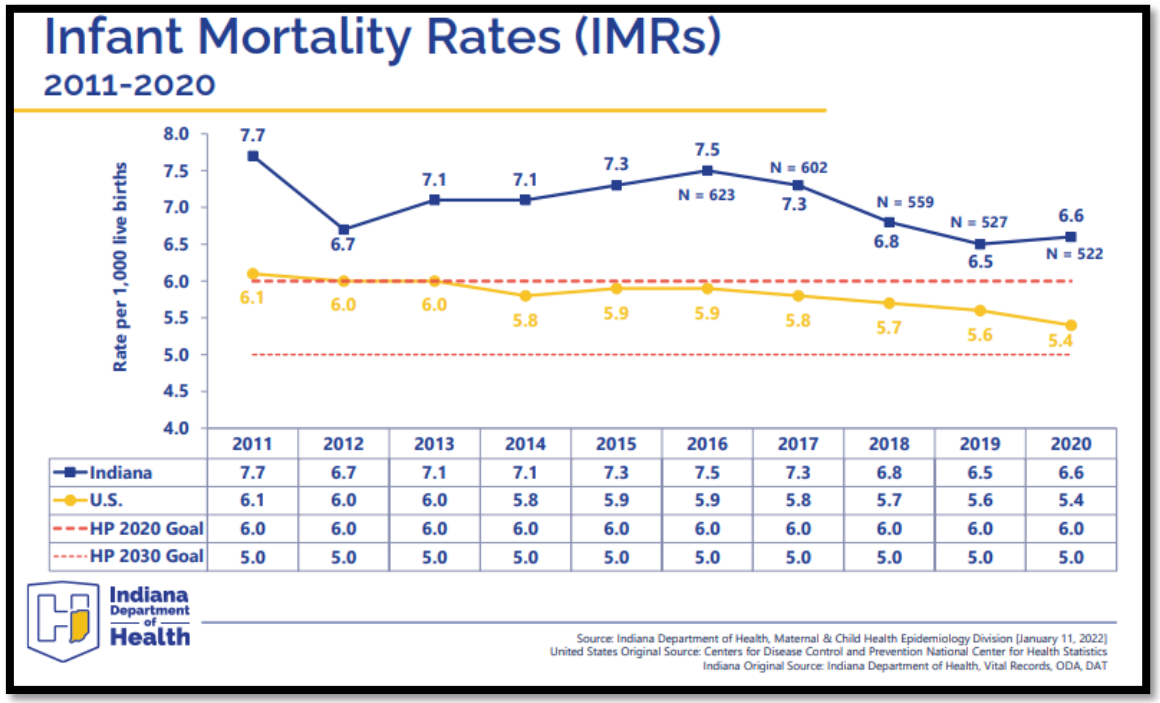

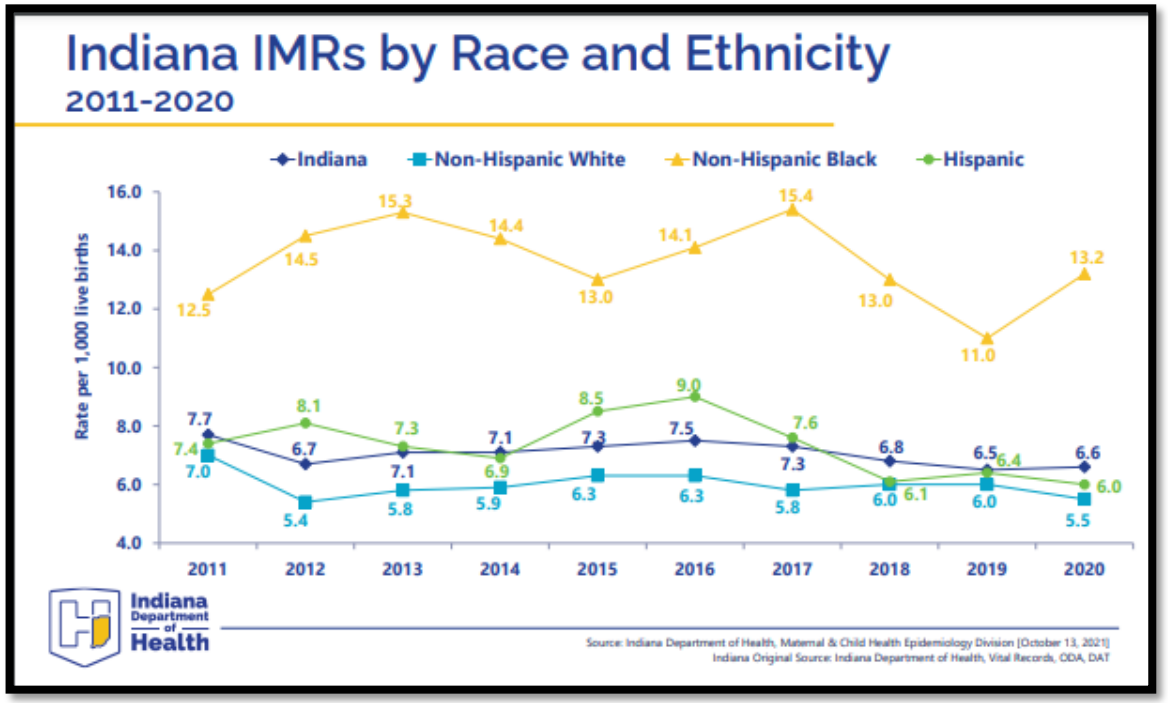

Indiana's Statistics

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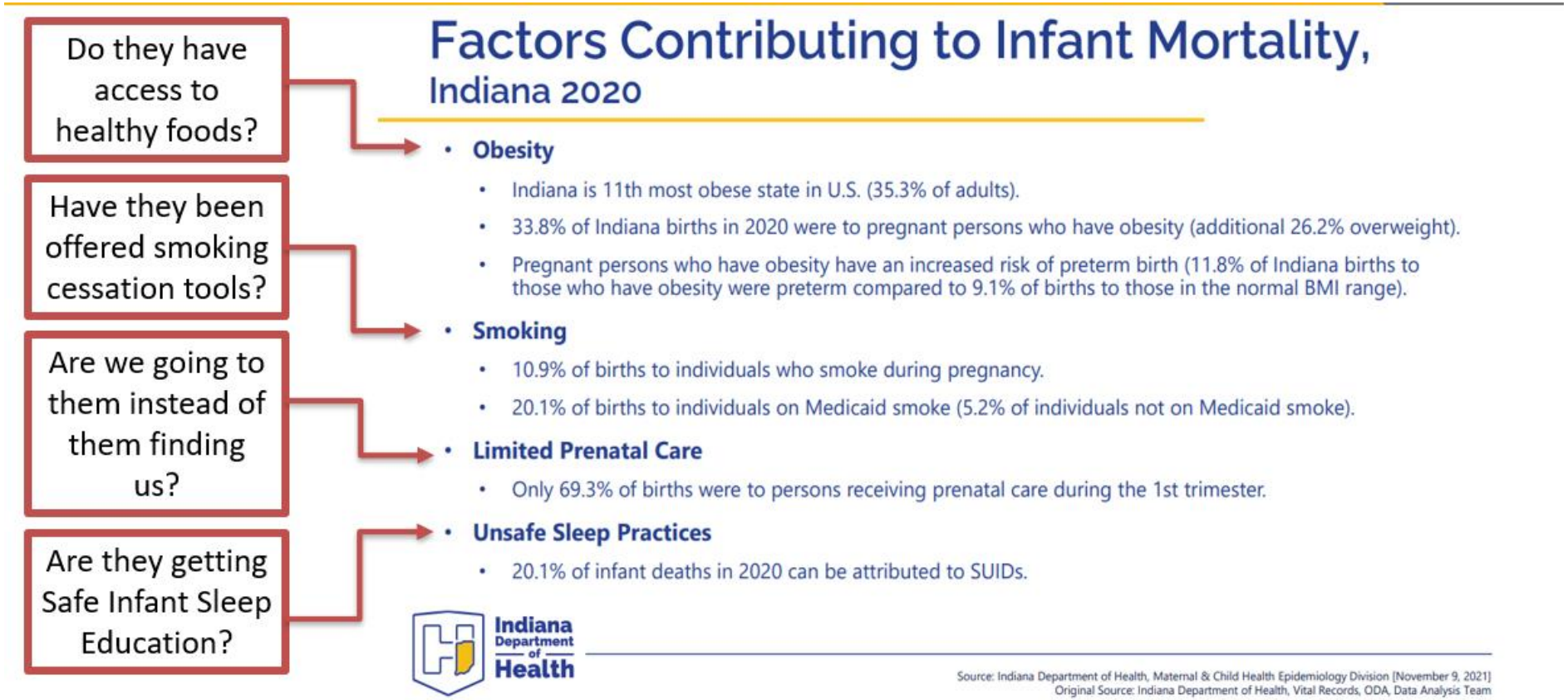

Safety PIN 2021-2024
Closing the Disparities Gap

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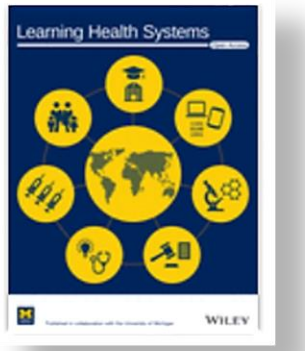
Closing the gap in disparities by integrating a health equity framework in the care hospitals provide as an integral part of developing a highly reliable maternal and infant healthcare system in Indiana.

Why – Year after year, the Indiana Infant Mortality Disparities Fact Sheets produced by the IDOH Maternal Child Health Division shows the unacceptable and substantial difference in infant mortality rates by race and ethnicity, both in causes of infant death as well as in birth outcome indicators.

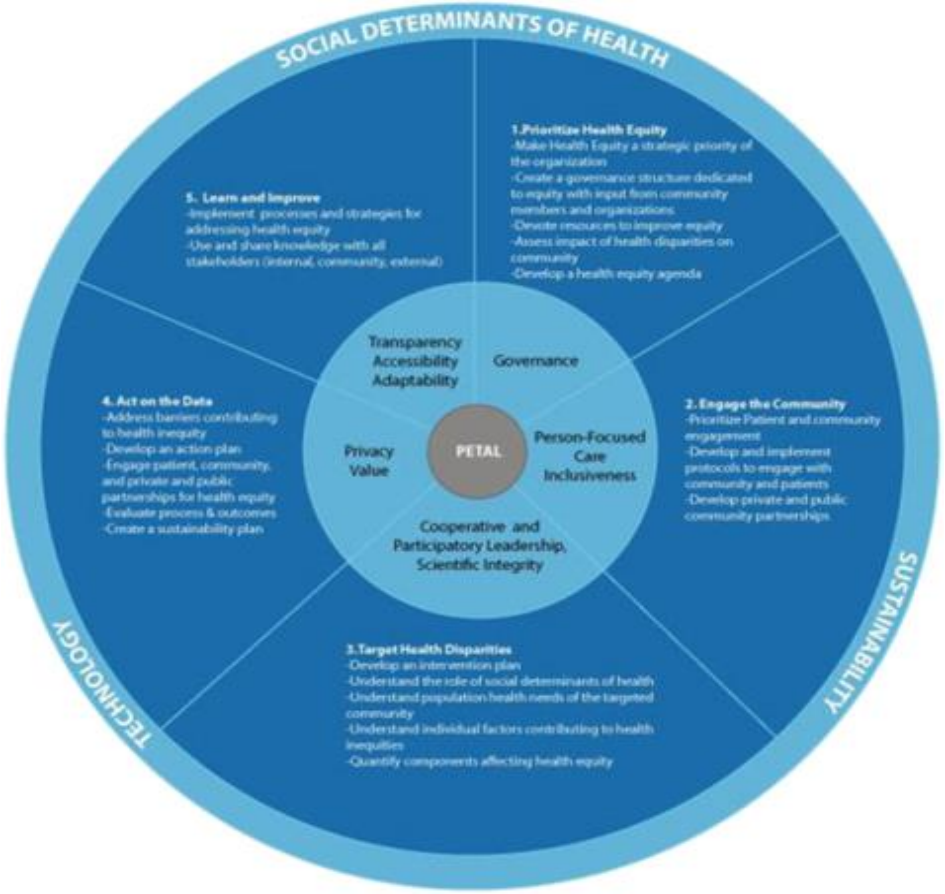
How – Implementation of Social Determinants of Health screening, systemized coding, data analysis and report visualization followed by action using the PETAL framework to connect women and infants to resources prior to crisis.

What – The project goal is for 100% of Indiana birthing hospitals to integrate the above health equity framework into the care they provide by December 31, 2024.

Safety PIN-PETAL Framework



- The PETAL Framework is built upon the Learning Health System principles (Brooks, 2017).
- Uses a targeted approach that raises awareness, increases the knowledge of causes and effective interventions, and provides actionable ways to reduce health care disparities and improve equity through community engagement, data and analytics.
- The core components of the framework include:
  - Prioritize health equity
  - Engage the community
  - Target health disparities
  - Act on the data
  - Learn and improve
- Additional elements that cut across all core components include supportive technology, social determinants of health and sustainability



Baseline Data

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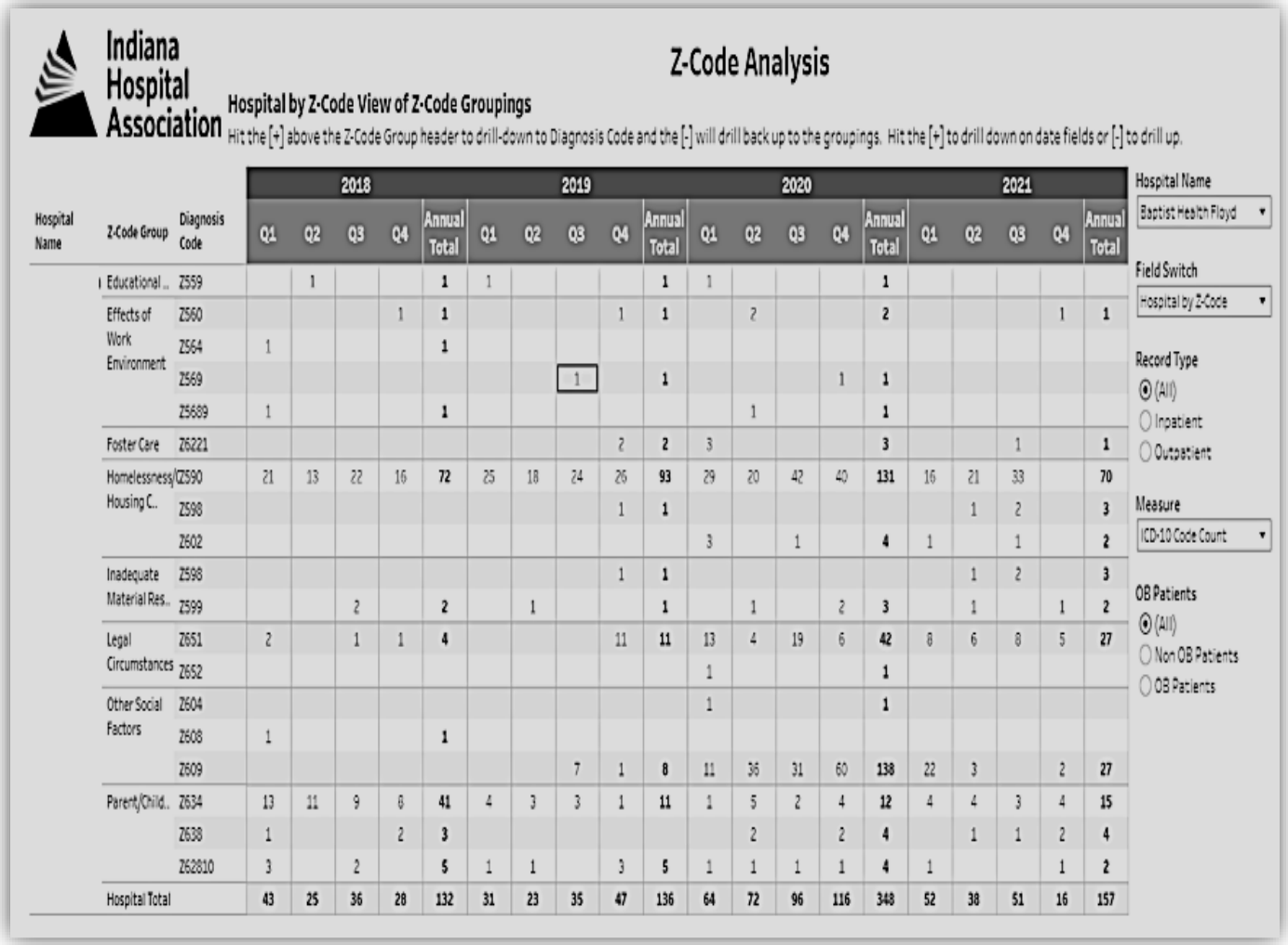

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DataLink

Figure 5: OB Diagnoses Coding with ICD-10

O00–O08. Pregnancy with abortive outcome

O09, Supervision of high-risk pregnancy

O10–O16. Edema, proteinuria, and hypertensive disorders in pregnancy, childbirth, and the puerperium

O20–O29, Other maternal disorders predominantly related to pregnancy

O30–O48, Maternal care related to the fetus and amniotic cavity and possible delivery problems

O60–O77, Complications of labor and delivery

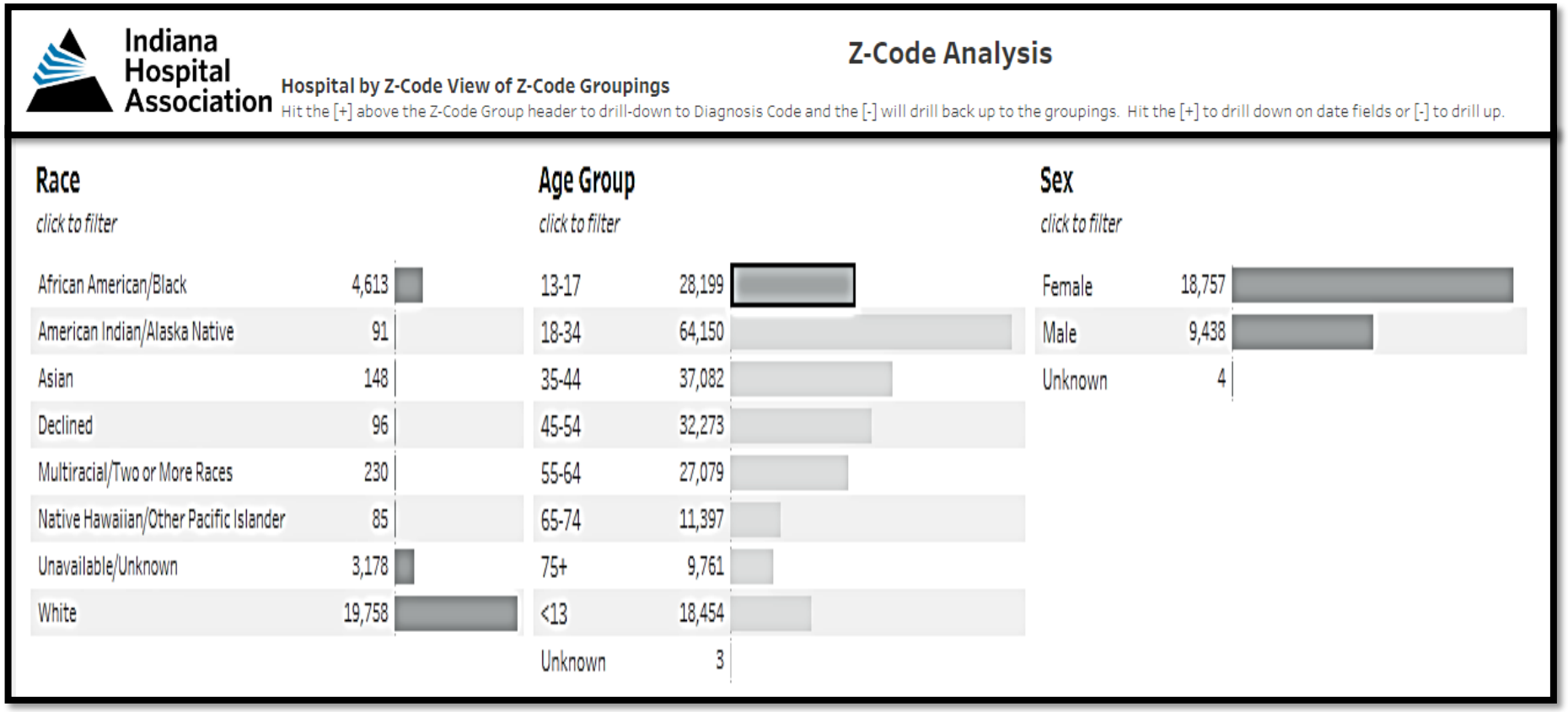
O80-O82. Encounter for delivery

O85–O92, Complications predominantly related to the puerperium

O94-O95, O96, O98–O9A, Other obstetricconditions, not elsewhere classified

A34. Obstetrical tetanus

REaL Data Capture



*Data retrieved from IHA DataLink

The Journey

April 1, 2021
Grant cycle begins

June 29, 2021
Population Health and Social Determinants of Health data virtual event

Q4 2021
100% of birthing hospitals have received education and training on the PETAL framework by Dec. 31.

Q2-Q4 2022
Evaluate process gaps & develop QI plan using PDCA cycle

January 26, 2023
All hospital call: Analyzing baseline data for IP efforts

February 2023
Assess current state of SDOH screening & Z code capture and work one-on-one with sites

Safety PIN "C" Social Determinants of Health (SDoH) in the maternal-infant population

June 3, 2021
IHA kicks off with informational webinar to birthing hospitals. Call to action

Q3 2021
Launch PETAL quality improvement framework

Q1 2022
Create Multidisciplinary Teams

December 31, 2022
100% of birthing hospitals will have deployed a screening process

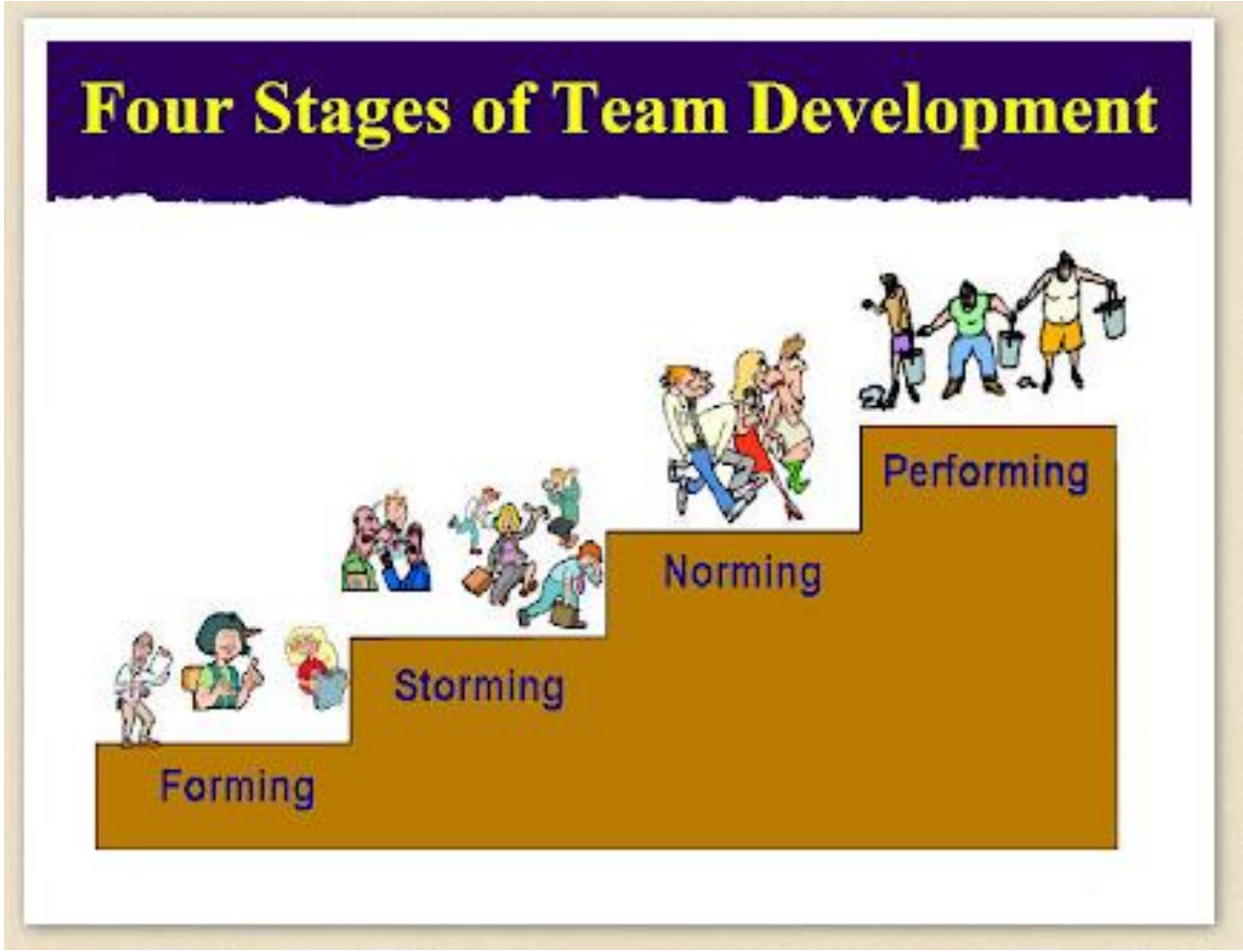
- Prioritize health equity
- Engage the community
- Target health disparities
- Act on the data
- Learn and Improve

Improvements

Patients	2018	2019	2020	2021	2022
Z-Code Group	Annual Total	Annual Total	Annual Total	Annual Total	Annual Total (3Q)
Occupational exposure to risk-factors	3	2	1	1	2
Other problems related to primary support group including family circumstar	114	130	116	146	183
Other problems related to upbringing	151	154	189	182	154
Problems related to certain psychosocial circumstances	87	44	44	80	61
Problems related to education and literacy	3	1	0	6	8
Problems related to employment and unemployment	49	70	117	178	386
Problems related to housing and economic circumstances	265	224	216	214	587
Problems related to other psychosocial circumstances	55	62	47	93	103
Problems related to social environment	35	31	34	125	206
Yearly Total	762	718	764	1025	1690
Total Births	78454	77934	75123	74916	70004 (est)
	0.97%	0.92%	1.01%	1.37%	

*Data obtained from IHA internal data dashboard- All Payor

Hospital Progress Report



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Indiana Healthy Opportunities for People Everywhere (I-HOPE)

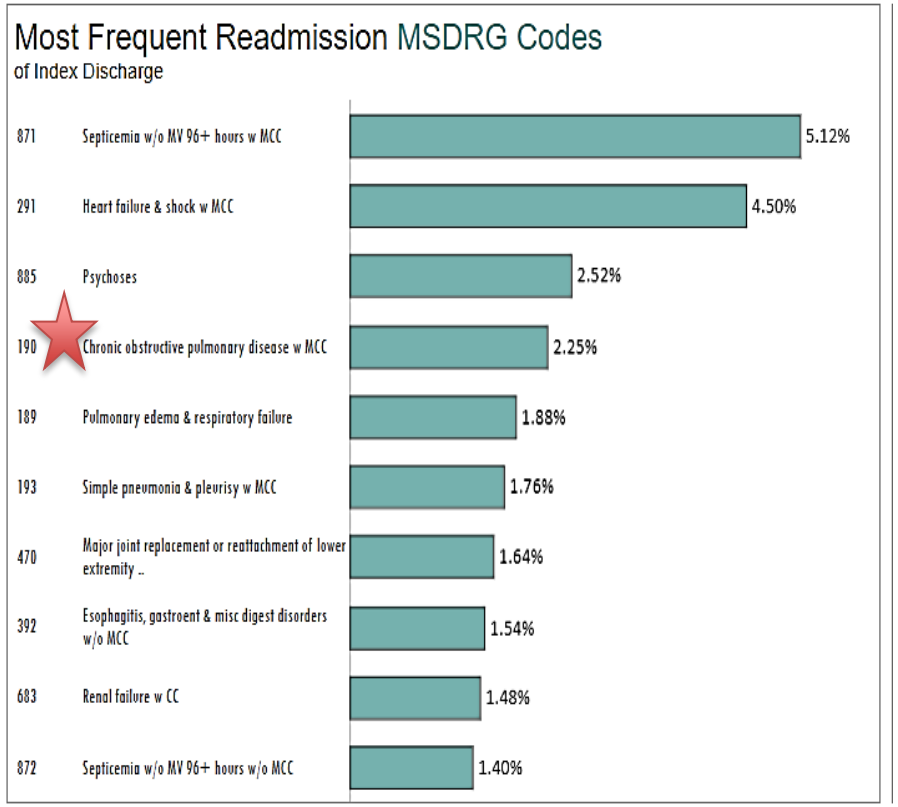
Indiana Healthy Opportunities for People Everywhere (I-HOPE)

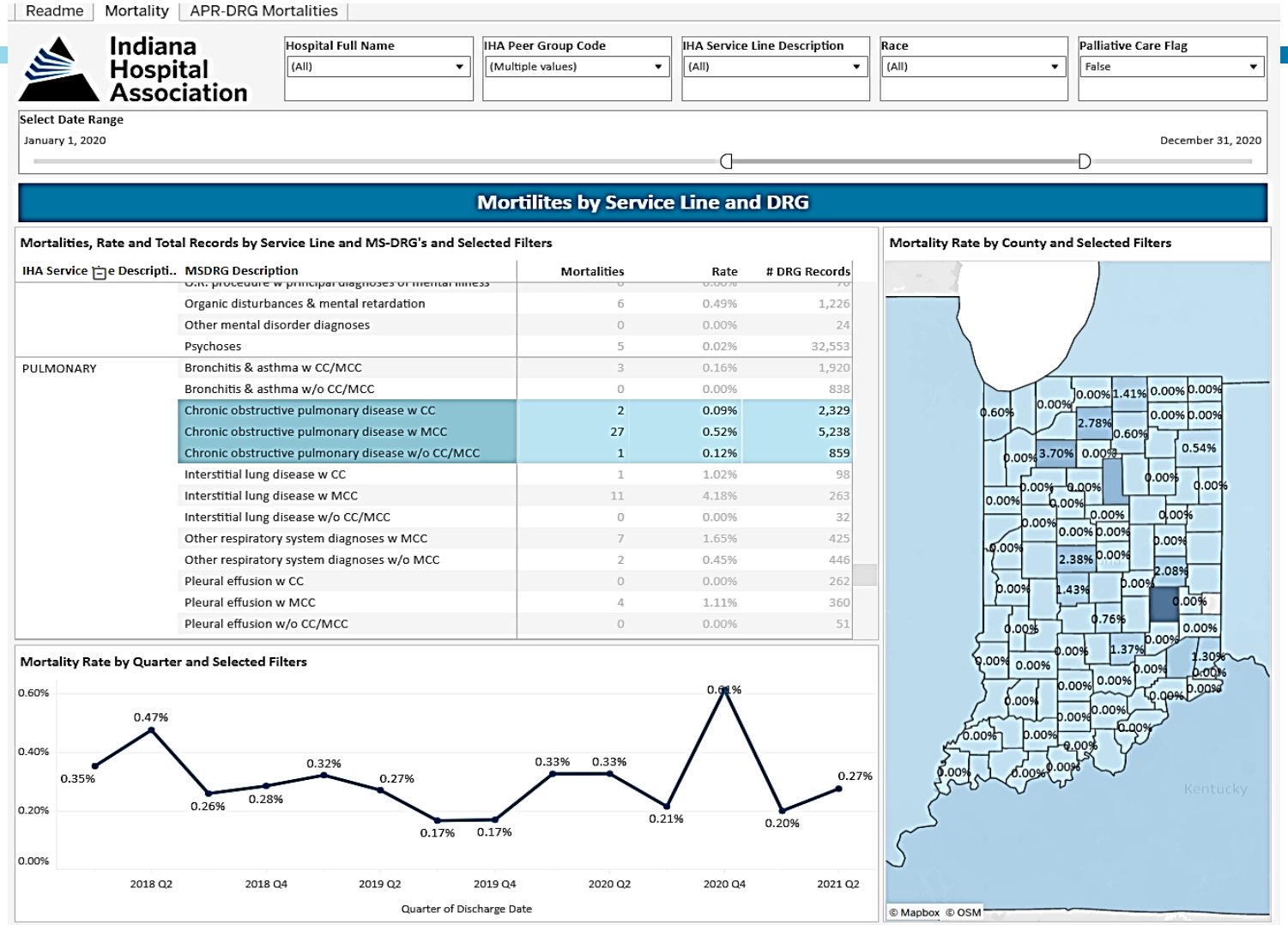
COPD

- Admit with COVID-19
- Readmissions
- Mortality

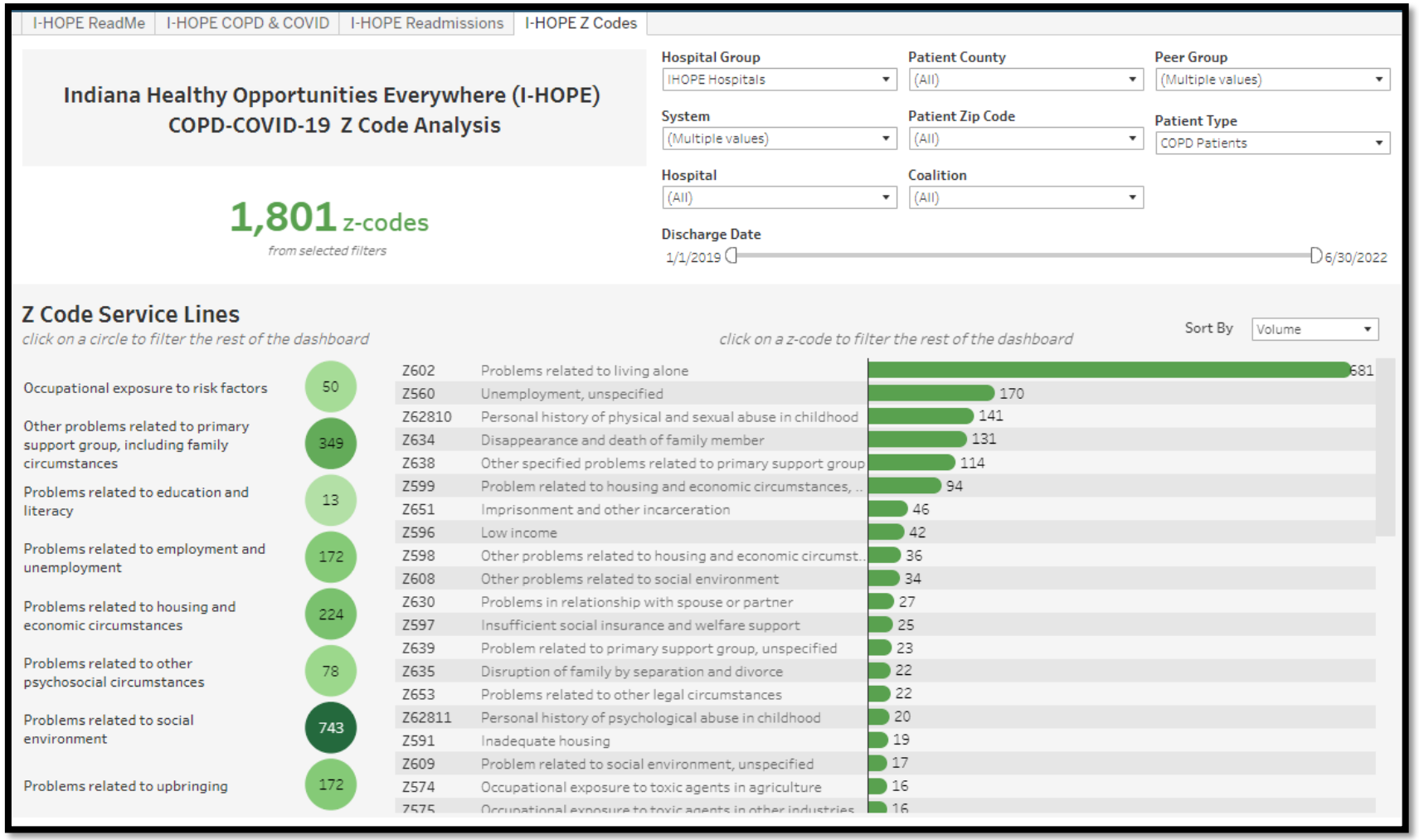
- Goal: Increase/improve data collection and reporting for populations experiencing a disproportionate burden of COVID-19 infection, severe illness, and death to guide the response to the COVID-19 pandemic.

Indiana COPD Readmissions

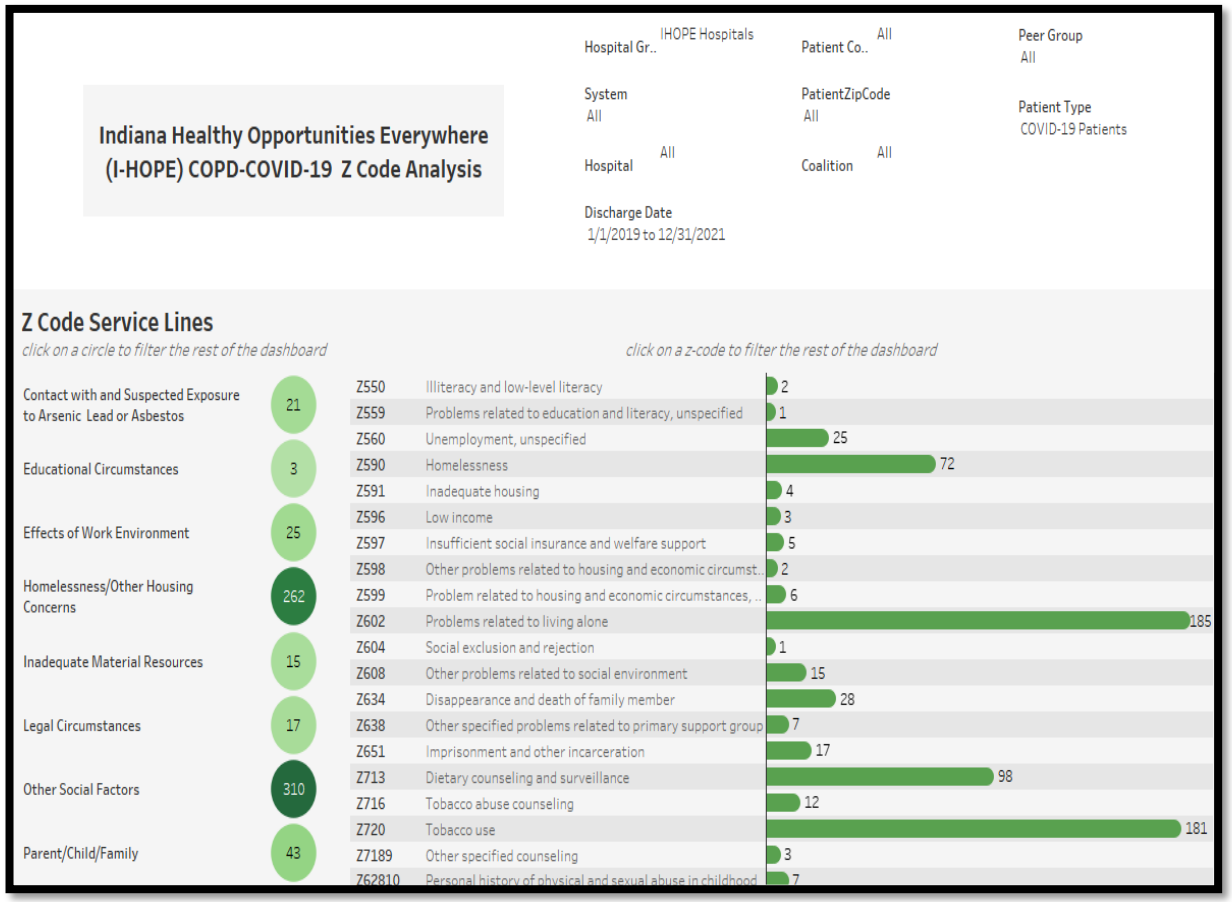


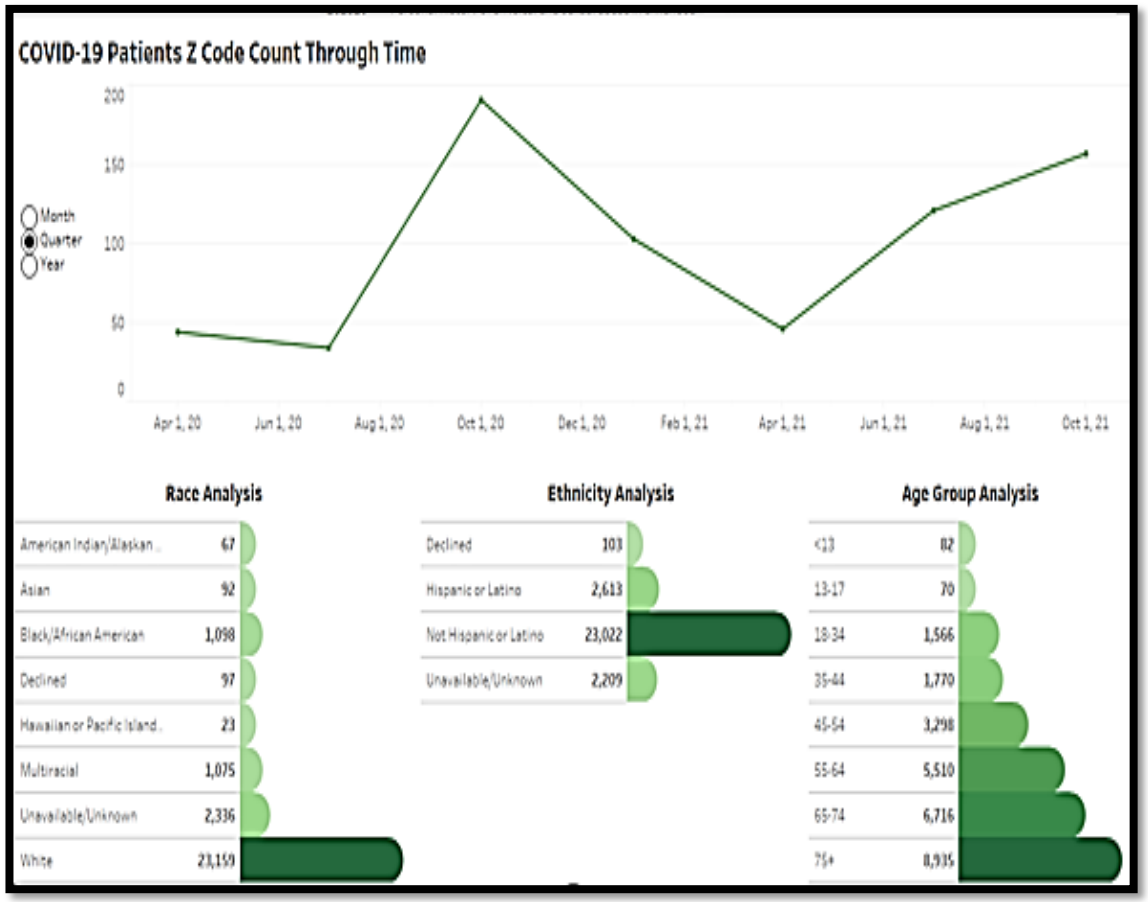


I-HOPE


I-HOPE ReadMe
I-HOPE COPD & COVID
I-HOPE Readmissions
I-HOPE Z Codes
Indiana Healthy Opportunities Everywhere (I-HOPE)
COPD-COVID-19 Z Code Analysis
1,801 z-codes
from selected filters
Hospital Group
IHOPE Hospitals
Patient County
(All)
Peer Group
(Multiple values)
System
(Multiple values)
Patient Zip Code
(All)
Patient Type
COPD Patients
Hospital
(All)
Coalition
(All)
Discharge Date
1/1/2019
6/30/2022
Z Code Service Lines
click on a circle to filter the rest of the dashboard
click on a z-code to filter the rest of the dashboard
Sort By
Volume
Occupational exposure to risk factors 50
Other problems related to primary support group, including family circumstances 349
Problems related to education and literacy 13
Problems related to employment and unemployment 172
Problems related to housing and economic circumstances 224
Problems related to other psychosocial circumstances 78
Problems related to social environment 743
Problems related to upbringing 172
Z602 Problems related to living alone 681
Z560 Unemployment, unspecified 170
Z62810 Personal history of physical and sexual abuse in childhood 141
Z634 Disappearance and death of family member 131
Z638 Other specified problems related to primary support group 114
Z599 Problem related to housing and economic circumstances, .. 94
Z651 Imprisonment and other incarceration 46
Z596 Low income 42
Z598 Other problems related to housing and economic circumst.. 36
Z608 Other problems related to social environment 34
Z630 Problems in relationship with spouse or partner 27
Z597 Insufficient social insurance and welfare support 25
Z639 Problem related to primary support group, unspecified 23
Z635 Disruption of family by separation and divorce 22
Z653 Problems related to other legal circumstances 22
Z62811 Personal history of psychological abuse in childhood 20
Z591 Inadequate housing 19
Z609 Problem related to social environment, unspecified 17
Z574 Occupational exposure to toxic agents in agriculture 16
Z575 Occupational exposure to toxic agents in other industries 16

Z-Code Analysis





Resources

American Lung Association.

- COPD Educator Course
- Asthma Educator
- Freedom From Smoking Facilitator

Hospital Quality Improvement Collaborative (HQIC)

HQIC

Indiana Hospital Association

PFCCpartners Cynosure HQIC

HEALTH EQUITY HOSPITAL ASSESSMENT

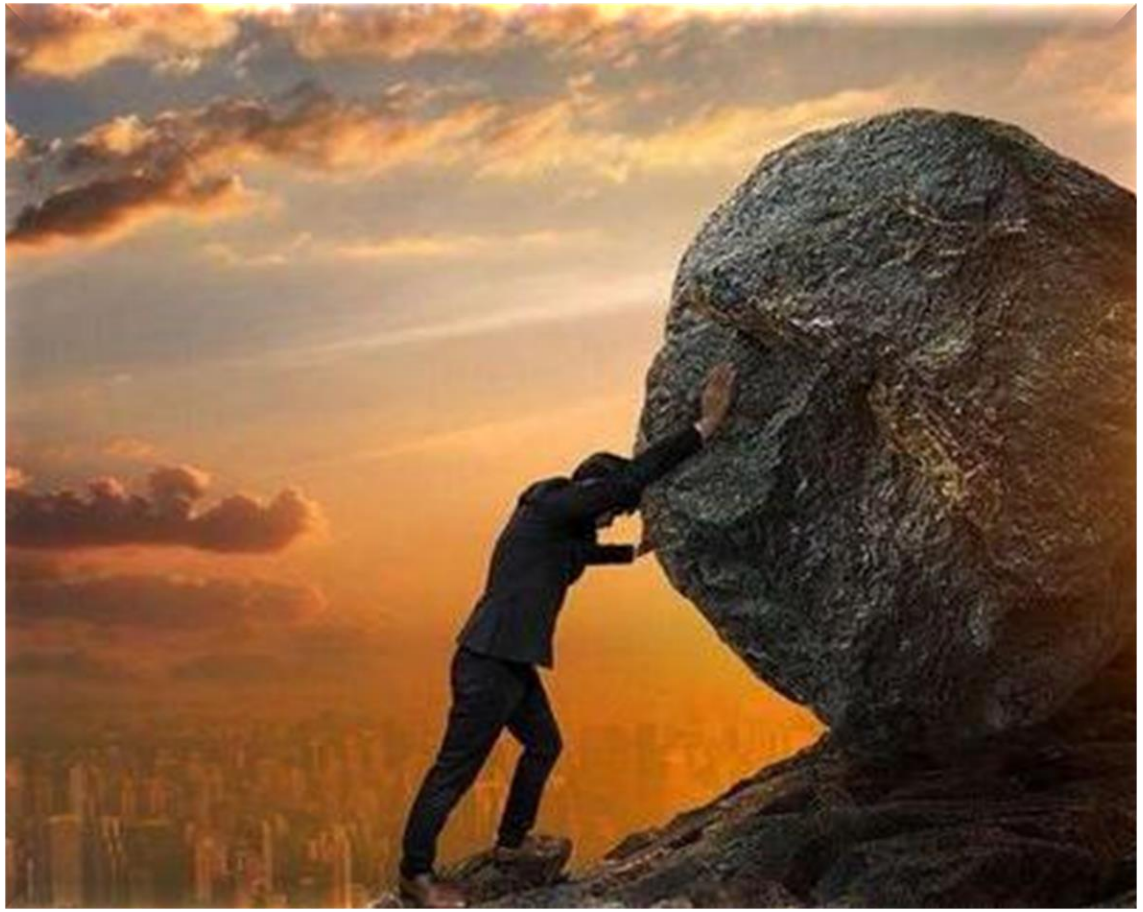
6. **DATA COLLECTION:** Hospital uses a patient self-reporting methodology to collect demographic data from the patient and/or caregiver Example of guidance: METRIC 6 GUIDANCE
   a. Forming: Hospital is not currently collecting REaL data or is staff reported
   b. Storming: Hospital is capturing self reported REaL data and
   c. Norming: Collecting self reported data for 95% of patients and has multiple verification points beyond registration
   d. Performing: Hospital collects additional data, such as SOGI, SSDOH, Disability Status
7. **DATA COLLECTION TRAINING:** Hospital provides workforce training regarding the collection of s reported patient demographic data METRIC 7 GUIDANCE
   a. Forming: Training in the collection of REaL data is not provided to staff
   b. Storming: Workforce training in the collection self reported REAL data is provided
   c. Norming: Workforce training is evaluated annually for effectiveness; staff can demonstrate in collecting self reported REaL data. Patient Family Advisors are informing training progra
   d. Performing: Advanced Workforce receives training in the collection of self reported data rel disability status or social determinants of health (or other data points, the hospital selects).
8. **DATA VALIDATION:** Hospital verifies the accuracy and completeness of patient self-reported demographic data METRIC 8 GUIDANCE
   a. Forming: Hospital does not yet have a process to evaluate the accuracy and completenes data to local demographic community data.
   b. Storming: Hospital evaluates data for accuracy (matches community demographics) and c (percent complete)
   c. Norming: Hospital addresses system level processes that interfere with collection of Real d
   d. Performing: Hospital evaluates for accuracy and completeness of additional data (SOGI, di social determinants of health or or data points selected.)
9. **DATA STRATIFICATION:** Hospital stratifies patient safety, quality and/or outcome measures using patient demographic data METRIC 9 GUIDANCE
   a. Forming: Hospital does not yet stratify one HQIC quality improvement topic by REaL
   b. Storming: Hospital stratifies at least one HQIC improvement topic by REaL
   c. Norming: Hospital stratifies more than one HQIC improvement topic by REaL
   d. Performing: Hospital stratifies more than one HQIC improvement topic by REaL and other data (SOGI, disability status, social determinants of health or or data points selected.)
   e.
10. **COMMUNICATE FINDINGS:** Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations METRIC 10 GUIDANCE
    a. Forming: Hospital does not yet have a reporting mechanism (equity dashboard) to commu population outcomes to senior leadership, medical leadership and the board.
    b. Storming: Hospital uses a reporting mechanism (equity dashboard) to communicate popul

outcomes to senior leadership, medical leadership and the board.

c. Norming: Hospital communicates population outcomes across the organization.
d. Performing: Hospital communicates population outcomes externally to patients and families and community members.

11. **ADDRESS & RESOLVE GAPS IN CARE:** Hospital implements interventions to resolve differences in patient outcomes METRIC 11 GUIDANCE
    a. Forming: Hospital does not yet have engage multi disciplinary teams to develop and test solutions to identified disparities.
    b. Storming: Hospital engages multi disciplinary teams, including patient family advisors, to develop and test solutions to identified disparities.
    c. Norming: Hospital implements interventions to resolve identified disparities and educates staff regarding findings
    d. Performing: Hospital has a process for continuously monitoring and adjusting interventions as needed to sustain improvement in outcomes.
12. **ORGANIZATIONAL INFRASTRUCTURE & CULTURE:** Hospital has organizational culture and infrastructure to support the delivery of care that is equitable for all patient populations METRIC 12 GUIDANCE
    a. Forming: Hospital does not yet have a standardized process to train its workforce in culturally sensitive and linguistically appropriate care.
    b. Storming: Hospital has a standardized process to train its workforce in culturally sensitive and linguistically appropriate care
    c. Norming: Hospital has a person or department that has leadership responsibility and accountability for health equity efforts who engages with patient family advisory councils and community partners to create strategy and action plans to promote equity in outcomes.
    d. Performing: Hospital demonstrates a commitment to ensure equitable care for all persons through policies, protocols, strategic plans and in its mission, vision and values

Obstacles in Data Collection



- Lack of definitions for SDOH terms
- Unfamiliarity with social needs
- Providers and coders
- Perceived priority/lack of incentives
- Number of codes that can be captured
- Operational processes
- EHR-based screening tool
- Standard documenting process
- Coding processes
- Lack of clarity about who can screen and document
- Productivity challenges

Indiana's Z Code Utilization

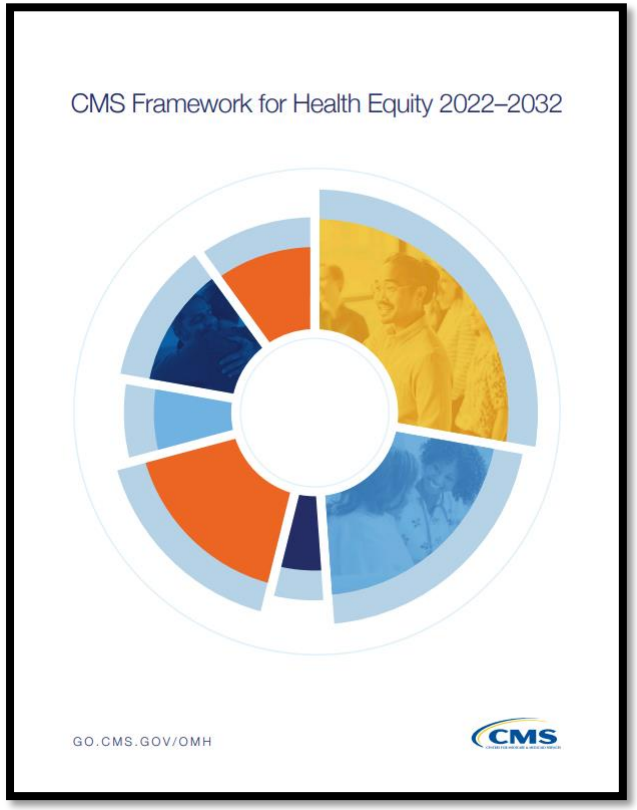
Patients	2018	2019	2020	2021	2022
Z-Code Group	Annual Total	Annual Total	Annual Total	Annual Total	Annual Total (3Q)
Occupational exposure to risk-factors	537	530	502	365	312
Other problems related to primary support group including family circumstar	5695	8049	6706	8575	8611
Other problems related to upbringing	10002	10633	9538	8891	6482
Problems related to certain psychosocial circumstances	307	265	229	391	292
Problems related to education and literacy	1296	1828	955	1030	990
Problems related to employment and unemployment	3774	4695	5848	7765	7410
Problems related to housing and economic circumstances	15469	17682	18924	20763	18898
Problems related to other psychosocial circumstances	1923	2379	2485	5239	4768
Problems related to social environment	1486	1934	1845	4505	4358
Yearly Total	40489	47995	47032	57524	52121
Total Claims	6,694,854	6,914,042	5,964,135	6,658,232	
	0.60%	0.69%	0.79%	0.86%	

*Data obtained from IHA internal data dashboard- All Payor

Indiana Hospital Association

Next Steps

Foundations



[CMS Framework for Health Equity Priorities]

[Rural Health Equity & Quality Summit Report]

Why ?

2023 Providers are Responsible for Social Determinants of Health Quality Measures

remingtonreport.com/intelligence-resources/home-health/2023-providers-are-responsible-for-social-determinants-of-health-quality-measures

Lisa Remington — September 18, 2022

New social determinants of health (SDOH) quality measures will be required by hospitals, health plans, and multi-payer federal and state programs.

Research shows that social determinants can be more important than health care or lifestyle choices in influencing health. Numerous studies suggest that SDOH account for between 30-55% of health outcomes. We explain the quality measures across providers and stakeholders.

[Remington Report]

[NPIC]

Fact sheet

FY 2023 Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospitals (LTCH PPS) Final Rule — CMS-1771-F Maternal Health

Aug 01, 2022 | Hospitals

Share

A Commitment to Improving Maternal Health in the U.S.

The Biden-Harris Administration is committed to achieving a government-wide vision that addresses the maternal health crisis in the U.S., including by reducing maternal mortality and morbidity and advancing maternity care quality, safety, and equity. As a part of this commitment, the White House held the first-ever federal "Maternal Health Day of Action" on December 7, 2021, at which time Vice President Kamala Harris issued a national call to action to Reduce Maternal Mortality and Morbidity. In addition, the U.S. Department of Health and Human Services (HHS) — through the Centers for Medicare & Medicaid Services (CMS) — announced critical steps to improve maternal health by supporting the delivery of equitable, high-quality care for all pregnant and postpartum patients. The White House also issued presidential proclamations on April 8 and April 13 in recognition of Black Maternal Health Week, which occurred the week of April 11 in 2022.

Specifically, CMS shared intentions to pursue rulemaking for the establishment of a

[IPPS]

TJC Standard Update for 2023

As of Jan. 1, accreditation programs for primary care clinics, behavioral health centers, critical access facilities and hospitals will include new mandates for their leaders. New standards include:

- Designating a leader or leaders to direct activities to reduce healthcare disparities within an organization.
- Assessing patients' health-related social needs and providing information about community resources and support services.
- Identifying healthcare disparities in the patient population by stratifying quality and safety data using socio-demographic characteristics.
- Developing a written action plan that describes how the organization will address at least one of the healthcare disparities identified in its patient population.
- Taking action when the goals in its plan to reduce health disparities are not achieved or sustained.

https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

What About Reimbursement?

Indiana Hospital Association

United Healthcare Community Plan

Fax Alert

Important Information "You Need to Know!"

Uni2KNOW

2022 Pay for Performance Primary Care Providers Care Coordination Codes and Quality Incentive Program

We've updated our 2022 Care Management and Quality Incentive Program starting Jan. 1, 2022. The program was designed with the goal of helping your patients, who are UnitedHealthcare Community Plan members, become more engaged with their preventive health care.

What's new for 2022?

Z Code Submission:

Primary care providers have a new opportunity to earn incentives for the submission of Social Determinant of Health (SDoH) ICD-10 Z codes (Z55-Z65 and Z75) based on the results of SDoH assessments. Providers who submit SDoH-related Z codes for 5% of their seen members will earn a $0.50 pmpm payment while providers who submit these codes for 10% of their seen members will earn a $1.00 pmpm payment. Membership for the pmpm payment will be based on the provider's entire assigned membership for the year. Z code incentives will be paid annually at the time of quality incentive payments.

https://lakelandcare.com/sites/lakelandcare.com/files/attachments/2022%20P4P%20notice%20%282%29.pdf

DIVE BRIEF

Humana program to reimburse providers for identifying social determinants like homelessness, food insecurity

Published March 5, 2020

By Hailey Mensik

Humana isn't the first payer to try this approach.

CMS has also aimed to expand value-based programs that reward health care providers for the quality of care they provide, especially in the MA program.

https://www.healthcaredive.com/news/humana-program-to-reimburse-providers-for-identifying-social-determinants-l/573557/

Contact Information

Madeline Wilson MSN, RN, CLSSBB

Quality & Patient Safety Advisor &
Health Equity Lead

317-974-1407

mwilson@IHAconnect.org